ACT Division of General Practice Submission to the GP Task Force

Response *A Discussion Paper - Issues and Challenges for General practice and Primary Health Care June 2009*

ACT Division of General Practice (ACT DGP) is one of a network 111 local organisations (Divisions of General Practice) as well as the ACT state-based organization working with the Australian General Practice Network. ACT DGP has 498 GP Members and 40 Associate Members.

The ACT DGP is involved in a wide range of activities including practice support and quality improvement, health promotion, early intervention and prevention strategies, chronic disease management, medical education, information management, health service development, health service delivery and workforce support. ACT DGP is an active participant in the ACT GP Workforce Working Group and its President is a Member of the GP Task Force.

Participation in the GP Task Force by the ACT DGP President was as an individual member of a selected group of participants, and both the President and the ACTDGP may hold views that differ from the GP Task Force.

Preamble

The ACT Division of General Practice (ACT DGP) welcomes the opportunity to comment upon the June 2009 *A Discussion Paper - Issues and Challenges for General practice and Primary Health Care*.

The discussion paper is most welcome and generally addresses the issues facing modern general practice and should provide a sound basis for further development of solutions to the issues raised.

ACT DGP is concerned that a reader of the Discussion Paper may conclude that there is a crisis in care in the ACT. We suggest rather that there are significant workload and access issues across many, but not all, parts of Canberra, and some categories of patients are nearing a crisis stage. Some recent sampling indicated that about one half of Canberra's practices still had open books and could meet patient access requirements within the 1-3 day benchmark. Many other practices had closed books or were only open to extended families of existing patients.

Certainly without change the situation will get worse as the ACT population ages. Current recruitment and education strategies are at best likely to maintain existing workforce levels in the face of a growing demand. We would not however wish to see the current situation painted as a crisis with the risk of

inappropriate and hasty solutions but rather we strive to work with other stakeholders to develop considered short, mid and long term responses.

ACT DGP and its Members see no compelling argument for radical change in the models of care but rather the elimination of inefficiencies of operations, and significant and urgent improvement in the electronic shared health record, effective communications, and investment in business flow improvements to build capacity for effective collaboration between existing players. The key issues conveyed from our Members are

- that there is a workforce shortage of GPs and practice nurses,
- that like all small business a significant amount of patient care time of the current workforce is taken up with bureaucracy, complexity of service coordination, and compliance issues,
- a need to improve on poor communications between providers involved in patient care,
- complexity of navigating the patient journey through ACT public sector services, agencies, not for profit providers and support groups.
- major problems in providing appropriate medical support to aged care facility residents
- support for increased teaching role with increasing numbers of medical students, interns, GP Registrars and other health professionals requiring clinical teaching in the general practice setting

Not all the levers of change are in the hands of ACT Health, rather the funding models and much of the red tape is firmly within the jurisdiction of the Federal Government. None the less there is still opportunity for improvement at the local level.

ACT DGP is concerned that more study of the workforce and mapping of future areas of need across the ACT is needed. The GP Task Force has not had access to important data sets from Medicare which would permit more considered mapping of the delivery of Medicare services, distribution of the workforce and estimates of the actual current and future shortages. These issues are expanded upon in our submission.

General Practice is largely viable and sustainable on its current private market model with the main impediment to accepting new roles in shared care and collaboration being due to workforce shortage and lack of technological enablement. The ACT DGP view is that governments have a role in priority setting on health care outcomes and providing the environment that enables change. It should not intervene to directly deliver primary care services except in areas of acute need or market failure. Rather in the primary health care market ACT DGP calls upon the ACT Health to build on its role as a partner and enabler to collaborative change. ACT DGP and the GPs also welcome the ongoing support and assistance of ACT Health for special needs areas such as after hour medical services and medical support for aged care facilities and support for their education and training role.

Role of Government

The ACT DGP view is that the ACT Government role is to assist with incentives and programs to –

- ensure the primary health market remains sustainable

- build on the work achieved to date with the ACT DGP to undertake comprehensive workforce planning and analysis to ensure the market is understood and responses are relevant including education and training
- facilitate care coordination for patients with chronic and complex needs
- facilitate care coordination for the frail aged and residents of residential aged care facilities
- improve interconnectivity of providers and the smooth flow of accurate and timely patient information
- provide incentives to the market to fill areas of need of access
- encourage and provide incentives to focus of resources on nationally and locally agreed priority areas of health care outcome without reducing service standards to existing patients
- address areas of potential market failure
- reduce red tape, duplication, simplifying processes, and supporting outcome focused collaboration.
- Lobby the Federal government for Medicare simplification, and improved funding for complex care with significant non-patient contact workload.

However with the current national shortage of general practitioners and a significant shortfall in the ACT of practicing GPs the current priority need for government support is on workforce issues. The ACT Assembly should also give due recognition to the collaborative work underway between the ACT DGP, AMA and ACT Health on support for after hours services, national and international GP recruitment campaigns, workforce analysis projects, and the establishment of the ANU medical school to provide a local supply of qualified practitioners.

ACT DGP has welcomed ACT Assembly support for the initiatives in the 2008/09 budget. These will certainly help the GP and primary workforce both with short and mid-term strategies through the establishment of the GP Development Fund, training incentives, scholarships, and in hours aged care support. We also recognise the Government contribution in supporting after hours services and call on the ACT Health to not disturb those critical elements such as CALMS that currently work well within the community.

Workforce in the ACT

Nationally there is a medical and nursing work force shortage. In the ACT there is an estimated shortfall of 60 GPs.

The ACT not only suffers the same overall pressures but compared to the 111 Divisions of General Practice across Australia the ACT DGP and the ACT general practice workforce as a whole has a number of divergent characteristics.

There are a number of ways of assessing the GP workforce in the ACT. Medicare billing data informs us of the numbers of GPs who bill for services using Medicare items, and also uses the measure of division of total claim numbers by the average claim numbers per full time GP to give a Fulltime Weighted Equivalent (FWE).

Australian Bureau of Statistics (ABS) data and roles of GPs

The ABS Census Data extracted on Selected Health Occupations 4819.0 indicates that the ACT has the highest number of medical practitioners at 190.7/100,000 compared to the national average of 178.6/100,000 but it is clear that a significant proportion of that potential workforce is employed in the

hospital sector (and multi-tiers of Federal and Territory government employment and other health employers such as the Department of Defence). The ABS also reports that medical practitioners not employed by hospitals are twice as likely to work part-time hours. ACTDGP has identified that we have GPs working in at least 45 locations other than general practices and high numbers of GPs working in multiple settings.

Our 498 GP Members self describe their primary roles as –

- 73% working in general practice delivering whole of person care to patients;
- 9% providing patient care in sub-specialties (e.g. occupational health, preventative medicine, plastics, skin, sports, sedationist, hospital RMO, surgical assisting etc)
- 10% predominantly non patient care activities (e.g. academic research, teaching, non-patient contact, reporting, policy and advisory work)
- 7% retired or currently non-active as a GP

38.9% of all Australia's doctors were born overseas and 10.1% immigrated within the last 5 years.

The ABS Census data reports that the overall workforce is 38.9% female, but 53% of medical practitioners under the age of 30 are female. The ACT DGP own survey data reports the overall female participation in the workforce at 47% approaching 55% by 2015.

The Discussion Paper may imply an unfair level of blame on the feminization of the workforce noting that nationally in 2006 male practitioners work an average of 46.2 hours a week and female medical practitioners on average 37.6 hours a week. Our own recent analysis of working hours by age cohort reveals small differences in the 40-49 group and much lower clinical hours worked by female GPs in the 30-39 cohort. To what extent this reflects child bearing years and family work life balance may be known as more study is undertaken. There is however no question that with the feminisation of the workforce, and the alternate career opportunities open to younger GPs, more opt for a work life balance consistent with the community they serve. This trend is not just with females but reflects a growing workforce who for a variety of reasons deliberatively chooses to work only part time in direct clinical care in traditional practice. However recent studies show that these same GPs still do have predominately full time careers. The unique characteristics of Canberra with multiple layers of government and a strong academic profile, combined with ease of transport makes this option more attractive and viable than other cities and could be a selling point for the profession.

Some individual feedback from interviews with part time female GPs was that they tended not to see their clinical currency of skills as an impediment to return to clinical work but the fact they found the changes in red tape and Medicare rules and new item numbers daunting and requiring much longer times to re-orientate to the clinical workforce than skills updates. This would be an interesting area of study for both the cohort of GPs returning to work and new international medical graduates entering the workforce.

It should also be noted that many medical schools are offering the MBS as a second degree. The GP Residents Association reports the average age of Registrars nationally at program intake, is now 34 years of age, and 65% of these were married or had permanent partners. It should also be noted this older profile of graduates, and longer times spent training also reduces the effective working lifespan of new GPs.

National GPET data also shows that fewer Australian medical graduates are choosing general practice as a career with only 29% making that choice in 2008 compared to 50% in 1996. One third of entrants into the Australian General practice Training Program are overseas trained doctors. There is evidence that early exposure to positive career experiences in general practice increases the likelihood of that career pathway being chosen. Medical students are currently being tracked in a longitudinal study examining their career pathways however further information is needed on what drives career choices in current graduating cohorts.

ACTDGP calls for a literature search and further research into the attraction and retention factors for career choice in general practice, and for the funding of a professional ACT specific survey of attraction and retention factors not dissimilar to the approaches taken in surveying nurse attraction and retention factors in recent years.

Medicare Australia data

The GP Task Force Discussion Paper does not report that the GP workforce in Canberra has been relatively stable in absolute numbers for at least the past 4 years with rises and falls by plus or minus 10 GPs. What the Medicare data does show is an average 2% increase in the FWE per annum pointing to a modest but steady overall rise in the workload burden on that relatively stable workforce from 61.0 FWE/100,000 in 2003/04 to 67.5 FWE in 2007/08. Neither ACT Health or ACTDGP currently have access to Medicare data by practice location that can show us where this burden falls, and whether the burden is distributed evenly across regions, and different practice settings. The only undisputed issue is a steady decline in timely medical support available to residents of aged care facilities. There is also a reasonable assumption that the larger practice settings may be more efficient as they have the infrastructure to distribute clinical and non clinical workload among other team members.

Medicare Australia reported that for 2007-08 that there were 425 claiming doctors and these equated to only 232 FWE. Medicare does not count the many GPs providing care in government and other clinics and not claimed on Medicare. The same data also indicates that the ACT has only 67.5 FWE doctors per 100,000 of population compared the national average of 87.2 and the NSW average of 94.1.

It is hard say with certainty what the appropriate level ought to be but with efficient systems and reduction in the burden of red tape then somewhere near the urban average of 90 GP FE per 100,000 is sustainable.

It is important to understand that simple extrapolation of this data to estimate a shortfall of 148 GPs misunderstands some unique ACT characteristics. As reported in the Chief Health Officers Annual Report ACT has a younger and healthier population profile that the rest of Australia. A proxy for this is the lower numbers of aged persons in Canberra, and overall lower use of Medicare services at 10.04 services per head of population compared to the national average of 12.28. Medicare utilisation rates for 65-74 year olds averaged 22.27 and 75-84 year olds 25.8 demonstrating the important impact of an ageing population on GP demand. However, it is important to note that the ACT population is ageing and demand will therefore increase.

A general trend is that as the population of the ACT ages by 1% the demand on services increases by 2%. Accordingly we are inclined to argue that the GP workforce is just coping but without growth in the numbers of GPs and/or supporting members of the clinical team the situation will become unsustainable in a relatively short period.

ACTDGP continues to stand by its early estimates that we would need 60 more GPs to adequately meet the projected short term workforce needs and calls for a more detailed modeling of current workload distribution and future demand projections.

Workforce response to date

The ACT DGP and the AMA ACT Branch are working in collaboration with ACT Health and other partners where appropriate to respond to the fundamental underlying issue of workforce shortage.

Some issues such as process reform in payment models, immigration, simplification of process and program support clearly lie with the Commonwealth and Medicare Australia.

The ACT DGP and the AMA ACT Branch are also currently surveying GP perceptions of the strengths and weaknesses of the interface with the public sector with a view to establishing priorities for action with ACT Health.

Significant steps have been made on the supply side with the establishment of the ANU Medical School and its significant support and input from general practitioners. Nationally as throughput of medical students increase there is now stress on finding training and intern places across the country and particularly in NSW. ACT DGP recognise the importance of encouraging GPs to participate in all levels of support to the education of future generations of medical practitioners.

In response to the shortage of GPs, in November 2007, the ACT Minister for Health announced a campaign to attract and retain GPs in the ACT. The ACT Government, in partnership with the ACT DGP has funded a 0.5FTE GP Marketing and Support Advisor position ($281,000) for four years from May 2008 to coordinate recruitment support for GPs and their potential employee(s) and to increase the profile of the Canberra region as a great location for GPs to work. The role also provides support and information for general practices trying to recruit GPs from interstate or overseas.

The role is overseen by the GP Marketing and Support Advisor Executive Committee consisting of the ACT Division of General Practice CEO, ACT Division of General Practice President of the Board, ACT Health Manager Workforce Planning and ACT Health GP Advisor.

To assist the GP Marketing and Support Advisor identify the key priorities for this role, a joint ACT DGP and ACT Government 'GP Recruitment Forum' was held on 1 July 2008. At this forum the complexity of the recruitment process and the areas where the processes could be streamlined were highlighted. Work is now progressing to address these with relevant stakeholders and to develop clear process guides/factsheets. There has also been agreement amongst stakeholders for ACT Health to vary the Area of Need process for the GP workforce while the ACT remains below the national average for GPs. Through a close working relationship with the ACT Australian Medical Association the requirement for general practices to advertise their vacancies before being granted Area of Need status has been waivered. This has reduced the Area of Need application process from 2 - 4 weeks to 2 days. The Division and ACT Health are currently conducting a nationwide advertising campaign showcasing the lifestyle benefits of living and working in Canberra as a GP with a Call to Action to potential applicants to investigate GP employment opportunities in Canberra

The GP Marketing and Support Advisor activity includes-

- updating GP Employment information on the Division website to allow a one stop access to GP job opportunities in the ACT

- recently added a series of recruitment related fact sheets for employers and potential employees.

- synergies between ACT Health, the ACT DGP and stakeholders are being explored (including Live in Canberra program, DoHA, Immigration, Skilled & Business Migration, recruitment agencies etc)

- Approximately 1 GP a month has been supported by this program into the ACT.

- Targeted overseas recruitment is planned for later in 2009

However there is still a perception interstate that the ACT has a surplus of GPs and a poor appreciation of the career opportunities and the lifestyle choices available to GPs in working and living in Canberra. Certainly our own recent GP Member survey indicates high levels of life and career satisfaction, and results are marginally above the national average despite the current workforce pressures.

A challenge remains in the lack of ability or willingness of many small to mid size practices to spend on recruitment agent and relocation costs, lack of overall retention strategies, and lack of readily available in hours locum support.

ACT DGP has a part time position funded by the Federal Department of Health and Ageing under the Nursing in General Practice Program. The focus of the position in 2009/10 will be on recruitment, orientation, and skilling practice nurses to take on a more active role in supporting GP led team care within general practice. At the same time ACT Health is actively reviewing scope of practice issues for both private and public nurses working in the primary health care environment.

There is merit in expanding the role, and resources of the GP Workforce Working Group and support role to extend to Practice Nurses and Nurse Practitioner workforce issues.

ACT Budget initiatives 2009

ACT DGP welcomes the ACT Health Budget 2009-10 and the significant investment of $272 million over four years to the health sector. As the sector is highly interconnected investment in part of sector benefits GPs patients.

This included a welcome $12 million dollar commitment to invest in general practice through-

- GP scholarships
- Support to GPs through teaching incentive payments
- A $4m GP Development Fund to fund initiatives to improve workforce capacity building, and
- In hours support to aged care residents
- Boost to prevocational places

ACT DGP looks forward to consultations on these initiatives and their early implementation.

ACT DGP will be making a separate submission on the priorities and the administration of GP Development Fund for which it proposes capped grants within targeted areas to build workforce capacity, support innovation, and improve quality of care.

Categories may include subsidies towards-

- Equipment, capital works, IT infrastructure, software upgrades in general practice and collaborative initiatives to provide and connect infrastructure for general practices working with aged care facilities
- Medical and nursing staff recruitment, staff development opportunities, locum support for disadvantaged patient groups, education support infrastructure for students, interns and registrars, and alternate care models, and uptake of practice accreditation
- An innovation pool to support innovations that could be replicated across the sector, collaborative support and interest groups to support disadvantaged patient groups (such as indigenous population, mental health, homeless, refugees), and GP self care initiatives, and access to GP training and orientation for IMGs

The $90 million dollar investment in e-health is also an important timely commitment. ACT DGP recognizes important internal priorities of the public hospitals to upgrade their own IMIT infrastructure to better coordinate care and provide meaningful electronic data exchange in a timely manner. We recognize that improvements in e-health will necessarily be incremental. High priority areas for general practice include-

- Expanded roll out of discharge summaries and their incremental transformation from blocks of text to usable atomized data that can be imported into GP desktops and shared electronic records
- Rollout of e-referrals past the pilot stage including standardization of intake and referral procedures and value added process redesign within public agencies and general practice
- Recognition and investment into GP Clinical Desktop systems to support connectivity of data
- Early implementation of ACT Shared Electronic Health Records to Canberra residents who will obtain maximum benefits from such a record (e.g.as maternal mothers and babies, diabetes and other chronic conditions, and aged care residents) and progressively to the wider community
- Introduction of electronic medication charting in public hospitals and aged care facilities to facilitate the transfer of medication record and prescribing information to a care team and improve the value and accuracy of patient discharge summaries
- Inclusion of a minimum data set within the electronic record that will allow for transition of care between providers on patients changing doctors, seeing other than their normal doctor, practice closures and transfers.
- Building on the replacement of X-Ray films by digital CDs to on line access to the full picture archive system and results system (RISPACS) accessible by all treating medical practitioners and their teams by on line enquiry

We also note the commitment to establishing nurse led walk in centres.

ACT DGP had previously submitted its views on nurse led walk in centres and the published research that reveals that such centres lend little positive impact to the GP workforce problems with little net

substitution of services. However there is evidence of a positive impact on emergency department services and ACT DGP supports a properly evaluation and trial of such a pilot co-located service at The Canberra Hospital. ACT DGP is committed to working with ACT Health on this project and its evaluation.

ACTDGP calls for the early implementation of the budget initiatives

Other

A GP Sessional Workforce survey was jointly funded by ACT Health, Division, ANU Medical School, DoHA to identify why so much of the ACT GP Workforce is part time (or split their role between agencies and community practice) and whether there is any scope for part timers to increase their hours. This study will report soon but the early findings are that apart from a normal pattern of choices of part time work around child care and pre-retirement that most of those identified as part time in clinical practice in fact have full time careers.

The 2008 *General Practice activity in Australia health priorities and policies 1998 to 2008* report (BEACH), clearly indicates a across the board reduction in the number of clinical sessions worked each week by GPs in the decade 1998 to 2008 from 9.2 to 8.8 sessions for male GPs and 7.3 to 6.8 for female GPs.

Further work also needs to be done on understanding the career aspirations of the ANU medical students (noting they are an older graduate group completing a second degree), and ensuring that graduates are retained within the ACT workforce and distributed fairly to all the areas of workforce shortage. We also need to better understand the drivers that motivate current GPs away from traditional general practice to join larger corporate entities, away from face to face clinical care, or move to salaried employment.

ACTDGP is recognizes the significant contribution of education and training providers in the Canberra Region including the ANU Medical School and Coast City Country. We support the development of an "integrated vertical GP stream model" for medical and GP education in the region in conjunction with general practice. This model is a coordinated, purposeful, planned system of linkages and activities in the delivery of education and training throughout the stages of learning from medical school, prevocational hospital training, vocational training, and continuing professional development.

ACT should continue to, demonstrate the advantages of an integrated vertical GP stream model for GP training.

Already General Practice has taken its first medical interns in the ACT on a program with the ANU Medical School and experienced GPs are actively engaged in teaching and mentoring throughout the student training program. The GP Student Network report that a major factor in choosing a career in general practice is an early exposure to general practice settings. ACT DGP believes there is equal merit in the early introduction of student nurses to general practice and aged care settings.

Similar initiatives should be considered for student nurse placements in the general practice setting and aged care setting.

ACT DGP notes the ACT Minister of Health has lobbied her federal counterpart on behalf the industry sector to increase the number of funded GP training places in the ACT. Ensuring equitable distribution of

current GP training places to the ACT through CoastCityCountry Training is also imperative, as is the need to extend the District of Workforce Shortage declaration for international recruitment to the whole of the ACT not just designated Outer Metropolitan areas. Our current view is that the shortages of GPs and practice nurses is across the whole of Canberra. Canberra, with its open spaces, excellent transit times, proximity to rural areas, no major business or retail central hub, and a mix of purpose built large shopping centres and smaller suburban shopping hubs is by design characteristic of outer suburbs and further supports the argument that all Canberra should be treated as an outer suburban area. Innovative alternate approaches may need to be explored that would allow additional funding incentives that might flow from boundary changes to be traded off against an industry commitment to focus a proportion of new resources on meeting the access needs of designated disadvantaged groups.

Adequate GP Registrar training positions for the ACT is essential through equitable distribution of current places through CoastCityCountry Training and lobbying for dedicated ACT positions with federal government

International medical graduate recruitment throughout the ACT would be enhanced through designation of the whole of the ACT as a district of workforce shortage

General Practice Settings

Primary health medical care is delivered, and should continue to be delivered on a private business model with income and incentives offered to ensure the optimum use of evidence based care, and appropriate distribution of services to ensure equity of access.

ACT DGP recognises the trend away from single provider practices towards groupings of GPs in clinics. Our most recent sampling indicates GPs is distributed as follows as primary work location sizes of -

- 4% solo clinics (compared to National average 17%)
- 15% 2 GP practices
- 30% 3-5 GP practices
- 21% 6-9 GP practices
- 29% 10 or more GP practices (compared to National average 13%)

A cautionary note is that the data we used and the data used by the GP Task Force in their map at page 47 of the Discussion Paper reflects numbers of GPs not FWE. It should also be noted that larger practice clusters are not always part of larger corporate chains. Only 50% of the “large Practices” mapped at page 47 of the Discussion Paper are in fact part of national corporate companies, and only one of the “medium practices” is a part of a national corporate company.

A similar mapping exercise as at page 47 of the Discussion paper should be undertaken using Medicare data on FWE distribution of the workforce.

ACT DGP also support the inclusion of skilled practice managers and practice nurses as integral members of care based teams within practices, and the involvement of larger practices in peer support

and graduate education programs. 83% of practices have a practice nurse and over 55% employ 2 or more practice nurses. ACT DGP Membership recently recognised the role of practice nurses and practice managers by changing our constitution and creating new categories of Associate Membership for these important members of the general practice team.

ACT DGP are cautious that any para-medical staff undertaking services previously delivered by GPs are not a substitute for qualified medical practitioners but a complement to general practice under close supervision by the GP as service coordinator and gatekeeper.

ACT DGP also recognise that large easy to access "super clinics" incorporating GPs, pathology, radiology and with proximity to allied health services provide an important substitute for emergency departments, and are convenient for in hours and after hours acute presentation of patients. However there are potential deficits in the current business model of some larger medical corporations in the areas of continuity of provider, care coordination for patients presenting with complex and chronic ongoing care needs, and share care arrangements with specialist hospitals.

The GP Task Force might also give due recognition to the equivalent well tried and successful market force model of individual independently owned clinics forming into convenient clusters of GP, pathology, and pharmacy around accessible local shopping hubs, and the additional more extensive clustering of more advanced services such as radiology and specialist clinics around public and private hospitals. The clinic of the future need not be a single corporate or business entity but can be an affiliation of connected activity. An ACT shared electronic health record would make such connectivity even more feasible.

The consolidation of practices into larger team care entities is endorsed by the National Health & Hospitals Reform Commission. However the unpredicted and rapid consolidation of general practices in the Belconnen area in 2009 was of obvious concern to the community and pointed to the implications of the actual implementation of consolidation strategies following market forces. There was obvious concern of loss of local access and amenity, threats to viability of smaller shopping and community hubs, and transport issues for the frail aged and disabled patients to access new service concentrations. The issues around the confusion over record access and transfer of care are well canvassed in the Discussion paper and commented upon later in this paper.

The ACT DGP is of the view that a rich range of service delivery options better supports emerging care needs and provides for innovation and diversity of ownership preventing the emergence of monopoly care providers as has been the trend in the area of radiology and pathology.

While today the ACT has only 9.4% of its population over 65 compared to the Australian average of 13.8% the proportion is rising rapidly. The chronic and complex disease burden falls mainly in this group and there is no question that multi- disciplinary teams and coordinated care will be the model of preference for a number of vulnerable groups.

The "super clinic" concept is only one model of delivery in what should be a rich range of delivery models that support individual choice, diverse community cultural values, and needs. With improvements in electronic communication between providers, shared summary care records, and shared care plans, technology can enable the evolution of interconnected care clusters and the virtualised equivalent of "super clinics".

Governments should support infrastructure to connect the major care providers of GPs, specialists, hospitals, aged care facilities, allied and community care organisations. This has certainly been a

significant part of the success of e-Health success stories in Denmark, Sweden, and Alberta, Canada to which ACT Health has been looking to learn lessons. This is the enabler for effective collaboration between providers, provides an up to date record for decision, and provides the foundation for team based care.

While the role of governments may extend to meeting the unmet needs of Australians (e.g. the 31 Super Clinics being subsidised by the Australian Government in areas of need), ACT DGP believes that the ACT Health should be cautious in advancing proposals for creation of public funded and run community health hubs in other than areas of proven need, and where other market based approaches have failed. To establish any service that simply redirects resources in an area of shortage from the private sector to the public sector is shuffling the deck chairs and not solving the underlying problems.

Any new centres created by ACT Health must be fully integrated with general practice and other primary health care providers in the area

Enabling New Roles

ACT DGP supports the extension of practice nurse roles but note that it is access to Medicare item numbers and Practice Incentive Payments (PIP) for Outer Metropolitan practices that provides the income flow to support employment of more practice nurses and improve their wages and conditions. The 2008 BEACH report found in its sample of 1000 GPs that the proportion of practice nurse activity supporting GPs rose from 3.9% in 2005/06 to 6.0% in 2007/08. However only 35% of these patient encounters by practice nurses were claimable under Medicare. In a market based mainly on fee for service work of an individual provider under Medicare, substitution of roles is not economic unless there is access to a replacement revenue stream. Accordingly there is a limit to what kinds of work a GP can delegate and still earn an income to sustain employment of the general practice team.

Allied health professionals (e.g. dieticians, speech therapists, occupational therapists, psychologists, social workers, etc) are an important and growing component of the modern general practice yet there is some nervousness among funders to the rapid growth in Medicare and Health Fund payments to these professions. When you build teams of care and encourage expanding roles there will inevitably be growth in Commonwealth and State outlays to nurses and allied health professionals. The strongest safeguard that the expenses are relevant to patient care is that these professions work with or within extended primary health care teams and within a defined scope of practice and evidence based guidelines.

If there is a move to more capitation or blended payments in some areas of care, and provided the scope of practice is well defined, this will provide more opportunities for changing roles within practices. Change cannot be forced where there is no economic model to support change.

Practice nurses, practice managers and reception staff are regarded as an essential part of GP led teams. GPs are also not opposed to other emerging roles such as Medical Assistants at the one end of the spectrum and Nurse Practitioners. This is as long as they are integrated in the care team or have specific roles in care which are well defined and communicate well with the GP as the whole of person care coordinator. However it is clear that there are competing demands for Nurse Practitioners and long lead times to train more and that the immediate focus should be on expanding the roles for practice nurses within the GP care teams and meeting the GP demand for more practice nurses.

ACT DGP is not intrinsically opposed to the evolution of changing roles in primary health care, but unless each provider is connected and can see the interventions of providers in a timely manner to develop new roles in the currently disconnected health care environment runs the risk of significant harm to patients. The primary care GP is the main medical professional category that look at whole of person care rather than periodic or specific specialised interventions and it is in the interests of community safety that the GP remains at the centre of care and is well informed on other care interventions.

ACT DGP has agreed to work with ACT Health on scope of practice issues and nursing roles in the nurse led walk in clinic pilot. The ACT Health Chief Nurse has expressed an interest to include the issues facing primary care nursing within her scope of interest and we are establishing a closer working relationship as we work with other stakeholders in reviewing scope of practice, and roles for nurses in diabetes education and treatment, aged care facilities, and general practice.

ACT DGP calls for close cooperation between ACT Health, ACT DGP and other stakeholders to review nursing scope of practice issues in primary health care and the aged care setting.

Enabling Technology

The investment of $91 million over 4 years by ACT Health in e-health is welcomed but ACT DGP call for high priority to be placed on investment in primary health care and potential quarantining of funds so that a disproportionate share does not go to the acute sector. Neither the public or private, acute or primary care sectors can provide safe, coordinated and cost effective care without connectivity.

Integration of all parts of the health sector will depend on strong e-health, data collection and information management systems. Care at the individual and health service levels will be informed by the collection of data, its transformation into 'information', and connectivity between health care providers for communication of that information.

On the national level the National E-Health Transition Authority has developed a national business case for a Personal Health Care Record for submission to the Australian Health Ministers Advisory Council (AHMAC) in October 2008. AHMAC received the Deloitte consultancy report on the vision for a national e-health strategy to be completed in August 2008. ACT Health is be congratulated on investing in a ACT SEHR scoping study and recognizing the importance of a SEHR for effective and connected care of the most vulnerable members of our community.

ACT Health is currently trialling electronic discharge summaries from hospitals to general practice and will need to build clinical system infrastructure in public entities as well as the provider directories, and messaging systems and templates to transmit timely and meaningful patient information for incorporation into GP desk top systems. Our experience in partnership with ACT Health in piloting new projects is that rolling out technology is the relatively easy part. Obtaining effective buy in by stakeholders, effecting changes in culture and business work flow reform, selling the value proposition, and avoiding missing quality improvement activities and efficiencies by simply automated long established procedures are the significant challenges. Much more attention needs to be given to this part of implementation of the governments $91m commitment to e-health.

Currently ACT Health IMIT initiatives are appropriately focused on the early stages of data exchange between public institutions and providers. But ACT DGP caution that connectivity between community providers (e.g. GPs, Specialists, and allied health professions), is a crucial end point in the e-heath

journey and we ought to be cogniscant of the need to move beyond thinking of communication on a hub and spoke model but rather see it as a web of connectivity.

As part of the emerging primary health care system, the general practice network will continue to improve e-health, data and information management systems by:

- developing or facilitating development of tools for the collection, management, interpretation and communication of health data and information
- providing education and training that increases primary health care's capacity and expertise in recording, searching and extracting clinical records
- assisting change management in general practices and for other members / customers
- informing policies and regulations that will ensure the security of consumer information, the development of interoperable tools and systems, and the development of commonly agreed and understood standards for data management (covering privacy, consent, governance, storage and access)
- working with software and IT providers as representatives of the primary health care sector
- building communication, agreement and common understanding between sector stakeholders, especially between primary health and the acute care sectors
- collecting, collating and interpreting practice data and returning it to practices as population level health information that will be used for benchmarking, peer review, clinical outcomes assessment and to offer more tailored packages of care
- informing regional decision making, health service planning, performance monitoring and policy development
- supporting engagement by primary health care in quality improvement initiatives such as the National Primary Care Collaboratives and the Audit and Best practice for Chronic Disease – Evidence (ABCDE) program.

Aged Care

ACTDGP had both Aged Care Panels and an Aged Care forum that was wound down at the end of 2007/08 when the DoHA ceased funding of its aged care panel's initiative to divisions. Some residual funds were used to hold Aged Care Forums in 2008 and 2009 which focused on issues for GPs, the community and RACFs (Residential Aged Care Facilities). The ACT DGP Board has provided some ongoing funding to maintain a smaller Aged Care Forum focused on generating solutions. This has now met three times since May 2008. It is being attended by a group of motivated professionals across the aged care continuum. It has established a work plan and has already started to progress activities, including:

- Working with both Emergency Departments (CH and Calvary) to improve communication and understanding between sectors. As a result a transfer envelope has been developed and will

- The development of a draft template Service Agreement between GP's and RACF to articulate responsibilities for service provision
- The development of a business case to pilot a model/s to improve the management of the deteriorating resident.

All parties also support the need for infrastructure improvement to facilitate the capability of GPs to support aged care residents in RACFS and remotely. E-Medication charting and e-prescribing was also seen as high priority need in aged care facilities.

The ACT DGP is acutely aware of the escalating demand for primary health services in RACF and the negative affect lack of access is having on resident quality of care, resident quality of life, residential care staff and those GP's who are regularly being asked to carry a greater share of aged care medical support.

The ACT DGP and the Aged Care Forum welcomes the introduction of the in hours locum service as one way to meet some of the demand. The Forum however is conscious of the need to optimize the use of this resource and urges considerable forethought and planning to ensure this service is integrated as part of the full service provision and where possible builds upon existing successful service models rather than commencing a new stand alone service with its inherent overhead costs. Whilst the Forum does not want to be seen to be favouring any one model over another we urge consideration of the relative merit of the service being established in conjunction with for example:

- CALMS
- RADAR
- HITH
- An aged care service model embedded in the Emergency Departments

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Physical Infrastructure

The physical infrastructure required will be largely dependent on the model of service delivery decided upon. At a minimum, requirements will include:

- A support system capable of managing the booking and scheduling of visits, billing, distribution of correspondence, maintenance of imprest stock, reporting (this can be done remotely through a 'virtual office' with the appropriate systems – note HealthCube model)
- An 'outreach kit' of appropriate medical equipment including some pharmacy imprest, sutures, examination kits, pathology collection
- Laptops with wireless interfaces and printing capability

Workforce Requirements / Advanced Nursing Positions

The workforce requirement of this service will also be largely dependent on the service model. The minimum levels of administrative support will need to be determined based on projected activity and reporting requirements.. However the ACT Division of GP Aged Care Forum strongly recommends the establishment of a multidisciplinary support team that will include at a minimum a Registered Nurse who can help expedite assessment and treatment, education and advice, and follow up on site with the GP in the RACF. Ideally the model will be integrated into a broader service capable of rapid access to other additional clinical staff.

There exists significant options for exploring the role of advance practice nurses or nurse practitioners in this service. RADAR has capably demonstrated the role of the advance nurse in the care of older people at risk of further deterioration and or hospitalisation. Roles for these nurses would include:

- Working with the RACF staff to develop capacity to assess and clearly articulate the state of an older persons health
- Conduct triage assessments to determine level of need and priority
- Undertake a range of standard treatments and some specialist treatments
- Undertake specific education of resident and staff
- Provide follow up.

As previously mentioned it is not considered ideal to have multiple fragmented services across the ACT to serve this population. It would not be wise use of this service to have it try to expand to be a comprehensive service when the current requirements identify the need for rapid access to GP services. There are a number of services currently available that can provide a more comprehensive, specialist or extended service including:

- GP servies
- RADAR
- HITH
- CAPAC

That noted what is still a significant gap is the rapid response of primary practitioners. It is important that a clearly defined service model is established that articulates an algorithm or decision making tool that defines the role of:

- RACF staff – what assessments should be undertaken prior to calling a GP, how should this information be communicated, what standing orders can be established in what situations
- GP – what responsibilities does a GP have to attend a resident, in what time frame, what options can be employed to improve the efficiency for the GP
- Locum service – what are the triggers for using a locum service, what assessments and information should be communicated, what level of service should the locum provide, what are the hand off options
- RADAR – how should clients be triaged to access this service
- Other specialist services – how should clients be triaged to access the most appropriate service, ensuring resources are optimized to match specialist skill with need.

It is highly recommended that the in hours locum service becomes part of a continuum of service provision that concentrates on meeting the need of first line rapid response for residents in RACF with a mandate on maintenance, preventing further deterioration and providing an avenue to escalation to ensure the specialist services are being appropriately targeted at more complex, long term issues.

In terms of identifying potential GPs to provide this service ACT Health may need to consider how to better attract International Medical Graduates.

Training

There would exist clear opportunities for the training of GPs and nurses. This service could be established as an accredited training position for both GP registrars and nurses wishing to further their specialty skills in aged care. This aim should be kept in mind in the establishment of the service, but in a pragmatic sense is a secondary aim and is unlikely to occur until at least after six months of operation when the process can be properly established.

Pharmacy

The issue of expeditious dispensing of pharmaceuticals is one that needs to be resolved through tight collaboration between RACF, GP's, the locum service and the pharmacists. RACF should work with their local pharmacy to have a small imprest of medications with reasonable shelf life and common usage. When a script is then issued for that medication for a resident, the pharmacy replaces the imprest stock as part of the supply to the resident. The locum service should carry a small imprest of those drugs less common or with shorter shelf lives where it does not make sense to have multiple stores across the RACF with a similar system where the pharmacy replaces the imprest once the script for the resident is written (indicating that imprest stock has been used).

The ACT DGP and the Aged Care Forum would be willing to collaborate with ACT Health to develop and deliver a business model suitable to the needs of Canberra's residents in aged care facilities

Chronic Disease

The ACT DGP recognizes the burden of chronic disease and aims to support its members to increase consumer management of their chronic illness by service integration of chronic disease management.

ACT DGP in the Funding Models section sets out deficiencies of the current funding models in supporting the management of patients with chronic disease. These patients will generally present with additional conditions as they age and this magnifies the complexity of care and the needs for coordination and integration of interventions across both care providers and care settings.

The 2008 BEACH report also found that in line with patient requests and public health promotion messages GPs are doing more health checks and detecting chronic disease earlier. Most chronic diseases once diagnosed require long term or life-long ongoing care, so the earlier a disease is detected the more GP services will be used in its management over its lifetime adding further to GP workload demands.

Advances in e-health and the existence of a shared health care record is an essential enabler for effective management of chronic conditions. This also provides capacity for patients to take an increased level of control by including additional evidence based add on or plug ins to their records (e.g. exercise programs, immunisation records, dietary notes, medication schedules, charts, etc) that enable consumer and peer led interventions in the self management of chronic conditions.

ACT DGP is very actively engaged with health consumer organizations, UNI NSW, the ANU and providers in exploring opportunities for promoting initiatives in the self management of chronic disease and inter-professional learning.

Self-management programs represent a way in which this care may be realised. Self-management programs focus on teaching patients to control their chronic illness more effectively.

The importance of self-management for those with chronic disease was first highlighted in the Chronic Care Model (CCM), consisting of six elements which enable successful chronic disease management to occur:

- Self-management support: the provision of tools, information and supports to enable patients to self manage.
- Delivery system design: clear definition of roles, and separation of acute and planned care.
- Decision support: evidence based clinical guidelines and reminder systems.
- Clinical information systems: use of information technology to improve compliance with guidelines, registries and feedback on performance.
- Community resources: linkages with medical and community resources to facilitate health behaviours.
- Health care organisations: governance structures of the provider organisations that reflect the importance and prioritisation of chronic disease management

ACT DGP recommends activities to:

- ensure options for self management are available to people with chronic illness
- assist primary health members and agencies in workforce development

- support primary health members and agencies to meet the needs of clients with chronic illness through comprehensive assessment and care planning

A threat to this activity is the Federal Budget announcement of cessation of the current Australian Better Health Initiative funding from July 2010 that funds these activities of both divisions and many community organisations. We are still waiting on advice that there will be replacement programs.

One regular complaint we get from GPs and the community is the short term nature of funding by governments to highly targeted interventions in critical areas, too short timeframes to effect mobilization of resources and product design and testing, then premature evaluations based on poor proxy measures (e.g. Medicare item number uptake) that see funding withdrawn just as programs are making a difference to the community.

Funding Models

Any coherent solution to funding reform in the primary health care sector requires a coordinated approach between the Territory and the Commonwealth. While primary health sector funding is the primary responsibility of the Commonwealth there will nonetheless be an increased emphasis on primary health care outcome indicators in health care reform.

Health care is intrinsically interconnected and many of the problems in the public and private hospital, and public community health networks need to address GP involvement and connectivity in order to provide comprehensive solutions. Certainly the ACT DGP has provided a wide range of already busy GP advisers to ACT Health committees and is open to work closely with ACT Health on solution finding within the limits of our current resources.

The current activities of the National Health and Hospitals Reform Commission, review of the Medical Benefits Schedule, and the national development of a Primary Health Care Strategy will all inform that process over 2009-10. It is important to ensure all the players sing from the same page, and that conflicting outcome incentives are not offered by the Commonwealth and the Territory. It would be entirely legitimate for the ACT to introduce its own targeted short term subsidies for those areas which are agreed acute areas of need and complement or fill gaps in Commonwealth funded services.

GPs complain that Medicare is generally structured around face to face contact of the patient but in areas such as chronic disease, aged care, and mental health a significant amount of the clinical time is spent in telephone advice, liaising with other members of the care team and arranging access to other services. Medicare does not adequately and efficiently reward that non patient time.

While the primary care GP is mainly funded on a fee for service basis there are more and more item numbers that reward team based care, care plans and coordination. However these item numbers are confusing, not consistent across different care boundaries, and usually not supported with readily by GP clinical desk top systems. There are also a range of specific non-fee for service payments made to individual practitioners under Service Incentive Payments to target particular outcomes, behaviors and data collections; and Practice Incentive Payments made to practices for achieving accreditation, subsidies for technology uptake and the like.

Many of these incentives are not considered attractive enough by GPs to effectively shift from coping with the high workloads in busy day to day practice to participate in other important interventions and activities. In addition, different target programs seem to be developed in isolation and compete for GP

attention and their most precious resource – time. GPs complain of the burden of red tape. The 2003 Productivity Commission research estimated that compliance costs through participating in Commonwealth Government programs alone cost $16,500 per annum per GP and 252 hours per annum of their time. GPs assert that situation has only got worse and is a significant diversion of patient care time.

ACT DGP has taken the position that fee for service payment is the most cost effective payment methodology and should remain the predominant method for payment of services by government and patients. However the ACT DGP recognizes that some services require additional incentive payments where there are extra burdens in service delivery and reporting that are non patient activity in either the patient or public good.

In addition the Divisions of General Practice nationally have taken on diverse roles funded by Commonwealth and State governments. Division core business is member services and practice support balanced with facilitation and promotion of new and existing government programs to general practice. Some rural divisions are the preferred employers to large networks of allied health professionals.

Almost all divisions are also fund holders for a growing range of services such as paying psychologists under the ATAPS scheme, and lifestyle modification providers for 40-49 year olds at high risk of diabetes.

There is active discussion within the 111 Divisions of General Practice on the future of general practice. The trend towards GP consolidation into health service teams, and the move away from a pure fee for service models towards some capitation and fund holding, as well as the growing divisional role as fund holders in targeted areas of service delivery are areas of active debate. The Australian General Practice Network has recently released a number of discussion papers for network comment on its picture of the future of general practice.

Records Access and Legislation

ACT DGP supports the general thrust of the Discussion Paper comments relating to records access and notice periods. However we note that there has been work done to move towards nationally consistent legislation. We suggest that a nationally consistent approach on policy, definitions and charges would be appropriate.

The current situation is very confused with some inconsistent advice available on the correct procedures on practice closure and transfer and a poor access to up to date information.

ACT DGP had been directing GPs to slightly dated advice in an information sheet prepared for us by the ACT Health Complaints Commission. The ACT Health advice and pamphlet was on the ACT Health website but in the consumer section and hard to find by GPs. To work out the actual fees GPs had to look up the actual determination. As there is no specific fee for access to a medical record on closure our advice from ACT officials had previously been to treat it as a transfer of record and charge at that rate. Some others felt because the ACT did not specify a fee no fee is chargeable. Interstate corporations have complained that the ACT fees are more than a third less than those of the NSW.

Records are technically meant to be stored within the ACT but at least one major corporate holds many records interstate. The trend towards the electronic health record, including patient created records, makes the whole issue of a “physical record” and safe storage and data ware-housing even more problematic. Legislation needs to be updated to account for growth of individual and shared electronic

records while remaining consistent with national trends and agreement by the States and Territories in March 2009 to a consistent legislative framework.

Following the confusion during the recent consolidation of services in the Belconnen area ACT Health, ACT DGP and the Health Complaints Commission met and agreed to develop a joint guideline on *Transferring or Closing a GP Practice.* Work on this guideline is completed except for clarification from the ACT Health legal area of the wording for advice on the issue of practice closures and charges.

Accordingly ACT DGP asserts the problem has been lack of clarity of the procedures and fee schedules, and there is no justification for introducing sanctions and penalties but rather education and awareness building.

If ACT residents had an adequate Shared Electronic Record with a minimum data set, and discharge summaries for transfer of care, then the major issues relating to the Belconnen and Wanniassa practice closures could have been averted. Additionally as a SEHR would be backed up centrally in a secure data warehouse by ACT Intact, the electronic record would be safe guarded from loss in storage.

ACT DGP propose-

- there be no sanctions
- the situation on closure of practices be clarified
- that the three week notice period is adequate
- legal and solicitors fees not be less than those in the Recommended Schedule of Fees as agreed between the AMA and the Law Society of the ACT and that those parties be consulted on all fee setting.
- that the current sensible practice of transferring of records to a patient or nominated doctor on request during the three week notice period be recognized by the legislation
- That ACT align with national standards and address the emerging issue of electronic records
- that the proposed ACT Shared Electronic Health record include sufficient minimum data sets to permit transfer of care and become an immediately useful care record on practice closure or transfer.

Navigating Health Care

A recurrent theme in consultations with GPs has been the desire to see a single and comprehensive provider directory for health care professionals in the ACT. At a recent meeting with ACT Health IMIT officials the ACT DGP was advised there at least 26 different provider indexes and numerous stand alone directories in the health sector.

Few if any of these directories are structured in the same way, are rarely integrated, and most do not have the resources to be kept up to date.

GPs complain that they and their staff spend considerable time organizing access to services, locating contact numbers and have a poor understanding of the various services available in the public sector and the community and their scope and access criteria.

GPs also get confused about services that sit in different governance areas at ACT Health but from the outside appear to have overlapping roles and currently don't seem to be well integrated. In aged care where ACT Health has made a substantial effort to support the frail aged the offering of such services that seem disconnected would include HITH, CAPAC, RADAR and Falls Clinic which are all in different areas of ACT Health.

A modern provider director should be accurate and complete and contain web links, on line templates for contact or service access, location maps, descriptions of service, exclusions to care, and comply with the prevailing industry directory standards. As timely and accurate details are required to facilitate electronic communications a best practice solution would be are built off the back of or connected to the health provider index used for e-health message transmission.

ACT DGP has provided ACT Health with details of the GP South Australia developed provider directory and indexing service solution which is now funded and in use in the states of South Australia, Northern Territory, Tasmania and Queensland. This solution was designed for the State Based Offices of divisions to maintain all medical specialists, general practice and registered allied health providers in a central and an authorative data base on behalf of all providers and the community.

Ideally such a provider directory could also include all agencies, clinics, outpatient clinics, and other services needed by GPs to help their patients navigate the very rich service selection available in the ACT.

High should priority be given to a creating a sustainable health care provider directory service

Fostering Self Care in General Practice

Board survey results from a 180 sample size Canberra's GPs report a high life satisfaction, feeling of safety, and achievements in life and community contributions. These rates are better than the national average. However their self reported satisfaction with their health falls marginally below the average.

Our recent Member Survey found that 79% of Canberra GPs had their own GP which is above the national sample survey below. Also the majority saw their GPs for 12 month checks-ups. However 69% of male doctors had a GP compared with 91% of females. Self reported GP utilization rates by female GPs was a third higher than males. GPs self reported their health on a scale of 1-5 at 3.99 for men and 4.18 for women which is possibly accounted for the different age profile but the overall picture is that male Gps self care requires further study and attention.

Nationally the Medical Observer engaged a consultant to survey 500 GPs with a mini stress test. Almost 6 in 10 reported their stress levels as troubling to unmanageable. Only half had their own GP (which was much lower than the reported results in our own ACTDGP survey). Men and women reported similar levels of stress and results didn't vary much across years in practice but were noticeably lower among GPs working part time in general practice. Female GPs reported they had better peer support networks which is consistent with general findings in the ways men handle stress and health issues.

The 5 key reasons listed as sources of stress were given as –

- Medicare bureaucracy/Red tape 24%
- Legal issues 20%
- Long hours and pressure of work 18%
- Keeping up to date to minimize mistakes 18%
- Poor remuneration and recognition 17%

The 5 top issues that GPs listed as directly affected health were-

- Time pressure/long hours 53%
- Bureaucracy/Red tape 47%
- Legal issues 30%
- Poor remuneration/ recognition 30%
- Stress issues 25%

The ACT DGP Mental Health Advisory Committee and our Education Unit are currently looking at appropriate support for GP self care building upon the consultations held by the AMA with the medical community earlier in 2009. RACGP have published GP self care resources that are also being evaluated.

ACT DGP gives cautious support to the concept of supporting peer support groups but in the current climate of GP shortage proposes these groups focus on special professional interest areas with the added benefit of social and peer support. ACT DGP has recently secured grant funding for such a professional group in the mental health and substance abuse sector and will be evaluating its success in 2010.

ACT DGP would be interested in receiving support and assistance to fund additional pilots.

ACT DGP has established practice nursing and practice managers as Associate Membership categories and is also keen to respond to their professional and peer support needs.

ACT DGP thanks the GP Task Force for the opportunity to make this submission and reaffirms its commitment to work in partnership with ACT Health on improving access to appropriate services and evidence based models of care for local community.

Mr Phil Lowen, Chief Executive Officer

Dr Jenny Thomson, Principal Medical Advisor

ACT Division of General Practice

31 July 2009