STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

Access to Primary Health Care Services

FEBRUARY 2010

Report 2

Committee Membership

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Ms Amanda Bresnan MLA (Deputy Chair, elected 25 November 2009)

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Resolution of Appointment

On 9 December 2009, the Legislative Assembly for the ACT resolved to establish the **Standing Committee on Health, Community and Social Services to:**

> Examine matters related to hospitals, community, public and mental health, health promotion and disease prevention, disability matters, drug and substance misuse, targeted health programs and community services, including services for older persons and women, families, housing, poverty, and multicultural and indigenous affairs.[1]

Terms of Reference

On 25 March 2009, a motion was passed in the Legislative Assembly for the ACT that included the referral of an inquiry into access to primary care services to the Standing Committee on Health, Community and Social Services. The terms of reference were to include:

a) role of nurse practitioners in providing primary health care;
b) role of allied health assistants in providing primary health care;
c) GP clinic closures since 2001;
d) the current level of GP shortages in the ACT and the reasons pertaining to this shortage;
e) how to arrest, and reverse, the decline in GP numbers in the short and longer term;
f) strategies to attract and retain GPs in suburban clinics; and
g) linkages between Government and NGO providers.[2]

[1] Legislative Assembly for the ACT, *Minutes of Proceedings No. 2*, 9 December 2008, pp 12–13

[2] Legislative Assembly for the ACT, *Minutes of Proceedings No. 12*, 25 March 2009, p 146

TABLE OF CONTENTS

Abbreviations

ACT DGP	ACT Division of General Practice
AGPT	Australian General Practice Training
AHA	allied health assistant
AMA	Australian Medical Association
BEACH	Bettering the Evaluation and Care of Health
CHC	community health centre
CHS	community health service
ED	emergency department
EPC	Enhanced Primary Care
FWE	full time workload equivalent
GP	general practitioner
GPET	General Practice Education and Training Ltd
HACC	Health and Community Care
HCCA	Health Care Consumers' Association ACT Inc
MBS	Medicare Benefits Schedule
NEHTA	National E-Health Transition Authority
OTD	Overseas Trained Doctor
NHHRC	National Health and Hospital Reform Commission
PBS	Pharmaceutical benefits Schedule
PGPPP	Prevocational General Practice Placements Program
PHC RIS	Primary Health Care Research and Information Service
PIP	Practice Incentive Payments
PHC	primary health care
RACF	residential aged care facility

RACGP	Royal Australian College of General Practitioners
RADAR	Rapid Assessment of the Deteriorating and At-Risk
TCH	The Canberra Hospital
WiC	walk-in centre

RECOMMENDATIONS

RECOMMENDATION 1

2.21 The Committee recommends that the ACT Government work with the ACT Division of General Practice to develop ways of raising the profile of general practitioners in the community.

RECOMMENDATION 2

2.27 The Committee recommends that the ACT Government extend their marketing strategy for GPs over the age of 55 to include attracting and re-engaging recently retired GPs from across Australia, with particular attention to NSW and Victoria.

RECOMMENDATION 3

2.33 The Committee recommends that ACT Health collect and publish data on the number of overseas trained doctors recruited to the ACT, including their country of origin, the length of stay, and whether they return to their country of origin.

RECOMMENDATION 4

2.62 The Committee recommends that the ACT Government conduct a feasibility study on employing salaried general practitioners in community health centres.

RECOMMENDATION 5

2.74 The Committee recommends that the ACT Government examine the provision of financial and other incentives to small suburban general practices in identified areas of need, and to new general practices wishing to establish in those areas.

RECOMMENDATION 6

2.101 The Committee recommends that the Minister for Health propose that the consideration of increased Medicare item numbers for allied health professionals be included for discussion at the next Australian Health Ministers' Conference.

RECOMMENDATION 7

3.22 The Committee recommends that the ACT Government consider ways of expanding health options for consumers by enhancing the provision of services provided by registered and accredited allied health professionals under the National Registration and Accreditation Scheme, in community health centres in the ACT.

RECOMMENDATION 8

3.49 The Committee recommends that the ACT Minister for Health enlists the assistance of all ACT federal members to lobby on behalf of the ACT, for the whole of the ACT to be considered a district of workforce shortage for GP services.

RECOMMENDATION 9

3.53 The Committee recommends that the ACT Government consider the provision of financial assistance to small general practices to employ a practice nurse that demonstrate a need for a practice nurse but are unable to employ one.

RECOMMENDATION 10

3.80 The Committee recommends that the ACT Government commission an independent evaluation of the walk-in centre at the Canberra Hospital after 12 months of operation, to examine the viability of establishing similar clinics in areas of greatest need.

RECOMMENDATION 11

3.93 The Committee recommends that ACT Health engage with the Pharmacy Guild to explore ways of better utilising the pharmacies in the ACT in the provision of primary health care services.

RECOMMENDATION 12

3.97 The Committee recommends that the ACT Government monitor the progress of the West Belconnen Health Cooperative and, if it proves to be successful, provide information and support to community groups interested in establishing a health cooperative, or a similar model in their local community.

RECOMMENDATION 13

3.104 The Committee recommends that the ACT Government conduct a community education campaign informing people about access points for health care needs, including general practitioners, allied health professionals and pharmacists.

RECOMMENDATION 14

4.40 The Committee recommends that the ACT Government trial a temporary shuttle bus service from Woden Town Centre and the Woden Interchange to the Canberra Hospital, and from an appropriate place at the Belconnen Town Centre to the Calvary Hospital, until such time as the Sustainable Transport Action Plan is implemented and public transport access to the hospitals is improved.

RECOMMENDATION 15

4.53 The Committee recommends that ACT Health promote the use of interpreters to general practitioners and the broader primary health care sector, to provide people for whom English is not their first language, greater choice in accessing medical services and to reduce the burden on services that cater specifically for this population group.

RECOMMENDATION 16

4.61 The Committee recommends that the ACT Government investigate ways of providing an in-hours locum service to cover general practitioners working in community-run health services that receive funding from the ACT Government, such as the in-hours GP Aged Day Service.

RECOMMENDATION 17

4.71 The Committee recommends that the ACT Government investigate the feasibility of establishing a pilot project for residents living in residential aged care facilities in the ACT, such as the Proactive Aged Care program proposed by Healthcube, or a similar model.

RECOMMENDATION 18

4.77 The Committee recommends that ACT Health negotiate a cross-border agreement with the NSW Government for health services provided by Winnunga Nimmityjah Aboriginal Health Service, to NSW residents.

RECOMMENDATION 19

4.85 The Committee recommends that the ACT Government provide funding to Winnunga Nimmityjah Aboriginal Health Service to enable the employment of at least one full-time general practitioner position.

RECOMMENDATION 20

4.92 The Committee recommends that the ACT Government extend the Better General Health Program to general practitioners that provide 'continuity of care' to elderly patients and those with chronic and complex conditions to ensure they are financially supported for the provision of that service.

RECOMMENDATION 21

5.18 The Committee recommends that the ACT Government conducts appropriate consultation with all relevant stakeholders in the development of its e-health strategy.

RECOMMENDATION 22

5.28 The Committee recommends that ACT Health widely promote the services of Healthdirect throughout the community.

RECOMMENDATION 23

5.29 The Committee recommends that ACT Health report on Healthdirect activity, including generic information about the number and nature of calls, and action taken, as part of ACT Health's quarterly performance reports. The Committee further recommends that the ACT Government examine the Western Australian Healthdirect reporting model, with a view to its introduction in the ACT, if deemed appropriate.

RECOMMENDATION 24

5.43 The Committee recommends that the ACT Government continue to monitor the innovations in primary health care delivery being trialled across Australia and overseas.

1 INTRODUCTION

> *The health of our people is critical to our national economy and national security, and arguably our national identity. Our own health and the health of our families are key determinants of our wellbeing. Health is one of the most important issues for the Australian people, and it is an issue upon which they rightly expect strong leadership from governments.*[3]

1.1 The Australian health system is under considerable pressure. Growing demands on health services from an ageing population, increases in the rate of chronic diseases, advances in technology and medications, increasing consumer expectations, an ageing general practitioner (GP) workforce and shortages across the health professional workforce are projected to continue.

1.2 Health expenditure accounts for the largest portion of general government expenses. Spending on health care in Australia during 2007–2008 was $103.6 billion representing 9.1 per cent of gross domestic product. This averaged out to $4,874 per Australian[4] and represented an increase of $8.6 billion on the previous year.[5] In 2008–2009 spending on heath care in the ACT accounted for 29 per cent of the ACT Budget at an estimated $896.4 million.[6]

1.3 Responsibility for policy, funding and organisation of health services in Australia is divided between the Australian Government and state and territory governments. The Australian Government has major responsibility for general practice while the state and territory governments have responsibility for hospitals and publically funded community health services.[7]

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[3] Australian Government, National Health and Hospitals Reform Commission, *A Healthy Future for All Australians, Final Report June 2009*, p 3

[4] Australian Institute of Health and Welfare, *Health Expenditure Australia, 2007–2008,* September 2009, p xi

[5] Australian Institute of Health and Welfare, *Health Expenditure Australia, 2007–2008*, September 2009, p 7

[6] ACT Government, *2009–10 ACT Budget Consultation*, p 7

The ACT context

1.4 The shortage of GPs in the ACT has become increasingly evident over the past few years. A motion put before the Assembly in 2003 welcomed concessions won by the ACT Government for the 2003–2008 Australian Health Care Agreement, pertaining to the extension of the Commonwealth's Outer Metropolitan GP Incentive Scheme to Belconnen, Gungahlin, Weston Creek and Tuggeranong; and the declaration of the ACT as a district of workforce shortage for GP services.[8]

1.5 The GP Workforce Working Group, founded in 2003, was reconvened in 2007 in partnership with the ACT Australian Medical Association (AMA) as the peak body to inform discussion, help set direction and consider general practice workforce strategies across the ACT.[9]

1.6 The ACT currently has the second lowest number of GPs per capita in Australia, behind the Northern Territory. This is discussed further in chapter two.

1.7 In August 2008, the Sixth Assembly Standing Committee on Health and Disability conducted an inquiry into the closure of the Wanniassa Medical Centre, owned by Primary Health Care Ltd. The inquiry was prompted by the sudden closure of the centre and the relocation of the doctors to the Phillip Medical Centre. The report highlighted a number of issues facing the ACT, including the shortage of practising GPs in the ACT, the role of corporations in health service delivery, and the impact of the Wanniassa Medical Centre closure on patients and GPs in the Tuggeranong Valley. The Committee made six recommendations.[10]

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[8] Legislative Assembly for the ACT, *Minutes of Proceedings*, Fifth Assembly, No. 73, 24 September 2003, p 930

[9] The Legislative Assembly for the ACT, *Government Response to the Standing Committee on Health and Disability Report No 9, Closure of the Wanniassa Medical Centre*, 31 March 2009, pp 6–7

[10] Standing Committee on Health and Disability, *Closure of the Wanniassa Medical Centre*, Report No 9, August 2008

2009–2010 budget initiatives

1.8 The ACT Government has invested $116.1 million in the current budget to address the GP workforce shortage and improve the efficiency of health services. This includes:

- $12 million over four years for GP workforce initiatives to establish GP scholarships, GP teaching payments, a GP Prevocational Placement Program and the ACT GP Development Fund;[11]
- $8.2 million over four years for Health Workforce Development to expand the roles of allied health professionals, including nursing and medical roles;[12]
- $1.9 million over four years for a business hours aged care GP locum service;
- $90 million for e-health to improve accessibility and flow of information between ACT Health and the primary care sector; and
- $4 million over four years for the ACT GP Development Fund.[13]

1.9 These initiatives are discussed further in this report.

GP Taskforce

1.10 In 2008 and early 2009 the sudden closure of several suburban health practices prompted major community concern. In March 2009, following the Assembly referral to the Standing Committee on Health Community and Social Services, the ACT Minister for Health, Ms Katy Gallagher MLA announced the establishment of a GP Taskforce to investigate GP workforce issues in Canberra.

1.11 The terms of reference for the GP Taskforce were:

i. to review and consolidate work already undertaken by the ACT and Commonwealth governments on access to primary care services in the ACT;

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[11] Budget 2009–2010 Australian Capital Territory, *Paper No. 3 Budget Overview*, p 78

[12] Budget 2009–2010 Australian Capital Territory, *Paper No. 3 Budget Overview*, p 78

[13] Submission no 12, ACT Health, pp 4–5

ii. to explore and recommend on legislative options to protect the rights of patients and the health workforce;
iii. to advise on workforce demand and training issues in primary health care, with regard to currently available published information;
iv. to explore and recommend on options and innovations to improve access to primary health care services in the ACT, including opportunities that may arise in the Commonwealth – State and Territory health reform agenda; and
v. to consider and make recommendations on provisions to improve access to primary care services for vulnerable populations, including the aged, people with mental illness and the isolated.[14]

1.12 In June 2009 the GP Taskforce released a Discussion Paper–Issues and Challenges for General Practice and Primary Health Care. The final report of the GP Taskforce, General Practice and Sustainable Primary Health Care - The Way Forward was tabled by the Minister for Health, Ms Katy Gallagher, on 15th September 2009. The Taskforce made 30 recommendations. The Minister tabled the Government response in the Assembly on 8 December 2009. The Government agreed to 17 recommendations and agreed in principle to 13 recommendations.

1.13 The Committee notes the work of the GP Taskforce in producing a comprehensive analysis of the current issues facing general practice and general practitioners in the ACT including the recommendations.

1.14 The Committee supports many of the recommendations in the GP Taskforce Report and will be drawing on the research of the Taskforce throughout this report.

The national context

1.15 The importance of health to national well-being is recognised in national and local health policy debates. At the national level the Australian Government established the National Health and Hospitals Reform Commission (NHHRC) (25 February 2008), the Preventative Health Taskforce (9 April 2008) and

[14] Submission no 12, ACT Government, p 2

announced the development of the first national primary health care strategy (11 June 2008), to begin its national health reform agenda.

1.16 The NHHRC was tasked to develop a long-term health reform plan for Australia. The Commission issued an interim report in December 2008 and its final report, *A healthier future for Australia,* was released in June 2009 containing 123 recommendations. The Australian Government is currently conducting public consultations around the country before formally responding to the report's recommendations. The recommendations, if adopted, could see the management and delivery of health care significantly altered.

1.17 The report focused on the following three areas of reform:

- tackling major access and equity issues that affect health outcomes for people;
- redesigning the health system to be better positioned to respond to emerging challenges; and
- creating an agile and self-improving health system for long-term sustainability.[15]

1.18 The Department of Health and Ageing was tasked with the development of a national primary health care strategy. *A Draft of Australia's First National Primary Health Care Strategy* and accompanying report, *Building a 21st Century Primary Health Care System* were launched by the Department on 31 August 2009. Among other things, the Draft Strategy 'sets the policy direction to better connect hospitals, primary and community care to meet patient needs, improve continuity of care and reduce demand on hospitals'.[16]

1.19 The National Preventative Health Strategy recommending a range of interventions aimed at reducing the chronic disease burden associated with

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[15] Australian Government, National Health and Hospitals Reform Commission, *A Healthy Future for All Australians, Final Report June 2009*, p 3

[16] Australian Government, Department of Health and Ageing, *Primary Health Care Strategy,* viewed 16 September 2009, p 6 <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draft-report-toc>

three lifestyle risk factors–obesity, tobacco and alcohol, was launched on 1 September 2009.[17]

1.20 A recent initiative of the Australian Government has been the introduction of the GP Super Clinic. To date 31 Super Clinics have been announced, with one planned for Queanbeyan. The Australian Government has indicated that it has no intention of funding a Super Clinic in the ACT at this stage. Tailored to the needs and priorities of local communities, Super Clinics have a multidisciplinary team-based approach which brings together GPs, medical specialists, allied health professionals and other health care providers. The Super Clinics:

> …are a key element in building a stronger national primary care system, including a greater focus on health promotion and illness prevention and better coordination between privately provided GP services, community health and other state and territory government funded services.[18]

1.21 With the burden of chronic disease also on the increase, due in part to the ageing population, the National Health Priority Action Council oversaw the development of the National Chronic Disease Strategy, as agreed by the Australian Health Ministers Advisory Council in 2002–2003.[19]

Health workforce

1.22 The Productivity Commission identified a shortage in overall numbers of health care workers across a range of medical, nursing, dental and allied health professionals, in its 2005 report, *Australia's Health Workforce*.[20]

1.23 The report cited the following examples:

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[17] Preventative Health Taskforce, viewed 16 September 2009, http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/national-preventative-health-strategy-1lp

[18] Australian Government Department of Health and Ageing, *GP Super Clinics*, viewed 9 September 2009, <http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinic->

[19] Australian Health Ministers Conference, National Chronic Disease Strategy, <http://www.health.gov.au/internet/main/publishing.nsf/Content/7E7E9140A3D3A3BCCA257140007AB32B/$File/stratal3.pdf>

[20] Productivity Commission, *Australia's Health Workforce,* 2005, p 11, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf>

- In 2002 the Australian Medical Workforce Advisory Committee estimated a shortage of between 800 to 1300 general practitioners.[21]
- In 2006 the Australian Health Workforce Advisory Committee estimated a nurse shortage of between 10,000 and 12,000.[22]
- In 2005 the Department of Employment and Workplace Relations identified shortages in the following health professions: dentists, hospital and retail pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists, pathologists, psychiatrists, registered nurses and sonographers.[23]

1.24 The Productivity Commission identified the following four strategies to address the workforce shortages in the health sector:

- focusing on the underlying demand for health services (prevention);
- increasing the number of education and training places;
- placing a greater emphasis on retention and re entry into the workforce; and
- improving the current system.[24]

1.25 The Commission was of the view that the best outcome would be achieved by focusing on improving the current system, stating:

> Improving the productivity and effectiveness of the available workforce, and its responsiveness to changing needs and pressures, will increase the level and quality of the workforce services that can be supported by any given level of

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[21] Australian Medical Workforce Advisory Committee, cited in, Productivity Commission, *Australia's Health Workforce*, 2005, p 12, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf>

[22] Australian Health Workforce Advisory Committee, cited in, Productivity Commission, *Australia's Health Workforce*, 2005, p 12, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf>

[23] Department of Employment and Workplace Relations, cited in, Productivity Commission, *Australia's Health Workforce*, 2005, p 12, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf>

[24] Productivity Commission, *Australia's Health Workforce*, 2005, p xviii, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf>

spending. This in turn will help to reduce the rate of growth in future health care expenditure, without compromising safety and quality.[25]

1.26 The Committee notes the significant investment in workforce reforms agreed at the COAG meeting of 29 November 2008. The package, comprising $1.1 billion of Commonwealth funding and $540 million in state /territory funding included:

- Commonwealth funding for undergraduate clinical training, including increasing the clinical training subsidy to 30 per cent for all health undergraduate places;
- an increase of 605 postgraduate training places, including 212 GP places (boosting the total number of GP training places to over 800 from 2011 onwards);
- the establishment of a national health workforce agency and health workforce statistical register;
- investment of $175.6 million over four years in capital infrastructure to expand teaching and training; and
- funding to train approximately 18,000 nurse supervisors, 5,000 allied health and other supervisors, and 7,000 medical supervisors.[26]

1.27 The Committee is also of the view that improving efficiency through better utilisation of the current workforce has the potential to improve health service delivery, not only in the short term but well into the future. Considerable evidence was presented to the Committee about the under-utilisation of the skills and training of nurses and other allied health professionals. The enhanced role of these health professionals is discussed in chapter three.

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[25] Productivity Commission, *Australia's Health Workforce,* 2005, p xviii, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf>

[26] Council of Australian Governments Meeting, Communiqué, Canberra, 29 November 2008, pp 14–15, viewed 20 November 2009, <http://www.nhwt.gov.au/documents/COAG/COAG%20Communique%20November%202008.pdf>

Conduct of inquiry

1.28 Following the closure of the Kippax Medical Centre (also owned by Primary Health Care) in March 2009, and ongoing community concern about the shortage of general practitioners in the ACT, the Legislative Assembly, on 25 March 2009, passed a resolution referring this matter to the Standing Committee on Health, Community and Social Services.

1.29 In its referral to the Committee, the Assembly recognised that:

- the ACT has the second lowest number of GPs per capita in Australia behind the Northern Territory;
- GP clinics across the Territory continue to close; and
- the number of aged and ageing in the community in need of access to general practitioners for ongoing primary health care is increasing.[27]

1.30 The Committee revised the terms of reference and adopted the following, at a private meeting on 29 April 2009:

To inquire into and report on access to primary health care services in the ACT, with particular reference to:

- the role of nurse practitioners, allied health assistants and other health professionals in providing primary health care;
- GP clinic closures since 2001;
- the current level of GP shortages in the ACT and the reasons pertaining to this shortage;
- how to arrest, and reverse, the decline in GP numbers in the short and longer term;
- strategies to attract and retain GPs in suburban clinics;
- linkages between Government and non-government health care providers including innovative and best practice models; and
- any other related matter.[28]

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[27] Legislative Assembly for the Australian Capital Territory 2008–2009, Minutes of Proceedings, No. 12, Wednesday 25 March 2009, pp 144-146

1.31 The Committee advertised the inquiry in *The Canberra Times*, *The Chronicle,* and on the Legislative Assembly Website, and invited submissions from a broad range of stakeholders.

1.32 The Committee held three public hearings on 22 July 2009, 29 July 2009 and 5 August 2009 and heard from 33 witnesses. The list of witnesses is at Appendix A.

1.33 The Committee also received 18 submissions and 8 exhibits from general practitioners, allied health professional groups, nurses, community groups and individuals. The full list of submissions and exhibits is at Appendix B.

Structure of this report

1.34 The evidence received by the Committee canvassed a wide range of issues, many of which are matters for the Australian Government. The Committee has however, included these in this report to highlight the complexity of the health care system and to demonstrate where improvements could be made at the national level. Many of the issues discussed in this report have also been covered by the GP Taskforce. The Committee has included this evidence in this report to add further weight, in many instances, to the arguments presented by the GP Taskforce.

1.35 Chapter two of this report focuses on the state of general practice in the ACT and general practitioner workforce issues, including ageing general practitioners. As per the Committee's terms of reference, strategies to retain general practices in suburban areas are explored.

1.36 Chapter three deals with primary health care, including a discussion on the enhanced role of allied health professionals, practice nurses and nurse practitioners, and the community pharmacy. This chapter also considers the ACT Government's nurse-led walk-in clinic and other alternative models of primary health care service delivery.

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[28] Standing Committee on Health, Community and Social Service, Minutes of Meeting, No 12, 29 April 2009

1.37 Chapter four looks at aspects of access and equity as they relate to the health care needs of disadvantaged and vulnerable members of the ACT community. The Committee considers targeted health care, including health care for the elderly, young people, refugees and Aboriginal and Torres Strait Islander people.

1.38 Chapter five explores some of the current trends in improving the efficiency of the current system such as e-health, health literacy and preventative health. The Committee also explores alternative models of primary heath care currently being trialled in other jurisdictions.

1.39 The final chapter presents a summary of the Committee's findings.

2 THE STATE OF GENERAL PRACTICE IN THE ACT

2.1 General practitioners have traditionally been the 'gate keepers' or the first point of access into the health care system and a major provider of primary health care in Australia. With the increasing pressure on the health care system the workload on general practitioners has also increased.

2.2 The Royal Australian College of General Practitioners (RACGP) defines general practice as:

> …the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.[29]

2.3 General practice is the business structure within which one or more general practitioners and other staff, such as practice nurses, provide and supervise health care for patients presenting to the practice. General practices are predominantly privately owned by GPs or corporate entities.[30]

2.4 The major funding for general practice is provided through the Medicare Benefits Schedule (MBS). The Australian Government also provides Practice Incentive Payments (PIP) and Service Incentive Payments (SIP) for practices accredited through Australian General Practice Accreditation Limited (AGPAL), against standards provided by the RACGP.[31] The Australian Government is also responsible for the training and distribution of general practitioners.

2.5 State and territory governments indirectly provide funding to general practice through various programs that may include:

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[29] Royal Australian College of General Practitioners, cited in Productivity Commission, *Report on Government Services 2009*, p 11.2, viewed 10 October 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0007/85408/47-chapter11-only.pdf>

[30] Productivity Commission, *Report on Government Services 2009*, p 11.2, viewed 10 October 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0007/85408/47-chapter11-only.pdf>

[31] Australian General Practice Accreditation Limited (AGPAL), viewed 10 October 2009, <http://www.qip.com.au/accreditation.asp?acrid=13>

> …support services for GPs (such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas), or education and support services for public health issues such as diabetes management, smoking cessation, sexual health, and mental health and counselling.[32]

2.6 General practitioners also receive payments through non-government sources such as private health insurance, workers compensation, third party and private individuals.[33]

GPs in the ACT

2.7 Australia is experiencing a shortage of general practitioners. A cap placed on university places for medical students in the mid 1990s reduced the intake from 670 to 400.[34] At that time, the introduction of compulsory vocational registration for GPs required medical graduates to undertake postgraduate training before becoming registered GPs.[35]

2.8 Despite the cap being raised in subsequent years Australia is still experiencing a shortage of GPs. While the reasons for this are complex, the Australian Medical Workforce Advisory Committee attributes this to 'increased demand, uneven distribution, decreased working hours and an ageing GP population'.[36]

2.9 The latest figures from the Productivity Commission show 82.7 full time workload equivalent (FWE) general practitioners per 100,000 people across Australia for 2008. Based on these figures the FWE for the ACT is around 63 GPs per 100,000 people, equating to a shortage of 60–70 general practitioners. Despite a slight increase in the number of GPs in 2007–2008, the ACT, as noted earlier, has the second lowest number of GPs per capita in Australia, behind

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[32] Productivity Commission, *Report on Government Services 2009*, p 11.6

[33] Productivity Commission, *Report on Government Services 2009*, p 11.6

[34] Dr Rhonda Jolly, *Medical practitioners: education and training in Australia,* Background Note, Parliamentary library, information, analysis and advice for the parliament, 15 July 2009, p 1

[35] Britt et al, *General Practice in Australia, health priorities and policies 1998 to 2008*, p 23

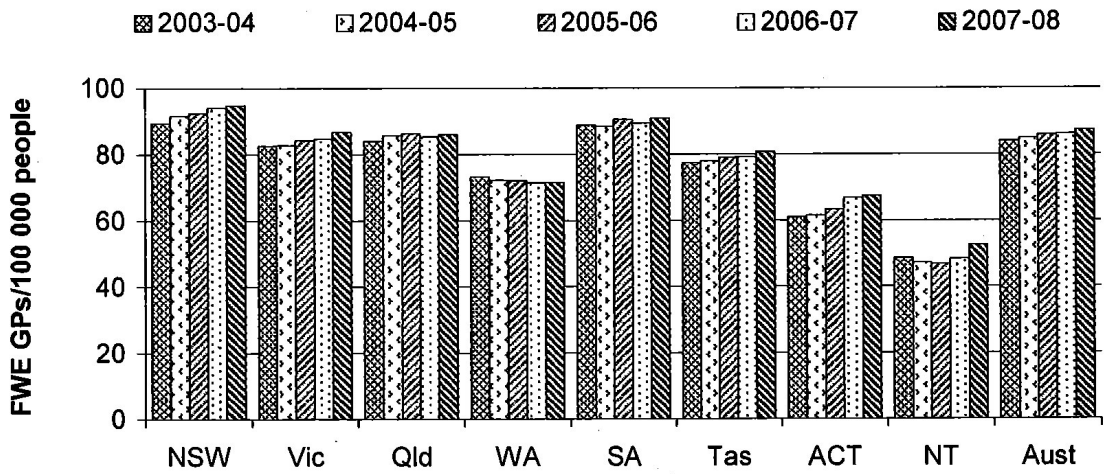
[36] Medical Workforce Advisory Committee, cited in, Britt et al, *General Practice in Australia, health priorities and policies 1998 to 2008*, p 23

the Northern Territory.[37] The ACT Government estimates the ACT to be approximately 74 FWE GPs short.[38]

2.10 Table 1, from the Productivity Commission Government Services Report, shows the availability of general practitioners (FWE) from 2003–2008 across Australia.[39]

Table 1 Availability of GPs (full time workload equivalent)[40]

Figure 11.1 **Availability of GPs (full time workload equivalent)[a]**



[a] Data include vocationally recognised GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice.

Source: DoHA (unpublished), derived from the MBS data system; table 11A.3.

2.11 Despite the low number of practicing GPs in the ACT, there are a greater number of GPs who are engaged in a variety of other roles. The GP Taskforce cites figures from Medicare billing data that show that while 425 GPs are claiming Medicare rebates in the ACT, the FWE figure translates to 232 GPs.[41] The GP Taskforce attributes this to the variety of employment opportunities within the ACT such as government, teaching and research positions, and notes that this 'could be used to sell general practice as an interesting and diverse career'.[42] The Taskforce goes on to recommend that the ACT is

[37] Productivity Commission, *Report on Government Services 2009*, p 11.8

[38] Submission no 12, ACT Government, p 1

[39] Productivity Commission, *Report on Government Services 2009*, p 11.9

[40] Productivity Commission, *Report on Government Services 2009*, p 11.9

marketed to GPs as 'a place of work choice and flexibility with employment opportunities additional to usual GP clinical work'.[43]

2.12 The Committee supports this recommendation and notes that the ACT Government has agreed in principle to the recommendation.

Ageing workforce

2.13 The general practitioner workforce is ageing, with fewer medical graduates taking up general practice. In the ACT, 37 per cent of the GP workforce is over 55 years of age.[44] As Dr Peter Sharp, Medical Director, at Winnunga Nimmityjah Aboriginal Health Service explained:

> … we have seven part-time GPs. Three of our doctors are over 70 years old. One turns 80 this week. One doctor, who is 75 years old, does four days a week. Without him, we would be completely lost and unable to provide the services we can.[45]

2.14 While training places for medical students have increased over the years, the number of medical gradates taking up general practice has declined. For those that do, it will still be many years before they are qualified general practitioners. Dr Sharp noted that this situation was not likely to improve in the near future, and that with the current pressure on GPs, in a time of high demand, coupled with low morale, the community could expect to continue to see ageing doctors retire.[46]

2.15 Dr Sharp told the Committee:

> People [doctors] feel undervalued, underrated. There is a feeling that I, we, can be replaced tomorrow by almost anybody else, that specialists are far

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[41] GP Taskforce, *Issues and Challenges for General Practice and Primary Health Care, June 2009, A Discussion Paper*, pp 12-13

[42] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 21

[43] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, recommendation 10, p 22

[44] ACT Medical Board, cited in GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 16

[45] AMA, *Transcript of Evidence*, 29 July 2009, p 62

[46] AMA, *Transcript of Evidence*, 29 July 2009, p 62

> more highly valued, that nurse practitioners can walk in and do the same job.[47]

2.16 A concern reinforced by Dr Steve Kennealy, Treasurer of the ACT Division of the Australian Medical Association (AMA), who told the Committee that some general partitioners considered there was an 'erosion of community and government support for general practice'.[48]

2.17 With the shortage of general practitioners in the ACT, the Committee is concerned about low morale, particularly for ageing GPs who are close to retirement.

2.18 Of even greater concern is the finding of the Australian Institute of Health and Welfare report that 'patient age mirrors the age of GPs'. The report *General practice in Australia, health priorities and policies 1998–2008* states:

> …general practitioners in the oldest age group see patients aged 65 years and older at more than double the rate of the youngest GPs. As age of GPs increases, the proportion of their workload spent with Commonwealth concession cardholders and non-English-speaking background patients also increases.[49]

2.19 The GP Taskforce also supported prolonging the working life of ageing GPs as a strategy to achieve short term sustainability. The Taskforce noted that:

> …there are some possible strategies to support older GPs in their current practice, and some options to provide new ways of part-time work for semi retired GPs in innovative service models–for example in aged care.[50]

2.20 While the GP Taskforce does not elaborate on what the strategies might be, the Committee strongly supports the implementation of any such strategies that are currently available. The Committee also supports the development of new

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[47] Dr Peter Sharp, *Transcript of Evidence*, 29 July 2009, p 62

[48] Dr Steve Kennealy, *Transcript of Evidence*, 29 July 2009, p 64

[49] J Childs, et al, 'The independent effect of age on general practitioner on clinical practice', cited in Australia Institute of Health and Welfare, *General practice series, No 24 general practice in Australia, health priorities and policies 1998–2008,* July 2009, p 22

[50] *General Practice and Sustainable Primary Health Care - The Way Forward,* GP Taskforce, Final report September 2009, p 21 (Note: the Committee received a submission from HealthCube proposing an innovative proactive model of care for residents in aged care facilities. This is discussed in chapter four and may well be suited to the older general practitioner.)

strategies to address this problem. Chapter four of this report examines health care for the elderly, with particular mention of an innovative service delivery model for elderly people in residential aged care facilities (RACFs). The Committee is of the view that this model, or similar, has the potential to utilise the services of older general practitioners, particularly those close to retirement who may wish to work reduced hours. (See recommendation 16).

2.21 The Committee considers that raising morale of general practitioners and supporting ageing doctors may also go some way to achieving this goal, and that a general education campaign to raise the profile of GPs could facilitate this.

RECOMMENDATION 1

2.22 **The Committee recommends that the ACT Government work with the ACT Division of General Practice to develop ways of raising the profile of general practitioners in the community.**

2.23 Dr Edmund Bateman, Managing Director of Primary Health Care Ltd told the Committee that his company 'extended the life of some ACT practitioners by stopping them retiring and/or freeing them up to do more hours than they used to do'.[51]

2.24 In its submission to the Committee, Healthscope Limited also reported that problems faced by GPs in smaller practices were leading many to close their practices, retire earlier than planned, or join a larger practice. One recent recruit to Healthscope's North Canberra Family Practice, was reported to have said 'the centre enabled me to prolong my work life'.[52]

2.25 The Committee acknowledges the role played by the corporate-owned medical centres in offering alternative employment to retiring GPs.

2.26 The Committee also notes that the ACT Government agreed in principle to the Taskforce's recommendation to 'create and publicise opportunities for GPs over 55 years of age to remain engaged with work in general practice in the

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[51] Dr Edmund Bateman, *Transcript of Evidence*, 5 August 2009, p 129

[52] Submission no 2, Healthscope Limited, p 2

ACT', stating the Government 'will look into marketing better opportunities for GPs over the aged [sic] of 55'.[53]

2.27 With the high proportion of the health care needs of the elderly being conducted by older GPs and the high number of retirements, the Committee considers that it may be possible to extend the working life of some general practitioners. While the Committee does not consider it appropriate to prevent people from retiring at the time of their choosing, from any profession, the Committee is concerned that the current climate is contributing to the early retirement of some general practitioners, and that more should be done to assist people to stay in the workforce, should they wish to do so.

RECOMMENDATION 2

2.28 **The Committee recommends that the ACT Government extend their marketing strategy for GPs over the age of 55 to include attracting and re-engaging recently retired GPs from across Australia, with particular attention to NSW and Victoria.**

Overseas trained doctors

2.29 According to the GP Taskforce, the predominant challenge for delivering primary health care in Canberra is the general practice workforce shortage.[54] To address this in the short to medium term, one of the strategies recommended by the GP Taskforce is that the ACT Government focus on overseas recruitment.[55] The Committee notes that this is a short term strategy, but has some concerns about the problems associated with recruiting overseas trained doctors (OTDs).

2.30 A Senate Select Committee on Medicare raised concern regarding the reliance on recruiting doctors from overseas as part of the Medicare Plus reform

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[53] ACT Government, *Government Response to the GP Taskforce Final Report General Practice and Sustainable Primary Health Care: The Way Forward*, p 4

[54] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, Final Report September 2009, p 16

[55] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, Final Report September 2009, p 16

package released by the Australian Government in 2003, following the Medicare Inquiry. The Senate Committee stated:

> …the increasing reliance on OTDs should represent both a moral and practical warning to policy makers. While Australia's recruitment from overseas of a number of doctors roughly equivalent to those Australian doctors choosing to leave is acceptable, the country's continuing status as a net importer of medical practitioners is morally questionable, and substandard from a policy perspective.[56]

2.31 The Minister for Health, Ms Katy Gallagher was asked about her views on the moral dilemma of recruiting doctors from countries experiencing shortages at the 2009 Estimates Committee hearing on 19 May 2009. The Minister advised:

> There are some benefits for countries in the long run too and many of these doctors do come for a short period of time and then return overseas.[57]

2.32 The Committee is not opposed to overseas recruitment from countries that have an oversupply of general practitioners, as a short term strategy.

2.33 The Committee was interested in further information regarding medical recruits from overseas countries, with particular regard to their country of origin, their length of stay in the ACT, and the details of the return to their country of origin. In response to a question on notice to the 2009 Estimates Committee, the Minister for Health advised that 'the information on country of origin is not recorded as 457 visas require only a valid passport'. The Minister further advised that information regarding the number of overseas recruits that do return to their country of origin is not available.[58] The Committee considers this to be important information that should be publically available.[59]

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[56] Senate Select Committee on Medicare, *Medicare Plus: the future for Medicare*, February 2004, p xv <http://www.aph.gov.au/Senate/committee/medicare_ctte/medicareplus/report/report.pdf>

[57] Minister for Health, Select Committee on Estimates, *Transcript of Evidence,* 19 May 2009, p 231

[58] See Estimates 2009–2010 Questions on Notice, numbers QTN 5 and QTON 535.

[59] Ms Mary Porter does not support recommendation 3 and does not support the term moral dilemma used in the 1st sentence of paragraph 2.34.

RECOMMENDATION 3

2.34 **The Committee recommends that ACT Health collect and publish data on the number of overseas trained doctors recruited to the ACT, including their country of origin, the length of stay, and whether they return to their country of origin.**

2.35 Apart from the moral dilemma of recruiting doctors from overseas countries there are also a number of problems related to red tape at the national level. While this is a matter for the Australian Government, the Committee considers it is important, to further encourage the ACT Government to lobby its federal counterpart to simplify the bureaucratic processes associated with overseas recruitment, such as medical registration and immigration requirements, the recognition of overseas qualifications and training, and obtaining medical indemnity cover and a Medicare provider number.[60]

2.36 Two recent examples reported in *The Canberra Times* highlight some of the problems faced by OTDs in Australia. In the first example it was reported that lack of communication between Medicare, the Department of Health and Ageing, and the ACT Medical board caused substantial problems for a German doctor.[61] In another example reported, a Canadian doctor was forced to give up her practice on becoming a permanent resident, as she had not received a Fellowship of the Royal Australian College of General Practitioners. She was subsequently granted a 12 month exemption by the Department of Health and Ageing, due to her position as an academic at the ANU.[62]

2.37 The Committee notes the Nationally Consistent Assessment process for international medical graduates as agreed to by COAG in 2006. These include three pre-registration pathways for OTDs seeking to practice in the ACT that require OTDs to be assessed prior to applying to be registered for practice in

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[60] Australian Government, Department of Health and Ageing, *DoctorConnect*, viewed 9 February 2010, <http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/splashpage>

[61] Ms Danielle Cronin, 'Overseas-trained doctors warned: 'Don't come here'', *The Canberra Times*, 24 August 2009, p 3

[62] Mr Tom Skotnicki, 'Red tape reprieve for doctor in limbo', *Sunday Canberra Times*, 18 October 2009, p 11

the ACT.[63] The Committee further notes that the implementation of these assessment processes began in July 2008 and expects to see positive results for the doctors being recruited from overseas countries, as well as for those sponsoring the recruits.

Female general practitioners

2.38 The latest figures from the Primary Health Care Research and Information Service (PHC RIS) show that 50 per cent of the general practitioner workforce in the ACT is female. This is higher than the national average of 37 per cent.[64] The ACT has recorded higher than average numbers of female GPs over the last three years.

2.39 The GP Taskforce discussion paper cited evidence, based on Medicare billing data, that many GPs are choosing to work part-time in their clinical practice. One of the reasons for this is the increasing feminisation of the general practitioner workforce.[65] Data from the Bettering the Evaluation and Care of Health (BEACH) survey also found that female GPs worked on average 13.6 fewer hours than male GPs.[66]

2.40 This trend is likely to continue as women accounted for 57.3 per cent of first year medical students in 2004, and 46.6 per cent of advanced vocational trainees in 2007.[67]

2.41 The Committee notes the comments from the GP Taskforce relating to difficulties female GPs experience in relation to childcare and re-entering the workforce. With more female GPs providing medical care, the Committee considers it important to be responsive to the needs of women and notes that the Government has agreed in principle to recommendation 11 of the GP Taskforce to:

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[63] Medical Board of the ACT, Registration, viewed 20 November 2009, <http://www.medicalboard.act.gov.au/Content.asp?IntContId=194&IntCatId=8>

[64] Primary Health Care Research and Information Service, *Female GPs by state*, 2007–2008, viewed 20 October 2009, <http://www.phcris.org.au/fastfacts/fact.php?id=8275>

[65] GP Taskforce, *Issues and Challenges for General Practice and Primary health Care, June 2009, A Discussion Paper*, pp 12–13

[66] Britt et al, *General Practice in Australia, health priorities and policies 1998 to 2008*, p 24

[67] Britt et al, *General Practice in Australia, health priorities and policies 1998 to 2008*, pp 24–25

Support GPs taking parental leave to stay engaged in the clinical workforce by developing a suite of supports including access to childcare and provision of re-entry programs for GPs returning to the clinical workplace.[68]

Training to become a general practitioner

It's a long and arduous road from student to medical practitioner.[69]

2.42 General practice is a specialist field of medicine that can take up to 12 years of full-time study and practical on-the-job training.

2.43 A career in medicine begins with an undergraduate degree of five to six years or a postgraduate degree of four years. Entry to university is based on matriculation results, admission test and an interview. On obtaining a medical degree, graduates must complete at least one year as an intern of supervised medical experience. This training is usually provided in a public teaching hospital. Students frequently choose a hospital in the state or territory where they have completed their degree.[70]

2.44 Following the completion of the internship, registrars may choose general practice as a career. To qualify as a general practitioner, registrars must complete a three-year full-time vocational training program, provided through the Australian General Practice Training Program (AGPTP).[71]

2.45 AGPTP describes the benefits of general practice as a career choice as:

- flexible working hours;
- continuity of patient care;
- varied clinical work; and
- dynamic, team-based medicine.[72]

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[68] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward,* September 2009, p 22

[69] Dr Rhonda Jolly, *Medical practitioners: education and training in Australia,* Background Note, Parliamentary library, information, analysis and advice for the parliament, 15 July 2009, p 37

[70] Jolly, *Medical practitioners: education and training in Australia,* p 20

[71] *General Practice can take you there,* Australian General Practice Training Handbook 2010

[72] *General Practice can take you there,* Australian General Practice Training Handbook 2010 p 2

2.46 However, the number of medical graduates moving into general practice has been declining. In its submission to the GP Taskforce the ACT Division of General Practice (ACT DGP) noted that only 29 per cent of medical graduates chose general practice as a career in 2008, compared to 50 per cent in 1996.[73] The GP Taskforce identified a number of reasons for the decline in general practice as a career choice, stating that general practice was:

- considered to be underfunded;
- professionally demanding;
- of a lower status than specialised medical practice; and
- not as well remunerated as other medical professionals and specialists.[74]

2.47 To counteract the declining interest in general practice the Australian Government introduced and funded the Prevocational General Practice Program (PGPPP) in late 2005, to provide voluntary, well supervised general practice placements for junior doctors in outer metropolitan, regional, rural and remote areas.[75]

2.48 Research has found that positive experiences and early exposure to general practice increases the likelihood of general practice being chosen as a vocation.[76]

2.49 The PGPPP aims to:

- build junior doctor confidence, exposure and interest in working in outer metropolitan and regional areas through supervised general practice placements;

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[73] ACT Division of General Practice, *Submission to the GP Taskforce, Response A Discussion Paper - Issues and Challenges for General Practice and Primary Health Care*, June 2009, p 5

[74] ACT Health, *General Practice and Sustainable Primary Health Care - The Way Forward*, GP Taskforce, September 2009, p 9

[75] Prevocational Program Quarterly, November 2005, p 2, viewed 18 October 2009, <http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/Prevocational/PGPPP/PGPPPquarterlynewsletter/200511PrevocProgram.pdf>

[76] Prevocational Program Quarterly, November 2005, p 3, viewed 18 October 2009, <http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/Prevocational/PGPPP/PGPPPquarterlynewsletter/200511PrevocProgram.pdf> also see ACT DGP submission to GP Taskforce and GP Taskforce Final Report p 18

- increase understanding of the integration between primary and secondary health care by junior doctors; and
- provide an experience that may encourage junior doctors to take up general practice as a career.[77]

2.50 The Committee heard supporting evidence for the PGPPP program at the local level. Dr Sharp told the Committee:

> …one of the most useful things is the PGPPP system where we start getting interns into training schemes in general practice. There are two or three in the system at the moment and more have been discussed. I understand at the moment it is a funding problem in getting the interns from the hospital into general practice. This will give the interns enormous and useful experience and … provide support to general practice as well.[78]

2.51 The Committee notes that the while the PGPPP has been in operation since 2005, the take-up in the ACT has been slow. The pilot was conducted in 2008, with interns from the Canberra Hospital placed at the Interchange General Practice and the Isabella Plains Medical Practice for 10 week placements. The pilot was successful with both practices expressing a desire to continue with the placements in 2009.[79]

GPs in community health services

2.52 In evidence to the Sixth Assembly Standing Committee on Health and Disability, Mr McGowan from the Health Care Consumers Association raised the issue of increasing the number of salaried positions for GPs in the ACT. As Mr McGowan explained:

> There are many GPs who are choosing to work for a salary so that they are not saddled with those extra responsibilities, and so that they have more freedom for family purposes, for travel, for career changes and going overseas and for

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[77] Royal Australian College of General Practitioners, Prevocational General Practice Program, viewed 10 October 2009, <http://www.racgp.org.au/pgppp>

[78] Dr Peter Sharp, *Transcript of Evidence*, 29 July 2009, p 63

[79] 2008 Annual Report, Coast City Country Training Ltd, pp 19–20 viewed 20 November 2009, <http://www.ccctraining.org/GPRime/documents/CCCT_AnnualReport_2008.pdf>

> serving with Medicins Sans Frontiers or whatever. There is a whole range of young doctors who want those freedoms.[80]

2.53 This may be evidenced in the ACT by the number of general practitioners choosing to join a corporate owned practice. There are currently two corporate providers, Primary Health Care Limited and Healthscope Medical Centres Pty Limited that employ general practitioners in the ACT.

2.54 The establishment of Medicare in 1984 and the introduction of bulk-billing for GP services changed the role that was previously played by community health services (CHSs) in providing health care to people on low incomes.[81] At that time there was no universal cover and community health services played an important role in the provision of general practitioner services to financially disadvantaged people.

2.55 The advent of Medicare and growing opposition from some medical organisations to GPs taking part in multi-disciplinary teams, 'on any other basis than as team leaders remunerated by fee-for-service' saw a decline in the number of GPs in community health services in the early 1990s. There was also the view expressed by some GPs that publicly funded CHSs offering free medical care, as well as a range of other health care services, was unfair competition, especially for small practices.[82]

2.56 The decision to cease funding salaried GP positions in community health services in the ACT was made in 1995 by the government of the day, based on the argument that it was no longer financially viable and was a duplication of services, as the Australian Government had taken over responsibility for funding general practitioners. At that time, it was argued that replacing the salaried positions with bulk-billing GPs would ensure that people were not disadvantaged.[83] Despite the ACT being the only jurisdiction at that time

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[80] Mr Russell McGowan, *Transcript of Evidence*, 14 August 2008, p 31

[81] Primary Health Care Reform in Australia, *Report to Support the Australia's First Primary Health Care Strategy*, 2009, p 17

[82] Paul Laris & Associates, *Community Health Centres In South Australia: A Brief History and Literature Review,* Report Commissioned by the Generational health review, November 2002, p 14 https://www.library.health.sa.gov.au/Portals/0/community-health-centres-in-south-australia-a-brief-history-and-literature-review.pdf

[83] Legislative Assembly for the Australian Capital Territory, *Hansard*, 22 August 1995, p 1199

funding salaried GP positions, the ACT opposition of the day strongly opposed the decision.[84]

2.57 However, the growing concern about people's access to GPs in the early 2000s saw some shifts in policy. In 2002, a study commissioned by the Victorian Government Department of Human Services into the role of GPs in CHSs found that these GPs were more likely to:

- service a greater number of clients with complex needs and chronic conditions;
- refer their clients to allied health professionals;
- service a higher number of people from culturally and linguistically diverse backgrounds; and
- work within the social model of health, taking into account the social problems facing the client.

The findings from the study formed the 'basis for the rationale to expand the role of GPs and increase access to medical services within a community health setting'.[85]

2.58 In 2004 the Victorian Government launched a strategy to expand general practice services within community health services, committing $2 million per annum. The aims of the strategy were to:

- improve access to general practice, particularly for Victorians experiencing difficulty accessing a GP;
- generate genuine service integration and coordination between GPs and CHSs; and
- improve workforce capacity for CHS medical teams.[86]

2.59 In 2002 a South Australian review conducted by Paul Laris et al also found evidence to suggest that the provision of general practitioner services through CHSs 'enhanced both the effectiveness of that care and enabled the overall

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[84] Legislative Assembly for the Australian Capital Territory, *Hansard*, 24 August 1995, p 1445

[85] Victorian Government, Departemnt of Human Services, *General Practitioners in Community Health Services Strategy*, p 6

[86] General Practitioners in Community Health Services Strategy May 2004, p 2, viewed 15 October 2009, <http://www.health.vic.gov.au/communityhealth/downloads/gps_in_chs_strategy.pdf>

primary health care system to be more effective'.[87] The review argued that increasing salaried GP positions in CHS should be considered, given the following circumstances:

- decline in bulk billing for private GP services;
- poor morale amongst private GPs who are experiencing high workloads associated with business administration, increased overheads and inadequate rebates leading to a reduction in bulk billing; and
- the increasing corporatisation of general practice, with GPs selling off their practices in favour of working for a salary or commission basis for medical entrepreneurs.[88]

2.60 The Committee is concerned about access to health care for low income earners and their families, particularly in light of the limited access to bulk-billing services in the ACT. Recent changes to Canberra's main bulk-billing services owned by Primary Health Care Limited is likely to impact disproportionately on those people already experiencing disadvantage, as discussed further in chapter four.[89] The circumstances today are significantly different from the 1990s and while some general practices in the ACT provide bulk-billing services to people with eligible concession cards, not all financially disadvantaged people have such a card. The Committee notes that the decision to bulk-bill patients is one for individual practices. Chapter four discusses bulk-billing in more detail.

2.61 In its submission to the Committee, the ACT Government advised of an allocation of $51.3 million for the construction of an enhanced community health centre in North Canberra, stating:

> This centre presents an opportunity for an integrated approach to primary health care delivery, with the possibility of including GPs as part of the multi-

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[87] Paul Laris & Associates, *Community Health Centres In South Australia: A Brief History and Literature Review,* Report Commissioned by the Generational health review, November 2002, viewed 28 January 2010, p 19 <https://www.library.health.sa.gov.au/Portals/0/community-health-centres-in-south-australia-a-brief-history-and-literature-review.pdf

[88] Paul Laris & Associates, *Community Health Centres In South Australia: A Brief History and Literature Review,* Report Commissioned by the Generational health review, pp 19–20 (Also see chapter five of this report for a discussion of the NSW HealthOne model, as an example of multi-disciplinary community based health care.)

disciplinary team, alongside diagnostic services and outpatient services on the same site.[90]

2.62 The Committee is pleased to note that the ACT Government is considering the inclusion of GPs in community health services. While the circumstances in the 1990s did not support this model, the landscape is such that the Committee considers it is timely to explore the reintroduction of salaried positions for general practitioners in community health services in the ACT.

RECOMMENDATION 4

2.63 **The Committee recommends that the ACT Government conduct a feasibility study on employing salaried general practitioners in community health centres.**

General practices

2.64 General practitioner services in the ACT are delivered through sole GP practices, group GP practices, corporate owned and managed medical centres, hospital emergency departments and the after hours locum service. However, the smaller family practices, many of which are located in local communities, are slowly diminishing and being replaced by larger practices located in or near town centres.

2.65 The Committee does not advocate for any one model of practice, acknowledging that the different models serve different purposes. The Committee also notes that consumers may alternate between the models, depending on the nature of their medical need. It has been argued that the corporate model is more suited to acute or episodic care, while the family practice offers a more personalised service and continuity of care, particularly for patients with chronic and/or complex conditions.[91]

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[90] Submission no 12, ACT Health, p 6

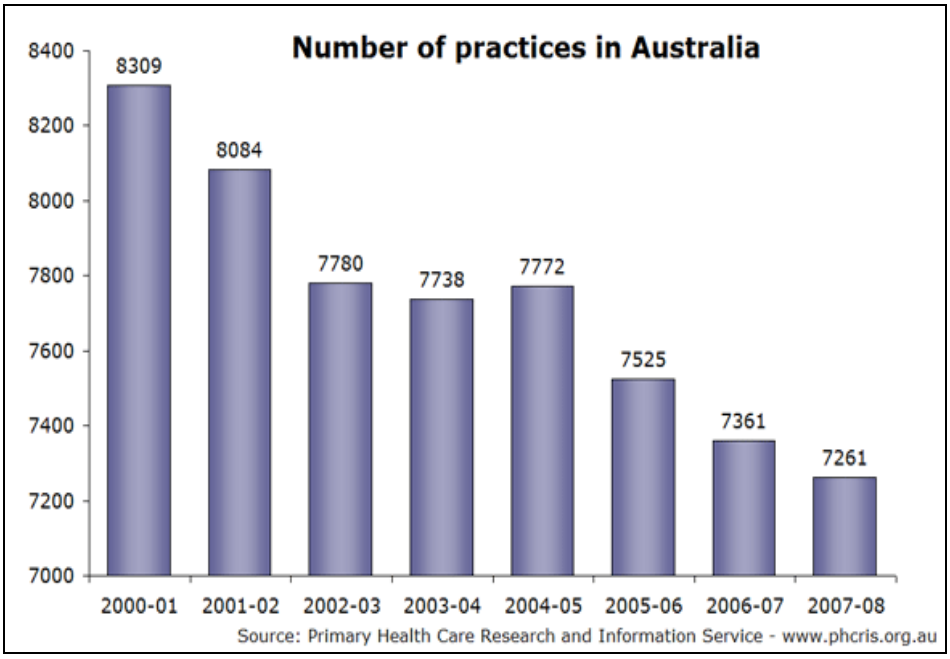
[91] for example see Submission no 13 Companion House; and Submission no 14, Dr Lee

General practice numbers

2.66 Divisions of General Practice across Australia are required to complete the Annual Survey of Divisions (ASD) 'which includes questions about their membership, activities (including population health) and infrastructure for the previous financial year'. The Primary Health Care Research and Information Service (PHC RIS) conducts the survey on behalf of the Australian Government Department of Health and Ageing.[92]

2.67 Since 2000–2001, Australia has seen a 12.6 per cent decline in general practice numbers. However, the rate of decline in the ACT has been higher at 25 per cent. The table below, from PHC RIS, shows an overall decline in reported practice numbers across Australia between 2000–01 and 2007–08, apart from a slight increase in 2004–05.

Table 2 Number of practices in Australia[93]



2.68 Figures to June 2008 for the ACT show an estimated 92 general practices. Prior to 2006–07, practice numbers remained relatively stable with a brief spike reported in 2002–03. However, as table 3 from PHC RIC on page 31 shows,

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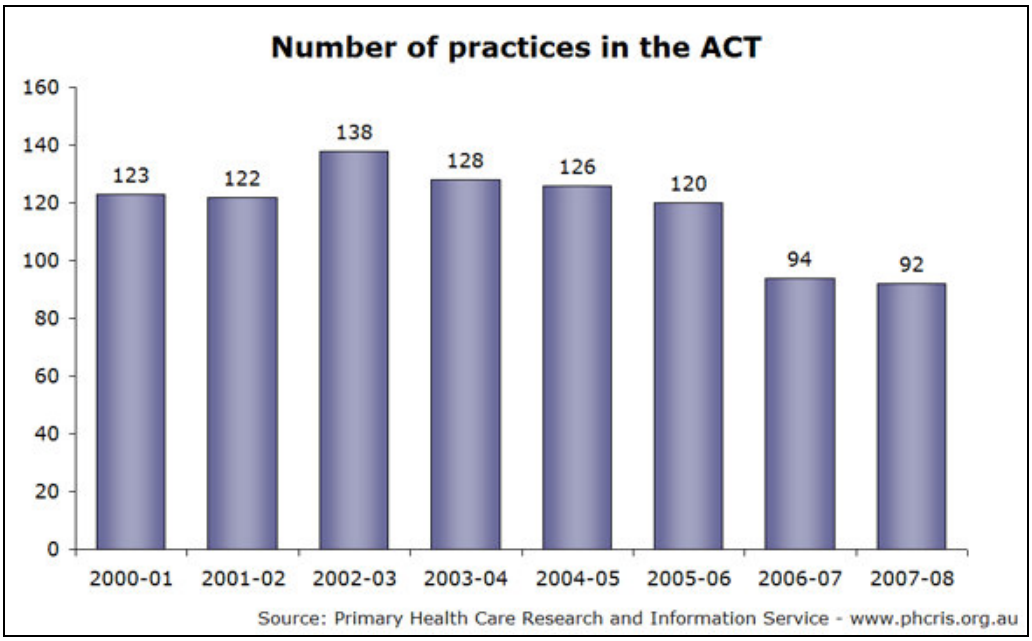
[92] Primary Health Care Research and Information Service (PHC RIS), *Annual Survey of Divisions*, viewed 24 September 2009, <http://www.phcris.org.au/products/asd/index.php>

[93] Primary Health Care Research and Information Service (PHC RIS), *Annual Survey of Divisions*, viewed 24 September 2009, <http://www.phcris.org.au/products/asd/index.php>

since 2005–06 there has been a decline of 28 practices in the ACT. Since 2000–2001 the Act has experienced close to a 25 per cent drop in the number of practices, a much greater decrease than experienced in other states and territories.[94]

Table 3 Number of practices in the ACT[95]



2.69 The decline in practice numbers coincides, for the most part, with the introduction of the 1999 Australian Government scheme, *GP Links: Making your practice work better.* At that time, it was thought that amalgamating smaller practices into larger ones would be more efficient. The program offered financial incentives to practices to encourage amalgamation.[96]

2.70 Mr Robert Wells, Director of the Australian Primary Health Care Research Institute, ANU, told the Committee that evidence supports the efficacy of larger practices, from a clinical perspective. This is attributed in part to a

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[94] Primary Health Care Research and Information Service (PHC RIS), Fast Facts, *General Practice Numbers in the Australian Capital Territory 2001–2008*, viewed 24 September 2009, <http://www.phcris.org.au/fastfacts/fact.php?id=6757>

[95] Primary Health Care Research and Information Service (PHC RIS), Fast Facts, *General Practice Numbers in the Australian Capital Territory 2001–2008*, viewed 24 September 2009, <http://www.phcris.org.au/fastfacts/fact.php?id=6757>

[96] Australian Government, Department of Health and Ageing, media release, *Government offers incentives for general practice amalgamation*, 10 March 1999, viewed on 10 October 2009, < <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-mediarel-yr1999-mw-mw99021.htm>

greater capacity to provide extended hours of operation, better links with other health professionals, the ability to employ practice nurses, improved access through appointment scheduling, and the provision of more comprehensive care to their patients.[97]

2.71 Furthermore, Mr Wells told the Committee that the consolidation of practices is an international trend being supported by current funding models, that could be quite costly to reverse.[98]

2.72 Despite ongoing community support for the locally based small family practice, the GP Taskforce noted that:

> …over the next few years there will likely be a redistribution of GPs into larger practices grouped closer to town centres in the ACT.[99]

2.73 The Committee understands that this is the current trend, but considers that while the demand for suburban practices continues, more needs to be done to support the smaller practices that wish to stay in the suburbs or indeed, to set up a new local practice.

2.74 The Committee heard a number of suggestions to help smaller suburban practices to stay viable, and proposes the following four incentives to assist in attracting and/or retaining general practices in suburban locations:

- subsidised or free rental and/or subsidised utilities;
- financial assistance to employ a practice nurse;[100] (see recommendation 8)
- extending the proposed in-hours locum service[101], or similar model, to suburban practices of two GPs or less (to cover sickness, unexpected absences, holidays, caring responsibilities etc); and
- low or no interest loans to GPs setting up new practices.[102] (also recommended by the GP Taskforce).

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[97] Mr Robert Wells, *Transcript of Evidence*, p 140

[98] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 140

[99] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 8

[100] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 65

[101] The Committee notes the ACT Government has renamed this initiative to the GP Aged Day Care.

[102] Submission no 14, Dr Chenault Doug Lee, p 5

RECOMMENDATION 5

2.75 **The Committee recommends that the ACT Government examine the provision of financial and other incentives to small suburban general practices in identified areas of need, and to new general practices wishing to establish in those areas.**

Corporate medical centres

2.76 The trend towards consolidation of general practices continues in the ACT. For example, an advertisement appearing in *The Canberra Times* on Friday 30 October 2009 announced that the Bromley Group Family Practice in Manuka, the Valley Medical Centre in Garran, and the Pearce Medical Centre were relocating to the Wentworth Avenue Family Practice stating they had:

> …signed an agreement to sell their practice management rights to Healthscope Medical Centre Pty Limited.[103]

2.77 Whilst concerned by these latest closures, the Committee was pleased to note that patients were being notified and that provisions were being made for the transfer of health records. Chapter five discusses health records further.

2.78 In its submission to the Committee, Healthscope outlined problems experienced by smaller practices that it considered contributed to its success of recruiting 14 general practitioners, from seven practices in the ACT, to its North Canberra Family Practice. The latest amalgamation would increase this figure to 21 general practitioners from 10 practices. Problems identified by Healthscope included:

- inability to take holidays due to lack of availability of locums;
- increasing burden of paperwork;
- billing demands;
- inadequate or outdated IT; and
- limited clinical resources.[104]

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[103] Public Notice, 'Notice to patients of the Bromley Group Family Practice, Valley Medical Centre, and Pearce Medical Centre', *The Canberra Times*, 30 October 2009

[104] Submission no 3, Healthscope Limited, p 1

2.79 In her evidence about why GPs join corporate practices the Minister for Health, Ms Katy Gallagher, suggested:

> It could be the work-life balance. It could be the fact that they are retiring and they do not have enough super and this is one way to build up their future fund. It could be that they are attracted to that model of care. They do not want those long-term relationships; they want medicine based on the model that exists in the corporate setting.[105]

2.80 Dr Paul Jones, President of the ACT Division of the Australian Medical Association (AMA) told the Committee that after 25 years of operating his own practice he had joined a very large corporate practice, stating:

> The harsh reality is that when I started about 40 per cent of GPs were solo, practising sometimes in houses. The world has changed. The world has moved on.[106]

2.81 Dr Chenault Doug Lee, a private GP told the Committee that the smaller practices could not compete with the huge incentives being offered by corporate medical centres:

> They are paid something between $150,000 and $500,000. They offered me $350,000 to leave my practice to join them. The type of medicine that they practise is not what I trained for. But I must say that refusing $350,000 dangled in front of you is not easy.[107]

2.82 There has been significant debate regarding the corporate owned practices in the ACT in recent times. The Committee notes that while this model is not appropriate for all patients, it does have a place in the delivery of primary health care services. As the Minister said:

> It is very difficult to say that the corporate model will not continue to grow, but I think we will end up with a mix of ways that GPs operate, in small, medium and large settings.[108]

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[105] Minister for Health, *Transcript of Evidence*, 22 July 2009, p 46

[106] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 65

[107] Dr Chenault Doug Lee, *Transcript of Evidence*, 29 July 2009, p 85

[108] Minister for Health, *Transcript of Evidence*, 22 July 2009, p 46

Reducing the burden on GPs

2.83 The Australian Government Minister for Health and Ageing, the Hon Ms Nicola Roxon MP, is reported to have expressed the view that 'greater involvement of allied health workers in the delivery of care could particularly ease the workforce burden of general practitioners by freeing up their time and skills, which could then be more efficiently used for the benefit of patients'.[109]

2.84 General practitioners are under considerable pressure. Much of this is related to the complexities of Medicare and other paperwork required at both the national and ACT levels. The Committee heard that the Medicare Benefits Schedule (MBS) favoured GPs, through the provision of rebates for services that could be provided by other health care professionals. The examples cited included:

- the requirement of GP generated referrals when other health professionals, such as physiotherapists, were qualified to make the referral;[110] and
- the restrictions on the nature of diagnostic imaging services, such as X-rays or diagnostic ultrasound procedures requested by physiotherapists that attracted the MBS rebate.[111]

2.85 The Committee also heard that while GPs may not always be the best health professional for managing certain conditions, they remain the first port of call due largely to Medicare funding requirements. By way of example, the Physiotherapists Association told the Committee that there is significant 'evidence to support the efficacy of physiotherapy for the role of female urinary incontinence [but] the funding is not there for that sort of treatment through physiotherapy'.[112]

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[109] Dr Rhonda Jolly, Bills Digest, Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009, p 5

[110] Physiotherapists Association, *Transcript of Evidence*, 29 July 2009, p 91

[111] Physiotherapists Association, *Transcript of Evidence*, 29 July 2009, p 92

[112] Physiotherapists Association, *Transcript of Evidence*, 29 July 2009, p 91

2.86 The Productivity Commission also noted that the operation of the MBS 'may not always facilitate the provision of health services by the most appropriate health professional'.[113]

2.87 The Committee considers that removing the barriers that prevent health professionals working to their full potential is an important step to increasing the current workforce capacity. Chapter three discusses the enhanced role of allied health professionals.

Medicare Benefits Schedule

2.88 Introduced in 1984, Medicare was designed to provide a 'simple, fair and affordable insurance system that provided basic health cover to all Australians'.[114] Medicare was seen as providing universal access to a set rebate, being well-suited to episodic care, and enabling patients to choose their own health provider. However, the introduction of new programs and other changes made to the Medicare Benefits Schedule (MBS) since the early 1990s have 'introduced significant complexity in Medicare arrangements for providers and patients'.[115]

2.89 Some of the programs and changes include:

- Enhanced Primary Care (EPC);
- MBS items for practice nurses;
- MBS rebates for allied health and dental services;
- MBS items for chronic disease management;
- bulk-billing incentives; and
- GP mental health plans.[116]

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[113] Productivity Commission, *Australia's Health Workforce 2005*, p 153

[114] *Primary Health Care Reform in Australia, Report to Support Australia's First National Primary Health Care Strategy*, 2009, p 14

[115] *Primary Health Care Reform in Australia, Report to Support Australia's First National Primary Health Care Strategy*, 2009, p 15

[116] *Primary Health Care Reform in Australia, Report to Support Australia's First National Primary Health Care Strategy*, 2009, p 15 (includes full discussion)

2.90 The Committee was further advised of a number of problems with the MBS that acted as a disincentive for the solo practitioner or the smaller practice. Dr Jones told the Committee:

> … from an AMA point of view [and] one of the big problems is that the Medicare benefits schedule has a perverse incentive towards brief, episodic medicine in terms of the way that it rewards GPs and practices and advises against the long and the complicated consultations.[117]

2.91 Dr Kennealy suggested that MBS rebates could be significant in maintaining the attractiveness of private practice. For example, he considered that a greater financial weight given for longer consultations, would potentially be of greater benefit to private practice than the larger corporate model, and thus encourage more doctors to remain in smaller private practices.[118]

2.92 The Physiotherapists Association was of the view that:

> The complexity of the Medicare benefits schedule consumes an excessive amount of GPs' time and sometimes discourages them from using those items.[119]

2.93 The Enhanced Primary Care (EPC) MBS item was highlighted to the Committee as a particular area of concern. These items were introduced to improve health outcomes for elderly people, people with chronic conditions and those with multi–disciplinary care needs. To receive the rebates, GPs must undertake comprehensive health assessments.[120] While the Committee recognises the importance of the care plans, it is concerned that the additional burden of completing the plans has the potential to discourage referrals to allied health professionals, at a time when they should be increasing. As noted by Mr Wells:

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[117] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 61

[118] Dr Steve Kennealy, *Transcript of Evidence*, 29 July 2009, p 68

[119] Physiotherapist Association, *Transcript of Evidence*, 29 July 2009, p 91

[120] *Primary Health Care Reform in Australia, Report to Support Australia's First National Primary Health Care Strategy*, 2009, p 16

> …the Medicare item that was supposed to help doctors provide more comprehensive care, the enhanced primary care item, actually imposes a fair bit of red tape on those doctors.[121]

2.94 Mr Jonathon Kruger, the Manager of the Policy and Professional Standards Division of the Australian Physiotherapists Association told the Committee that EPC was problematic from their point of view, and advised they had been working with Medicare Australia, and the Department of Health and Ageing to improve the process.[122]

2.95 Mr Murray Stark, President of the Chiropractors Association of Australia (ACT) told the Committee that while his practice gets a large number of referrals for GPs, very few are EPC referrals.[123]

2.96 The Productivity Commission also noted that the restriction on the range of services subsidised under the MBS created problems and workforce inefficiencies. The Productivity Commission, in its 2005 report on Australia's Health Workforce made three recommendations relating to improving the efficiency of the MBS, including that:

> The Australian Government establish an independent standing review committee to advise the Minister for Health and Ageing on the safety, effectiveness and cost-effectiveness of proposals for changes to:
>
> a) the range of services (by type and provider, whether medical or non-medical) covered under the MBS (including the rebate to apply);
>
> b) referral arrangements for diagnostic and specialist services subsidised under the MBS; and
>
> c) prescribing rights under the PBS.[124]

2.97 The Australian Government did not agree with the recommendations stating:

> The Medical Services Advisory Committee, Medicare Benefits Consultative Committee and related committees fulfil discrete functions. It remains a priority for the Commonwealth Government to improve the efficiency and

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[121] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 142

[122] Mr Jonathon Kruger, *Transcript of Evidence*, 29 July 2009, p 97

[123] Mr Murray Stark, *Transcript of Evidence*, 29 July 2009, p 101

[124] Productivity Commission, *Australia's Health Workforce 2005*, p XLI

> transparency of existing mechanisms and strengthen the links between these processes.[125]

2.98 While there has been changes to the MBS since this time, such as new Medicare item numbers to support practice nurses, nurse practitioners and registered Aboriginal health workers, for and on behalf of general practitioners, the Committee is of the view that further improvements can be made.

2.99 The Physiotherapist Association considered that the ACT Government had a role:

> … to lobby the federal government to review and amend the current legislative regulatory and funding barriers that undermine the potential utilisation of physiotherapists and other allied health practitioners.[126]

2.100 While Medicare and the MBS is an issue for the Australian Government, the Committee agrees with the Physiotherapist Association that the ACT Government has a role to play in instigating changes at the national level, to ensure the seamless operation of the MBS. The Committee is not suggesting major changes to the MBS but considers that increased items for allied health professionals could be beneficial. The removal of barriers to enable health professionals to work to the full scope of their practice has the potential to reduce the need for people to access a GP for a condition that could be treated by another heath professional, or simply to get a referral to enable them to access the Medicare rebate.

2.101 The Committee welcomes the recent changes to the MBS, as a result of the MBS review, which will take effect from 1 May 2010. The changes include simplifying the schedule with fewer item numbers, reducing red tape and encouraging longer consultations by increasing the Medicare fee paid to GPs.[127] Despite these changes the Committee considers that more can be done

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[125] Council of Australian Government Meeting, 14 July 2006, see attachment A, viewed 25 November 2009, <http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/index.cfm>

[126] Physiotherapist Association, *Transcript of Evidence*, 29 July 2009, p 91

[127] MBS Primary Care Items, *A Fact Sheet for General Practitioners - The Changes to Medicare Primary Care Items*, viewed 18 December 2009, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-changes-to-medicare-primary-care-items-for-gps>

to relieve the pressure on the current system and give people greater choice in accessing the health care professionals best placed to meet their health care needs.

RECOMMENDATION 6

2.102 **The Committee recommends that the Minister for Health propose that the consideration of increased Medicare item numbers for allied health professionals be included for discussion at the next Australian Health Ministers' Conference.**

Red tape

2.103 The administrative requirements placed on GPs and their practices by the Australian Government and state and territory governments have been an ongoing concern to the medical profession. In its 2009 submission to the Productivity Commission's Annual Review of Regulatory Burdens on Business – Social and Economic Infrastructure Services the AMA argued that GPs can spend up to nine hours per week complying with red tape and that '[E]very hour a GP spends doing paperwork equates to around four patients who are denied access to a GP'.[128]

2.104 Of particular concern to the AMA was the compliance burden imposed by the MBS (despite the recent MBS review) and other Government requirements relating to:

- Centrelink programs;
- Department of Veterans Affairs programs
- The Practice Incentive Program paperwork and compliance requirements
- Workforce programs such as the rural retention program
- Roads and Traffic Authority

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[128] AMA Submission to Productivity Commission, *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services Research report*, September 2009, p 1, viewed 9 February 2010, <G:\Committee\01A Seventh assembly\Health, Community and Social Services\Primary health care\Report\AMA Submission on Red Tape to the Productivity Commission Australian Medical Association.mht>

- Subsidised taxi services for patients.[129]

2.105 In 2003 the Productivity Commission Research Report into General Practice Administration and Compliance Costs found that 'many Commonwealth policies and programs impact specifically on GPs and the way general practices are managed and operated'. The report made a number of recommendations to 'reduce both tangible and intangible administrative and compliance costs'.[130] Many of the same issues were again raised by the Regulation Taskforce in 2006.[131]

2.106 While there has been some progress in reducing the red tape placed on GPs, such as the Medicare review mentioned earlier, the Productivity Commission recently found that 'a number of the 'red tape' issues impacting on GPs addressed in the previous reviews remain in place'.[132]

2.107 An earlier study commissioned by the Productivity Commission in 2002 concluded that the paperwork and compliance programs were significantly impacting on GPs.[133]

2.108 The report found that the burden of paperwork was exacerbated for GPs as they:

> … do not appear to delegate these tasks to anyone else in their practice. While is it feasible that a competent practice manager or practice nurse could complete some of the tasks, the ultimate responsibility lies with the GP him/herself. In addition, the compliance tasks are seen as an integral part of treating patients – a task that they have full responsibility for. For this reason,

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[129] AMA Submission to Productivity Commission, *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services Research report*, September 2009, pp 4–5

[130] Productivity Commission, *General Practice Administrative and Compliance Costs*, Key points, 2003, viewed 9 February 2010, <http://www.pc.gov.au/projects/study/gpcompliance/docs/finalreport/keypoints>

[131] Productivity Commission, *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services Research report*, September 2009, viewed 9 February 2010, p 319

[132] Productivity Commission, *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services Research report*, September 2009, viewed 9 February 2010, p 322

[133] Millward Brown, *General Practice Compliance Costs Qualitative Project-Topline Report*-prepared for The Productivity Commission, 2002, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0006/18429/consultancy1.pdf>

> GPs tend to complete the paperwork and other compliance tasks themselves.[134]

2.109 According to the CEO of the ACT Division of General Practice, Mr Phil Lowen, red tape can cost GPs up to $15,000 per year. Mr Lowen considered one of the major problems in the ACT was the way GPs interacted with the public system. Mr Lowen told the Committee he was keen to see the development of a provider directory in the ACT, describing the following example:

> There are more than 26 different provider directories and indexes in the ACT. There is no consolidated navigation framework or easy web-based point we can go to. Links are often poorly coordinated, they do not look the same in the field, and GPs probably do not even have a high awareness of the full range of services that are available and tend to use segments of services they become familiar with because of the incompleteness of provider information and accessibility to understanding what those services do.[135]

2.110 Dr Jenny Thompson, Principal Medical Advisor, Aged and Palliative Care, from the ACT Division of General Practice further elaborated on the situation in the ACT:

> Here in the local system, again, we have different referral forms for different agencies. They all have their own way of wanting us to do business with them, and that creates additional loads for us, as does the complexity of actually navigating people through the system and being the advocate for that navigation. It is complex for the patients as much as for us as GPs.[136]

2.111 The AMA doctors who appeared before the Committee were also concerned with the amount of red tape. While they acknowledge that much of it is at the Commonwealth level such as the EPC plans mentioned earlier, [137] they also mentioned ACT specific red tape including over eight different medical

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[134] Millward Brown, *General Practice Compliance Costs Qualitative Project-Topline Report*-prepared for The Productivity Commission, 2002, p 4, viewed 24 September 2009, <http://www.pc.gov.au/__data/assets/pdf_file/0006/18429/consultancy1.pdf>

[135] Mr Phil Lowen, *Transcript of Evidence*, 5 August 2009, p 120

[136] Dr Jenny Thompson, *Transcript of Evidence*, 5 August 2009, p 123

[137] AMA, *Transcript of Evidence*, 29 July 2009, p 70

certificates and different referral forms and processes for different ACT Health agencies.[138]

2.112 The Minister told the Committee that the issue of the red tape had been raised with her and she has been responding to those concerns that are under her control, stating:

> The areas that we are working on … are around ensuring that we have processes in place that streamline the time it takes them to get information—things like discharge planning, corresponding with the hospital on a daily basis about their patients, getting in touch with doctors. We do hear stories; they say they have made repeated calls to try and get somebody who is on duty. So we are looking at that very closely, around what processes we can put in place for general practice specifically.[139]

2.113 Ms Annemarie Ashton, Policy Advisor from Carers ACT, told the Committee that:

> A lot of the paperwork, too, for the carers payment can be done without having to go to a GP, but it is often a matter of finding somewhere to go to get that assessment done. While many carers are aware that Centrelink will accept forms completed by nurses, they do not know where to access them so they go to a GP instead.[140]

2.114 The Committee notes the comments made by the GP Taskforce in relation to red tape and supports its recommendation to 'consider ways to address red tape'.[141] The Government agreed in principle to this recommendation stating they:

> …will continue to strengthen links with major stakeholders in order to contribute to the debate and progression of ideas on how best to address the reduction of "red tape".[142]

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[138] Dr Steve Kennealy, *Transcript of Evidence*, 29 July 2009, p 64

[139] Minister for Health, *Transcript of Evidence*, 22 July 2009, p 47

[140] Ms Annemarie Ashton, *Transcript of Evidence*, 22 July 2009, p 51

[141] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, recommendation 18, p 30

[142] Government Response to the GP Taskforce Final Report General Practise and Sustainable Primary Health Care: The Way Forward, p 4

Overall comment

2.115 Increasing the overall number of GPs has been comprehensively covered by the GP Taskforce that made 14 specific recommendations to improve the situation in the ACT. The Committee acknowledges the significant work being undertaken to increase the number of GPs at both the national and ACT levels.

2.116 At the national level there is:

- opening of new medical schools;
- increasing the number of university places for medical students;
- GP Links program;
- Prevocational General Practice Training Program (PGPPP); and
- programs to attract overseas trained doctors.[143]

2.117 In the ACT there is:

- an ACT Government funded position to attract GPs;
- the Live in Canberra program specifically targeting GPs;
- lobbying to increase the overall number of Australian GP trainees and those training places allocated to the ACT;
- campaigning to attract overseas-trained doctors;
- working in partnership with other key stakeholders;
- advertising in the national and medical press;
- assisting GP practices with recruitment processes;
- providing opportunity for current medical students to experience general practice through the PGPPP;
- exploring new models of care such as nurse practitioner roles working in partnership with GPs; and
- improving our knowledge and understanding of the GP workforce.[144]

2.118 Despite these strategies, many of which have been in operation for a number of years, there has been little change in the overall number of FWE GPs in the

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[143] Britt et al, *General Practice in Australia, health priorities and policies 1998 to 2008*, pp 23-24

[144] Submission no 12, ACT Government, p 1

ACT, with a slight increase in the number of GPs between 2006–2007 and 2007–2008 and a slight decline in 2008–2009.[145]

2.119 While the Committee supports the efforts to increase the number of GPs, this is a long term strategy, with no guarantees, that only addresses one part of the problem–access to primary health care.

2.120 GPs are vital players in the provision of health services. However, the Committee considers the doctor-centric model of health care provision is unsustainable in the current health climate. The Committee also considers it is timely to further explore enhanced roles for nurses and allied health professionals, and alternative models of primary health care delivery.

[145] Productivity Commission, *Report on Government Services 2010*, Volume 2, Health, Community and Social Services, 11.9

3 PRIMARY HEALTH CARE

3.1 Recognising the need for reform in primary health care, the Australian Government Department of Health and Ageing, with the assistance of an external reference group, developed and released a national primary health care strategy. The Department launched *A Draft of Australia's First National Primary Health Care Strategy*, in August 2009.[146]

3.2 The Australian Primary Health Care Research Institute defines primary health care as:

> …socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.[147]

3.3 However, there are many definitions of primary health care and varied understandings. According to the report supporting the National Primary Health Care Strategy, the term primary health care is not widely used or even understood by the majority of Australian health care consumers:

> ... with most people simply distinguishing between health care they receive in the community and the health care they receive in hospital.[148]

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[146] 'Building a 21 Century Draft Primary Health Care System: A Draft of Australia's first National Primary Health Care Strategy', viewed 15 November 2009 <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draft-report-toc>

[147] Australian Primary Health Care Research Institute, viewed 12 September 2009, <http://www.anu.edu.au/aphcri/General/phc_definition.php> also cited in Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy (September 2009)

[148] Australian Government Department of Health and Ageing, Primary Health Care Reform in Australia, *Report to Support Australia's First National Primary Health Care Strategy*, 2009, p 22

3.4 The shortage of GPs and the increasing demands on the health system have laid fertile ground for the exploration of new models of service delivery. As noted by ACTCOSS:

> The focus of primary health care reform cannot lie with GP recruitment and retention strategies alone, as these methods are not sustainable in the environment of global workforce shortages.[149]

3.5 ACTCOSS further argued that the current doctor-centric model was not only unsustainable with the increasing demands being placed on the health care system, but could also exacerbate the access problems faced by many people in the community, particularly those experiencing disadvantage.

3.6 The Committee also heard evidence to support alternative pathways into the primary health care system.[150] In their submission the Health Care Consumers Association ACT Inc(HCCA) stated:

> As a result of what is seen as a chronic GP shortage not only in ACT but also nationally and in many overseas countries, the organisation and strategies adopted in the provision of primary health care are moving away from having the general practitioner as a single pivotal point of primary health care.[151]

3.7 ACTCOSS also advocated for the expansion of service delivery models and options to better support those who are most vulnerable.[152]

3.8 Mr Arthur Skimin, a health care consumer, carer and parent, told the Committee that he would be 'quite comfortable with working outside of the box of the GP being the sole provider'. He also told the Committee that he considered this to be true for many of the people he supports.[153]

3.9 Aside from general practice, primary health care services in the ACT are delivered through ACT Government community health centres, community run health services such as the Junction Youth Health Service and Companion House, allied health professionals (mostly in private practice) and the local

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[149] ACTCOSS, *Transcript of Evidence*, 22 July 2009, p 1

[150] see submission No 7, ACTCOSS, and submission No 10, Health Care Consumers Association

[151] Submission No 10, Health Care Consumers Association, p 5

[152] ACTCOSS, *Transcript of Evidence*, 22 July, p 7

[153] Mr Arthur Skimin, *Transcript of Evidence*, 22 July 2009, p 58

pharmacy. People may also seek health advice through the telephone information service, Healthdirect and/or from the internet.

Allied health professionals

3.10 According to ACT Health, the allied health workforce in the ACT includes 23 disciplines such as:

> Audiology, biomedical engineering, nuclear medicine technology, pharmacy, physiotherapy, radiochemistry, radiation therapy and social work. Professions requiring tertiary education, delivering a clinically related service which are non-medical and non-nursing are also included in the Allied Health cohort in the ACT.[154]

3.11 The majority of allied health services are delivered in the private sector on a fee-for-service basis. Funding for private services is provided through insurance schemes and private insurance rebates, and certain allied health services are available under Medicare to patients with chronic conditions and complex care needs under the EPC program, discussed earlier.[155]

3.12 As most allied health care is provided in the private sector, the Committee was told that allied health care services are underutilised, due mainly to the cost.[156] As noted by Mr Russell McGowan from the HCCA:

> … there are a number of allied health services in the community that people would access, if not for cost barriers that would in fact deal with some of the problems that turn into acute primary health care or acute service problems. So this is all about the preventive agenda—getting people's problems seen to at the time that you can nip them in the bud before they become acute.[157]

3.13 The Chiropractors' Association told the Committee that:

> … disadvantaged people often do not have equality of access to health care. Extending the range of services offered by ACT Health would help address

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[154] ACT Health, *ACT Workforce Plan 2005-2010*, viewed September 15 2009, p 9 <http://health.act.gov.au/c/health?a=dlpubpoldoc&document=855>

[155] Productivity Commission, *Report on Government Services 2009*, January 2009, p 11.4

[156] Health Care Consumers Association, GP Snapshot Survey, viewed 30 November 2009, <http://www.hcca.org.au/cms/media/GP_Snapshot_Results_Summary.pdf>

[157] Health Care Consumers Association, *Transcript of Evidence*, p 34

> this inequity, provide timely access and achieve better health outcomes and thereby reduce the burden on private and government health services.[158]

3.14 The Committee considers that increasing choices for people regarding their own health care needs is an important step towards self-management.

Allied health care in the community

3.15 Community health services are defined as:

> …multi-disciplinary teams of salaried health and allied, health professionals who aim to protect and promote the health of particular communities. The services may be provided by governments or indirectly through a local health service or community organisation funded by government.[159]

3.16 The Health Care Consumers Association was supportive of having allied health care professionals set up in community settings to enable them to 'become a part of people's thinking'.[160]

3.17 While physiotherapists are employed in hospitals and other community settings the Committee was told that there are currently no chiropractors employed in the public health sector,[161] despite chiropractors being the most utilised of the registered health professions that do not fall into the 'mainstream' of health care provision.[162]

3.18 The Committee was told that a pilot proposal by the Chiropractors Association to ACT Health was rejected on the basis that there was no service gap that could be filled by chiropractors.[163] While the Chiropractors Association reported they were unhappy with this decision, the Committee considers that this is a matter best dealt with between the Chiropractors Association and ACT Health. The Committee notes the variety of allied health practitioners and does not consider it is in a position to advocate for any one professional stream.

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[158] Chiropractors Association of Australia (ACT), *Transcript of Evidence*, 29 July 2009, p 99

[159] *Report on Government Services*, cited in, *Primary Health Care Reform*, p 18

[160] Mr Russell McGowan, *Transcript of Evidence*, 22 July 2009, p 35

[161] Mr Michael Badham, *Transcript of Evidence*, 29 July 2009, p 100

[162] Submission no 15, Chiropractors Association of Australia (ACT), p 1

[163] Mr Michael Badham, *Transcript of Evidence*, 29 July 2009, p 102

3.19 The Committee is of the view, however, that improving access to allied health professionals through community health centres would not only give patients greater choice regarding their health care needs, but also has the potential to address preventative health issues and relieve some of the current pressure on GPs.

3.20 The Committee notes the National Accreditation and Registration Scheme is expected to come into effect from July 2010 for the following ten health professions: chiropractors, dentists (including dental hygienists, dental prosthetists and dental therapists), medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, and psychologists. The new scheme will:

> … help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce. For example, the new scheme will maintain a public national register for each health profession that will ensure that a professional who has been banned from practising in one place is unable to practise elsewhere in Australia.

3.21 The Committee was advised that the ACT is represented on nine out of 10 of the boards, but only six are official ACT designated spots. The Minister advised:

> We have ACT jurisdictional reps for medical, dental, nursing, midwifery, pharmacists, physios and psychologists. In addition, we have a practitioner rep, who I understand is from the ACT but it is not an ACT designated position, for osteopaths, and we have two community reps, one on podiatry and one on chiropractors…There is no representative on the optometrists board.[164]

RECOMMENDATION 7

3.22 **The Committee recommends that the ACT Government consider ways of expanding health options for consumers by enhancing the provision of services provided by registered and accredited allied health**

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[164] Ms Katy Gallagher, *Transcript of Evidence*, 2 December 2009, p 32

professionals under the National Registration and Accreditation Scheme, in community health centres in the ACT.

Allied health assistants

3.23 In 2004 the ACT Government conducted a project examining the need for an allied health assistant (AHA) training program. The project also examined the feasibility of expanding the number of AHAs employed in the ACT.[165] As a result of this project the Canberra Institute of Technology offers a Certificate IV in Allied Health Assistance.[166] The training began as a two-year part time course in 2006. From 2009 the course is being offered on a full-time basis with 12 on-going students expected to complete their second year of study in 2009.[167]

3.24 The qualification is also recognised as part of the National Health Training Package. Vocational study is currently offered in the areas of physiotherapy, occupational health, speech pathology, nutrition and dietetics and podiatry. However, as a relatively new area of study it is expected that additional areas will be included as the demand dictates. The Committee understands that most graduates are employed by ACT Health or through the Department of Disability, Housing and Community Services, and that few are employed in the private sector.

3.25 The Physiotherapy Association was supportive of more extensive use of health care assistance, such as allied health assistants, to support the health workforce. Mr Philip Cossens, ACT Branch President of the Australian Physiotherapy Association, told the Committee:

> The diversity of physio practice should be recognised by governments so that the skills and knowledge of physiotherapists can be fully utilised and so that

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[165] ACT Health, Assistant project, viewed 30 October 2009, <http://www.health.act.gov.au/c/health?a=da&did=10128585&pid=1105657036>

[166] Canberra Institute of Technology, Allied Health Assistant - Certificate IV, viewed 30 October 2009, <http://www.cit.act.edu.au/future/courses/allied_health_assistance_certificate_iv>

[167] ACT Health, *Allied Health Assistants- Update Communiqué January 2009*, p 1, viewed 30 October 2009, <http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=-116408297&sid=>

> they can work to the full extent of their professional competence, providing better support to the health system and its users.[168]

3.26 Mr Cossens further advised that the Australian Physiotherapy Association encourages membership of physiotherapy assistants but noted some problems with the competency standards:

> We think that a cert 4 in allied health assistance is probably where it needs to be pitched at. That is not always being reached in some facilities, but it is an evolving thing.[169]

3.27 An inquiry into vocational and education training to address skills shortages, conducted by the Sixth Assembly Standing Committee on Education, Training and Young People, considered the role of allied health assistants in relation to the aged care skills formation project, that was designed 'to improve the way in which the community, residential and acute care sectors recruited, skilled and utilised its workforce across the continuum of care offered by these sectors.'[170]

3.28 One of the components of this project was to examine 'ways to increase allied health and rehabilitative services while operating within a climate of a shortage of allied health professionals.'[171] The use of AHAs was examined and the role and skills were defined through a consultative process. The Committee reported that there was a high level of satisfaction with the care patients received by AHAs, due mainly to additional time spent with patients.

3.29 The Committee also reported being impressed with the use of AHAs to address the shortage of allied health professionals which they considered

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[168] Mr Phillip Cossens, *Transcript of Evidence*, 29 July 2009, p 92

[169] Mr Phillip Cossens, *Transcript of Evidence*, 29 July 2009, p 97

[170] Queensland Community Services and health industries training Council Inc. (2006) *Queensland Aged Care Skill Ecosystem (supply chain) project: Final report,* p 9 cited in Sixth Assembly Standing Committee on Education, Training and Youth Affairs, *Vocational education and training to address skill shortages*, p 40

[171] Queensland Community Services and health industries training Council Inc. (2006) *Queensland Aged Care Skill Ecosystem (supply chain) project: Final report,* p 9 cited in Sixth Assembly Standing Committee on Education, Training and Youth Affairs, *Vocational education and training to address skill shortages*, p 40

'moved beyond a single focus on recruitment to consider clever and innovative ways to utilise and extend existing resources'.[172]

3.30 The Committee supports the introduction of the allied health assistant role and expects it will grow over time. As a relatively new area it will require further evaluation to gain full understating of the benefits of the role. The Committee looks forward to future updates from the ACT Government.

Nurses, nurse practitioners and practice nurses

> *In Australia there is untapped potential to expand the role of nurses and nurse driven programs throughout the health care system to provide better services to the community.*[173]

3.31 With the current shortage of general practitioners and the changing landscape of the health sector, the Committee considers that nurses are well placed to assist in the delivery of primary health care services. Enhancing the role of nurses will not only assist in the delivery of services but may also go toward encouraging more people to take up nursing as a career, or to encourage those who have left the sector to return.

3.32 Ms Debra Cerasa, Chief Executive Officer of the Royal College of Nursing, Australia told the Committee:

> … 80 per cent of nurses currently work in acute health and that is part of the exhaustion that they feel. The most common reason that gets cited for leaving acute health is that they are tired; it is complex care; it is difficult; it is exhausting; all those sorts of issues.[174]

3.33 Furthermore, as the majority of nurses are women, the long hours are not conducive to their caring role in family life and often result in them moving in and out of their careers.[175]

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[172] Sixth Assembly Standing Committee on Education, Training and Young People, *Vocational education and training to address skills shortages,* p 42

[173] Submission no 16, *Royal College of Nursing Australia*, p 3

[174] Ms Debra Cerasa, *Transcript of Evidence*, 5 August 2009, p 159

[175] Ms Debra Cerasa, *Transcript of Evidence*, 5 August 2009, p 161

3.34 Ms Cerasa was of the view that the provision of more family friendly working hours would contribute to retaining nurses within the profession. She told the Committee:

> …opening up opportunities like nurse practitioner, advanced practice nurse, practice nurses, more roles and scope within primary health, within aged care, recognising the contribution that nurses make to the community's health and wellbeing, is what will absolutely attract nurses to be better regarded.[176]

3.35 The Committee was also told that many nurses exit the profession because they are not given the opportunity to work to their full potential. While nurses leave the profession for a variety of reasons, Ms Kathleen McLaughlin, Director Professional Services, Royal College of Nursing, Australia explained:

> …allowing nurses to work to their full scope of practice that they have been educationally prepared for and have the experience to work to will assist in retaining nurses in the workforce. [177]

3.36 The Committee supports the role of nurses in the provision of primary health care and welcomes any strategy that contributes to the attraction of nursing as a career and the retention of nurses in the current workforce.

Practice nurses

3.37 Practice nurses are qualified registered or enrolled nurses who deliver primary health care in a general practice setting. Practice nurses help to relieve the burden on general practitioners and work within their defined scope of practice, which will vary across general practices. Data from the Primary Health Care Research and Information Service shows a national increase of 130 per cent in the use of practice nurses in the period 2003–2007, up from 3255 in 2003–04 to 7493 in 2006–07.[178]

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[176] Ms Debra Cerasa, *Transcript of Evidence*, 5 August 2009, p 159

[177] Ms Kathleen McLaughlin, *Transcript of Evidence*, 5 August 2009, p 160

[178] Primary Health Care Research and Information Service, Fast Facts, *Practice Nurse Numbers in Australia, 2003 to 2007*, viewed 23 September 2009, <http://www.phcris.org.au/fastfacts/fact.php?id=4824>

3.38 Based on data to 30 June 2007, the ACT Division of General Practice estimated that 72 practice nurses were employed in the ACT.[179]

3.39 A snapshot survey conducted for the GP Taskforce in 2009 found that there were 55 practice nurses: 35 part-time and 25 full-time employed in 69 per cent of general practices in the ACT. The survey further found that the larger the practice, the greater likelihood of having a practice nurse, with practice nurses in 48 per cent of practices of up to three GPs, 91 per cent of practices up to 10 GPs, and 100 per cent of practices with 11 or more GPs.[180]

3.40 The Committee is concerned that the available figures indicate a decline in the use of practice nurses between 2007 and 2009 in the ACT, despite support for practice nurses employed in general practices increasing across Australia. A recent joint study into Australian general practice nursing conducted by the Australian Primary Health Care Research Institute and the Australian General Practice Network, stated that:

> The introduction of nurses into Australian general practices is one of the great quality improvement initiatives of the last decade. Between 2005 and 2007, the number of nurses in general practice increased by nearly 60 per cent.[181]

3.41 However, despite this, a recent report *Charting New Roles for Australian General Practice Nurses: A Multi-centre Qualitative Study* found that nurses in general practice were being underutilised by working in administrative and receptionist roles. Further, their clinical work, in many instances was limited to immunisation and wound management, reflecting the federal funding for those services.[182]

3.42 To better utilise the skills of practice nurses, the study found that nurses' capabilities were well suited to the following six roles: patient care; quality

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[179] Primary Health Care Research and Information Service, Fast Facts, *Practice Nurse Numbers in the Australian Capital Territory, 2003 to 2007*, viewed 23 September 2009, <http://www.phcris.org.au/fastfacts/fact.php?id=4825>

[180] ACT Health, GP Snapshot Survey, viewed 24 September 2009, <http://health.act.gov.au/c/health?a=da&did=11034130&pid=1252369487>

[181] Dr Christine Phillips et al, *Charting New Roles For Australian General Practice Nurses* Abridged Report of the Australian General Practice Nursing Study, December 2008, p 25, viewed 23 September 2009, <http://www.anu.edu.au/aphcri/Spokes_Research_Program/Stream_Three/Phillips_abridged_25.pdf>

[182] Mr Robert Wells, Primary Health Care research Institute, *Transcript of Evidence*, 5 August 2009, p 138

controller within the practice; organiser; problem solver; educator; and agent of connectivity. The study showed that there is significant potential to extend the scope of practice for the nursing workforce.[183]

3.43 In evidence to the Committee, representatives from the AMA were very supportive of increased incentives for general practices to employ practice nurses at the local level. As Dr Kennealy stated:

> There is a scope to improve the role and function of the practice nurse. There is an ability for practice nurses to extend what they do, to be provided for better by Medicare so that more practices feel they are able to employ and provide for them. The efficiencies that can be gained there, I think, are enormous.[184]

3.44 As the figures from the GP snapshot survey indicate, smaller practices do not engage practice nurses as often as larger practices. The Committee is concerned that the smaller practises are limited by financial constraints.

3.45 In evidence to the Committee, GPs were of the view that one of the best ways to support general practices was to improve the ability to employ and use practice nurses.[185] The Committee understands that some financial assistance is available from the Australian Government to support general practices to employ practices nurses, but this is limited to areas that have been identified as a district of workforce shortage. In the ACT this includes Gungahlin, Belconnen, Western Creek and Tuggeranong.

3.46 The Committee notes that the ACT Government has agreed to the recommendation by the GP Taskforce for the ACT Government to work with the Australian Government to extend the district of workforce shortage provisions to the whole of the ACT to improve access to practice nurses, stating that it will continue to raise the issue with the Australian Government.[186]

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[183] Australian Primary Health Care Research Institute, Charting New Roles For Australian general Practice Nurses: A Multicentre Qualitative Study, viewed 28 October 2009, <

[184] Dr Steve Kennealy, *Transcript of Evidence*, 29 July 2009, p 64

[185] Dr Paul Jones and Dr Steve Kennealy, *Transcript of Evidence*, 29 July 2009, p 66

[186] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 11

3.47 The Minister has noted that she has not been successful in her previous attempts to negotiate for change. On 7 August 2008 after the closure of the Wanniassa Medical Centre, the Minister advised the Assembly that she had written to the Australian Government Minister for Health regarding the GP shortage.[187] More recently, the Minister said that the Government would continue to lobby the Commonwealth:

> I have to say also that the Commonwealth have been reluctant to treat the ACT as a special isolated case, which is something that I have been arguing for some time. I was unsuccessful in those arguments with Minister Abbott, who refused to even listen to them. I am making slow but steady progress with Minister Roxon.[188]

3.48 While the Committee is pleased to note the Government's agreement to the GP Taskforce's recommendation, it does not consider that it goes far enough. The Committee considers that lobbying by the ACT's federal members on behalf of the ACT could strengthen the case for change.

RECOMMENDATION 8

3.49 **The Committee recommends that the ACT Minister for Health enlists the assistance of all ACT federal members to lobby on behalf of the ACT, for the whole of the ACT to be considered a district of workforce shortage for GP services.**

3.50 The Committee is of the view that all general practices should have access to a practice nurse, should they wish to do so. The employment of a practice nurse should not be limited by financial constraints.

3.51 The Committee was particularly interested in the South Australian GP Plus Practice Nurse Initiative, whereby:

> In partnership with the South Australian metropolitan Divisions of General Practice, SA Health is providing funds to support the recruitment, training,

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[187] Legislative Assembly of the ACT, *Hansard Transcript*, 7 August 2008, p 3045

[188] Legislative Assembly for the ACT, *Hansard Transcript*, 25 March 2009, p , 1317

orientation and skill acquisition for nurses new to general practice or to up skill existing practice nurses.[189]

3.52 The Committee considers that the ACT Government has the capacity to provide financial support to general practices, particularly the smaller suburban practices, to employ a practice nurse and can perhaps develop a similar model as the South Australian GP Plus Practice Nurse Initiative.

RECOMMENDATION 9

3.53 **The Committee recommends that the ACT Government consider the provision of financial assistance to small general practices to employ a practice nurse that demonstrate a need for a practice nurse but are unable to employ one.**

3.54 Practice nurses are an important part of community based health services. The Committee was pleased to note that the practice nurse employed by Companion House was highly skilled and was utilised to the full scope of her practice.[190]

3.55 Companion House told the Committee that as they are not able to transition their clients to general practices they need staff on the ground, and more antenatal nurses to address the needs of their clients. Companion House also advised of the important triage role played by the practice nurse.[191] Companion House said that without the recent funding for a full time nurse, they would not be able to deliver the level of service they do.[192]

3.56 The Junction Youth Health Service also told the Committee they rely heavily on their two practice nurses and their two outreach nurses. However, the Junction reported frustration at the lack of autonomy afforded to their nurses, particularly those working in the outreach positions.[193]

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[189] The GP Plus Practice Nurse Initiative, viewed 30 October 2009, <http://www.gpplusnurses.com.au/about-gp-plus>

[190] Companion House, *Transcript of Evidence* 22 July 2009, p 23

[191] Companion House, *Transcript of Evidence*, 22 July 2009, p 23

[192] Companion House, *Transcript of Evidence*, 22 July 2009, p 21

[193] Ms Pauline Le Riche, *Transcript of Evidence*, 5 August 2009, pp 146–147

Nurse practitioners

3.57 Nurse practitioners are registered nurses with appropriate education, skills and expertise to perform in an advanced clinical role. The Australian Nursing and Midwifery Council define the role and competency standards of a nurse practitioner as:

> … educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic imaging.[194]

3.58 Nurse practitioners were first introduced in Australia in 2000. As Ms Cerasa told the Committee:

> It took a long time to get the recognition of nurse practitioners into our health arena. Currently all states and territories have different criteria by which to register a nurse practitioner. So there was considerable work done in gaining acceptance of this status and the experience and qualification of nurse practitioners.[195]

3.59 The Royal College of Nursing Australia told the Committee that there are approximately 360 nurse practitioners in Australia and that the majority of them are currently working in acute health. Creating more nurse practitioner positions in the primary health care setting could lead more nurses to consider seeking the nurse practitioner qualification.[196]

3.60 The Committee is pleased to note the Health Legislation Amendment Bill currently before the Senate, which proposes to amend the *Health Insurance Act 1973* and *National Health Act 1953* to:

> …enable nurse practitioners and appropriately qualified and experienced midwives to request appropriate diagnostic imaging and pathology services

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[194] The Australian Nursing and Midwifery Council, cited in *Primary Health Care in Australia, A nursing and midwifery consensus view*, April 2009, p 65

[195] Royal College of Nursing, Australia, *Transcript of Evidence*, 5 August 2009, p 155

[196] Royal College of Nursing, Australia, *Transcript of Evidence*, 5 August 2009, p 155

> for which Medicare benefits may be paid; and allow these health professionals to prescribe certain medicines under the Pharmaceutical Benefits Scheme.[197]

3.61 However, the intention of the Bill was that nurses and midwives would only have access to the MBS and PBS if the service was rendered in a collaborative arrangement with a doctor, contrary to a perception that the Bill would grant greater autonomy to nurse practitioners and midwives. The Australian Government has introduced an amendment to the Bill to ensure the provision is reflected in the legislation and not just in the explanatory memorandum.[198]

3.62 While the medical profession demonstrates significant support for an enhanced role for practice nurses, the profession has been less supportive of an enhanced role of nurse practitioners. Some may consider that granting access to the MBS and PBS to nurse practitioners challenges the medical practitioner centric focus on health care. The Committee supports the enhanced role for nurse practitioners, and agrees with the comments made by Dr Rhonda Jolly that 'it need not devalue the doctor's role, as some have argued, but instead place more value on the role of nurses'.[199] The Committee supports greater autonomy for nurse practitioners.

3.63 The Junction Youth Health Service was particularly supportive of nurse-practitioner clinics for their capacity to provide services for young people at risk. They emphasised the need for any such centre to be serviced by public transport to ensure young people could access it. Ms Le Riche said:

> NP's [nurse practitioners] would be an essential part in improving the health care and wellbeing needs of high risk and homeless young people who don't access mainstream GPs. As part of a NPs clinical assessment they can focus on intervention and prevention programs.[200]

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[197] Parliament of Australia, Bills of the Current Parliament, *Health Legislation Amendment(Midwives and Nurse Practitioners) Bill 2009*, viewed 15 October 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22legislation%2Fbillhome%2Fr4151%22>

[198] 'Doctors welcome change to laws on nursing powers', *The Canberra Times*, November 2009.

[199] Dr Rhonda Jolly, Parliament of Australia, Department of Parliamentary Services, Bills Digest, *Health Legislation Amendment(Midwives and Nurse Practitioners) Bill 2009*, p 21

[200] Submission no 11, Junction Youth Health Service, p 5

3.64 The Committee considers that nurses are underutilised and largely undervalued in the health care sector and supports any move to raise the status of the essential community service that nurses provide.

3.65 The Committee notes the report by the Australian Nursing Federation *Primary Health Care in Australia: A nursing and midwifery consensus view* that describes a number of excellent new and emerging nurse-led models of primary health care successfully operating in Australia. Initiatives include: 'Health promotion, illness and injury prevention for students at school, a place of learning'; 'MERV and a Men's Shed - primary health care for men'; and Occupation health nursing - safety and care at the workplace'.[201]

Nurse led walk-in clinic

3.66 The ACT Government allocated $150,000 for a scoping study for primary care walk-in centres (WiCs) to:

> …improve access to primary care for patients who require episodic, non-ongoing care for minor illness and injuries.[202]

3.67 In 2008 the Government issued a discussion paper and conducted public consultations. The discussion paper feedback report, issued in March 2009 found 'overwhelming support for the concept of WiCs'.[203]

3.68 The feedback report also found strong support for nurse led care 'with some preferring a multidisciplinary approach incorporating allied health professionals and medical staff'. The feedback report found that the three preferred locations for WiCs were:

- on a hospital campus, near to an emergency department;
- in the community close to public transport hubs; and
- co-located with a general practice or medical centre.[204]

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[201] Australian Nursing Federation *Primary health Care in Australia: A nursing and midwifery consensus view,* April 2009

[202] ACT Government, *2008–2009 Budget Paper No. 3,* p 75

[203] ACT Health, Walk-in Centres in the ACT, Discussion Paper Feedback Report March 2009, p 2

[204] ACT Health, Walk-in Centres in the ACT, Discussion Paper Feedback Report March 2009, p 2

3.69 On 25 May 2009 the Australian Government announced $10 million in funding to establish the walk-in centre at the Canberra Hospital with the aim of taking pressure off the emergency department. The walk-in centre will be staffed by nurse practitioners and is expected to be operational by June 2010.[205]

3.70 The ACT Government is working closely with the medical sector to establish the nurse led walk-in clinic in the ACT. The Minister is reported to have said 'it is impossible to reform health care services without the co-operation of doctors'.[206]

3.71 The ACT Division of General Practice provided conditional support of the clinic on the proviso that it was co-located on a hospital campus or 'proximate to a hospital based emergency department (ED) and addressing integration issues with the local CALMS service at the site'. The Division was not supportive of any 'stand-alone nurse or allied health professional clinic that proposes to be a substitute for services currently provided by GP led coordinated teams'.[207]

3.72 While the Committee heard that there would be some people who may be reticent about embracing new models of care such as the walk-in clinic, most presenters to the Committee showed considerable support for the nurse-led clinic as an additional access point for primary health care. For further discussion see the section on alternative models of care later in this chapter.

3.73 The Committee also heard from both the Chiropractors Association and Physiotherapists Association who were supportive of the WiC and considered they had a greater to role to play. The Chiropractors Association was particularly keen to be included as a referral point for patients of the WiC presenting with muscular skeletal conditions.[208]

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[205] Prime Minister, Kevin Rudd, Media Release, *'Walk-in Centre' at the Canberra Hospital*, 25th of May 2009, viewed on 25 October 2009, <http://www.alp.org.au/media/0509/mspm250.php>

[206] ABC News, Walk-in medical centres given conditional approval, 2 April 2009,

[207] ACT Division of General Practice, media release, 'Division supports trial of walk in centres', 3 April 2009, viewed 28 October 2009, <http://www.actdgp.asn.au/content/Document/Board%20March%202009/090326%20Med%20Release%20Walk%20in%20Clinics%20Final.pdf>

[208] Mr Michael Badham, *Transcript of Evidence*, 29 July 2009, p 103

3.74 The Committee was also told the location of the clinic would impact on the services provided, and the clients who accessed the clinic. It was argued that the initial establishment of the clinic on the campus of the Canberra Hospital (TCH) would limit access to many in the community and serve as a 'siphoning mechanism within the hospital to triage people who might otherwise just turn up at an emergency department'. While this is a useful model and of benefit to the hospital (the Committee understands that this was the initial intention), there is an opportunity for future clinics located in communities to have a much broader function.[209]

3.75 Closer links with the broader primary care sector, including GPs and allied health professionals, has the potential to deliver a more integrated model of primary health care. Mr Wells told the Committee:

> This is based on my reading of the evidence in Australia and overseas that nurse-led clinics in the primary care sector away from the hospital would be better integrated with other professions and not just another stream of a professional group you would go to.[210]

3.76 Speaking about the UK experience of nurse-led clinics Mr Wells, told the Committee that the location of the clinic would determine the role, stating:

> We will have one at the hospital and its role is specifically around this function. But if you were then to have another one in the community, one would need to redefine its role and its links with the rest of the sector… The United Kingdom has introduced some nurse-led clinics in the community sector, as distinct from the siphoning measures in hospitals, and there is evidence to suggest that they work quite well.[211]

3.77 Ms Cerasa of the Royal College of Nurses also considered that the location of the walk-in centre at TCH would initially dictate the clients that attended. She said:

> We know that people will often go to an emergency department because they have not been able to get a GP appointment and there will often be that very general need of care that is immediate and short term; whereas if the nurse-

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[209] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 104–105

[210] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 104–105

[211] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 139

> led clinics are established in areas where there are specific needs—and I am thinking more of low socioeconomic or greater long-term conditions or needs in community areas—I think it will initially determine the type of clientele that will go there.[212]

3.78 The Committee supports the introduction of the WiC and considers it has the capacity, to not only relieve the pressure on the emergency department at TCH, but to also give consumers an alternative choice for after hours health care. However, the Committee is limited in its comment until such time as the details of the model are available.

3.79 Mr Wells of the Primary Health Care Research Institute considered that full autonomy given to suitably qualified nurse practitioners from the outset would achieve the best possible outcomes.[213] The Committee is disappointed that the Health Legislation Amendment Bill has not provided this autonomy.

RECOMMENDATION 10

3.80 **The Committee recommends that the ACT Government commission an independent evaluation of the walk-in centre at the Canberra Hospital after 12 months of operation, to examine the viability of establishing similar clinics in areas of greatest need.**

3.81 The Committee notes the recent addition of the Revive Clinic to the ACT health care landscape, established at the Healthetc Pharmacy at the Tuggeranong Hyperdome. There are currently seven such clinics operating out of pharmacies, and one stand alone clinic, in Australia. The privately-run clinics are staffed by nurse practitioners and are a 'new concept designed to provide accessible basic health care and preventative care'.[214]

3.82 The clinics do not require appointments and while Medicare rebates are currently not available, the website does report that rebates through Medicare are pending. Rebates are provided through some private insurers.

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[212] Royal College of Nursing, Australia, *Transcript of Evidence*, 5 August 2009, p 157

[213] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, pp 104–105 (check Reference)

[214] Revive Clinic, viewed 28 January 2010, <http://reviveclinic.com.au/about.asp>

3.83 Unlike the nurse led walk-in clinic, soon to begin operation at TCH, this is an untested model that has drawn criticism from doctors and pharmacy groups.

Enhanced role of the community pharmacy

3.84 There are currently 61 pharmacies operating in the ACT. Pharmacies cannot operate without a registered pharmacist on duty. Pharmacies not only dispense medicine but also provide advice about medicines and provide a triage service. The Pharmacy Guild believes that the triage service they operate has not been fully recognised by governments and has recently commissioned a project to characterise the triage role of community pharmacies.[215]

3.85 HCCA provided anecdotal evidence suggesting that consumers utilise the community pharmacy when unable to access GPs.[216] This is also reflected in the preliminary results from the HCCA 2009 GP snapshot survey.[217]

3.86 In its submission, the Pharmacy Guild of Australia (ACT) outlined two proposals that had been put to the National Health and Hospitals Reform Commission. The proposals, intended to make better use of scarce health resources and to relieve some of the burden on general practitioners, are the Treatment of Minor Ailments Scheme and Medication Continuance.[218]

3.87 The Fourth Community Pharmacy Agreement expires on 30 June 2010, and negotiations for the fifth agreement have begun. The agreement sets out the remuneration for pharmacists for dispensing PBS medicines, arrangements regulating the location of pharmacies, and guidelines for professional pharmacy programs and services.[219]

3.88 While these negotiations would be the appropriate place for considering greater involvement of pharmacists in providing consumer support, the

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[215] Submission no 8, Pharmacy Guild of Australia ACT, p 6

[216] Health Care Consumers Association ACT LTD, *Transcript of Evidence*, 22 July 2009, p 35

[217] Health Care Consumers Association ACT LTD, GP Snapshot Survey viewed 30 November 2009, <http://www.hcca.org.au/cms/media/GP_Snapshot_Results_Summary.pdf>

[218] Submission no 8, Pharmacy Guild of Australia ACT

[219] Australian Government, Department of Health and Ageing, Pharmacy and Government Arrangements, viewed 2 October 2009, <http://www.health.gov.au/internet/main/Publishing.nsf/Content/pharmacy-4cpa>

Committee was advised that there is currently no community involvement in this process. Mr McGowan advised:

> At this stage it tends to be a commercial-in-confidence discussion between the Pharmacy Guild and the commonwealth and we are disappointed about that. We think consumers have a very important role to play in setting the standards that they seek from their pharmacists in providing health advice because there is certainly a lot of health advice dispensed, along with medications, in community pharmacies, often in less than adequate settings where privacy issues are not addressed.[220]

3.89 The Pharmacy Guild reported an excellent relationship with GPs and other health professionals but was less impressed with the current relationship with the ACT Government, feeling excluded from major decisions impacting on their services, stating:

> …when models are being developed or issues that we may have, the community pharmacy is not engaged in the ACT, where in some other jurisdictions they very much are.[221]

3.90 However, the Minister advised that she was most supportive of an increased role for the community pharmacy. She said:

> We work quite closely with the Pharmacy Guild. I think they have just recently requested to be involved in the steering group of the walk-in centres. They fill other lines very much with some of the business that they do, particularly out of hours. So they are very keen. They have some ideas about what role they would like to see community pharmacies play in years to come, particularly if the nurse-led clinic is successful. I have had representations from them saying: "We would like you to operate a walk-in centre inside one of our pharmacies. Have you thought of that?" So all of those are very much being considered.[222]

3.91 The Minister noted the Guild's readiness to accept a greater role in providing primary health care and was prepared to consider any proposals presented by the Guild. The Minister raised the issue of co-location of ACT Health services within pharmacies stating:

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[220] Health Care Consumers Association, *Transcript of Evidence*, 22 July 2009, pp 28–29

[221] Pharmacy Guild of Australia (ACT), *Transcript of Evidence*, 22 July 2009, p 13

[222] Minister for Health, *Transcript of Evidence*, 22 July 2009, pp 40-41

> …it is not that it has not been done before—the clinic over at Civic pharmacy, where the Civic pharmacy used to operate. I do not think it operates there now. I cannot recall the reason, but it was not through lack of ability to work together. That is where babies could get their injections and things. Our nurses would go and work out of there. I think it works quite well.[223]

3.92 The Committee considers that pharmacies provide an invaluable service to the community that could be better utilised. As the Guild pointed out the infrastructure is there in local suburban areas, many with extended hours of operation. Greater promotion of the services provided by the pharmacy through the Pharmacy Guilds annual 'ask your pharmacist' campaign would help to raise community awareness.

RECOMMENDATION 11

3.93 **The Committee recommends that ACT Health engage with the Pharmacy Guild to explore ways of better utilising the pharmacies in the ACT in the provision of primary health care services.**

Alternative models of primary health care

3.94 Alternative models of primary health care are slowly being introduced into the Australian health care sector. The Australian Government's Super Clinics and the nurse led walk-in centre in the ACT are two such examples.

3.95 The West Belconnen Health Cooperative is also another model of interest to the Committee. The Centre, which began operating in January 2010, is a community owned medical centre with co-located health services including Aboriginal and Torres Strait Islander health, allied health and early intervention services provided by 'community, government and business sector partners'.[224] The Centre is designed to fill a need in the West Belconnen area, including the provision of affordable and bulk-billing GP services.

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[223] Minister for Health, *Transcript of Evidence*, 22 July 2009, p 41

[224] West Belconnen Health Cooperative, *Feasibility Study and Business Plan: West Belconnen Community Health and Wellbeing Centre*, April 2008, p 27

3.96 The Committee considers this to be an exciting initiative, that if successful, has the potential to be emulated in other suburban areas experiencing problems with access to GPs. The Committee understands that other community groups, particularly in the Tuggeranong area, have expressed an interest in establishing a similar model in their local community.

RECOMMENDATION 12

3.97 **The Committee recommends that the ACT Government monitor the progress of the West Belconnen Health Cooperative and, if it proves to be successful, provide information and support to community groups interested in establishing a health cooperative, or a similar model in their local community.**

3.98 With the understanding that the general practitioner workforce is not going to increase in the near future, the Committee received overwhelming support for alternative models of primary care delivery that moved away from the doctor-centric model. As noted by Carers ACT 'other models of primary health care service delivery offer opportunities to expand services to meet needs in a more flexible manner'.[225] ACTCOSS was also of the view that there should be 'no wrong doors' and that people should be able to enter the primary health care sector through a variety of means.[226]

3.99 The doctor-centric model of health care has been the mainstay of health care for decades and one that many people have grown up with. The Committee notes that moving away from this model would require a major cultural shift in some people's thinking, to let go of the ties to the GP as the first point of contact.

3.100 However, as Ms Cox pointed out 'it comes back to the appropriateness of the care in the right setting. The GP perhaps is not always the most appropriate first port of call'.[227]

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[225] Submission no 5, Carers ACT, p 11

[226] Submission no 7, ACTCOSS, p 6

[227] Ms Darlene Cox, *Transcript of Evidence*, 22 July 2009, p 30

3.101 HCCA was of the view that people would be more inclined to embrace new models if appropriate information was presented. Mr McGowan considered that Government had a role in:

> …raising the health literacy standards within the community so that not only consumers understand that there are viable alternatives which are equally safe and equally likely to maintain their wellbeing but which are more accessible and at more reasonable cost. The very important part of all of this is that the health practitioners themselves need this raising in health literacy of understanding of what is possible within the health care system, because many of them have been trained in the traditional model.[228]

3.102 Carers ACT told the Committee that while carers were supportive of new models to improve affordability and access, many carers would also need more information about new services to feel confident enough to use them.[229]

3.103 The Minister agreed that consumers did need to be informed about all available health options, stating:

> There will need to be quite a bit of work done around how we empower consumers to make those decisions.[230]

RECOMMENDATION 13

3.104 **The Committee recommends that the ACT Government conduct a community education campaign informing people about access points for health care needs, including general practitioners, allied health professionals and pharmacists.**

Social determinants of health

The social determinants of health are the conditions in which people are born, grow up, live, work and age, which are in turn shaped by political, social and economic factors.[231]

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[228] Mr Russell McGowan, *Transcript of Evidence*, 22 July 2009, p 29

[229] Carers ACT, *Transcript of Evidence*, 22 July 2009, p 50

[230] Minister for Health, *Transcript of Evidence*, 22 July 2009, p 39

[231] ACTCOSS, *Transcript of Evidence*, 22 July, p 2

3.105 The Committee recognises the importance of considering the social determinants of health in health care planning. ACTCOSS explained:

> This approach would encompass all sections within and across all government departments, agencies and organisations to develop and deliver coordinated health care processes. By adopting a social determinants of health approach to health planning and services provision, we are acknowledging that people require a range of supports and services to improve their wellbeing and health outcomes. The investment in this approach could contribute to increasing the health outcomes of the people within our communities that are experiencing disadvantage and require the most assistance.[232]

3.106 The Committee notes that the holistic model of care health provided by community run health services, such as Companion House, the Junction Youth Health Service and Winnunga Nimmityjah Aboriginal Health Service, are an excellent example of how the 'social determinants of health' are used in the planning of service delivery.

3.107 The Committee noted that the turnover of GPs in these services was very low. Dr Phillips has been with Companion House for nine years and attributed this, in part to:

> …working in a holistic model, with support from counsellors, with support from all of these other services within the entire Companion House.[233]

3.108 The Committee also notes that Dr Peter Sharp, the Medical Director from Winnunga Nimmityjah (see chapter four) has been in his position for 20 years. The benefits of working within such a model are described by Dr Sharp:

> As a GP, one of the really satisfying things about working at Winnunga is having the team around you to refer people on and to be able to deal with far more than I probably could in a normal general practice. I have all that support there. My general practice practitioner colleagues will appreciate that very much and it is a good place to work because of that.[234]

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[232] ACTCOSS, *Transcript of Evidence*, 22 July, p 2

[233] Dr Christine Phillips, *Transcript of Evidence*, 22 July 2009, p 23

[234] Dr Peter Sharp, *Transcript of Evidence*, 29 July 2009, p 76

3.109 The Junction Youth Health Service has also been fortunate to have the services of their GP for over ten years, despite paying her below the average salary for a GP.[235]

3.110 The Committee commends the work of these general practitioners who have demonstrated such commitment to the disadvantaged population groups they service, particularly in the current climate of high demand for general practitioners.

3.111 The Committee understands that the West Belconnen Health Cooperative has also partnered with a range of service providers to offer support to patients alongside the medical care they require. Services that have set up at the Cooperative currently include Carers ACT, Diabetes ACT, and the Mental Health Outreach Service. The Committee looks forward to monitoring the progress of the West Belconnen Health Cooperative.

3.112 Mr Mark Cormack, CEO of ACT Health, noted that the holistic model of care does not suit everyone, saying:

> …in fact, the overwhelming majority of the population do not necessarily need that form of coordination. Indeed, good general practice access will often give you that.[236]

3.113 While the Committee agrees that the holistic model of care is not for everyone, the holistic model has proven to be particularly beneficial to the disadvantaged population groups.

3.114 In its submission to the Preventative Health Taskforce, the ACT Government stated that the 'social determinants of health are a central part of the ACT Government's vision for Canberra'.[237] The submission also stated:

> …the health gains we are seeking to achieve will only be reached with a broader focus on the underlying structures and fabric of our society to reduce inequity and disadvantage.[238]

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[235] Ms Pauline Le Riche, *Transcript of Evidence*, 5 August 2009, p 145

[236] Mr Mark Cormack, *Transcript of Evidence*, 22 July 2009, p 44

[237] ACT Health, Submission to the National Preventative Health Taskforce Discussion Paper, December 2008, p 1

3.115 The Committee is pleased to note the Government's commitment to acknowledging the social determinants of health in its health planning. Targeted services funded by the ACT Government are discussed in the next chapter.

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[238] ACT Health, Submission to the National Preventative Health Taskforce Discussion Paper, December 2008, p 2

4 ACCESS AND EQUITY

4.1 The National Health and Hospital Reform Commission identified access and equity as one of its three reform goals.[239] The Draft National Primary Health Care Strategy also identified 'improving access and reducing inequity 'as one of four key priority areas.[240] The Strategy states:

> There are disparities in access and outcomes across different parts of Australia and between different population subgroups, often associated with disadvantage, perhaps most significantly for Indigenous Australians.[241]

4.2 In Australia, it is well recognised that Aboriginal and Torres Strait Islander people have worse health outcomes than the rest of the population. This is addressed at the national level through a range of targeted programs.[242] Winnunga Nimmityjah provides holistic health care services to Aboriginal and Torres Strait Islander people in the ACT.

4.3 We are fortunate in the ACT that most people appear to be satisfied with their health care arrangements. A recent survey conducted by HCCA found that the majority of respondents had a regular GP and were satisfied with their current health care arrangements.[243]

4.4 However, this satisfaction is not enjoyed by all in the ACT, particularly for people with chronic and/or complex conditions. While there are some targeted services in the ACT catering for particular population subgroups 'not everyone

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[239] Australian Government, National Health and Hospitals Reform Commission, *A Healthy Future for All Australians, Final Report June 2009*, p 3

[240] Australian Government Department of Health and Ageing, *Building a 21st Century Primary Health Care System, A draft of Australia's First National Primary Health Care Strategy*, 2009, p 18

[241] Australian Government Department of Health and Ageing, *Building a 21st Century Primary Health Care System, A draft of Australia's First National Primary Health Care Strategy*, 2009, p 8

[242] For example see Department of Families, Housing, Community Services and Indigenous Affairs, programs and services for Indigenous people and grants and funding for organisations providing services for Indigenous people, viewed 9 January 2010, <http://www.fahcsia.gov.au/sa/indigenous/overview/Pages/default.aspx>

[243] <http://www.hcca.org.au/cms/media/GP_Snapshot_Results_Summary.pdf>

with complex needs is eligible to access these targeted services.[244] As the GP Taskforce notes:

> There are significant numbers of people living in poverty, with chronic and complex health problems unable to access primary health care in suitable settings.[245]

Impact of GP shortage on ACT community

4.5 The shortage of GPs in the ACT is impacting disproportionately on people experiencing disadvantage. For people with chronic and complex conditions, including people with a disability and the aged, 'continuity of care' is an important factor in their health care.

4.6 The Health Services Commissioner, Ms Julie Field, highlighted the impact of the GP shortage on people with a disability. She described diagnostic overshadowing, a situation where a person's symptoms are attributed to the person's disability and no further investigation or testing is done, or where a small injury that would not greatly impact on someone without a disability can have a significant impact if not treated. The likelihood of this occurring is reduced if the patient has a regular GP.[246]

4.7 In their submission to the Committee, Carers ACT stated:

> The General Practitioner (GP) shortage in the ACT has increased the difficulty many carers face in meeting their health needs in a timely manner. Limits on the time and financial resources of carers, due to the demands of their caring role, are key factors contributing to this difficulty.[247]

4.8 Carers ACT also raised concern regarding the health and well-being of carers whose health care needs often become secondary to their care recipients' needs. For some carers, a simple visit to a general practitioner may require significant planning. As Carers ACT explained:

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[244] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 33

[245] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 33

[246] Ms Julie Field, *Transcript of Evidence*, 5 August 2009, p 110

[247] Submission no 5, Carers ACT, p 1

> Some carers need temporary respite so that they can get out of the house and get to the doctor. That respite has to be organised through a community organisation and it takes time. It has to be pre-organised and then it goes for a set duration. If the doctor is running late then that appointment may be missed because they have to get back to the care recipient before the respite ends.[248]

4.9 As Carers ACT stated in their submission:

> Carers need to be healthy to continue in their caring role and prevent premature entry of the care-recipient into supported accommodation and/or tertiary health care facilities. Reduction of preventable illness and injury, especially in vulnerable populations, is also essential to enable an already overburdened health system to meet current and future demand.[249]

4.10 The Committee considers this to be a significant concern that should be treated as a priority. Ensuring carers' physical and mental well-being needs are met, is essential to enable them to conduct their caring role. The important role played by carers cannot be underestimated. Increased GP awareness of the existence of respite-linked appointments could assist these carers to better meet their primary health care needs.

4.11 The Committee will be examining this issue further in its inquiry into respite care services in the ACT.

Barriers to accessing health care

4.12 ACTCOSS and HCCA identified the following major barriers to accessing primary health care in the ACT:

- the lower rate of GPs per capita in the ACT;
- the lower rate of bulk-billing by ACT GPs;
- the cost of accessing primary health care;
- the limited access points to primary health care; and

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[248] Carers ACT, *Transcript of Evidence*, 22 July 2009, p 53

[249] Submission no 5, Carers ACT, p 4

- physical access to primary health care, including transport and location barriers.[250]

Cost of health care

4.13 The Committee heard that the cost of health is a significant barrier. Not only the cost of paying the practitioner or health service provider but also paying for medications and other therapeutic treatments.

4.14 The Committee was advised that general practitioners are aware of the financial implications of decisions they make for their patients in terms of medication prescribed and referrals they make. As Dr Jones stated:

> I think the question of people's economic wellbeing has become more important in terms of their accessing health care rather than less important.[251]

4.15 Cost is also a concern for young people. The Junction Youth Health Service advised the Committee that they offer 'a brokerage service' to assist their clients to fill prescriptions or assist with the costs of obtaining a birth certificate and Medicare card.[252]

4.16 ACTCOSS told the Committee that cost is also a problem for older people experiencing disadvantage who sometimes need to take a number of medications.[253]

Bulk-billing

4.17 The availability of bulk-billing services increases people's choices and improves access to health care services, particularly for people on low incomes or experiencing disadvantage. The ACT has the lowest rate of bulk-billed services, with the 2008–2009 financial year recording 63.1 per cent of services bulk-billed compared to the national average of 73.9 per cent.[254]

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[250] Submission no 18, ACTCOSS and HCCA, p 152

[251] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 69

[252] Mr David Hekimian, *Transcript of Evidence*, 5 August 2009, p 152

[253] ACTCOSS, *Transcript of Evidence*, 22 July 2009, p 5

[254] Medicare Australia, Table 3, viewed 18 December 2009, <https://www.medicareaustralia.gov.au/cgi-

4.18 However, the rate of bulk-billed GP attendances is significantly lower. Since the introduction of the vocationally registered GP in 1989, the ACT has recorded the lowest or close to lowest rate of bulk-billing for GP attendances. For the 2008–2009 financial year 50.1 per cent of GP attendances were bulk-billed in the ACT compared with 60.5 per cent for the Northern Territory and 78.3 per cent for Australia.[255]

4.19 The rate of bulk-billed GP attendances was further reduced in the 2009 September quarter, which shows the ACT to be down 2 percentage points compared with the 2008 September quarter, to 47.9 per cent. This compares to 64.1 per cent for the Northern Territory and 84.2 per cent for NSW.[256] This drop in the September quarter could be due, in part, to the change in bulk-billing arrangements for the Primary Health Care Medical Centres announced in August 2009, discussed further below.

4.20 The limited access to bulk-billing services in the ACT is of major concern.

4.21 Mr Robert Wells, Director, Australian Primary Health Care Research Institute at the ANU, told the Committee that the rate of bulk-billing is a useful measure for the GP shortage. Mr Wells explained:

> The ACT has, and has consistently had ever since Medicare came in, by far the lowest rate of bulk-billing in Australia. Given that Medicare provides, if you like, a floor price for services, if the charge in the ACT is consistently above the floor price, I would suggest that there is a shortage. So I think yes, the ACT does have a problem that is greater than that of other major cities. Obviously we are better off than some of the remote areas of Australia.[257]

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bin/broker.exe?_PROGRAM=sas.std_standard_report.sas&_SERVICE=default&_DEBUG=0&start_dt=0&ptype=quarter&end_dt=200909&VAR=Services&RPT_FMT=table3>

[255] Table C3–Medicare: *Percentage of Services Bulk Billed by Broad Type of Service Financial Year of Processing by Patient State and Territory*, viewed 18 December 2009, <http://www.health.gov.au/internet/main/publishing.nsf/Content/33AA2575ABB83577CA25766D0000DEA7/$File/tablec3.pdf>

[256] The Hon Nicola Roxon MP, Minister for Health and Ageing., Media Release, *September Quarter 2009 Medicare Statistics*, 13 November 2009, see also Table E3–Medicare: Per centage of Non-referred (GP) attendances Bulk Billed By Type, By Patient State/Territory and Quarter of Processing, viewed 18 December 2009, <http://www.health.gov.au/internet/main/publishing.nsf/Content/7423A28D87398DADCA25766D0000DEAA/$File/tablee3.pdf>

[257] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 137

4.22 The GP snapshot survey. conducted for the GP Taskforce, found that only seven practices (9 per cent) in the ACT bulk-billed all clients. This will be slightly altered with the decision by Primary Health Care Ltd to limit its bulk-billing provisions–see below, and 64 per cent of practices bulk-billed patients who had a Commonwealth Health Care Card or Pension Card. However, as mentioned earlier, the decision to bulk-bill patients is one made by GPs and often this is done on a case-by-case basis. Fourteen practices bulk-billed children under 16.[258]

4.23 The Committee was concerned to learn that the two medical centres owned by Primary Health Care Ltd had reduced their bulk-billing provision to children under 16, pensioners and people with health care cards.[259]

4.24 Much of the support for Primary Health Care Ltd Medical Centres was based on their provision of bulk-billing for all patients. The Sixth Assembly Standing Committee on Health and Disability reported that since the establishment of the Primary Health Care medical centres at Phillip and Belconnen in 2006, the rate of bulk-billing in the ACT had increased.[260]

4.25 With the bulk-billing provision now limited at Primary Health Care Ltd Medical Centres, the Committee is concerned about the future of those patients who relied on the bulk-billing provisions. Unable to pay for their medical care, these patients may seek treatment from the emergency departments, thus placing greater pressure there.

4.26 The Committee is supportive of the ACT Government's nurse led walk-in centre and considers that this has the potential to relieve some of the pressure from the hospital emergency departments. It may also provide an alternative option for low income earners otherwise unable to pay for a visit to the doctor, despite this not being the intention of the centre. However, until the centre is operating, the problems will continue.

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[258] ACT Health, GP Snapshot Survey, viewed 24 September 2009, <http://www.health.act.gov.au/c/health?a=da&did=11034130&pid=1252369487>

[259] The Canberra Times, *Medical centre rolls back bulk billing*, 25 August 2009

[260] Standing Committee on Health and Disability, Report no. 9, *Closure of the Wanniassa Medical Centre*, August 2008, pp 16–17

4.27 The Committee welcomes the opening of the bulk-billing West Belconnen Health Cooperative, expected to be in December 2009.

Transport

4.28 While a recent survey has found that most people in the ACT travelled by car to get to their health appointments,[261] for consumers without personal transport options, getting to medical appointments can be problematic. In its submission to the National Hospital and Health Reform Commission, the ACT Government noted the difficulty experienced by a significant proportion of the community in physically accessing health care services, and stated:

> … distance to a health service is inversely related to the use of that service, particularly if it is a specialist service.[262]

4.29 The ACT Government further noted that the results from the 2005 ACT General Health Survey showed:

> …that around 17 per cent of respondents stated that they had transport problems that made it difficult to get to medical appointments, hospitals and other day-to-day commitments.[263]

4.30 The GP Taskforce also noted that getting to medical appointments is an issue for people who do not have access to personal transport. This is particularly so for the ageing population. And while the Taskforce found that many general practices were close to bus stops it noted that people 'who are sick, frail, disabled and elderly may find walking even relatively small distances an insurmountable challenge'.[264]

4.31 The Committee agrees with this but also notes that while general practices may have bus stops located close by, this does not take into consideration the

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[261] Health Care Consumers Association ACT, viewed 10 September 2009, http://www.hcca.org.au/cms/media/GP_Snapshot_Results_Summary.pdf

[262] ACT Health, Submission to the National Health and Hospitals Reform Commission, May 2008, p 1, viewed 1 September 2009, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/005-acthealth/$FILE/005%20-%20SUBMISSION%20-%20ACT%20Health_org_submission.pdf>

[263] ACT Health, Submission to the National Health and Hospitals Reform Commission, May 2008, p 1, viewed 1 September 2009, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/005-acthealth/$FILE/005%20-%20SUBMISSION%20-%20ACT%20Health_org_submission.pdf>

[264] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, September 2009, p 36

distance that people travel from their home to the bus stop. Furthermore, scheduling an appointment to fit in with public transport can be difficult.

4.32 There are currently two ACT Government funded transport services other than ACTION– Home and Community Care (HACC) services and the ACT Regional Community Bus Service. The Sixth Assembly Standing Committee on Health and Disability recommended that 'the ACT Government consult with the regional community services regarding the demand for transport to medical appointments for the frail aged and people with disabilities'.[265]

4.33 The Government agreed to the recommendation and advised that service providers are required to report on the number of transports provided and any additional demands on the service, every six months. The Government also advised that the annual funding round of the HACC program provides an opportunity for transport providers to apply for additional funding to meet any increased demand.[266]

4.34 The Regional Community Bus Service operates six minibuses from the Belconnen Community Service, Southside Community Services, Gungahlin Community Service, Northside Community Service, Woden Community Service and Communities@Work in Tuggeranong. This is a flexible service for people who are socially isolated and lack other transport options.[267] The HACC transport service provides door to door assistance to medical, social, day care and therapeutic groups, for eligible users.[268]

4.35 Despite the availability of these services the Committee is concerned that there are still many people in the community that do not know about them and / or how to access them. The Committee is pleased to note the Governments' agreement to the recommendation from the GP Taskforce 'to clarify and

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[265] Legislative Assembly for the ACT, The Standing Committee on Health and Disability, *Closure of the Wanniassa Medical Centre*, August 2008, p 9

[266] The Government Response the Standing Committee on Health and Disability, Report no 9, Closure of the Wanniassa Medical Centre, Tabled 15 October 2009

[267] Department of Disability, Housing and Community Services, ACT regional Community Bus Service, viewed 9 February 2010,<http://www.dhcs.act.gov.au/wac/community>

[268] Woden Community Services Inc, *Home and Community Care Program and Related Service Handbook*, p 8

publicise the criteria around accessing government funded community transport services'. [269]

4.36 ACTCOSS was particularly concerned with the centralisation of health services at The Canberra Hospital (TCH) stating:

> There are difficulties associated with accessing the Canberra Hospital base, particularly in terms of public transport, for people that do not have their own transportation. This was raised with us during our consultations for our ACT budget submission. There have been a few different suggestions on how this can be fixed, in terms of having more accessible bus services, and even having a shuttle bus running from Woden to the hospital to make it easier for people to access.[270]

4.37 The GP Taskforce also noted that the proposal for a shuttle bus to help transport people from large bus interchanges to the hospitals needed further investigation and recommended that the Sustainable Transport Action Plan 2010 –2016 currently being developed, make appropriate provisions.[271]

4.38 The Health Care Consumers Association was also supportive of a shuttle bus, particularly as access to TCH is expected to be further hampered over the coming 12 months, while the new car park is being built. HCCA suggested that the shuttle bus run every 15 minutes, not only between Woden Town Centre and the bus interchange, but also on a circuit around the hospital grounds for pick ups and drops offs. HCCA considers this would be particularly beneficial for mothers with prams, seniors without disability stickers, and visitors and consumers who come to the hospital with a range of needs and physical abilities.[272]

4.39 The Committee considers accessible transport to major hospitals in the ACT needs to be addressed, as a matter of urgency.

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[269] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward,* recommendation no 25, p 36

[270] Ms Caterina Giorgi, *Transcript of Evidence*, 22 July 2009, p 4

[271] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, September 2009, p 36

[272] Health Care Consumers Association, The Canberra Hospital Car Parking - *A Shuttle Bus part of the solution*, viewed 29 January 2010, <http://hcca-act.blogspot.com/2009/12/canberra-hospital-car-parking-shuttle.html>

RECOMMENDATION 14

4.40 **The Committee recommends that the ACT Government trial a temporary shuttle bus service from Woden Town Centre and the Woden Interchange to the Canberra Hospital, and from an appropriate place at the Belconnen Town Centre to the Calvary Hospital, until such time as the Sustainable Transport Action Plan is implemented and public transport access to the hospitals is improved.**

4.41 One of the major consequences of practices amalgamating and moving to the town centres is that practices are moving further away from where people live. It has been suggested that one way to deal with this is to 'improve the mobility of patients' who are adversely affected.[273] As Dr Lee stated:

> … if we cannot take the doctor to the people, we can take the patients to the doctor. The taxi scheme currently operating is terribly expensive. If the government can provide a taxi scheme that would provide the transport between home and the doctor's surgery, that would at least ease some of the problem of transport and disadvantage faced by the patients.[274]

4.42 Mr Wells also suggested developing specific measures to suit the groups most adversely affected. As he stated 'in the long run they might actually get better care if we have more consolidated practices.[275]

4.43 Mr Wells further made the point that 'part of the problem with the move to the town centres is that they [medical centres] are actually not in the town centres; they are to the service areas nearby. And, of course, they are not as easy to access by public transport as the town centres themselves'.[276]

4.44 The Committee was also concerned that with limited bulk-billing practices, people without their own transport could be required to travel significant distances to have their needs met.

4.45 The Committee notes the Taxi Subsidy Scheme that assists people who have a disability that prevents them using public transport. The scheme provides a subsidy towards the cost of taxi transport for travel by regular taxi or a

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[273] Submission no 14, Dr Chenault Doug Lee, p 5

[274] Dr Chenault Doug Lee, *Transcript of Evidence*, 29 July 2009, p 88

[275] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 140

[276] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 140

wheelchair accessible taxi, where required.[277] Depending on eligibility, the subsidy is either 50 per cent, capped at $17 per trip or 75 per cent, capped at $26 per trip.

4.46 Recent changes to the funding of the scheme from a departmental appropriation means 'that funding under the scheme is not capped and all ACT residents who are eligible can access benefits under the scheme'.[278] There is no limit to the number of trips used.

4.47 However, the Committee notes that despite the subsidy, travel to medical appointments outside of one's immediate locale, could prove to be costly, particularly for people on low incomes, with complex medical conditions that require regular medical appointments.

Targeted health care

4.48 There are number of excellent targeted health services in the ACT. Many of these operate with funding received from the ACT Government. These include:

- Companion House Medical Service for refugees;
- Junction Youth Health Service (outreach model for young people 12-25);
- Winnunga Nimmityjah Aboriginal Health Service;
- Hume Health Centre at the AMC for prisoners (and their families); and
- Althea wellness clinic for people with drug and alcohol problems.

4.49 Both Companion House and the Junction Youth Health Service told the Committee that they faced significant difficulties trying to link their clients to general practices. As Mr David Hekimian, Coordinator of the Junction Youth Health Service explained:

> We see young people from 12 to 25. On their 26th birthday they no longer fit our criteria. Part of our funding agreement is to then link them up, as they are

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[277] Application for the ACT Taxi Subsidy Scheme, viewed 28 January 2010, <http://www.dhcs.act.gov.au/__data/assets/pdf_file/0019/5248/Application_for_the_ACT_Taxi_Subsidy_Scheme.pdf>

[278] Question Taken on Notice, No 10, Minister for Disability, Housing and Community Services, received 27 January 2010

> reaching their 26th birthday, with a GP in their own community. But all the GPs have got their books shut. It is so difficult to find a GP that is willing to take on a young person, particularly a young person with complex mental health and drug and alcohol issues et cetera.[279]

4.50 Ms Ragless from Companion House told the Committee that:

> …we have become, against our will, more and more a service that is seeing people in parallel, rather than the transitional model that we would really like to be running'.[280]

4.51 Another problem identified by Companion House was the infrequent use of interpreters in the health care sector. A telephone interpreter service is provided by the Department of Immigration and Citizenship and on-site interpreters are provided through the ACT Government. As Dr Phillips explained:

> One of the challenges we find in terms of accessing primary health care is that, across the sector, they are [interpreters] very infrequently used. One of the roles of our nurse is to educate repeatedly the people we refer to about the access that is available to free interpreters within three minutes on a telephone.[281]

4.52 The Committee considers that better use of interpreters could provide more positive experiences, not only for transitioning clients from Companion House, but also for clients across the ACT for whom English is not their first language.

RECOMMENDATION 15

4.53 **The Committee recommends that ACT Health promote the use of interpreters to general practitioners and the broader primary health care sector to provide people for whom English is not their first language, greater choice in accessing medical services and to reduce the burden on services that cater specifically for this population group.**

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[279] Junction Youth Health Service, *Transcript of Evidence*, 5 August 2009, p 152

[280] Companion House, *Transcript of Evidence*, 22 July 2009, p 20

[281] Companion House, *Transcript of Evidence*, 22 July 2009, p 22

4.54 The Committee heard that the Junction Youth Health Service was unable to secure a locum GP while their regular GP took leave. Ms Le Riche, the Health Manger, told the Committee:

> I contacted the ACT Division of GPs for a locum. They have no-one on their books. I then contacted Sydney. We are looking at about $1,200 a day. We cannot afford that.[282]

4.55 Without a locum GP, the Junction is limited in the services it can provide and requires significant forward planning to ensure maximum efficiency while the GP is absent. Ms Le riche told the Committee:

> We will make sure that everyone whose immunisations are due and need to have their pathology tests all come. We will get Jocelyn [Junction GP] to write all the files up for this so that there is work for the nurse to continue during that time. But also clients would still come in and see the nurse about whatever medical issues and we will then refer them on to other places.[283]

4.56 The Junction also told the Committee that they were unable to meet the demands on their service estimating an approximate 50 'turn-aways' per month. While the outreach funding, received in 2009, was designed to alleviate some of the burden on the centre, Mr Hekimian advised:

> …the areas that we are servicing are almost different clientele to the regular clients. So it is not as if the outreach work that we are doing has decreased the number of turn-aways. If anything, more people in the outer suburbs are learning about the Junction…they hear about us, they meet us, they see that is where they want to come for their health care.[284]

4.57 The Committee was advised that the Junction has employed two practice nurses to decrease the number of clients that are turned away. As the main youth-friendly GP health service in the ACT, the demands on the service continue to increase.[285]

4.58 Companion House also told the Committee that they relied heavily on their practice nurses, stating that recent funding for a full time nurse has:

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[282] Junction Youth Health Service, *Transcript of Evidence*, 5 August 2009, p 145
[283] Junction Youth Health Service, *Transcript of Evidence*, 5 August 2009, p 153
[284] Junction Youth Health Service, *Transcript of Evidence*, 5 August 2009, p 150
[285] Junction Youth Health Service, *Transcript of Evidence*, 5 August 2009, p 151

> …increased our capacity and made it possible for us to operate like a parallel service; otherwise that would have been impossible.[286]

4.59 The Committee heard that it is often the people with complex care needs that attend at the Junction. It is not just one or two visits to a GP that is going to resolve their health care needs. It is usually one or two visits, to begin, to open up the doors into their health care.[287]

4.60 The Committee notes the excellent work that is being conducted by the Junction Youth Health Service and Companion House. The Committee urges the ACT Government to continue to support these services and the GPs working in these services.

RECOMMENDATION 16

4.61 **The Committee recommends that the ACT Government investigate ways of providing an in-hours locum service to cover general practitioners working in community-run health services that receive funding from the ACT Government, such as the in-hours GP Aged Day Service.**

Health care for the elderly

4.62 Of all the vulnerable groups the GP Taskforce found that the 'most urgent area for action in the provision of primary health care is aged care'.[288]

4.63 In its submission to the Senate inquiry into Aged Care, the Australian Medical Association said that older Australians in residential aged care facilities 'do not have access to medical care equal to the standard enjoyed by the rest of the population'. The AMA went on to say that the Australian Government, as the funder of aged care, should 'provide specific funding to approved aged care providers to enable them to secure appropriate medical care and supervision on an ongoing basis for their residents'.[289]

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[286] Companion House, *Transcript of Evidence* 22 July 2009, pp 20-21

[287] Junction Youth Health Service, *Transcript of Evidence*, 5 August 2009, p 151

[288] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 36

[289] AMA Submission to Senate Inquiry into Aged Care

4.64 The Committee considers the recent ACT Government initiative to provide an in-hours GP Aged Day Service to support general practitioners providing services to the elderly in residential facilities, to be commendable. The Rapid Assessment of Deteriorating and At-Risk (RADAR) is also an excellent initiative. However, despite the availability of these services, the GP Taskforce reports that many people are finding it extremely difficult to get primary health care for elderly family members living in aged care residential facilities, partly because 'aged care is viewed as a very unprofitable area of general practice'.[290] The Health Services Commissioner told the Committee that home visits for the elderly had also declined.

4.65 The GP Taskforce also noted that a small proportion of the GP workforce is providing care to the elderly, and many of these general practitioners are ageing themselves. Further to this is the BEACH data that shows that 'patients' age mirrors the age of the GPs'.[291]

4.66 In its submission to the Committee, HealthCube, a Canberra based company highlighted an innovative model of health care for residents in RACFs. The model, Proactive Aged Care (PAC), is a preventative aged care service based around patient consent, proactive team management, carefully selected and trained clinicians, including general practitioners and practice nurses, supported by quality management systems.[292] The model is currently being trialled in the Sutherland Shire of Sydney and the Committee understands that the trial is achieving positive results.

4.67 HealthCube argues that the proactive preventive care model being proposed can have significant cost saving benefits. It can reduce inappropriate admissions to acute health facilities and significantly improve quality of life for residents, who will be more appropriately managed.[293]

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[290] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 35

[291] J Childs, et al, 'The independent effect of age on general practitioner on clinical practice', cited in Australia Institute of Health and Welfare, *General practice series, No 24 general practice in Australia, health priorities and policies 1998–2008,* July 2009, p 22

[292] Submission no 17, HealthCube, p 2

[293] Submission no 17, HealthCube, p 2

4.68 This model was also supported by the Senate Committee's recent inquiry into aged care, which stated:

> The Committee's attention was drawn to innovative models of health service provision within aged care facilities to secure more holistic tracking of the health status of residents and their subsequent treatment.

4.69 The Committee was referring to the HealthCube model and went on to say '[S]uch models may benefit in the medium term from demonstration funding to explore their efficacy'.[294]

4.70 Despite its comment the Senate Committee made no recommendation regarding any further support. The Committee understands that this model would require four FWE general practitioners to service the residents in the 23 RACFs in the ACT. The Committee considers that with the current situation of health care for residents in RACFs the ACT is well placed to trial this model, or a similar model.

RECOMMENDATION 17

4.71 **The Committee recommends that the ACT Government investigate the feasibility of establishing a pilot project for residents living in residential aged care facilities in the ACT, such as the Proactive Aged Care program proposed by Healthcube, or a similar model.**

4.72 Another problem identified by general practitioners who provide services to elderly patients in RACFs is the lack of 'adequately equipped clinical treatment rooms that affords patient privacy and contains appropriate stocks of essential medical equipment and supplies'.[295] The GP Taskforce also noted the potential benefits of designated consultation rooms in RACFs.[296]

4.73 The Committee notes that funding for residential aged care facilities lies mainly with the Australian Government. However, the Committee is of the view that improving facilities in RACFs may encourage more general

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[294] The Senate, Standing Committee on Finance and Public Administration, *Residential and Community Aged Care in Australia*, April 2009, p 45

[295] Australian Medical Association, Submission to the Senate Finance and Public Administration Committee, *Inquiry into Residential and Community Aged Care in Australia*, November 2008, p 3

[296] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, 2009, p 35

practitioners to provide services in aged care facilities. The Committee considers that some ACT Government funding, such as the ACT GP Development Fund, should be considered for use to appropriately equip all aged care facilities with a consulting room.

4.74 The Committee notes that the ACT Government is inviting proposals for a new ACT GP Aged Day Service to be funded through the 2009–2010 $12 million appropriation to support and grow the general practice workforce. The service aims to improve GP services to elderly residents of aged care facilities or residents who are housebound. It is expected that the new service, to begin operation from 1 July 2010, will also reduce the pressure on other parts of the health care system.[297]

Aboriginal and Torres Strait Islander health

4.75 Winnunga Nimmityjah Aboriginal Health Service is an Aboriginal community controlled health service primarily established to serve Aboriginal people in the ACT. As a regional service, 30 per cent of its clients are from New South Wales, however, there is no cross-border agreement with NSW. As Ms Julie Tongs, CEO of Winnunga Nimmityjah explained:

> I have been at Winnunga for 12 years and there has been a lot of turnover with CEOs of ACT Health and whatever. I have been raising this issue virtually since day one about why is it so hard to have an agreement between New South Wales and ACT for Aboriginal health when the ACT hospital is a regional hospital and there is an agreement there. We had an arrangement with New South Wales as far as the prison went.[298]

4.76 With such a significant proportion of clients from NSW, the Committee considers financial compensation from NSW would greatly assist Winnunga in its service delivery. The service is doing a wonderful job on a shoe string budget, and any additional financial resources would only enhance service delivery.

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[297] ACT Government Media Release, 'Proposals Invited for GP Aged Day Service', 25 January 2010

[298] Ms Julie Tongs, *Transcript of Evidence*, 29 July 2009, p 77

RECOMMENDATION 18

4.77 **The Committee recommends that ACT Health negotiate a cross-border agreement with the NSW Government for health services provided by Winnunga Nimmityjah Aboriginal Health Service, to NSW residents.**

4.78 Another issue impacting on Winnunga is that 25 per cent of clients are non-Aboriginal. This not only includes the non-Aboriginal partners of Aboriginal people but disadvantaged and elderly people living in the Narrabundah area. As Ms Tongs described:

> When we first moved into Narrabundah we had a private GP that shared space in our service. Because of the shortage of GPs, that GP has now moved over to Chisholm. That left a gap for the Narrabundah community. We have filled that gap…But we need to be resourced to be able to continue to do that.[299]

4.79 In their submission Winnunga Nimmityjah stated that:

> …disadvantaged people use Winnunga because it is an accessible, bulk-billing, walk-in service. Again Winnunga is not funded for these additional non-Indigenous clients who add a significant workload for the GPs and practice nurses.[300]

4.80 Ms Tongs told the Committee that while the specialised services are for Aboriginal people only, the demand from non-aboriginal people wanting to access these services, such as the diabetes clinic, is increasing. It is only the lack of resources that prohibits Winnunga from offering these services to non-Aboriginal people.[301]

4.81 Winnunga Nimmityjah is fortunate to have the services of Dr Peter Sharp, who has been with the service for 20 years. Ms Tongs told the Committee that the impact of the GP shortage in the ACT, has been such, that for the first time in 12 years, Winnunga has had to advertise for general practitioner positions. Ms Tongs further advised that this has been difficult as Winnunga Nimmityjah is

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[299] Ms Julie Tongs, *Transcript of Evidence*, 29 July 2009, p 75

[300] Submission no 9, Winnunga Nimmityjah Aboriginal Health Service, p 2

[301] Ms Julie Tongs, *Transcript of Evidence*, 29 July 2009, p 77

in no position to offer competitive wages and 'we are never going to be able to compete unless there is some equity in that'.[302]

4.82 Winnunga Nimmityjah also raised concerns about Aboriginal and Torres Strait Islander people in the ACT who access mainstream primary health care services. As Ms Tongs explained:

> These services do not always recognise the particular health needs and culture of Aboriginal and Torres Strait Islander people. An analysis conducted by Winnunga indicates that Winnunga has done 95% of all Aboriginal and Torres Strait Islander Medicare health checks in the ACT. This implies that mainstream general practices are either not identifying Indigenous clients and/or not providing specific services to address Aboriginal and Torres Strait Islander health issues. Mainstream services need to work much more closely with Aboriginal and Torres Strait Islander people to address the needs of our community.[303]

4.83 Winnunga Nimmityjah is under considerable financial pressure. The comprehensive services provided at Winnunga not only for the Indigenous community but also for the disadvantaged population of Narrabundah, needs to be supported by government funding. As Ms Tongs noted:

> Income generated by Medicare can in no way cover the extent of the services provided. Winnunga constantly experiences financial pressure associated with delivering an expanded range of services and does not have sufficient funding to provide all that is required. Multiple funding sources and a significant burden of reporting add to the management burden of the organisation.[304]

4.84 Winnunga Nimmityjah offers an invaluable service to the ACT community. However, Winnunga is currently operating with one GP and one GP registrar short, and as noted earlier, is having difficulty recruiting a general practitioner. Ms Tongs told the Committee that Government funding for a GP position would assist them to attract a general practitioner.[305]

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[302] Ms Julie Tongs, *Transcript of Evidence*, 29 July 2009, p 74

[303] Submission no 9, Winnunga Nimmityjah Aboriginal Health Service, p 2

[304] Submission no 9, Winnunga Nimmityjah Aboriginal Health Service, p 2

[305] Ms Julie Tongs, *Transcript of Evidence*, 29 July 2009, p

RECOMMENDATION 19

4.85 **The Committee recommends that the ACT Government provide funding to Winnunga Nimmityjah Aboriginal Health Service to enable the employment of at least one full-time general practitioner position.**

Overall comment

4.86 People with chronic and complex conditions, including the elderly and people with a disability, rely heavily on 'continuity of care' to have their health care needs met in an appropriate way. The Committee is of the view that the ACT Government has a responsibility to ensure all ACT residents have access to timely and affordable health care.

4.87 The ACT Government's Better General Health Program links people living with chronic and enduring mental illness proactively to general practices using nurse led coordination and service agreement payments between general practices and Mental Health ACT.[306] The Committee agrees with the suggestion made by the GP Taskforce that this model could be used to expand access to primary health care 'for vulnerable populations currently unable to access general practice'.[307]

4.88 The Committee strongly supports the recommendation made by the Taskforce '(T)o support existing general practices to provide comprehensive primary health care to vulnerable populations in partnership with other relevant services'.[308]

4.89 However, the Committee is firmly of the view that GPs who provide these services should not be disadvantaged, but rather should be financially supported and/or compensated to ensure that these patients are afforded the health care that they require.

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[306] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 33

[307] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 33

[308] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 33

4.90 The Committee notes the Government has agreed in principle to recommendation 15 of the Taskforce calling for the development of new models of primary health care service delivery stating that the Government would consider 'expanding the Better General Health Program to cater for targeted populations in the ACT'.[309]

4.91 While the Committee is pleased to note that the Government is considering this, the Committee is of the view that this is an excellent model that could readily be extended to include other disadvantaged groups, as a matter of priority.

RECOMMENDATION 20

4.92 **The Committee recommends that the ACT Government extend the Better General Health Program to general practitioners that provide 'continuity of care' to elderly patients and those with chronic and complex conditions to ensure they are financially supported for the provision of that service.**

[309] *Government Response to the GP Taskforce Final Report*, p 4

5 IMPROVING EFFICIENCY

5.1 Increasing the health workforce is only one part of the solution of relieving the pressure on the primary health care sector. This chapter looks at a range of other measures, currently in various stages of implementation, aimed at improving the overall operation of the health sector.

Health records

5.2 With general practices closing down and/or relocating to larger practices across the ACT, access to patients' health records has been raised as a matter of concern. The Health Services Commissioner, Ms Julie Fields, told the Committee that approximately 20 per cent of the complaints received by her office were in relation to health records. The Commissioner advised that the most common complaint related to the timely receipt of records, followed by the cost of retrieval and people wanting their original records.[310]

5.3 Access to personal records including health records is governed at the federal level by the *Privacy Act 1988*[311] and more specifically in the ACT by the *Health Records (Privacy and Access) Act 1997*. The GP Taskforce found that:

> …notice of practice closure and arrangements for access to health records are not well understood – either by the community in general or the medical profession.[312]

5.4 The GP Taskforce covered this issue extensively in chapter five of its final report and recommended:

- the development of easy of to read guidelines for consumers and health professionals about rights and obligations under the Act;
- amending legislation to improve access to health records and clarify requirements for general practices;

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[310] Ms Julie Fields, *Transcript of Evidence*, 5 August 2009, p 109

[311] Privacy Act 1988, s16C

[312] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, p 37

- greater public promotion of the roles and responsibilities of the Health Services Commission; and
- the introduction of a mandatory requirement for GP practices that open, close, merge or move location to notify a relevant government authority.[313]

5.5 The Committee considers that this issue is covered comprehensively by the GP Taskforce and is pleased to note that the Government has agreed and agreed in principle to the recommendations. The Committee is also pleased to note however, that the latest amalgamation of general practices does appear to have complied with the legislation in regard to providing sufficient notice and making provisions for the transfer of patients' records.[314]

E-health

5.6 E-health is defined by the Australian Government Department of Health and Ageing as:

> …the electronic management of health information to deliver safer, more efficient, better quality health care.[315]

5.7 There is a significant amount of work being done around e-health initiatives at state, territory and national levels.[316] The National E-Health Transition Authority (NEHTA) 'has been tasked by the governments of Australia to identify and foster the development of the right technology necessary to deliver the best e-health system'.[317] NEHTA has recently launched its strategic plan.[318]

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[313] GP Taskforce, *General Practice and Sustainable Primary Health Care - The Way Forward*, pp 37-39

[314] Public Notice, The Canberra Times, *Notice to patients of the Bromley Group Family Practice, Valley Medical Centre, and Pearce Medical Centre*, 30 October 2009

[315] Australian Government Department of Health and Ageing, *eHealth*, viewed 1 November 2009, <http://www.health.gov.au/internet/main/publishing.nsf/Content/eHealth>

[316] For example see CSIRO -Health Information and patient management , viewed 1 November 2009, http://www.csiro.au/science/Health-Information-and-Patient-Management.html

[317] National E-Health Transition Authority, viewed 29 October 2009, http://www.nehta.gov.au/

[318] National E-Health Transition Authority, viewed 29 October 2009, http://www.nehta.gov.au/about-us/strategy

5.8 While NEHTA is putting the structures in place to enable e-health to become part of the Australian health sector on the national level, there are a range of independent state and territory based projects underway.

5.9 The Committee received overwhelming support for a patient controlled health record[319] and is pleased to note the NHHRC recommendation that by 2012 'every Australian should be able to have a personal electronic health record that will at all times be owned and controlled by that person'.[320]

5.10 The Committee notes the ACT Government budget allocation of $90 million for the devolvement of e-health in the ACT, and is pleased that a personally held electronic record is being created. Mr Cormack, CEO of ACT Health told the Committee that the record would enable:

> …the clients, the patients and their families, to be able to be the holder and keeper of that information and empower them to pull a lot of the services together.[321]

5.11 Carers ACT demonstrated the importance of a patient controlled e-health record for people with chronic and complex conditions. Speaking about people with a disability, Carers ACT stated:

> The care histories are very long and complex and you cannot carry around a load of folders even on the basic stuff, such as when they had particular procedures done, let alone what the current list of drugs is and what you stopped six months ago and what the symptoms were then—all of that clinical depth of information that is required.[322]

5.12 From the general practitioner's perspective, a patient controlled health record has the potential to streamline current time-consuming processes such as having to chase up patients' test results and records.[323] The Committee was

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[319] Submission no 7, ACTCOSS p 8, Submission no 1, Mr Skimin, p 2, Health Care Consumers Association, *Transcript of Evidence*, 22 July 2009, p 32, AMA (ACT), Transcript of Evidence, 29 July 2009, p 64

[320] Australian Government, National Health and Hospitals Reform Commission, *A Healthy Future for All Australians, Final Report June 2009*,, recommendation 13, p 18

[321] Mr Mark Cormack, *Transcript of Evidence*, 5 August 2009, p 22 July 2009, p 44

[322] Carers ACT, *Transcript of Evidence*, 22 July 2009, p 52

[323] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 71

also advised that this would reduce the amount of duplication of services that currently occur. As Dr Jones explained:

> …I have a patient completely, as the professional jargon says, "worked up", X-rays, blood tests et cetera, and you discover from their discharge referral from the hospital that most of those things have been repeated at enormous costs to both the territory and the federal government.[324]

5.13 The AMA ACT expressed some concern that they were not being consulted on the introduction of e-health strategies at the local level.[325] The AMA also warned that any e-health developed must be interactive with general practice software. Dr Jones cited the example of the delivery of x-rays on DVD stating:

> There was no discussion with GPs about how that might interact with our software, no training for GPs about how to use it.[326]

5.14 Not everyone was supportive of e-health records. Dr Lee pointed out that while people's health records will be stored in one place, those records for the aged, or people with chronic and complex conditions would require time for full comprehension.[327]

5.15 Dr Bateman also questioned the quality of the record, stating:

> Most doctors want to do it again and will do it again. So the idea that you are going to save duplication, everything is going to be so much better—the answer is it is not as good as you think.[328]

5.16 The Physiotherapists Association considered that the focus of e-health has historically been on general practice and advised the Committee that they had been in negotiations with NEHTA and that:

> …a number of projects are going on now to look at the ICT infrastructure requirements of the other health professionals. [329]

5.17 Despite these concerns, the Committee is in full support of the establishment of personally controlled electronic health records for individuals. Not only

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[324] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 72

[325] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 71

[326] Dr Paul Jones, *Transcript of Evidence*, 29 July 2009, p 71

[327] Dr Chenault Doug Lee, *Transcript of Evidence*, 29 July 2009, p 84

[328] Dr Edmund Bateman, *Transcript of Evidence*, 5 August 2009, p 134

[329] Mr Michael Badham, *Transcript of Evidence*, 29 July 2009, p 97

does this have the potential to improve efficiency of the health sector by reducing duplication and freeing up GPs time, but it will give people more control over managing their own health care needs, an important step towards improved health literacy.[330]

RECOMMENDATION 21

5.18 **The Committee recommends that the ACT Government conducts appropriate consultation with all relevant stakeholders in the development of its e-health strategy.**

Health literacy

5.19 Improving health literacy is central to improving health outcomes for people. The Health Care Consumers Association (HCCA) argued that self management was not only important for people with chronic conditions but also for increasing consumers' awareness of health and wellbeing, so that people would be able to make informed decisions about their health needs, supported by good, reliable information.[331]

5.20 HCCA also argued that consumer participation is essential in any health care planning, stating:

> This input is critical to identifying access issues and barriers as well as providing insight into measuring performance in respect of safety and quality.[332]

5.21 Improving health literacy is also an important component of the NHHRC's reform agenda of 'creating an agile and self-improving health system'. To encourage consumer engagement the NHHRC recommended that health

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[330] An evaluation of the Healthelink Electronic Health Record Pilot found one of the benefits of the pilot to be 'patients access to their own EHR enabling them to take more control over their care management' and also found that this could be further enhanced by broadening the database to 'enable patients and clinicians to directly and interactively share responsibility for on-going management of the patients health'. NSW Healthelink project, viewed 9 October 2009, <http://www.nehta.gov.au/case-studies/401-nsw-healthelink pilto ended June 2009>

[331] Health Care Consumers' Association, *Transcript of Evidence*, 22 July 2009, p 29

[332] Health Care Consumers' Association, *Transcript of Evidence*, 22 July 2009, p 27

literacy be included as a core element of the National Curriculum in primary and secondary schools.[333]

5.22 The Committee supports this recommendation and considers that access to accurate information regarding health services and health conditions is an essential part of empowering people to manage their own health needs.

5.23 One source of health information available to residents in the ACT is the national telephone service, Healthdirect. This service provides a broad range of health related information, including a telephone triage service that assesses the urgency of a person's medical condition through a series of questions. All calls to Healthdirect are answered by qualified and experienced nurses.[334]

5.24 The HCCA told the Committee that Healthdirect is underutilised in the ACT, citing a recent survey that showed that only 10 to 15 per cent of the respondents had accessed the service.[335]

5.25 Carers ACT was also of a similar view stating:

> …there was very little awareness in the general community of the advantages of using the healthdirect system, and the fact that it can help to almost fast-track you into a GP. If you get a recommendation from them that you need to see your GP within two hours, you can then tell the receptionist at the clinic, "Look, I spoke to healthdirect and they said this." That suddenly makes things easier: "Okay, we accept you've been triaged and that this is a genuinely urgent issue."[336]

5.26 The Committee considers Healthdirect to be an important community service in the delivery of health information. For people and/or carers experiencing a health concern, a conversation with a qualified nurse has the potential to quell the concern and reduce the need for an emergency department presentation (if it is after hours) or fast track them to the health care they require.

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[333] Australian Government, National Health and Hospitals Reform Commission, *A Healthy Future for All Australians, Final Report June 2009*,, recommendation 11, p 18

[334] http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=799

[335] Health Care Consumers' Association, *Transcript of Evidence*, 22 July 2009, p 27 and pp 33–34

[336] Carers ACT, *Transcript of Evidence*, 22 July 2009, p 52

5.27 The Committee notes that the Western Australian Government provides comprehensive quarterly reports on all Healthdirect activity in WA. The Committee understands that Western Australia is the only jurisdiction that currently reports on Healthdirect.[337] The Committee considers that comprehensive information regarding Healthdirect activity in the ACT should be publically available.

RECOMMENDATION 22

5.28 **The Committee recommends that ACT Health widely promote the services of Healthdirect throughout the community.**

RECOMMENDATION 23

5.29 **The Committee recommends that ACT Health report on Healthdirect activity, including generic information about the number and nature of calls, and action taken, as part of ACT Health's quarterly performance reports. The Committee further recommends that the ACT Government examine the Western Australian Healthdirect reporting model, with a view to its introduction in the ACT, if deemed appropriate.**

Preventative health

5.30 The old adage *prevention is better than cure* is taking on a significant role in health planning. The National Preventative Health Taskforce launched its National Strategy recommending a range of interventions aimed at reducing the chronic disease burden associated with three lifestyle risk factors–obesity, tobacco and alcohol.[338]

5.31 Programs promoting healthy lifestyles are increasingly being used to ensure good health from an early age. Examples of such programs include:

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[337] Department of Health, Government of Western Australia, *Consumer Health Services Directory*, viewed 10 October 2009, <http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=799>

[338] National Preventative Health Taskforce, viewed 2 November, 2009 <http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/national-preventative-health-strategy-1lp>

- National Walk to Work Day;[339]
- Centre for Physical Activity in Ageing–*A Guide to Walking*–promoting health through walking for elderly people;[340]
- Australian Better Health Initiative, *Measure Up*–promoting healthy eating and physical activity to combat chronic disease;[341]
- *Go for 2&5*–promoting good health and disease prevention through healthy eating;[342]
- *Find thirty. It is not a big exercise*.–promoting good health through 30 minutes of physical activity on most days of the week;[343] and
- ACT Health Promotion Grants.[344]

5.32 The Committee notes the Australian Government is seeking to establish a dedicated Preventative Health Agency, by January 2010, to focus on 'driving the prevention agenda and combat the complex challenges of preventable chronic disease'.[345] The Bill to establish the Agency is currently before the Senate.[346]

5.33 The Committee strongly supports all programs and campaigns aimed at promoting healthy living and lifestyle choices. Keeping people healthy means less pressure on the health system.

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[339] Pedestrian Council of Australia, Walk to work day, viewed 2 November 2009, <http://www.walk.com.au/wtw/page.asp?PageID=207>

[340] Royal Adelaide Hospital, Centre for Physical Activity in Ageing–A guide to Walking, viewed 10 October 2009, <http://www.cpaa.sa.gov.au/benefits_exercise/walking.html>

[341] How do you measure up?, viewed 30 October 2009, <http://www.measureup.gov.au/internet/abhi/publishing.nsf>

[342] *Go for 2&5*, viewed 30 October 2009, <http://www.gofor2and5.com.au/>

[343] *Find thirty*, viewed 30 October 2009, <http://www.find30.com.au/>

[344] ACT Health, viewed 10 October 2009, http://health.act.gov.au/c/health?a=sp&did=10028428

[345] The Hon Nicola Roxon, Media Release, *Australia's First Preventative Health Agency*, viewed 2 November 2009, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-nr-nr182.htm?OpenDocument&yr=2009&mth=10>

[346] The Hon Nicola Roxon, Media Release, *Prevention Put on Hold by the Senate*, viewed 2 November 2009, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-nr-nr195.htm?OpenDocument&yr=2009&mth=10>

Lessons from other jurisdictions

5.34 States and territories across Australia are implementing strategies that use a range of service delivery models, including those that do not focus on the GP being the 'gatekeeper' to health care.[347] While there are many examples of innovative health service delivery models being trialled in Australia and overseas, the following were brought to the Committee's attention.

HealthOne NSW

5.35 As part of the NSW Government's commitment to greater integration and coordination in primary health care, HealthOne was established in 2007 to bring together health professionals, including GPs and community health workers, in a 'one stop shop'.[348] HealthOne services are located in 15 sites across NSW with each site specifically designed to accommodate the local circumstances and populations. The models of HealthOne services include:

- co-located services, incorporating GPs into community health;
- hub and spoke model, where a central site supports and coordinates other services; and
- virtually integrated services, where various services work as virtual teams rather than face to face.[349]

5.36 The 15 HealthOne sites located throughout NSW are in various stages of development and planning. The Committee considers this to be an exciting initiative and awaits results of the evaluation, expected to be carried out at each of the sites, as the project develops.

Physician Assistant Program

5.37 Another project brought to the Committee's attention is the Physician Assistant Pilot Program being trialled in Queensland. Physician assistants are currently used in the United States, Canada, England and Scotland. Ten

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[347] Submission no 7, ACTCOSS, p 22

[348] NSW Health, *Integrated Primary Health and Community Care — NSW is well on the way*, Accessed http://www.health.nsw.gov.au/Initiatives/HealthOneNSW/newsletters/200704.asp

[349] NSW Health, cited in Submission no 7, ACTCOSS, p 23

physician assistants have been recruited from the United States to be involved in this 12 month pilot project.[350]

5.38 The University of Queensland is offering a Graduate Certificate in Physician Assistant Studies and a Master of Physician Assistant Studies, and describes the role of a physician assistant as:

> …a midlevel health care practitioner working under the delegated authority of a medical practitioner. At the core of the physician assistant profession is a team approach to patient care. With this approach a physician assistant is able to provide continuity of care, increase provider accessibility and improve quality of life for both patients and practitioners to better meet the long-term needs of the community.[351]

5.39 Not dissimilar to the introduction of allied health assistants, the use of physician assistants is a relatively new addition to the Australian health sector and will need to be tested before the role is guaranteed. However, with the current shortage of health care workers the creation of new roles is worth considering, and the Committee looks forward to the results of the pilot project.

Flexible funding

5.40 The Committee was interested in flexible funding models as described by the National Hospital Health Reform Commission for selected groups of patients.[352] Mr Wells was also supportive of alternative funding models particularly those based on capitation. Mr Wells further explained:

> There is evidence to suggest that the incentive then for doctors is to actually look after the practices, to use all the health workers or health resources they need to do that and keep people out of hospital as much as they can.[353]

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[350] Media Release: Minister for Health The Honourable Stephen Robertson, Saturday, August 16, 2008, *Physician Assistant Trial Sites Announced*
<http://www.cabinet.qld.gov.au/mms/StatementDisplaySingle.aspx?id=59727>

[351] University of Queensland, Master of Physician Assistant Studies (MPhysAsstSt), viewed 2 November 2009, <http://www.uq.edu.au/study/program.html?acad_prog=5474>

[352] Australian Government, National Health and Hospitals Reform Commission, *A Healthy Future for All Australians, Final Report June 2009*, pp 134–136

[353] Mr Robert Wells, *Transcript of Evidence*, 5 August 2009, p 140

5.41 Capitation (fixed fee per person) is the predominant funding model in New Zealand and Great Britain. A study conducted by the Centre for Primary Health Care and Equity at the University of NSW found that:

> Capitation funding makes it easy to fund service providers for the full range of tasks involved in comprehensive primary health care, where fee-for-service is generally used for more narrowly defined tasks.[354]

5.42 While acknowledging the role of Medicare, particularly its effectiveness in funding acute and episodic care, the Committee supports the exploration of alternative models of funding for primary health care and for general practitioners and general practices, to enable greater choice for both practitioners and their patients.

RECOMMENDATION 24

5.43 **The Committee recommends that the ACT Government continue to monitor the innovations in primary health care delivery being trialled across Australia and overseas.**

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[354] Julie McDonald et al, *What can the Experiences of Primary Care Organisations in England Scotland and New Zealand Suggest About the Potential Role of Divisions of General Practice and Primary Care Networks/partnerships in Addressing Australian Challenges*, Australian Journal Primary Health, Vol. 13, No 2, August 2007, p 52

6 CONCLUSION

6.1 Increasing the number of general practitioners is only one part of the solution to improving access to primary health care. This is an ambitious long term strategy particularly given the duration of education and training. Furthermore, there are no guarantees that medical gradates will take up general practice. Improving the conditions of general practice and raising the morale of general practitioners, along with vocational training initiatives has the potential to increase the uptake of general practice by medical graduates.

6.2 While acknowledging the vital role that GPs play in the provision of primary health care, there is considerable community support for alternative models of primary health care delivery, that move away from the doctor-centric model of health care.

6.3 Enhanced roles and greater access to Medicare rebates for services provided by practice nurses, nurse practitioners, and allied health professionals must be considered. The local pharmacy also has a role to play in the dissemination of health care related services.

6.4 The GP shortage in the ACT is disproportionately affecting disadvantaged residents due to limited availability of bulk-billing services, the cost of health care and treatments, and physical access to medical centres. Targeted services for disadvantaged population groups are struggling to meet the current demand. These services must be fully supported by the ACT Government and alternative, affordable options need to be created, as a priority.

6.5 The Committee has made 24 recommendations with a focus on practical solutions to improve people's access to primary health care services in the ACT.

6.6 With the shortage of general practitioners, nurses and allied health professionals, better utilisation of the current skills and expertise of the available health workforce, will have the greatest impact on health outcomes, not only in the short term, but until such time as there is an improvement in workforce numbers.

6.7 The Committee thanks the participants to the inquiry who provided submissions and/or oral evidence.

Steve Doszpot MLA

Chair

17 February 2010

APPENDIX A: Public hearings

22 July 2009

- Ms Roslyn Dundas, Director, ACT Council of Social Service
- Ms Caterina Giorgi, Policy Officer, ACT Council of Social Service
- Mr Peter Brady, Branch Director, Pharmacy Gild of Australia (ACT Branch)
- Mr Vincent Tran, Pharmacist Manager Capital Chemist Curtin, Pharmacy Gild of Australia (ACT Branch)
- Ms Kathy Ragless, Director, Companion House
- Dr Christine Phillips, General Practitioner, Companion House
- Dr Adele Stevens, President, Health Care Consumers' Association ACT Inc
- Ms Darlene Cox, Executive Director, Health Care Consumers' Association ACT Inc
- Mr Russell McGowan, Secretary, Health Care Consumers' Association ACT Inc
- Ms Katy Gallagher, Minister for Health
- Mr Mark Cormack, Chief Executive, ACT Health
- Mr Ross O'Donoughue, Co Chair, GP Taskforce
- Dr Clare Willington, Co Chair, GP Taskforce
- Ms Dee McGrath, CEO, Carers ACT
- Ms Annemarie Ashton, Policy Advisor, Carers ACT
- Ms Natasha Flores, Policy Project Officer, Carers ACT
- Mr Arthur Skimin, Health Care Consumer

29 July 2009

- Dr Paul Jones, President, AMA (ACT Division)
- Dr Steve Kennealy, Treasurer, AMA (ACT Division)
- Dr Peter Sharp, Board Member, AMA (ACT Division)
- Ms Julie Tongs, CEO, Winnunga Nimmityjah Aboriginal Health Service

- Dr Chenault Doug Lee, Erindale Medical Practice
- Mr Phillip Cossens, President, Australian Physiotherapy Association (ACT)
- Mr Jonathon Kruger, Manager Policy and Professional Standards Division, Australian Physiotherapy Association (ACT)
- Mr Murray Stark, President, Chiropractors Association of Australia (ACT)
- Mr Michael Badham, Policy Officer, Chiropractors Association of Australia (ACT)

5 August 2009

- Ms Julie Field, Health Services Commissioner, Human Rights Commission
- Mr Phil Lowen, CEO, ACT Division of General Practice
- Dr Jennifer Thomson, Chief Medical Advisor, ACT Division of General Practice
- Dr Edmund Bateman, CEO, Primary Health Care
- Mr Robert Wells, Director, Australian Primary Health Care Research Institute (ANU)
- Ms Pauline Le Riche, Health Manager, The Junction Youth Health Service
- Mr David Hekimian, Coordinator, The Junction Youth Health Service
- Ms Debra Cerasa, CEO, Royal College of Nursing, Australia
- Ms Kathleen McLaughlin, Director, Professional Services , Royal College of Nursing, Australia

APPENDIX B: Submissions and exhibits

Submissions

1. Mr Arthur Skimin
2. Healthscope
3. Ms Marcia Stuart
4. Australian Physiotherapy Association (ACT)
5. Carers ACT
6. Primary Health Care
7. ACTCOSS
8. Pharmacy Guild of Australia ACT
9. Winnunga Nimmityjah Aboriginal Health Service
10. Health Care Consumers Association
11. The Junction Youth Health Service
12. ACT Health
13. Companion House
14. Dr Chenault Doug Lee
15. Chiropractors' Association of Australia (ACT)
16. Royal College of Nursing Australia
17. HealthCube Pty Ltd
18. ACTCOSS and Health Care Consumers

Exhibits

1. Chiropractors' Association of Australia (CAA) ACT Ltd, Submission to ACT Health, Walk-in Centres in the Australian Capital Territory

2. Chiropractors' Association of Australia (CAA) ACT Ltd, Submission to the ACT Minister for Health, Appointment of a Chiropractor(S) to an ACT Health Facility, March 2007

3. Chiropractors' Association of Australia (CAA) ACT Ltd, Proposal for Pilot Project, Investigation of publicly-provided chiropractic care in the Australian Capital Territory (ACT), March 2008

4. Dr Chenault Doug Lee, Concerns about the future of primary health care in Australia

5. Dr Chenault Doug Lee, "superclinics" model of care Vs personalised GP care

6. Dr Chenault Doug Lee, Comments on funding assistance for GP

7. Dr Chenault Doug Lee, Proposed policy for bringing GPs to the suburbs/bush, November 2007

8. ACT Division of General Practice, Submission to ACT GP Taskforce, June 2009

9. Mr Nick Tsoulias (Doctors4Tuggeranong), Submission to ACT GP Taskforce

10. Mr Doug Rankin, Submission to ACT GP Taskforce