May 2008

Attachment to GPV submission to NHHRC
Infrastructure for workforce development

In the last several years general practice has been overwhelmed by three problems:

- The chronic shortage of GPs, exacerbated by the combined effects of reduced working hours and longer consultations due to chronic disease management issues.
- A need to ensure that the profession capitalises on the wave of students coming through from 2008 onwards by offering high-quality clinical placements in appropriately designed settings.
- The shift to team-based practice, in particular through the employment of practice nurses, which should help alleviate workforce shortage but which creates substantial demands upon a practice during the transition.

Divisions of general practice have been at the forefront of developing workforce strategies in response to local need and our research with RWAV has identified some excellent models at the local level. There is a great opportunity to ensure that these strategies are analysed and developed into models that can be adapted to other settings across the country.[1]

Divisions of general practice are the organisations that have a very close knowledge of and working relationship with the practices in their areas. If resourced to do so, they could play a major role in assisting practices to develop the systems and organisational arrangements to support student placements. At present, GPV is working in partnership with RWAV, regional training providers and universities to define the potential division role to increase practice capacity in order to address workforce issues.

Divisions need to be recognised and resourced to play this stronger role in workforce development. But there are also critical workforce problems that depend on policy changes and resource commitment by state and national governments. The key problems beyond divisions' control are:

- The lack of infrastructure to further expand the provision of team-based care.
- The failure of definitions of district of workforce shortage to recognise real areas of workforce need.
- The failure of government to extend the number of general practice training places beyond the present 600.

There has been widespread recognition in recent years that without the room to develop, general practice will not be able to compensate for workforce shortage with the further recruitment of other team members, will not be able to strengthen team-based approaches to chronic disease management and most importantly will not be in a position to train and attract to general practice the necessary numbers among the next wave of students. Consequently, this submission focuses in particular on the need to invest in general practice infrastructure.

[1] We would be happy to provide the Commission with more information on particular models and the results of our current survey, but rather than document them here, we would like to focus in this submission on what we consider to be the most pressing current policy issue in the area: infrastructure for workforce development.

Capacity to capitalise on student numbers

A key to the future workforce will be the capacity of general practice to attract a high percentage of the greatly increased student numbers coming through between 2008 and 2017. The capacity to attract students will depend on the extent to which GPs are trained and motivated to offer supervision, the incentives to take students, the extent to which practices are organised and designed to offer a positive training experience and the availability of space and IT. The same arguments apply to extending the workforce capacity through the employment of other health professionals, especially practice nurses.

Despite the problems associated with relative value between general practice and other specialities, there is substantial evidence to show that if students are offered a positive training experience in a suitable environment they are much more likely to choose general practice as a profession.[2] The problem at present is the capacity of existing practices to offer such an experience to the large numbers of students expected in the next 10-year period.

But it will be impossible for general practice to capitalise on the increased number of students unless the government commits to increasing the training places within general practice. General Practice Victoria wishes to endorse GPET's proposal to progressively increase GP training places from 600 per annum to 900 per annum by 2011.

The key barrier to growth: Lack of infrastructure

Numerous reports have documented the urgent need for infrastructure investment to ensure that general practice can shift to models of care appropriate to chronic disease management and to offer clinical placements for students.[3] [4]The first report of the National Hospitals and Health Reform Commission, *Beyond the Blame Game*, also acknowledged that:

> Training institutions such as universities are limited in their ability to offer comprehensive and adequate training for students because of difficulty in obtaining sufficient clinical placements. Primary care also suffers from a lack of teaching infrastructure, yet is expected to be the new teaching domain.[5]

The report*, Medical Student Clinical Placements in Victorian General Practices*[6]*,*showed that the massively increased need for clinical placements would not be met unless there is significant investment in additional space as the universities' teaching models recommend a dedicated room for the student. Many practices find this to be a challenge for two reasons. From a financial perspective, practices can get better returns from using the available space by engaging another doctor or practice nurse (especially so in the current funding and service environment) or by taking on more clinically and financially productive categories of GP learners such as registrars and PGPPPs.[7] Even so, **'in many practice settings these options are not feasible, as the extra**

[2] Thistlethwaite, J Shaw, T et al. (2007), Attracting health professionals into primary care: Strategies for recruitment, APHCRI, ANU, Canberra

[3] RACGP, n.d. (?2007) *A quantitative study of GP members to determine the barriers and enablers to their increased involvement in medical education*. This survey found that 45% of 601 respondents said that not having a consulting room was the main barrier to taking on students or registrars. This same study found that the estimated cost of increasing practice infrastructure ranged between $10,000 and more than $80,000 with an average of about $50,000 but the basis for the estimates is not clear.

[4] Thistlethwaite, J, Shaw, T et al As above, pp 44-47

[5] National Health & Hospitals Reform Commission (2008), Beyond the blame game: Accountability and performance benchmarks for the next Australian health Care Agreements, p.17

[6] Burgell Consulting, February 2008, Medical Student Clinical Placements in Victorian General Practices Report.

[7] ie participants in the Pre-vocational General Practice Placements Program.

space is not available, and the practice for a variety of reasons is simply not in a position to create additional room, and certainly not for a medical student.'[8]

Suggestions from interviewees were that the incentives to invest in training need to be improved. In particular, the report suggested that 'Appropriate recognition needs to be made of the infrastructure requirements of students, with money available to equip practices for students (e.g. room contents, IM&IT equipment etc) as well as room rental or subsidies or infrastructure payments to expand the practice capacity. Most respondents supported the notion that increased funding would come with increased obligations, such as commitment to hosting student placements.

Survey of general practice nursing in Victorian divisions – GPV 2007

In 2007 GPV surveyed all Victorian divisions to identify the factors supporting and inhibiting the further development of the practice nurse role.[9] The report found that while the practice nurse workforce had increased substantially in the last three years (from 4924 Australia-wide in 2005 to 7728 in 2007) it found that **many practices were reportedly at capacity with the main barrier to further recruitment being the lack of physical space.**

The Government Response

Commonwealth and state governments have stated that extending the capacity of general practice to take students is a policy goal. Both levels of government have also made explicit statements about the need to develop new models of team-based care. However, the 2008 budgets at state and Commonwealth levels fail to provide adequate incentives for practices to develop the infrastructure required to host students and to develop new models of care.

In its first budget, the Rudd Government announced a National Rural and Remote Health Infrastructure Program will be established to provide better access to funding for infrastructure through a competitive grants process. It will amalgamate the Rural Medical Infrastructure Fund and the Rural Private Access Program. While revised program guidelines are currently being developed, a commitment has been made to increase the population size to eligible communities to 20,000, the grant size has been increased to $500,000 and private practices will be able to apply for funding where it will be used for training facilities for medical students.

This investment is welcome but it misses two vital points. First, infrastructure development is required in the city, especially in outer metropolitan areas, as well as in rural areas, and often at greater cost than in rural areas. Second, any competitive grants program that involves all health services fails to recognise the urgency of planned and systematic investment in general practice specifically, within the short term.

The Victorian State Government has repeatedly noted the need to create intern placements in settings other than hospitals given that the large numbers will overwhelm hospital capacity especially in 2012 in Victoria. While engaging general practice organisations in discussions to ensure that such placements are available, and while including budget provision (2008-09) for infrastructure development for additional places, nevertheless it appears that all of the available infrastructure funds will go to DHS-funded services.

[8] Burgell Consulting, p.23.
[9] The report is available from GPV.

Discussion

At a time when both levels of government are placing great hope in the capacity of general practice to (a) keep patients out of hospital (b) provide extended access to services through the use of multidisciplinary teams (c) act as a training site for the development of undergraduate, prevocational doctors, registrars, International Medical graduates, practice nurses and allied health professionals, it is short-sighted for state governments to view it as a Commonwealth matter and for the Commonwealth to view it as private business only. Both levels of government are seeking public health goals through private general practice to an extent that is beyond the present capacity of private general practice to deliver.

The major infrastructure development in general practice at present is taking place on the government's part through the establishment of super clinics that, even if they were to model best practice, will not increase capacity in the network of local practices across the country. The other area of significant investment is by the private corporate models, most of which have found no business case to participate in training the workforce of the future. This makes it clear that those private practices that take students risk substantial opportunity costs.

If the Australian Government is committed to the maintenance of local general practices as the means of providing accessible primary care to all Australians then it has no option but to develop an infrastructure investment policy in the immediate future and one which might include the requirement for appropriate contribution from the states.

A range of models exist to support infrastructure development, from capital investment incentives to various forms of public–private partnership. There is scope for flexibility but the key is to commit to infrastructure development in a comprehensive and systematic way.

Recommendations

We recommend that the Commission ensure its recommendations to government address the need:

- to ensure the capacity of general practice to expand its models of care, to serve as a training site and to attract future medical students to the profession
- to support GPET's proposal to progressively increase GP training places from 600 per annum to 900 per annum by 2011.
- to document infrastructure costs and the present shortfall both for clinical placements and for the expansion of team-based models of care
- to establish an infrastructure investment fund that ensures general practices are supported to make the transition to a substantially increased teaching commitment and a broader model of primary health care service delivery
- to ensure that the Australian Health Care Agreements require state investment in infrastructure at a level that reflects the states' use of private general practice for the achievement of their public sector goals.