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National Primary Health Care Strategy
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Dear Sir/Madam

Submission on the Discussion Paper: *'Towards a National Primary Health Care Strategy'*

On behalf of our membership, the Executive Committee of the Australian Association for Academic General Practice are pleased to have the opportunity to comment on the Discussion Paper: Towards *a National Primary Health Care Strategy'.* Given the focus of our organisation on medical education and research we have chosen to comment specifically on sections 5 and 9 of the paper.

Section 5
It is important that the Discussion Paper acknowledges the need for Australian primary health care to be informed by relevant evidence and that we need to identify approaches to support greater involvement of primary care professionals in high quality research. We were concerned that Section 5 appears to conflate primary care research solely with quality improvement. While much primary care research can inform best approaches to quality improvement in healthcare delivery, primary care research has much broader relevance than this to improving the health of Australians (see Snapshot of Australian Primary Care Research, Primary Health Care Research and Information Service, 2008 for some excellent examples http://www.phcris.org.au/phcred/snapshot/2008/index.php). Primary care and the health problems that it deals with are very different to those in tertiary care, where most research currently occurs. Primary care is a domain of healthcare separate to those defined by organ systems or technologies. It focuses on the patient's health and illness, and the prevention, management and rehabilitation of – typically – multiple health problems, taking the patient's particular personal, family, social and cultural needs into account. For this reason we need robust descriptive research, such as the BEACH Study, that provides ongoing data about primary care patient presentations, investigations and management. In addition, we need high quality intervention research to determine effective disease management strategies in primary care and inform best practice.

We agree that significant investment is required to improve the capacity and quality of recording activity in primary care. Several barriers exist to achieving this at present, not least the variability of clinical software systems in general practice in their ease to record data in a systematic way. **We recommend implementation of a minimum set of standards for clinical software systems that would promote simple, systematic recording of healthcare data in practice.** We believe that, until the ability to record electronic healthcare data in a systematic way has been improved, it would be premature to implement any form of payment system linked to performance. More importantly however, evidence from the UK Quality and Outcomes Framework suggests that such a pay-for-performance system can create perverse incentives. For example, practitioners may focus their clinical activity on data

recording for single diseases and processes which have simple outcome measures (e.g. smoking status, HbA1C, BP). This may be at the expense of more complex generalist care that is less easily measured, with the risk of poorer quality care for non-incentivised conditions. **We recommend the establishment of a taskforce to identify relevant primary care outcome measures that reflect patient health from a consumer perspective in addition to the disease-specific indicators in current use.**

The Discussion Paper suggests the need for 'improved targeting, funding and dissemination of research.' We would entirely agree with this statement. **Probably the most important early strategy we recommend is a continuation of the Primary Health Care Research, Evaluation and Development (PHCRED) funding stream.** While we understand that this is currently subject to a review, we believe that it is vital to continue this approach to research capacity building in primary care. Delaying decisions about the future of PHCRED funding could result in the loss of established primary care research expertise in academic departments as staff seek positions elsewhere in the research or healthcare sectors.

Furthermore, we believe strongly that **funding needs to be expanded to support academic primary care pathways** that offer sufficient incentives for primary care professionals to undertake PhDs. Consideration should be given to early recruitment of GP registrars into academic careers, for example, through PhD programmes linked to registrar training schemes. We believe that University Departments of General Practice should have a much greater role than currently in academic GP registrar training. Without opportunities to develop skills and experience in education and research, which are best provided by university departments, we will continue to struggle to recruit academic general practitioners. Additional fellowship schemes are also required to support primary care researchers who choose to develop further at post-doctoral and senior researcher levels so that Australia has a growing cadre of internationally recognised leaders in primary care research.

The current NHMRC project grant scheme is an important potential source of funding for high quality primary care research. However, partly due to the greater challenges of demonstrating feasibility and innovation in primary care research compared to the laboratory sciences, only a handful of primary care grants have been funded through this stream in recent years. **We recommend reinstitution of an additional source of NHMRC funding for highly ranked primary care project grants.** In addition to this investigator-driven research, priority-driven research in primary care requires additional targeted funding to inform specific policy and practice such as that funded through the Australian Primary Health Care Research Institute.

We need to identify strategies that support healthcare professionals at the coalface to be research literate and also become involved in research. The current funding models of primary care are mainly based on the small business model with financial disincentives to participating in research. GPs often give a great deal of time to research studies and are penalised by loss of income as a result of their involvement. While the PHCRED funding has been important in supporting early career researchers to conduct their own small-scale projects, we also need to support the conduct of large scale, competitively funded projects in primary care practice. As identified in the Discussion Paper, lack of time and remuneration prohibit primary care professionals from involvement in both small and large scale research projects. Practice-based primary care networks are an important model that provide the necessary infrastructure support to create a 'primary care research laboratory'. **We recommend the establishment of a national primary care practice-based research network, which could be modelled on the Cancer Australia national cooperative clinical trials groups.** This would provide infrastructure funding for the conduct of large scale, multi-site research in primary care, supported by a national clinical trials and biostatistics unit. Funding national and local initiatives in practice-based networks ensures sustainability of research and greater potential for getting evidence into practice by creating a crucial interface between research and practice sectors.

Section 9

We agree that, with the expansion of university training places in medicine and other healthcare disciplines, there needs to be a parallel growth in the capacity to deliver high quality education in primary care. For the last few years our organisation has promoted a range of strategies to achieve this, including greater vertical and horizontal integration of education in primary care and new models of reimbursing general practitioners for their time and expertise in teaching. Primary care faces the additional challenge of low numbers of graduates choosing to specialise in general practice. It will only be by giving adequate value to the role of general practitioners and practice nurses, and offering high quality educational experiences in primary care, that primary care will be seen as a positive career option.

As outlined in the Discussion Paper, general practice is limited in its teaching capacity by both physical facilities and time. We hope that the GP Super Clinics will go some way to building the physical infrastructure required to support high quality education and research, and strongly endorse hub-and-spoke models that could create much greater capacity for teaching in primary care than a single new clinic. **Furthermore, we recommend that the GP Super Clinics or other similar primary care sites, contribute to the development of community clinical schools, particularly in outer metropolitan areas applying hub-and-spoke arrangements.**

We believe there are significant opportunities for horizontal integration of education, and specifically to improve and expand training for practice nurses, and also of GPs about the expanded roles of nurses in general practice. However, whilst accredited courses for practice nurses exist in Australia, the current practice environment provides nurses with little incentive to undertake additional training unless their role is allowed to develop to apply these new skills. GPs have little incentive to pay for nurse training if there are no item numbers to support extended practice nurse roles. The challenge for health professionals and policy makers in Australia is to **provide an environment which values highly trained practice nurses and provides opportunities for them to utilise and further develop their skills to compliment the work of GPs** in providing high quality chronic disease management. Only then will more practice nurses and GPs be prepared to invest in nurse training.

The current separate funding systems for undergraduate, pre-vocational and vocational medical education add to the challenges of integrating education in general practice. Where there is close alignment of undergraduate and vocational training, either through universities delivering both programs, or where strong cooperative relationships exist between universities and regional training providers, there is great potential for developing new models of vertical integration. However, **we strongly discourage national alignment of funding and management of clinical training between undergraduate and postgraduate training.** This would fail to recognise the different local needs and funding models for undergraduate general practice teaching in each university. Such a model of aligned funding could only work if universities were to deliver both undergraduate and postgraduate training.

There is no doubt that current approaches to remunerating general practice for undergraduate education are insufficient incentive. The important role of teaching in general practice at undergraduate and postgraduate level needs to be suitably recognised and rewarded. Current Practice Incentive Payments (PIP) are insufficient recompense for loss of income from teaching, and furthermore often do not reach the GP who is involved in teaching. **Our preferred model to truly support and recognise the role of teaching would be through a Medicare item for teaching consultations. At the very least, we believe that the teaching PIP requires a significant increase, at least by 50%, if it is to truly be an 'incentive payment' and reflect the critical importance of undergraduate education in general practice.**

We would be pleased to engage further with the Department of Health and Aging as it develops a National Primary Health Care Strategy.

Kind regards

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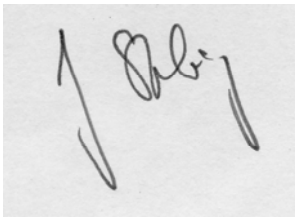

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