RACGP submission to Unleashing the Potential of our Health Workforce – Scope of Practice Review – Issues Paper 1 (2nd consultation)

March 2024

Contents

Introduction 3
Executive Summary 4
Reform priorities to enable GPs and practice teams to work to their top of scope 6
Enable GP dispensaries 6
Remove artificial restrictions 6
United Kingdom and Canada – inspiration or a 'cautionary tale'? 7
RACGP's key recommendations by theme and responses to consultation questions 8
1. Theme – Legislation and regulation 8
2. Theme – Employer practices and settings 9
3. Theme – Education and training 11
4. Theme – Funding policy 12
5. Theme – Technology 13
RACGP's general feedback to Issues Paper 1 15
Glossary definitions in Issues Paper 1 15
References 16

RACGP submission to the *Unleashing the Potential of our Health Workforce* – Scope of Practice Review – Issues Paper 1 (2nd consultation)

Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Department of Health and Aged Care's (DoHAC) independent Scope of Practice Review ('the Review'), led by Professor Mark Cormack. This is the RACGP's submission to Phase 2 of consultation.

The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or toward a specialty career in general practice. The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support general practitioners (GPs) and their broader healthcare teams to address the primary healthcare needs of the Australian population.

Healthy Profession.
Healthy Australia.

Executive Summary

The RACGP re-iterates its position that the *Scope of Practice Review* must be about more than role or task substitution. There is a disproportionate emphasis on first contact access and an oversimplification of general practice and the role of the generalist. **There is a serious likelihood of wasted financial resources and recommendations that will have very costly outcomes for patients, the health system and the health budget.** More specifically for GPs, the perceived devaluing of the specialised training required for general practice will **impact on morale and GP workforce attraction and retention**.

Reasons:

1. **Primary care continues to be viewed solely as an initial entry point to the healthcare system.**

   There are four main features of primary care services: first contact access for each need; long-term person (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere. **All** of these features need to be fulfilled to achieve the best patient outcomes and provide a return on investment for governments and funders. GPs are the only health professionals that are trained to deliver all four features of primary care comprehensively.

   There is a serious likelihood of wasted financial investment with little improvement to healthcare access and patient health outcomes if first contact access is prioritised above all other features of primary care.

2. **General practice is being oversimplified to the detriment of patient safety, health outcomes and the future of the GP workforce.**

   General practice is a specialty area requiring skills in managing uncertainty and complexity. These skills are initially taught during three years of supervised in practice training and affirmed through assessment of competency for Fellowship. This specialist training is in addition to the eight years of foundational medical training (medical degree and post-graduate hospital training) undertaken by every medical practitioner. The perceived devaluing of GP training will impact GP workforce attraction and retention.

   Despite there being limited economic evidence for role substitution in primary care and acknowledgment more economic evaluations are needed,[1] this continues to be the focus of the Review. The philosophy that general practice is a compilation of independent tasks that can or should be indefinitely delegated to multiple health professionals with accompanying algorithms and flowcharts is flawed.

   Issues Paper 1 is deafeningly silent on the large body of high-quality evidence for general practice. The Review is overlooking the existing broad scope of general practice and the benefits for patients when GPs and their teams are enabled to work at their top of scope. Focusing only on increasing the number of access points will not have the same impact.

3. **The Review neglects the benefits of continuous and coordinated care beyond the initial episode.**

   Issues Paper 1 has a very narrow focus for continuity of care – 'access' and 'information sharing'. This is dismissive of the evidence for relational continuity and therapeutic alliances in continuity of care. There is substantial evidence showing that continuity of care (in the context of the doctor-patient relationship) improves health outcomes.[2, 3, 4,5] Access should not be at the expense of continuity.

   - University of Cambridge researchers studied over 10 million consultations in English primary care practices over 11 years and found that patients who regularly saw the same GP extended the time between consultations (18% longer) and importantly, did not equate to a need for longer subsequent GP consultations or more emergency department appointments.[6]

- Lumos[7] data in New South Wales demonstrates the benefits of GP access to reduce hospital readmissions and in the management of chronic disease.
- A 2018 Norwegian study[8] demonstrated that the length of the patient- same regular general practitioner (RGP) relationship is significantly associated with lower use of out-of-hours (OOH) services and acute hospital admissions and lower mortality.

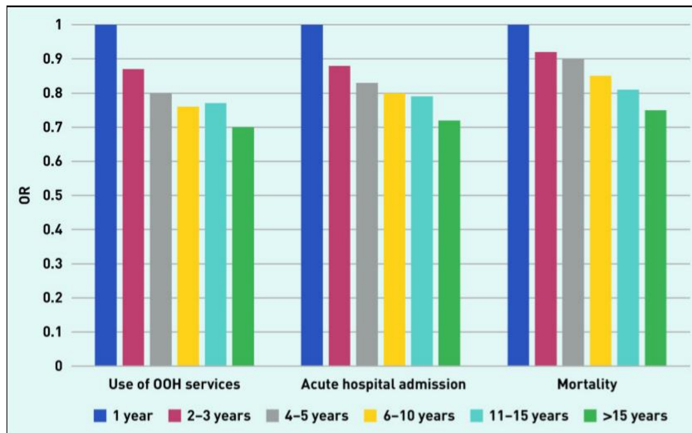

Figure 1:

Length of patient-regular doctor relationship is associated with lower use of out-of-hours services, fewer acute hospital admissions and lower mortality.

4. **General practice is viewed as a problem or barrier rather than a solution or protection for the health system.**

Finite health budgets require appropriate rationalising of limited health resources and fiduciary responsibility.

- Many of the transformative reforms suggested in Scope of Practice Roadshow sessions will require an enormous investment from the government, and into models that have limited or no evidence of cost-effectiveness.
- Over-prescribing, over-testing, over-imaging and over-diagnosis are the expected outcomes of removing the 'gatekeeper' role of highly trained generalists.
- There has been overconfidence from the Review team and allied health professionals that My Health Record and enhanced secure messaging will overcome all concerns about care fragmentation and duplication. These systems are still embryonic and doctors are regularly encountering issues that can potentially result in poor health outcomes.

5. **General practices are largely private businesses and the majority of GPs are self-employed, meaning they face specific cost challenges.**

Reviewers must consider:

- The role of medical indemnity insurance in limiting scope of practice of GPs and other health professionals in the general practice team.
- Payroll tax implications for practices.

6. **Alternative models may not be properly equipped to deliver high-quality care.**

Liability is not well defined, therefore appropriate clinical governance frameworks should be a core consideration to protect patients, health professionals and the broader healthcare system.

Reform priorities to enable GPs and practice teams to work to their top of scope

Enable GP dispensaries

Recent jurisdictional and federal reforms are signalling that governments are deprioritising the importance of maintaining a separation between prescribing and dispensing of medicines. General practice should not be excluded from these reforms. There is opportunity to fully harness the skills, systems and standards already in place within general practice and increase patient access to medicines.

GPs and general practices have demonstrated the skill and competency to supply medicines through the Prescribers Bag, delivery of palliative care, and by being approved medical practitioners for the purpose of supplying Pharmaceutical Benefits Scheme (PBS) medicines (in remote locations where there is no convenient and efficient pharmaceutical service).

This should be expanded to all GPs so they can make local decisions to meet community need. The ways forward include but are not limited to:

- reviewing pharmacy location and ownership rules to allow dispensaries within general practice
- allowing all GPs to dispense medication, including PBS
- enabling dispensing general practice-based pharmacist models.

Remove artificial restrictions

Medicare Benefits Schedule (MBS) item descriptors and PBS restrictions unnecessarily curtail GP and general practice team scope of practice. Eg removing restrictions to GP MRI which would reduce costs for consumers. The RACGP will address these through direct submissions and advocacy to the relevant regulatory bodies.

United Kingdom and Canada – inspiration or a 'cautionary tale'?

The Review is looking to the United Kingdom and Canada for inspiration, despite evidence at the coal face that primary care policies in these countries are failing. The **United Kingdom, Canada and the United States are all reporting GP workforce crises** despite at least a decade of attempting role or task substitution through nurse and pharmacist prescribing.

- Alberta, Canada (which has the most liberal pharmacist prescribing) is experiencing a doctor shortage which is sparking concerns about patient care and safety.[9,10] A board member from the Alberta College of Family Physicians stated that government support for primary care has eroded, leaving physicians demoralised and driving family physicians to retire or move to other provinces.
- A 2023 UK Pulse survey revealed that 45% of full-time GPs in the age range 30-50yrs were considering reducing their hours.
- UK-trained doctors in Australia rose from 3949 in 2013 to 6621 in 2021.[11] The UK's General Medical Council's workplace experiences 2023 report found that among the doctors who said they were likely to leave the profession in the UK, 21% had contacted a recruiter and 14% had applied for a role abroad.[12] Australia is the preferred destination for these doctors.
- Most recently, the UK is further blurring the lines of medicine with plans to license non-doctor associate roles (physician assistants). This has created uproar with reports of misdiagnoses leading to deaths and grieving family members accusing the National Health Service (NHS) of 'trying to cut corners' by allowing physician assistants to carry out 'complicated tasks they're not qualified to perform'. Other misdiagnoses included a patient's metastatic cancer being repeatedly misdiagnosed as muscle ache, despite blood results that were 'tantamount to a cancer diagnosis'.

Australia should learn from the UK…on what not to do.

- The King's Fund released their report 'Making care closer to home a reality' in February 2024. It identified that:
  - 'the failure to grow and invest in primary and community health and care services ranks as one of the most significant and long-running failures of policy and implementation in the National Health Service (NHS) and social care for more than 30 years'
  - there are 'misconceptions about how the public think health and care services should be prioritised'
  - 'treatment of urgent medical problems take priority over services that prevent the development of problems'
  - the 'way the workforce is trained and organised is not set up to deal with complexity of people's needs'[13].

- The United Kingdom House of Commons Health and Social Care Committee *Future of General Practice* report showed there was a high level of consensus about the potential benefits of 'an array of professionals working in general practice' and identified that there needs to be better funding for these roles **in general practice** to allow GP supervision and flexibility in the type of staff recruited to meet community need. It also stated that 'there can sometimes be a trade-off between access and continuity, and…the balance has shifted too far towards access at the expense of continuity'.

- Research in 6287 general practices across England between 2015 and 2019 found the highest quality of care was seen in teams with more GPs. It was only slightly more expensive to employ GPs than non-GPs. Higher numbers of pharmacists within the general practice team increased the quality of prescribing and lowered prescribing costs. Teams comprised predominantly of GPs and nurses were associated with lower accident and emergency attendances than teams which had higher numbers of other clinicians.[14]

Scandinavian and Danish models represent the gold standard in optimal GP care internationally. In Australia, Aboriginal and Torres Strait Islander Health Services have excellent models of GP-led team-based care with proven health outcomes. The Commonwealth Fund's *Mirror, Mirror 2021: Reflecting Poorly – Health Care in the US Compared to Other High-Income Countries* report[15] **ranked Australia with Norway and the Netherlands as the top-performing countries overall**, outperforming the United Kingdom, New Zealand, Canada and the United States**.**

RACGP's key recommendations by theme and responses to consultation questions

1. Theme – Legislation and regulation

Consultation questions

1.1 What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professional's ability to work to full scope of practice? (For example, harmonisation of specific legislation between jurisdictions, or regulating health professionals differently).

1.2 To what extent do you think a risk-based approach is useful to regulate scope of practice (ie one which names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than named professions or protected titles)?

1.3 What do you see as the key barriers to consistent and equitable referral authorities between health professions?

The RACGP has chosen to list key recommendations to overcome barriers and highlight the key risks associated with changing from the status quo.

Key Reform Recommendations – Legislation and regulation

- Facilitate GP and/or general practice-based dispensing, which (as mentioned earlier in the document) already exists through a variety of models depending on the needs of the community.
    - Review pharmacy location and ownership rules to allow dispensaries within general practice.
    - Dispensing general practice-based pharmacist
    - Allow GPs to dispense medication/GP dispensary.
- Harmonise legislation across jurisdictions – a unified regulatory framework would provide consistency, a reduced administrative burden and streamline processes, particularly in border towns and rural settings. This needs to address:
    - prescribing restrictions
    - prescription monitoring systems
    - voluntary assisted dying
    - mandatory reporting requirements
    - immunisation schedules and recording.
- Implement streamlined statewide or national hospital credentialling rather than relying on multiple individual institutions to facilitate this.
- Recognise GPs as specialists with agencies like Centrelink, workers compensation bodies, the Department of Veterans Affairs and the National Disability Insurance Agency.
- Recognise GPs as specialists and the equivalent of salaried non-GP specialists in all state and territory government local health service structures.
- Move the Distribution Priority Area (DPA) to metropolitan areas according to population and migration of people in the suburbs, not according to the catchment area.
- Enable the broader general practice team to deliver more independent practice. E.g practice nurses to deliver wound management and administer immunisations independently. Remove barriers to general practice-based pharmacists providing immunisations within general practice.

Key risks:

- If referral authorities are expanded…
  - **Extension to already long wait lists** for non-GP specialist appointments. Education will become more important (particularly for new referrers) to ensure the quality and appropriateness of referrals.
  - **Systems to triage referrals** to manage volume in the private sector if more professions are referring.
  - **Patients become very unwell with no communication to the GP.** This is already being seen with psychology visits funded through the NDIS, where GPs are not kept informed about their patient's progress or changes to their condition.
  - **Limited referral pathways due to maldistribution** of non-GP specialists and allied health.
- If protected titles are replaced by risk-based approaches...
  - **Patient confusion around role delineation** – any radical reforms must include a consumer awareness campaign including extensive communication, education and advertising about the changes.
  - **Unsuitable approach for general practice** – risk-based approaches may be useful for some tasks being delegated to people with specified skillsets. However, general practice is more than the sum of a series of individual tasks.
  - **Balancing flexibility and accountability** – overlapping scopes of practice presents an increased risk of fragmentation, a lack of clearly defined responsibilities and clarity on when and how clinical handover should occur.
- If jurisdictional variations are addressed by 'catching up' jurisdictions who cannot currently do tasks to align with more liberal jurisdictions…
  - **Paucity of evidence** to demonstrate patient outcomes and cost-effectiveness of the change to the usual model of care.

2. Theme – Employer practices and settings

Consultation questions

2.1 What changes at the employer level would you like to see to enable health professionals to work to full scope of practice (e.g. changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements.)

2.2 Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?

2.3 How can multidisciplinary care teams be better supported at the employer level, in terms of specific workplace policies, procedures, or practices?

The RACGP has chosen to list key recommendations to overcome barriers and highlight the key risks associated with changing from the status quo.

Key Recommendations – Employer practices and settings

- Recognise GP advanced skills. GPs advance their skills through structured training in areas such as anaesthetics, obstetrics and emergency medicine to meet the needs of their local communities. Often these skills are not recognised by employers.
  - Facilitate access for GPs as visiting medical officers or employees within hospitals (admitting rights, access to day surgery units or local hospital lists).
  - Recognise GPs as specialists within state and territory government local health service structures.
  - Review senior medical officer awards to improve remuneration equity between GP and non-GP specialists.
  - Recognise GPs can also play valuable roles in hospital care, including liaison roles between hospitals and primary care as well as providing direct clinical care.
- Enhance clinical governance mechanisms and tailor to rural settings to ensure all health professionals will have the necessary support and oversight. This may involve the establishment of regional or collaborative governance structures.
- Explore incentives and innovative models of employment for GPs (in collaboration with the RACGP) to increase GP workforce attraction/retention rates. This could include:
  - improved working conditions for GPs in training through direct incentives, parental and study leave payments
  - mechanisms to support GPs to accrue superannuation, particularly self-employed female GPs who can have much lower superannuation balances when they retire due to maternity leave
  - flexible industrial agreements that account for the unique demands of rural practice (and improve attraction/retention rates) – for example, incentives for remote placements or increased support for continuing education
  - single employer models or guaranteed income (similar to the Community Pharmacy Agreement models).

Key risks:

- If allied health professionals expand their scope of practice…
  - **Employers may not have capacity to adequately consider additional responsibilities or implement structures within appropriate timeframes to:**
    - Support/monitor the quality, effectiveness and efficiency of services.
    - Support development of and access to up-to-date, best practice clinical guidelines.
    - Fund protected time for administration, CPD and self-reflective practices.
- If payroll tax issues are not resolved…
  - **It can impact on the success of multidisciplinary teams in general practice.** Costs will be passed on to patients and/or lead to the closure of practices. This will be an issue for any team setting where members are self-employed, which is the case for the majority of GPs.
- If hospitals continue to perform procedures and tasks that are within the scope of general practice…
  - **Skill decay and skyrocketing health costs** – Prevent skill decay and improve cost-efficiency by supporting GPs to continue doing minor office-based procedures.

3. Theme – Education and training

Consultation questions

3.1 What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope?

3.2 How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements or advanced practice) be improved?

The RACGP has chosen to list key recommendations to overcome barriers and highlight the key risks associated with changing from the status quo.

Key Recommendations – Education and training

- Avoid micro-credentialling and reduce the risk of a multi-tiered health system.
- Streamline accreditation processes and endorsements for additional skills or advanced practices to encourage health professionals to pursue ongoing education.
- Recognise the Advanced Rural Skills of GPs and consider a metropolitan equivalent to the Rural Generalist Advanced Skills recognition.
- Invest in infrastructure, telehealth and online training platforms to support accessible education and training.
- Invest in scholarships and bursaries to subsidise the cost of education to meet the ever-changing needs of the community.
- Invest in 'living' clinical practice guidelines to support best practice healthcare. Medical literature grows at an astounding rate and there is a pressing need to synthesise evidence to support Australian treatment recommendations.
- Provide financial support to subsidise direct and indirect travel costs of those in rural and remote areas needing to travel to metropolitan centres.
- Increase emphasis on primary care sector within undergraduate healthcare education.
- Provide support for co-designed training and resources by relevant organisations/peak bodies where there is overlap of scope of practice.

Key risks:

- If there is a lack of clinical governance frameworks and other in-built protections…
  - **Unacceptable levels of risk.** Expanding scope of practice is best attempted in well-supported team-based settings such as hospitals, general practices and Aboriginal Community Controlled Health Services that have established clinical governance frameworks and other in-built protections.
- If there are reduced training and skill maintenance opportunities…
  - **Skill decay across multiple health professions** – Maintenance of skills may be difficult where there is limited opportunity to practise those skills either because of low volumes within the community or competition with non-GP specialists and/or other health professionals for service delivery. The potential also exists for loss of opportunities for GPs in training to learn certain essential skills and tasks at the edge of their scope if they are being performed by others.
- If multiple professions overlap in scope…
  - **Increased burden of redesign and maintaining governance requirements for education and training** to suit new learners. The costs of developing, promoting, delivering and maintaining education and training is significant and will potentially be duplicated by more than one profession.
  - **Increased demand on the health workforce and services to monitor and maintain professional standards at national, jurisdictional and local levels** This increased demand will also be in the public and private settings.
  - **Additional costs of quality assurance activities** such as audits for compliance and competency.
- If Medicare is expanded to even more health professionals…
  - **Medicare complexity** is already a significant challenge for health professionals who can access it. Additional education is frequently requested to ensure billing compliance. Other health professionals will potentially require even greater support and education, particularly if they have had no or limited exposure to MBS item numbers previously.
- If simple tasks are allocated to others…
  - **Unknown impact of increased cognitive load from sustained complexity.**

4. Theme – Funding policy

Consultation questions

4.1 How could funding and payment be provided differently to enhance health professionals' ability to work to full scope of practice, and how could the funding model work?

4.2 Which alternative funding and payment types do you believe have the most potential to strengthen multidisciplinary care in the primary health care system?

4.3 What risks do you foresee in introducing alternative funding and payment types to support health professionals to work to full scope of practice, how do these risks compare to the risks of remaining at status quo, and how might these risks be managed?

The RACGP has chosen to list key recommendations to overcome barriers and highlight the key risks associated with changing from the status quo. **The RACGP does not support a capitation model and we caution the Reviewers against funding models that do not align with the flexibility required in general practice.**

Key Recommendations – Funding policy

- Increase funding to support interdisciplinary and multidisciplinary care in general practice.
  - Provide MBS rebates to patients when practice nurses perform tasks without direct supervision from GPs (eg influenza vaccinations).
  - Increase blended funding to support training and ongoing professional development and remunerate tasks performed by the broader multidisciplinary general practice team.
- Remove artificial restrictions that curtail scope (simplifying MBS item descriptors and PBS restrictions).
- Incentivise GPs to perform office-based procedures (such as iron infusions, joint injections, IUD insertion), rather than referring to more costly providers and within the hospital setting.
- Harmonise MBS item numbers to provide patients with the same rebate for services provided by GP and non-GP specialist medical practitioners.
- Streamline healthcare funding streams so that state and territory governments can incorporate general practice into their local health service structures.

Key risks:

- **Fiduciary responsibility and accountability** will be important to avoid a health budget 'blowout'.
  - GPs are subject to restrictions like caps on the number of consultations they undertake within a specific time period and rules such as the existing clinical relationship requirement for MBS telehealth appointments. An appropriate level of regulatory oversight must also be put in place for other health professionals considering they could be adding new tasks on top of an existing busy workload.
- **Fee-for-service model increases focus on adequately remunerated tasks** – Impetus to maximise outcome from transactional episodic care. Enabling more health professionals to access Medicare funding will continue a focus on episodic and reactive care. Blended funding (such as increased Practice Incentive and Workforce Incentive payments) provides an opportunity to have a whole-of-practice approach to improving patient health outcomes.

5. Theme – Technology

Consultation questions

5.1 How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?

5.2 If existing digital health infrastructure was to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?

5.3 What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?

The RACGP has chosen to list key recommendations to overcome barriers and highlight the key risks associated with changing from the status quo.

Key Recommendations – Technology

- Refer to the RACGP's Interoperability and useability requirements for general practice CISs position statement.
- Improve user experience of the current electronic medical record software. It is clunky, hard to use and does not give an overall picture of a patient.
- Support increased competition among electronic health records providers to reduce GP vulnerability to systems that do not best fit their practice needs.
- Explore the safe use of artificial intelligence (AI) for notetaking, assisting with documentation and providing real-time clinical decision-making support.
- Improve connectedness by enhancing digital health infrastructure to facilitate two-way synchronous (telephone or video consults) or asynchronous (secure messaging with ability to send photographs) communication with other specialists and real-time data sharing.
- Expand access to broadband and digital training programs to facilitate more equitable use of telehealth and other digital health services.
- Invest in cybersecurity and transition from on-premises to cloud-based systems – can offer scalability, flexibility and enhanced data security. Address negative perceptions and highlight the benefits of cloud solutions to move primary care towards more modern, efficient practices.
- Improve integration of clinical software with external registries (eg AIR, NCSR, Safescript) to reduce duplication of work by streamlining data processes (eg auto-generation of referrals from notes).
- Introduce IT training into medical school curricula. Many GPs do not understand the potential of the information available in their clinical software to enhance patient care.
- Increase practitioner access to local community and hospital health data (eg antibiotic resistance and infectious disease data) and other disease information and evidence to assist in tailoring care to the local community.
- Leverage technology for telehealth and remote monitoring to bridge the gap in rural healthcare access.
- Integrate evidence-based digital decision support into GP clinical software to support implementation of best practice clinical guidelines.
- Develop an open-source ethos. A culture of technological openness, where solutions are developed with interoperability and community improvement in mind can foster innovation, collaboration, and a more cohesive healthcare technology ecosystem.

Key risks:

- If there is an over-reliance on My Health Record (MHR) for continuity of care…
  - **Poorer patient care and an increased administrative burden.** MHR is not a clinical record; it is a summary of patient encounters. It is not sufficient to provide good patient care. It is under-utilised and this creates an administrative burden for practices in having to gain access to patient results, specialist letters and discharge summaries. Effective use of MHR is also reliant on patients choosing not to opt out, which many did when the tool was first launched.
    - Ideally these would be automated processes.
    - Increasing issue of significant delays in specialists sending letters or in hospitals sending discharge summaries, which impedes on safe and effective patient care.
    - Electronic health records do not replace a formal clinical handover. More can be done to make MHR fully operational and interactive.

RACGP's general feedback to Issues Paper 1

Glossary definitions in Issues Paper 1

Definition of accreditation

"Refers to a formal process of approval for a program of study or training that provides a person who completes that program or training with the knowledge, skills and professional attributes needed to practice their health profession or undertake that activity."

RACGP comment: This is incorrect. Accreditation certifies that the person or organisation meets a standard that is required to practise or operate (as an organisation) in a specified area of healthcare. Accreditation of general practices does NOT require a program of study or training.

Definition of acute care

"Care in which the intent is to perform surgery, diagnostic or therapeutic procedures in the treatment of illness or injury. Management of childbirth is also considered acute care."

RACGP comment: Care of people with chronic disease involves diagnostic procedures, for example monitoring of glycated haemoglobin, lipids and renal function, measurement of blood pressure and fundoscopy among others. 'Acute care' refers to care of people who have an acute condition, that is, one that has arisen or become apparent only recently, such as in the last few minutes, hours or days.

Definition of continuity of care

"Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time."

RACGP comment: This is a definition used by the Australian Institute of Health and Welfare and is incomplete. Continuity of care traditionally refers to the therapeutic doctor-patient relationship that develops over time. It is a fundamental element of traditional general practice, increasingly linked with important patient and system effects.

Clarification re credentialling

"A formal process used to verify the qualifications and experience of health professionals within a specific health care setting and role, used predominantly in the acute health system."

RACGP comment: Does 'acute health system' translate only to hospitals? GPs provide care of acute problems, such as lacerations or pneumonia and should therefore be considered part of the acute care system'.

Definition of full scope of practice

"Professional activities that a practitioner is educated (skill / knowledge), competent and authorised to perform, and for which they are accountable.
Individual scope of actual practice is time-sensitive and dynamic. Scope of actual practice for individual practitioners is influenced by the settings in which they practice, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority / governance) of the service provider. "

RACGP comment: Health professionals might be qualified and trained for a certain scope, but in their actual practice restrict their activities to a smaller scope. For example, some GPs become breast physicians, working for screening mammography services. Some physiotherapists restrict their practice only to care of people with pelvic floor problems.

Definition of GP-centred primary health care model

"*Refers to the central role that general practitioners play in primary care by providing care for most of their patients most of the time for most of those patients' problems and referring only when needed to other health professionals or service providers."*

RACGP comment: This is an important point to emphasise this definition. The models being proposed as part of this consultation are lacking in all features of good primary care, except access.

Definition of Primary health care

"Primary health care is health care people seek first in their community, such as GPs, pharmacies and allied health professionals. Generally, this is health care outside of a hospital or non-GP medical specialist."

RACGP comment: This definition does not adequately define primary care. It is only defining a setting. The four main features of 'good' primary care services include: first contact access for each need; long-term person (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere. Primary care is assessed as 'good' according to how well these four features are fulfilled. (Barbara Starfield, Liyu Shi and James Macinko)

References

[1] Anthony BF, Surgey A, Hiscock J, Williams NH, Charles JM. General medical services by non-medical health professionals: a systematic quantitative review of economic evaluations in primary care. Br J Gen Pract. 2019 May;69(682):e304-e313. doi: 10.3399/bjgp19X702425. PMID: 31015223; PMCID: PMC6478480.
[2] Sandvik H, Hetlevik O, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. BrJ Gen Pract. 2022 Jan 27;72(715)
[3] Frandsen B, et al, Care fragmentation, quality, and costs among chronically ill patients, Am J Manag Care. 2015: 21(5):355-362.
[4] Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8(6):e021161-e
[5] Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: Cross sectional study of routinely collected, person level data. BMJ (Clinical Research Ed) 2017;356:j84-j
[6] Anthony BF, Surgey A, Hiscock J, Williams NH, Charles JM. General medical services by non-medical health professionals: a systematic quantitative review of economic evaluations in primary care. Br J Gen Pract. 2019 May;69(682):e304-e313. doi: 10.3399/bjgp19X702425. PMID: 31015223; PMCID: PMC6478480.
[7] NSW Health. Lumos Shining a light on the patient journey in NSW 2021 [cited 2 December 2022]. Available from: https://www.health.nsw.gov.au/lumos/Pages/default.aspx.
[8] Sandvik H, Hetlevik O, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. BrJ Gen Pract. 2022 Jan 27;72(715)
[9] CBC News. Concerns grow as more and more Albertans can't find a family doctor. 27 April 2022. Available at: https://www.cbc.ca/news/canada/calgary/fewer-family-doctors-accepting-new-patients-1.6432767#:~:text=Daphne%20Pauls)-,A%20dramatic%20drop%20in%20the%20number%20of%20family%20physicians%20accepting,about%20patient%20care%20and%20safety [accessed 8 June 2022].
[10] https://www.albertadoctors.org/8196.aspx
[11] OECD Stats. https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI
[12] General Medical Council. The state of medical education and practice in the UK. Workplace experiences 2023.
[13] Baird B, Fenney D, Jefferies D, Brooks A. Making care closer to home a reality. Refocusing the system to primary and community care. The King's Fund. 2024
[14] National Institute for Health and Care Research. GPs' overall workload and job satisfaction did not improve when practices employed other clinicians. [Accessed 12 October 2023 via https://evidence.nihr.ac.uk/alert/gps-workload-did-not-improve-when-practices-employed-other-clinicians/)
[15] Schneider EC, et al. Mirror, Mirror 2021 Reflecting Poorly: Health Care in the U.S. compared to other high-income countries. Aug 2021. The Commonwealth Fund.