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EXECUTIVE SUMMARY

A strong primary health care system has been shown to improve patient health outcomes, reduce costs, reduce health inequities and increase patient satisfaction in their care[1]. To achieve this in Australia the primary health care workforce will need to be adequate, sustainable and effective. However, Australia's primary health care workforce is facing challenges in numbers, distribution, changing demands, and role delineation.

This paper describes the outcomes of the Australian Primary Health Care Research Institute (APHCRI) Primary Health Care Workforce roundtable which was held to synthesise current Australian evidence around primary health care workforce and, further, to provide policy options on how best to move primary health care workforce forward to meet these challenges. The paper also provides a brief synopsis of the evidence from APHCRI commissioned research on primary health care workforce completed in 2007.

The following recommendations arose from the meeting:

Recommendations

1. Simplify the current Medicare Benefits Schedule, which is unnecessarily complex and inflexible, by:
    a. deconstructing general practice nurse item numbers so that payment would be made for a patient attendance, rather than limited to a specific activity. This would allow greater autonomy and flexibility so practice nurses could have variable roles depending on skill mix and team needs
    b. resisting the temptation to expand the complexity of the Enhanced Primary Care Medicare item numbers
    c. developing descriptive, rather than prescriptive, performance indicators.
2. Effectively fund medical and nurse education and training in the primary health care sector by:
    a. increasing the primary health care focus of the undergraduate/pre-internship/prevocational medical and nursing education which includes providing support for infrastructure and the teaching commitment required to effectively educate in the community. This should include continued support for promising programs such as the Pre-vocational General Practice Placements Program (PGPPP) for medical graduates and the introduction of similar programs in primary care nursing
    b. adequately fund community-based placements in primary health care for nurses and medical students. Shifting training from the hospital systems to the community will require a funding shift.
3. Develop career structures and training pathways for general practitioners and primary health care nurses that enables career development *in situ*.
    a. develop a nationally agreed set of competencies linked to postgraduate training programs for primary health care nurses.
4. Facilitate the development of functional primary health care teams by:
    a. increasing interprofessional health care education and clinical placements at all levels
    b. supporting interprofessional primary health care organisations. One possibility is for the Divisions of General Practice to evolve into larger inter-professional organisations
    c. learning from existing functional multidisciplinary team models (such as Aboriginal Medical Services) to build scalable models of primary health care teams. These models need to be flexible and variable to take account of local needs and

resources. Examples could include co-located teams (like a GP Super clinic) or locally supported networks of providers funded on performance and clinical outcomes

d. instituting a quality assurance framework to provide the framework for funding.

5. Introduce a blended funding model for primary health care consisting of a mix of fee-for-service as well as capitation for patients with chronic or complex needs.

    a. patients voluntarily register with a primary health care practice that would then receive capitation funding

    b. the practice would be responsible for providing the registered patient with an agreed program of care with measurable outcomes. The funding stream would pay the practice (rather than an individual) for the clinical outcome. Who provides the service would not be mandated; instead it would be flexible depending on available skills and resources within the accredited practice or local area

    c. the level of capitation funding would include a loading component that reflected complexity of activity, age of patient, degree of rurality (based on RRMA), social disadvantages (using a socio-economic index) and possibly also workforce need and difficulty of recruitment and retention

    d. transactions outside the agreed program of care would continue to be provided on a fee-for-service basis

    e. practices and or individuals could opt out and continue to use fee-for-service for all care.

INTRODUCTION

The Australian Primary Health Care Research Institute (APHCRI) was established in 2003 to provide national leadership in improving the quality and effectiveness of primary health care through the conduct of high quality priority-driven research and the support and promotion of best practice. The Institute's research focuses on important questions relating to the organisation, financing, delivery and performance of primary health care, including its interaction with public health and the secondary and tertiary health care sectors. Since its inception APHCRI has funded 13 streams of research and more than 50 individual projects and has an explicit commitment to improving the translation of research into policy. Recent APHCRI streams have included Sustainability of Primary Health Care Innovation, Chronic Disease Management, Primary Health Care Workforce, and Drivers of Successful Primary Health Care.

During discussions with senior APHCRI staff, members of the National Health and Hospital Reform Commission Professor Justin Beilby and Dr Mukesh Haikerwal articulated a need for a synthesis of the evidence around primary health care workforce and guidance on policy options regarding primary health care workforce. This paper reports on the Primary Health Care Workforce roundtable which was held by APHCRI on 29th August 2008 as a response to these preliminary discussions.

The Institute gathered a diverse group of primary health care experts from around the nation to contribute to the meeting. Participants were encouraged to use their individual expertise and the recent APHCRI and international research base to build a vision for the future of primary health care workforce in Australia. The discussion was focussed specifically on primary health care workforce and the broader issues such as funding and models of care were discussed particularly with respect to their potential impact on workforce profile and capacity.

REPORT OF THE DISCUSSION

The discussion was structured around three major questions:

- What are the problems or potential problems and trends in primary health care workforce in the future?
- What are the different models Australia could explore to make the best use of the workforce both now and into the future?
- What kind of recruitment and retention measures does Australia need to attract people in, and keep them in, the primary health care workforce?

1. What are the problems or potential problems and trends in primary health care workforce in the future?

A strong primary health care system has been shown to improve patient health outcomes, reduce costs, reduce health inequities and increase patient satisfaction in their care[1]. To achieve this in Australia the primary health care workforce will need to be adequate, sustainable and effective. However, Australia's primary health care workforce is facing challenges in numbers, distribution, changing demands, and role delineation.

a. Workforce numbers

Australia's significant shortages in primary health care workforce, as well as difficulties with recruitment and retention in areas of workforce need, have been well documented[2]. Workforce shortages are more acute in remote, rural and outer metropolitan settings, but exist even in urban settings including the nation's capital[3]. General practitioners (GPs) are working fewer hours, and the GP workforce is ageing[2]. Despite the significant increase in medical training places and the recently announced boost of 175 GP training places in 2009 and 2010 the number of people entering the GP workforce will still fall well short of the Australian Medical Workforce Advisory Committee (AMWAC) estimated requirements over the next five years[4].

Australia is not alone in facing challenges with health worker numbers. In 2006 the World Health Organisation (WHO) estimated a shortage of four million health workers and 2.4 million doctors, nurses and midwives worldwide[5]. Overseas trained doctors and other health professional play an important role in Australia's health care workforce, particularly in rural and remote areas, but given the international shortage they cannot be viewed as a long-term solution.

The Australian-trained workforce of the next 20 years will consist of Generation X (born 1965-79) and Y (born 1980-94) who have different skills, expectations and demands than the Baby Boomers (born 1946-64) who currently dominate the workforce. This future primary health care workforce will be increasingly female, have more than one degree or formal qualification, have greater expectations of career flexibility and will view multiple careers in a lifetime as the norm rather than the exception. With the shift to post-graduate medical education the graduates will be older, have greater educational and personal debt and are more likely to have a professional spouse or partner and dependents than previous cohorts of graduates. All of these factors will impact on their career choice and location of practice. The primary health care sector will have to compete with the secondary and tertiary sectors, which are also experiencing significant medical and nursing shortages, to attract graduates. The graduates of the next five years will have significant choices and it is imperative that primary health is a valued and positive option.

b. Distribution of workforce

Despite significant funding incentives, multiple programs, and considerable focus on improving the mal-distribution of the primary health care workforce, significant inequities in health care provision remain, particularly in rural and remote Australia and outer-metropolitan areas.

The 'inverse care'[6] law still applies in Australia with some populations of greatest need having poorest access to the health care system. The great need and established inequalities in health care provision for rural and remote populations is undisputed; however, ironically, some of the programs introduced to address the rural inequities have made it even harder for inner-city practices servicing significantly disadvantaged populations to find staff.

Overseas trained doctors arriving in Australia have a 10 year rural moratorium and those who wish to complete formal general practice training must do so in a rural region. In previous generations about half of all medical graduates moved into general practice, now closer to 25 percent of Australian trained doctors become general practitioners resulting in some urban training locations failing to fill all their positions. Shortages are now widespread.

c. Changing demands

Exacerbating these shortages in workforce numbers is the increasing demand for services driven by the consumer, technological innovations, and by the ageing population and associated increasing burden of chronic illness.

Australia has an ageing population, an increasing prevalence of chronic diseases requiring complex treatment and rising rates of lifestyle risk factors. As the cost of treatment and management rises and demand threatens to overwhelm existing services, there is an increased awareness and greater political will to focus on preventative health care in community settings.

Self management of chronic disease is clearly recognised as an important part of an effective and efficient health care. Improved health literacy and empowerment of individuals to achieve lifestyle change has the potential to minimise increases in health care costs in the future. The primary health care sector is the logical part of the health care system to support patients to become active participants in their own health care. There is increasing evidence that non-medical primary health care providers are effective in providing these services.

The health care system has become progressively more specialised and often fragmented. The navigation of the system and co-ordination of care for complex care patients is another important and time consuming role that often falls to the primary health care workforce to provide.

The need for these new foci in primary health care occurs in addition to the continuing role of episodic and acute care. Consumers today have high expectations of ease of access, timeliness of delivery and quality of service.

The current fee-for-service funding model, even with additional targeted payments, has difficulty in adequately supporting:

- a mechanism for GPs to allocate time for comprehensive management of chronic/ complex conditions
- adequate health promotion and illness prevention activity
- the use of team care approaches for people or groups whose care might be better provided in this way, such as under five-year-old children, older people, or people with chronic and or complex conditions
- the full use of non-medical staff in providing care within the general practice
- cross sectoral planning for a local population or planning for services for particular groups of patients.

To allow the primary health care system to effectively respond to changing demands it will be necessary to consider adapting the current fee-for-service funding arrangements.

d. Role delineation and teamwork

Given inadequate workforce numbers, mal-distribution and increasing demands, there is an obvious need to maximise the effectiveness of the existing primary health care workforce. In recent years, there has been an increasing emphasis on the role of multidisciplinary team work, care co-ordination and integration of services in an effort to achieve greater efficiency whilst retaining and/or improving quality of care.

Team work is often mentioned but less often clearly articulated; in reality it is probably conceived of differently by patients, doctors, nurses and allied health workers. Ideally, effective teams make maximal and efficient use of members' different professional skills and attributes to provide high quality, timely and accessible care whist still allowing patients to retain a sense of personal continuity and provider's professional satisfaction and variety. At the moment the phrase "team work" is used as if it is the panacea for the health system challenges. Effective team work requires mutual trust between members, excellent communication, clear role delineation, shared goals and leadership - none of which occur automatically just because professionals are co-located or both care for the same patient. There needs to be shared understanding about the enablers and barriers to effective collaboration and team work in primary health care. Further, better methods for facilitating and funding effective primary health care teams are needed.

Many general practitioners express feelings of being overworked and stretched by existing acute and chronic care workloads. The EPC item numbers are often charged with adding increased bureaucracy and red tape without fundamentally altering the nature or organisation of practice. The complexity and frequent changes to item numbers and eligibilities leave many general practitioners without a full understanding or the ability to apply them properly. As a result many find that they can just keep pace with their current workload demands but cannot find the emotional and intellectual energy to participate in further change.

Nurses in general practice have received much attention as a potential and/or necessary part of the primary workforce solution. Indeed the number of general practice nurses increased by 59 per cent in 2005-2007 and now represent the fastest growing specialty of nursing in Australia[7]. Despite this there is no nationally agreed set of competencies required to enter primary health care nursing, nor is there formalised post-graduate training or accreditation in primary health care nursing and there is minimal exposure to primary health care nursing in the undergraduate courses. These issues need to be addressed. While the number of nurses in general practice is increasing rapidly there is disquiet at the inflexibility of the current funding mechanisms. Nurses are funded for particular actions only, thereby significantly limiting a practice's ability to maximise the use of their various talents.

Improvements in e-health provide significant opportunities to support team work, integration of services, evaluation and monitoring of the health care system. Once Australia has a unique patient identifier and the capacity for shared electronic records then rapid improvement should follow. To effectively support team care and integration of services systems need to be developed that allow central repositories of information. Point-to-point information transfer will not be good enough in the complex, multi-layered health care system that has evolved. The central repositories could be accessed and contributed to by individual clinicians with the patient permission and de-identified aggregated data could be used in health surveillance and monitoring health systems performance. Technology can potentially contribute through point-of-care testing, electronic decision support, home monitoring and improved communications. However, so far the promise of e-health has not been matched with progress. Indeed, implementation of any national e-health strategy will increase pressure on providers in the first instance, eg implementing new systems, cost and training of staff. The gains to providers will be realised later.

2. What are the different models Australia could explore to make the best use of the workforce both now and into the future?

Given the changing demands on the health care system it seems inevitable there will be increasing pressure on the primary health care sector to play a role in minimising demand and expenditure in the hospital system. Comprehensive, integrated primary health care can deliver on many areas of need - such as self management support, improved preventative care and chronic disease management, but it will require significant investment to do so. If Australia is to take on these sorts of interventions as part of the long-term investment in health, there needs to be a shift in the allocation of funding, giving a greater proportion of the total funds to the primary health care sector.

A quality primary health care system should not be viewed as a cheap option, although it provides better value for money than investment in the secondary and tertiary health care sectors. This is because primary health care identifies and treats earlier in a patient's illness, and offers continuity and integration of care across multiple disease processes as well as across time. As stated by WHO in their recent report "Primary Care - Now More than Ever":"primary care requires adequate resources and investment, and can then provide much better value for money than its alternatives"[8].

There is general recognition that the fee-for-service payment system alone does not meet the needs of all situations, even with targeted incentive payments. Australia may need to change the profile of funding in primary health care, with less emphasis on a fee-for-service model, but this will undoubtedly prove to be controversial. A sensible first step would be to introduce a blended funding model for primary health care which consists of a mix of fee-for-service as well as capitation for patients with chronic or complex needs.

Practices would register to provide programs of care and would receive capitation funding for the ongoing care of voluntarily registered patients. The practice would be responsible for providing the registered patient with an agreed appropriate program of care with measurable outcomes. The funding stream would pay the practice (rather than an individual practitioner). It would not be mandated who provided the service; instead it would be flexible depending on available skills and resources within the accredited practice or local area. This would have a number of possible outcomes; practices receiving capitation funding could afford to employ practice staff to undertake work in these programs, thus increasing the range and capacity in primary care; and patients would be assured of an appropriate program of care for their condition.

In order to be equitable, the level of capitation funding would include a loading component that reflected: complexity of activity, degree of rurality (based on RRMA), social disadvantages (using a socio-economic index), and possibly also workforce need and difficulty of recruitment and retention. Medical and nursing transactions outside the agreed program of care would continue to be provided on a fee-for-service basis. Practices and or individuals could choose not to register at all and would then continue to use fee-for-service for all care.

It is recognised that capitation funding has risks, for example providers could cull high-cost patients from the register or reduce care for patients with conditions not covered by the scheme. However, these risks are well known and documented from other countries' experiences and appropriate performance measurement and monitoring arrangements can be devised to minimise them.

The funding of such a system is complex. In the United Kingdom and New Zealand there has been a move to regionalised primary health care organisations during the past two decades. Such a shift here would require pooling of State and Federal funds and the formation of regional primary health care organisations. The Australian Divisions of General Practice are currently the only organisations with national coverage and a specific primary health care remit, but they would require radical restructuring in order to evolve into a primary health care organisation and fund or deliver services. It is anticipated that such a restructure would be met with considerable resistance from many general practitioners. The Divisions were designed with, and have maintained, a very strong general practice focus, although more recently some divisions have expanded and evolved to include other nursing and allied health primary care professionals.

In a complex, expensive system the need for continuous quality improvement (CQI) will become increasingly important. The Australian Primary Care Collaboratives have been responsible for the introduction of CQI principles in Australian general practice and have made considerable progress. Nevertheless CQI is generally not well developed or consistently applied across the breadth of the primary health care sector. Further development will require more regional development, entrenchment in clinical practice and workforce training.

3. What kind of recruitment and retention measures does Australia need to attract people in, and keep them in, the primary health care workforce?

For the future Australia will need to make best use of the workforce it has and facilitate effective teamwork and rational use of limited workforce resources. Career pathways need to be flexible and allow evolution over time to reflect the changing needs of both the individual within them and of the health care system they serve. Undoubtedly there will be different mechanisms for retention of staff already working in primary health care compared with recruitment of the next generation.

For those already committed to general practice, retention is increased by a suite of factors which include: recognition for the wide ranging, challenging and vitally important role they play, professional satisfaction and variety, adequate and flexible continuing education, realistic expectation that holidays can be taken and locum support found, and financial reward[11].

For this current generation of primary health care workforce and for those training in the future it is vital that career structures and training pathways that enable career development exist. Generation Y graduates value flexibility and the capacity to change – the financial burden of buying the physical structure of a practice may be seen as unattractive and restricting, particularly as it adds to the significant debts accumulated during training[10]. "Difficult-to-staff' regions may need to consider providing the infrastructure of practice which would allow medical practitioners, nurses and other allied staff to more easily move into (and out of) an area.

Measures have been put in place to increase the number of medical and nursing graduates – it is now vital that the proportion of recent Australian graduates who choose to work in primary care is increased. To do this it is imperative students are exposed to positive community-based clinical environments throughout their training and the primary health care focus of early postgraduate experience is increased. Clinical training in the community must be effectively funded, both to allow development of infrastructure but to also realistically cost the teaching commitment in the community. This will require a shift from the hospital systems in which the majority of nursing and medical clinical placements are completed, to the primary health care system. Some promising programs such as the PGPPP for medical graduates should be continued and new programs for nursing established.

The future education of the primary health care workforce should actively facilitate the development of functional primary health care teams. A starting point would be to increase inter- professional health care education and clinical placements. This is currently extremely difficult to achieve due to poor vertical integration of undergraduate-postgraduate training as well as almost no horizontal integration of medical, nursing and allied health training. Improving integration will be an additional cost to universities which provide medical and nursing training. First steps forward should include supporting the development of interprofessional primary health care organisations and providing targeted funding to universities to improve integration.

It is important to remember that there are existing functional multidisciplinary team models (like Aboriginal Controlled Medical Services, Primary Care Collaboratives) in the Australian primary health care system. Australia needs to learn from these and build scalable models of primary health care teams. One size will not fit all, and these models should be flexible and variable depending on local needs and resources. These could include co-located teams (eg GP Super clinics) or locally supported networks of providers funded on performance and clinical outcome; and instituting a quality assurance framework to provide the framework for funding.

SUMMARY OF THE APHCRI EVIDENCE BASE ON WORKFORCE

In 2006 APHCRI commissioned "Stream Six – Workforce" and funded nine research teams to examine how to increase general practitioner (GP) numbers, how to optimise the workforce that exists and the place of generalism in primary health care. This research provides a good foundation for looking at changing roles in general practice and thinking about what primary health care teams might look like in 2020. The following is a brief summary of the major outcomes of the research and is reproduced from the APHCRI Dialogues of 2008 available on the web at: http://www.anu.edu.au/aphcri/General/aphcri_dialogue.php .

Professor Jane Gunn's team undertook to answer one of the big questions in general practice – what is "generalism" and what will it look like in the future?[9] The team developed a conceptual model that outlined the key personal and work characteristics and knowledge frameworks that are particular to generalists. Generalist are often reflexive and interpretive individuals who share biographical as well as biotechnical epistemological frameworks and this, combined with their community-orientated and patient-centered approach to doing, mean that generalists have the potential to deliver 'health for all'. Gunn and colleagues believe that generalism is a professional ideal worth understanding and striving for.

Professor Gunn looked at the primary health care team in 2020 and called for policy which "increase(s) the importance and status of primary health care generalist workforce through career pathway development and remuneration, among other facilitators"[9].

Professor Jill Thistlethwaite[10] used a systematic review and targeted interviews to establish how to entice more medical graduates into general practice. She concluded that the profession needed to improve its image with medical students and those thinking of studying medicine and be more flexible in training and working hours to attract young professionals.

Her research showed medical students are influenced by a number of factors when making a career choice, including work/life balance opportunities, experiences during training and at medical school, and their personality.

With increasing numbers of women in medical training and choosing general practice the solo General Practitioner model is becoming increasingly unattractive. Professor Thistlethwaite's work suggests funding maternity leave and developing more salaried positions and a greater emphasis on team working would tip the balance in general practice's favour.

While these solutions might result in more GPs in the cities on Australia's eastern seaboard, areas of need and rural/remote communities may well still struggle to fill the workforce void. Rurally bonded medical graduates will soon start coming through the system, but how many will stay - and for how long - is less certain. On all projections rural and remote Australian workforce solutions are still desperately needed.

Professors John Humphreys and John Wakerman[11] examined the issue of continuing professional development (CPD) to discover if opportunities to maintain a strong knowledge base develop further skills and meet with other professionals in a learning environment contributed to GPs commitment to rural towns. They discovered that while CPD was a contributing factor, it was one of a 'package' of components that kept GPs in rural and remote Australia – including spousal and family support, the ability to access locums and medical team work.

Dr David Perkins et al[12], considered the wider roles of medical practitioners in building a sustainable workforce into the future. Looking specifically at generalism in primary health care mental health they concluded that generalists across the health spectrum, not just GPs, have a role to play.

The report noted international evidence that endorses increasing the range of elements of care provided by non-GP generalists, with appropriate supports. GPs would then be helped by other generalists to provide elements of care where they are more effective, but encouraged to share or delegate care, which can be provided effectively by other generalists.

Professor James Dunbar[13] and his co-authors considered general practice as an organisational structure, considering how organisational development could be applied to general practice, particularly in the care of chronic disease. Professor Dunbar argues that performance in health care organisations is linked to leadership, culture, climate and collaboration and these features need to be a key part of any reform or change agenda in primary health care. He also noted that unless organisations are willing to change, attempts to influence clinical practice change remain ineffective.

The Dunbar team believes that an organisational development approach in primary health care will lead to better health outcomes for chronically ill patients by improving team work, communication, integration and co-ordination and by facilitating the creation of clinical networks across organisational boundaries. With this in mind in order to see patient health outcome benefits, Australia's workforce solutions need to be part of a broader change in the system and organisation of primary health care.

The research showed that approaches to improving primary health care workforce numbers in Australia require a broad range of strategies. Researchers reaffirmed that a well developed primary health care workforce is necessary for good quality patient care. The research has indicated that aspects of primary health care do not necessarily need to be delivered by general practitioners. However, expanded roles for other generalists should be considered in the context of best practice patient care and developed through closer working relationships between health care professions. Generalists, of many forms, have an important role to play in Australia's health care in the future.

Professor Nicholas Zwar has examined the use of teams in two APHCRI research streams. Looking at chronic disease management in 2006[14], Professor Zwar found that patient self-management was a potent tool in managing chronic illness and combined with a multidisciplinary team approach, will improve physiological measures of disease.

In his Stream Six[15] work, Professor Zwar looked at optimising skill mix for the care of older Australians and concluded that there are particular roles that primary health care nurses can successfully adopt. These include pro-active patient follow-up, general patient consultation and support, care planning and goal setting. Professor Zwar cautions that the expansion of nurse roles needs to be developed through improving inter-professional trust and handled with sensitivity.

Professor Helen Keleher's[16] research on community nursing suggests the role of practice nurses should be expanded and the profession given a clear career pathway and training. Most practice nurses come into the profession via hospital work and the training in the tertiary environments is not always compatible with work in the primary health care sector. Clear role delineation of the primary health care/general practice nurse may help attract nurses to the sector in the face of declining overall workforce numbers.

Professor Keleher's research affirms that primary health care nurses have a role to play in chronic disease management and that, within their scope of practice, they can achieve similar patient health outcomes to doctors. Professor Keleher states 'Nurses working in primary health care can help address workforce shortages, improve access to health care and contribute to the management of chronic conditions and illness prevention."

Professor Dennis Pashen[17] looked at the expanding role of generalists in rural Australia given that both nursing and GP numbers are at a crisis point in many rural communities. In his review Professor Pashen concludes that: "greater investment in primary health care and 'generalist' medical services maybe more cost effective, efficient and equitable for rural communities compared with specialist and sub-specialist medical service providers". He notes Queensland has developed specific training and career pathways for 'rural generalists' which reflects the importance of broad procedural and cognitive skills and is supported with attractive remuneration. In an effort to support existing generalists Professor Pashen suggests that mid-level practitioners such as physician assistants, practice nurses and nurse practitioners are part of the solution because "they can extend the reach and enhance the viability and sustainability of rural and remote medical generalists."

The use of other medical professionals to supplement general practice care for mentally ill patients – particularly those suffering from depression and anxiety – was examined by Dr Grant Blashki[18] and his team from Melbourne. They concluded there was good evidence for GPs providing problem-solving therapy for depression, good evidence for psychologist delivered psychotherapy and good evidence that collaborative, multi-professional approaches to depression care are superior to treatment as usual for depression and some other illnesses.

These reports indicate that good patient health outcomes for elderly Australians, those with chronic and/or mental illness and patients in the bush are possible with the evolution and adaption of the roles and responsibility of the primary health care team.

Practice nurses could be given more responsibility and have their role extended to take a more active role engaging with and teaching patients about self-management. In rural areas new medical workforce roles like physician's assistants could be working alongside GPs and nurses doing some procedural tasks at both hospital and primary health care levels.

A common thread in many of the reviews is the need for sensitive development of roles, mutual trust and respect between team members leading to effective communication and collaboration amongst the primary health care team. How best to achieve this might be the next important question to address in the evolution of primary health care multidisciplinary teams.

SUMMARY

The evidence compiled from the APHCRI funded research projects and workshop highlights several aspects of the primary health care workforce that require significant systemic change and reform in order to ensure the provision of appropriate, equitable, accessible, quality health care for all Australians, regardless where they live or their economic or cultural backgrounds.

This report has made five specific recommendations. The implementation of the simplification of the current Medicare Benefits Schedule is possible quickly and could rapidly show effect. Other recommendations such as the funding of medical and nurse education in the primary health sector, the development of career structure and training pathways and the development of functional primary health care teams need to be initiated in the short term as they will take years before their full benefit is achieved.

While this report has focused specifically on workforce issues, it is clear that our ability to ensure an adequate supply of an appropriately-trained primary health care workforce requires broader systematic changes that tackle issues of funding, financing arrangements, service organisation, role delineation and career pathways, and education and training paradigms. The recommendation of the introduction of a blended funding model for primary health care may be politically challenging but the evidence is mounting that it is worth developing and trialling. In the absence of attention to broader macro-context issues, specific workforce reform alone may founder and not achieve intended goals.

A clear implementation strategy is important to ensure that action is taken, monitored and evaluated using appropriate performance indicators. Importantly the implementation strategy should include constant ‘feedback loops’ from the evaluation to inform progressive policy improvement.

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