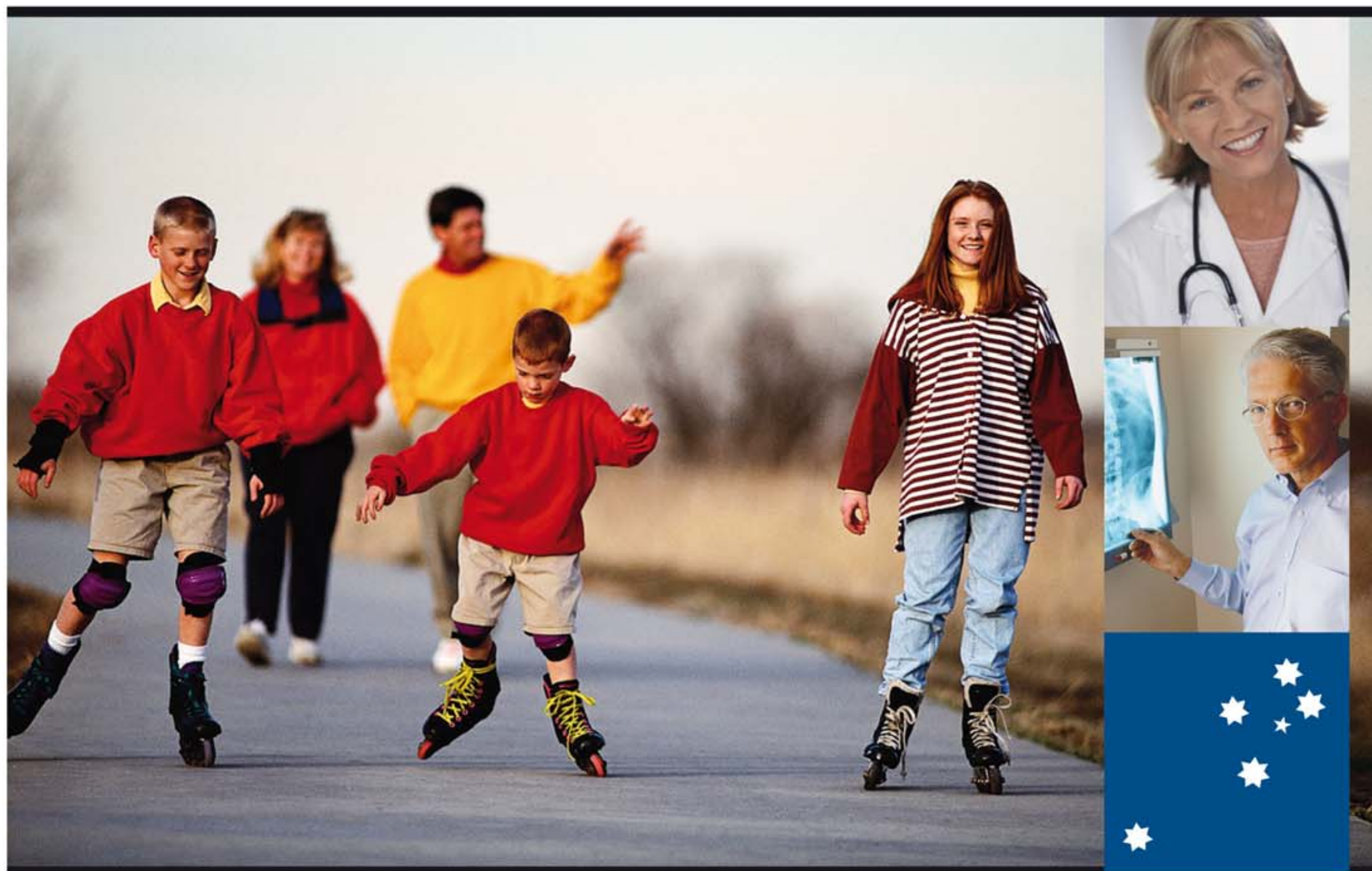
New Directions for Australia's Health

Delivering GP Super Clinics to local communities



Kevin Rudd MP
Federal Labor Leader

Nicola Roxon MP
Shadow Minister for Health

August 2007

Australian Labor

www.alp.org.au

Executive Summary

Health services around Australia are under strain. Hospitals and health services are struggling under the weight of the ageing population and growing burden of chronic disease; the health workforce is stretched; and people in many communities around the country find it hard to access the care they need.

To tackle these challenges and end the blame game, Labor has announced a $2 billion **Health and Hospitals Reform Plan** aimed to improve health and hospital services around Australia.

Labor's *Health and Hospitals Reform Plan* will provide **upfront investment** in improving health and hospital services, and **incentive payments** to states and territories who meet agreed reform outcomes in areas such as:

- reducing avoidable hospitalisations and readmissions to hospital;
- reducing non-urgent accident and emergency presentations;
- reducing waiting times for those people who require essential hospital services such as elective surgery; and
- providing more appropriate non-acute care for older Australians.

An integral part of Labor's Health and Hospitals Reform Plan is to provide funding to **strengthen primary care services** in local communities.

The first and most common contact that Australian families have with the health system is through their GP. The family doctor plays a critical role in helping treat illnesses as well as helping families keep themselves healthy and out of hospital.

However, as a result of workforce shortages, long-term under-investment in infrastructure and a lack of strategic planning around the Medicare Schedule, GPs are finding it harder to meet the community's health needs and mums and dads are finding it harder to get their kids or parents to the doctors.

The nature of general practice and the general practice workforce are also changing. Increasingly, new doctors want more flexibility in their careers and working conditions that general practice, particularly in regional areas, don't always allow.

This means that young doctors and other health professionals are not being attracted to regions that need them most. As a result, the universality of Medicare is under threat – not because people aren't *entitled* to services, but because doctor shortages and poor health infrastructure mean they can't *access* them locally or close to home.

And with an increase in the prevalence of many chronic diseases and the ageing population, doctors are seeing more and more patients with complex care needs. This takes time, and adds pressure to a primary care system already under strain.

Many individual Australians suffer poor health as a result.

And it means our health system suffers too. It also puts pressure on our public hospitals. People who can't get good primary care in their community, inevitably end up in the emergency departments of our hospitals.

On top of this, failing to provide proper services for people with preventable chronic diseases also ultimately hurts our economy – with productive time lost from work.

Australia needs to strengthen its frontline health care services, and bolster our GP-centred primary care system so that it is equipped to deal with these pressing current problems and to meet the challenges of the future.

This is why, as part of our $2 billion Health and Hospitals Reform Plan, a Rudd Labor Government will invest **$220 million** in the health system to establish ***GP Super Clinics*** in local communities – bolstering frontline health care for Australian families.

Labor's *GP Super Clinics* will help to deliver more frontline health services in local communities – they will help get doctors and other health professionals into areas that need them most, working together to meet the new service delivery challenges of modern medicine.

Labor's *GP Super Clinics* will provide infrastructure for GPs and other health professionals, including allied health workers, nurses, and some specialists, to work together in the one place, providing a greater range of quality services in local communities – and **much greater convenience for patients**. They will be tailored to the needs of local communities.

Federal Labor's *GP Super Clinics* will provide infrastructure funding to establish a greater range of convenient and quality services in local communities such as renal and cancer services – particularly in rural and regional areas and where Medicare has not been utilised to its fullest extent.

Along with incentives to help pay for administrative and nursing support, funds could be used to provide for teaching rooms and facilities to make the *GP Super Clinics* attractive to new graduates, trainees and GP registrars – encouraging health workers into regions where there are currently workforce shortages.

And by having renovated or purpose-built facilities that allow space for group sessions and a range of staff, the *GP Super Clinics* will have a particular focus on assisting people to stay well, or better manage existing chronic conditions.

To complement Labor's *GP Super Clinics* policy, the *National Health and Hospitals Reform Commission*, which Labor will establish within 100 days of coming to office, will be asked to identify strategies to **better integrate primary care and other health services** as part of its brief. Poor integration between Commonwealth-funded primary care services and state and territory-government funded services – both community health services and hospitals – is one of the key areas of inefficiency and duplication in the current system.

Combined with the prevention strategies Labor has already announced, Labor's *GP Super Clinics* will:

- help take the pressure off hospitals,
- provide a greater focus for tackling the challenge of chronic disease in local communities, and
- mean much greater convenience for patients.

Investing in *GP Super Clinics* is part of Federal Labor's comprehensive plan to end the blame game on health and provide local solutions and services within a broader national strategy.

Labor's *GP Super Clinics* will not be about salaried medicine. Rather, they will encourage existing private practitioners and health professionals to better tailor their services to meet 21st century health challenges.

Australia needs a systematic approach to fixing the health system; not just one-off policies for marginal electorates.

Labor understands that taking pressure off hospitals requires ensuring good quality health services in local communities. And through bolstering Commonwealth investment in primary care by supporting new *GP Super Clinics,* it signals that a Rudd Labor Government is prepared to do its bit.

Introduction

Our system of primary health care, usually delivered by a local General Practitioner and aimed at meeting the basic health needs of Australian families, is under increasing strain.

National Medicare figures show that there are many areas which are missing out on frontline health care. Data on Medicare benefits by geographic region shows under-utilisation of Medicare services in many areas, particularly rural and Indigenous communities.

This is not because Australians in these communities are not *entitled* to access Medicare-funded services, but because of structural barriers – such as workforce shortages and infrastructure constraints – which mean that services aren't always readily accessible on the ground in local communities where they are needed.

Labor wants to ensure that the promise of Medicare – universal access to health care for all Australians – is fulfilled. This requires bolstering current services in areas which are currently missing out.

Too many families who cannot access a GP service are forced to attend a hospital emergency department. In total, 12 per cent of all presentations to public hospital emergency departments are for non-urgent conditions – conditions which could be attended to by a GP.[1]

When families have to use hospitals for regular health care, it also costs our health system more. According to the Independent Pricing and Regulatory Tribunal of New South Wales, the use of emergency departments to provide GP-type services in New South Wales was estimated to cost an additional $110 million per annum. In comparison, delivering the same services through the Medicare Benefits Schedule would have cost approximately $30 million.[2]

In other words, it costs the system almost four times as much when individuals who could see their GP are diverted to a hospital for non-urgent care.

It is also important that our nation's health system is equipped to respond to future challenges. Chronic diseases already account for almost $34 billion each year and nearly 70 per cent of allocated health expenditure. Left unchecked, this figure is expected to increase to 80 per cent of allocated health expenditure by 2020.[3]

Demand for health care for chronic conditions such as cardiovascular disease and diabetes is placing increasing pressure on acute services such as our public hospitals. Each year around 500,000 hospital admissions are for mostly preventable conditions that would have been better treated in the community.[4]

Good quality and accessible primary health services such as comprehensive GP services can play an important part in maintaining peoples' good health and, importantly, help reduce future demand for acute hospital services.

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[1] Department of Health and Ageing, *The State of our Public Hospitals*, June 2007.
[2] Independent Pricing and Regulatory Tribunal of New South Wales, *NSW Health: Focusing on Patient Care,* August 2003.
[3] AIHW, *Health System Expenditure of Diseases and Injuries in Australia 2000-01*, 2005.
[4] AIHW, *Atlas of Avoidable Hospitalisations in Australia: ambulatory care-sensitive conditions*, 2007.

On top of all this, there are also good economic reasons for tackling early the growth in chronic disease through improved primary health care services.

Poor health diminishes the quality of life of Australians, reduces their capacity to participate in the workforce, and can cost our businesses and the economy through sub-optimal levels of productivity.

The Productivity Commission's estimates suggest that workforce participation rates are significantly affected for those people who have a chronic disease. Depending on the condition, workforce participation can be reduced by between 12 and 40 per cent.[5]

The Productivity Commission also estimates that as many as 175,000 extra people could be in the workforce by 2030 and that implied expenditure savings could be around $2.8 billion if modest investments are made in improved preventative health care.[6]

This represents an increase of around 0.6 of a percentage point in the workforce participation rate – a substantial increase at a time of significant skills shortages around the country.[7]

Federal Labor has announced a **$2 billion National Health Reform Plan** over four years to improve Australia's health system and ensure better health services for patients in hospitals.

Labor's $2 billion *National Health Reform Plan* will provide funding for three related types of reforms:

- Up front funding for health and hospital reforms;
- Incentive payments for the achievement of improved health outcomes; and
- Funding to boost the provision of primary health care services.

The funding of *GP Super Clinics* is one of the key ways in which Federal Labor aims to boost the capacity of our primary care services.

While there have been recent increases in university places for medical students, this will not solve current workforce shortages for a number of years – and it will be vital to ensure GP services in areas of need have the types of facilities which can make it attractive for young graduates to work in these areas.

Meanwhile, the structure of the delivery of health services to the community needs reform. This is what Labor's *GP Super Clinics* addresses.

A Rudd Labor Government will shift preventative health care from the margins to the centre of our country's health policy.

This means providing access to services on the ground, in response to local solutions developed by local communities.

Labor believes the best way to equip our health system to tackle the growing burden of chronic disease is to re-invigorate the role of the primary care system – the front line of the health system, providing health care to local communities.

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[5] Productivity Commission, *Effects of Health and Education on Labour force participation*, Staff Working Paper, 2007.
[6] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.
[7] Productivity Commission, *Potential Benefits of the National Reform Agenda,* 2007.

Establishing *GP Super Clinics* will take the pressure off hospitals and provide a greater focus for tackling the challenge of chronic disease in local communities.

GP Super Clinics will provide infrastructure for GPs and other health professionals, including allied health workers, nurses, and some specialists, to come together in the one place.

Providing the facilities for multi-disciplinary teams to work together will mean a greater focus on prevention and management of chronic disease. This will also mean greater convenience for patients and increase the likelihood that patients will follow up with treatment, thus improving health outcomes.

Labor's *GP Super Clinics* will also help attract health professionals to areas that currently missing out because of workforce shortages and an inability under the current policies to attract young doctors to the areas of most need.

Labor will work cooperatively with state and territory governments to identify areas most in need.

Labor's primary care policy will provide a new way of delivering health care to local communities into the future.

Labor has already announced four key policies which will mean a greater focus on prevention under a Rudd Labor Government. Labor will:

- Establish a ***National Preventative Health Care Strategy*** to bring a true preventative focus to the health system. The Preventative Health Care Strategy will be supported by a permanent expert Taskforce
- Establish new ***Preventative Health Care Partnerships*** with the states and territories, to work together on keeping people out of hospitals
- Establish a reform process to simplify Medicare rebates, ***shift the focus from six minute medicine***, and provide incentives for GPs to practice quality, preventative health care
- Commission the Treasury to produce a series of special reports ***assessing the impacts of chronic disease on the economy***.

In line with these strategies, Labor's *National Health and Hospitals Reform Commission* to be established within 100 days of taking office, will be asked to identify strategies to **better integrate primary care and other health services.**

Poor integration between Commonwealth-funded primary care services and state and territory-government funded services – both community health services and hospitals – is one of the key areas of inefficiency and duplication in the current system.

The current system of primary care in Australia

Primary care is 'first level' or frontline care, predominantly provided in Australia by general practitioners in private practice.

Our GP-led model of care involves treatment of non-acute (that is, not immediately life-threatening) conditions, as well as some health screening.

As the funder of GP services through Medicare, the Commonwealth is primarily responsible for the provision of frontline primary care in Australia. Under Medicare, all Australians are entitled to free treatment at a public hospital, and a Medicare rebate for services provided by GPs, specialists (on referral from a GP), and allied health providers in some circumstances.

State and territory governments also play a role in delivering some primary care services through community health services, as shown in the following chart.[8]

Chart 1: Funding of primary care in Australia, 2004-05[9]

Area of activity	Commonwealth government expenditure ($ million)	State/territory government expenditure ($ million)	Total
GP/primary care services funded through Medicare	3301	N/A	3301
Community and public health	1265	3804	5069
Total	**4566**	**3804**	**8370**

Universality of Medicare: no longer a reality?

Labor established Medicare in 1984 to ensure that all Australians would have universal access to health care.

Before Labor created Medicare, two million Australians had no form of health insurance, and therefore no guarantee of access to health care services. The creation of Medicare ensured that guaranteed access to health care, including treatment provided free of charge at a public hospital, became the right of all Australians.

But since then, cracks have started to appear in the Medicare system, which mean that the promise of universal access to Medicare-funded services, particularly primary care services, is no longer always a reality.

Structural barriers mean that Medicare services which are still a universal entitlement are not always universally accessible.

For example, workforce shortages in many areas mean that it is not always possible to access Medicare-funded GP services in many communities.

Chart 2 illustrates that there are often considerable disparities in the availability of GPs between rural and urban areas. The availability of GPs in different regions directly affects people's capacity to access services provided through general practice, because people have to travel further or wait longer to see a GP. Low numbers of GPs can also have an effect on bulk-billing rates, as there is less 'competition' for patients.[10]

This is highlighted in national figures on Medicare expenditure.

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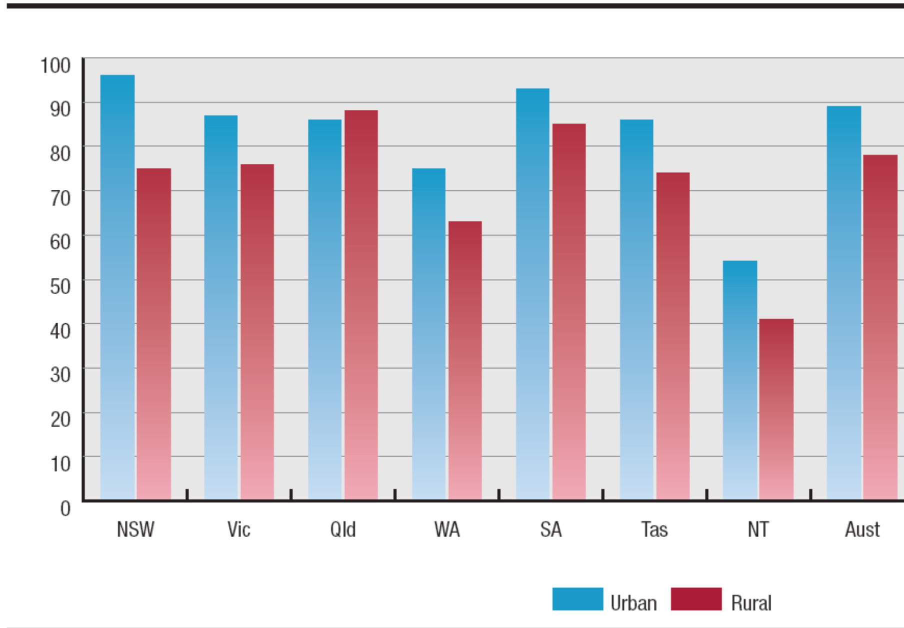
[8] Medicare expenditure in the table includes expenditure on all GP and other non-referred items, including health assessments, care plans and case conferences, items associated with Practice Incentive Payments, practice nurse services administered on behalf of a medical practitioner, and allied health services.
[9] Figures compiled from Medicare Australia and Australian Institute of Health and Welfare data.
[10] Productivity Commission, *Report on Government Services 2007,* 2007.

According to the Productivity Commission, the Commonwealth spent approximately $4.9 billion, or $239 per capita, on general practice services in 2005-06.[11]

The vast majority of this expenditure is comprised of medical benefits paid under Medicare, but also includes some expenditure through other funding programs (such as practice incentives and payments direct to Divisions of General Practice, and expenditure by the Department of Veterans' Affairs on veterans' health).[12]

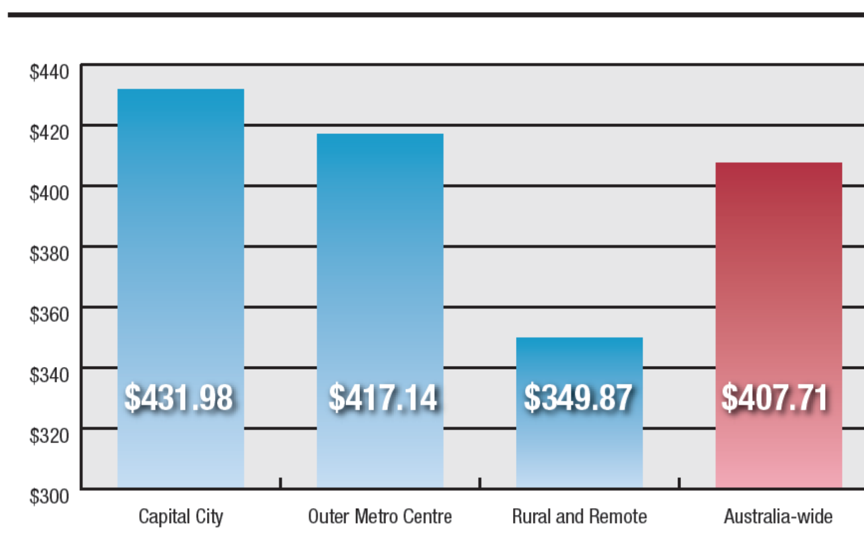
Chart 2: Availability of GPs (full time workload equivalent), 2005-06[13]



Yet analysis of expenditure on Medicare in different geographical areas reveals vast disparities in benefits paid per capita. People in many outer metropolitan, regional, and rural areas are missing out. The following chart highlights the differences between Medicare benefits per capita by geographic region in 2002-03 (the most recent year for which this data is available).

[11] Productivity Commission, *Report on Government Services 2007,* 2007.
[12] Productivity Commission, *Report on Government Services 2007,* 2007; Australian Institute of Health and Welfare, *Health expenditure Australia 2004-05,* 2006.
[13] Productivity Commission, *Report on Government Services 2007,* 2007.

Chart 3: Medicare benefits per capita in metropolitan, rural and remote areas, 2002-03[14]



Analysis of variations in Medicare benefits per capita by federal electorate also reveals considerable discrepancies. For example, in 2004-05, total Medicare expenditure in the electorate of Lingiari (NT) was just over $15 million. In the same year, total Medicare expenditure in the electorate of Wentworth (NSW) was almost $90 million. Similarly, the electorate of Bass in Tasmania received $39 million in Medicare benefits – less than half of the almost $85 million paid out in Goldstein in metropolitan Melbourne.[15]

These discrepancies are just as apparent in benefits paid out under the Medicare Safety Net. For example, in 2006 the electorate of Braddon in Tasmania received a total of $122,826 in Safety Net benefits, whereas the electorate of Wentworth received over $7.7 million. Similarly, the whole of Kalgoorlie received $320,041 in Safety Net benefits in 2006, compared to over $6.4 million in Bradfield in Sydney.[16]

These kinds of differentials in Medicare and Safety Net benefits are often indicative of barriers – both physical and financial – to accessing Medicare services, particularly specialist services (as the majority of Medicare safety net benefits are for specialist services).

The statistics show these inequities are particularly acute in rural and remote communities.

Uneven distribution of access to Medicare services is most obvious in the data on Medicare benefits per capita for the Indigenous population: benefits per capita for Indigenous people were $156.68 in 2001-02, less than half those for non-Indigenous people at $399.80.[17]

A second barrier to accessing Medicare services for many people is cost. Under-investment in Medicare over the long-term has led to record high out-of-pocket costs for Medicare services.

[14] Department of Health and Ageing, *Annual Report 2002-03.*
[15] Medicare Australia, Medicare Services and Benefits by Electoral Division for the 2004/05 Financial Year.
[16] Department of Health and Ageing, Medicare Statistics.
[17] AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001–02,* 2005.

For example, according to the latest quarterly data, the average out-of-pocket cost for seeing a GP is almost $19. This figure has more than doubled from an average of $8.52 per GP visit in 1996.[18] And the national GP bulk-billing rate – which currently sits at 77 per cent, is only just recovering from being attacked and starved of funds in the early years of the Howard Government. Today, national GP bulk-billing rates are is still below the 1996 level of nearly 80 per cent.[19]

Poor access to frontline GP and primary care services in their community means many people can't or don't tackle their health problems early. Attending to them after the problems have become worse puts pressure on other parts of the health system, particularly public hospital emergency departments.[20]

According to the recently released *State of Our Public Hospitals* report, 12 per cent of presentations to public hospital emergency departments were for non-urgent conditions (that is, conditions that could be better managed by a GP).[21]

The hospital system is under pressure more generally. A recent AIHW report revealed that over 500,000 hospital admissions in just one year were the result of mostly preventable conditions that would have been better treated in the community.[22]

The *State of Our Public Hospitals* report showed that the most common reason for admission to a public hospital in 2005-06 was the need for renal dialysis. Renal dialysis is used to treat end-stage kidney disease, the most common cause of which is Type 2 diabetes – a largely preventable chronic disease.

In its recent submission to the House of Representatives Standing Committee Report into health funding, The Blame Game, the Australian Medical Association noted that one of the weaknesses of our health system was its lack of focus on prevention:

> *In terms of health prevention, Australia has not made nearly enough progress with tobacco control, with control of elicit drugs or in addressing obesity and, as a result, many Australians in future will experience poor health outcomes including cancers mental illnesses and diabetes.*[23]

But rather than invest in Medicare with a view to the long-term health needs of the Australian community, the current Howard Government has engaged in a series of pre-election patch-ups.

There have been some positive programs established, such as the Rural Medical Infrastructure Fund which was set up to provide grants to small rural communities to improve health and medical infrastructure in these communities.

But poor design of the program has meant that almost 70 per cent of the funds committed to it have not been spent. For example, the program will not fund facilities attached to hospital grounds but in some rural communities this is the best solution.

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[18] Department of Health and Ageing, Medicare Statistics.
[19] Department of Health and Ageing, Medicare Statistics.
[20] Productivity Commission, *Report on Government Services 2007,* 2007.
[21] Department of Health and Ageing, *The State of Our Public Hospitals – June 2007 report.*
[22] AIHW, *Atlas of Avoidable Hospitalisations in Australia: ambulatory care-sensitive conditions*, 2007.
[23] AMA submission to the Inquiry into Health Funding, 2005.

Although community outcry has led to some recent positive initiatives, such as the extension of Medicare rebates to allied health professionals for people with chronic conditions and complex care needs, the current ad hoc approach to Medicare policy which has continued for the last eleven years has created a Medicare schedule which is weighed down by red tape.

This is why Labor has committed to a reform process to modernise and simplify Medicare. Labor's review of Medicare will focus on ways of providing incentives to GPs to practice quality preventative health care, through longer consultations when appropriate, and through facilitating multi-disciplinary care through primary health care teams.

Making health care accessible for everyone

As well as the workforce shortages and cost pressures which prevent equal access to Medicare services for certain groups or people in certain areas, there are other barriers to people accessing the health care they need.

One of these is time. For more and more people, lack of time is a serious obstacle to visiting the doctor and other health professionals. Increasingly, people find it hard to make the time – amidst busy working and family lives – to look after their health.

This is particularly so for things which may not seem like particularly pressing problems, like the mild shortness of breath that comes with walking up a flight of stairs, or difficulty shifting that bit of extra weight. But of course these sorts of problems can turn into much bigger ones, such as like cardiovascular disease and Type 2 diabetes, down the track.

Time poor parents are frustrated by having to make multiple, separate trips to the doctor and then on to other health professionals when their children have problems. Each trip takes time, money and often lots of travel.

Preventative health care needs to be made more accessible to ordinary Australians struggling to find the time in their busy lives to look after their own health. We can't expect people to take better care of their health if we won't help provide the health services they need to make this a reality.

More health services, located together in local communities, with purpose built facilities that focus more on prevention clinics and services would help to achieve this.

Doing battle with the system when you have a chronic disease

Just as preventative health care is not always readily accessible; the current system does not meet all the needs of people who already have a chronic disease.

The Commonwealth Fund, a US health policy think tank, reported recently that Australia rates poorly – second last out of the countries surveyed for the report – on preventative and chronic disease care.[24]

People with chronic disease waste time and resources negotiating their way through an often fragmented health care system.

[24] The Commonwealth Fund, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, May 2007.

People with chronic disease are often shuttled from one service to another, repeating the same information over and over each time they encounter a new provider.

They often struggle to find out and access the best mix of services for their condition, for example, from physiotherapists, dentists, dieticians and podiatrists. People who don't have the time or the financial resources sometimes just don't bother.

This results in their conditions worsening, creating an unnecessary burden on the hospital system which could be significantly reduced through better chronic disease management in the community.

Many people with serious illnesses such as cancer have to travel long distances, often several times a week or in many cases they have to stay away from home for lengthy periods, to go to big city hospitals.

But many services, such as dialysis and chemotherapy, which historically had to be provided in hospitals, can now be provided safely and often more cost-effectively in community settings. In many cases, community-based settings would be much more convenient for patients.

All this means that people with chronic diseases often don't get the extra help they need to manage their condition, or to stop getting sick in the first place.

Ensuring the system is properly equipped to tackle chronic disease is as fundamental an equity issue as ensuring that Medicare services are accessible to the whole community.

This is because the chronic disease burden falls unevenly on the community – people from disadvantaged groups, including Indigenous people, people from low socioeconomic areas, and people in rural areas, suffer high rates of chronic disease.[25]

We must ensure that Medicare meets the needs of these Australians in our community, as it is central to ensuring that Medicare's promise of universality is properly fulfilled.

Community health services provided by state and territory governments

As noted, state and territory governments provide some primary health care through community health centres. The Commonwealth contributes indirectly to these services, for instance through the Public Health Outcome Funding Agreements (PHOFAs) which will provide around $800 million to the states and territories over the life of current agreements from 2004-05 to 2008-09.[26]

Community health services usually consist of multidisciplinary teams of salaried health professionals (unlike the privately provided fee-for-service care provided through Medicare). Community health services are either provided directly by governments (including local governments), or in some case they are funded by government and managed by a local health service or community organisation.[27]

As community health services are provided through each of the state and territory governments, and because there is no national strategy for primary

[25] AIHW, Australia's Health 2006, 2006.
[26] *Budget Paper 3 – Federal Financial Relations 2007-08.*
[27] Productivity Commission, *Report on Government Services 2007.*

and/or community health, there is significant variation in the services provided across jurisdictions.[28]

Too often, state and territory-government funded community health services are poorly integrated with Commonwealth-funded Medicare services, even though each of these systems are designed to provide frontline health care services to local communities.

Recently, some state and territory governments have begun to invest in models of service delivery which are designed to provide integrated health care to local communities.

These models include South Australia's GP Plus centres; Victoria's 'Super Clinics'; and HealthOne centres in NSW.

These are all examples of modern thinking about health care service delivery in the future – integrated, multi-disciplinary team-based care which is focused on prevention and better management of chronic disease.

Yet these state-sponsored services lack the impact and reach they could have if they were part of a national system and properly integrated with other primary care services in the community, including services funded by the Commonwealth via privately practising GPs (Medicare) and allied health providers.

This is why Labor will ask the *National Health and Hospitals Reform Commission* to identify strategies to better integrate primary care and other health services.

And if we are to end the 'blame game' between the Federal and State Governments we must commit to not only working better together, but also to responding to community initiatives and best practice models to meet the needs of local communities.

The changing nature of general practice

Just as the health care needs of the community are changing, as the population ages and more patients have chronic illnesses and complex care needs, so too is the nature of general practice.

A report on general practice workforce issues prepared by the Australian Medical Workforce Advisory Committee (AMWAC) in 2005 found that the nature of general practice is changing in a number of ways.[29]

According to the report, practice ownership has become much less attractive to GPs than it was previously, for a range of reasons:

- the financial viability of general practice is less certain than it used to be;
- a generational preference amongst newer graduates for flexibility in employment arrangements and greater work/life balance;
- many GPs don't want to buy into a practice they may not be able to sell later if they want to. The fact that many registrars have high HECS debts

[28] Productivity Commission, *Report on Government Services 2007.*
[29] Australian Medical Workforce Advisory Committee (AMWAC), *The General Practice Workforce in Australia - Supply and Requirements to 2013,* August 2005.

also makes practice purchase a less attractive proposition than it used to be; and subsequently,

- many GPs are attracted to corporatised practices where they can be salaried GPs, work standard hours, and not have to run a small business.[30]

As a result of practice ownership becoming less attractive, solo practices, particularly in urban areas, are in decline: the proportion of sole practitioners declined between 1991 and 2003 from 25.5 per cent to 13.7 per cent. (Over the same period, the proportion of GPs in practices containing four or more partners increased from 34.3 per cent to 59.8 per cent.)[31]

Further, younger, female GPs with children are more likely to want to work part-time. They are also more likely to need childcare services, which can be hard to access in some areas. Many GPs may be reluctant to move away from urban areas for this reason.[32]

Like many other people, GPs are increasingly seeking more of a work/life balance and 'see general practice as a job, not a vocation'. Fewer doctors want to work the long hours, particularly outside business hours, that were previously seen as the norm in general practice.[33]

Rural practice is less attractive to many GPs, because of lack of sufficient support services including the availability of locums. The AMWAC report also noted that many rural communities are purchasing practices themselves (for instance through unit trust ownership structures) to encourage GPs to work in their communities, without expecting them to buy in to a practice.[34]

At the same time as the nature of general practice itself is changing, the workforce is ageing.[35] A significant proportion of the GP workforce particularly in some rural areas is due to retire within the near future.[36]

What young doctors want

The traditional model of general practice – a handful of doctors going into business together for life – is no longer an attractive career proposition for many young doctors leaving university. As a result, fewer graduates are choosing general practice as a career.[37]

Instead of the traditional single doctor practice for life model, newly graduating doctors are increasingly attracted to working in multi-disciplinary teams, more flexible models of practice (for example, which allow them to buy in and buy out easily), and more flexible working arrangements. Currently, salaried positions at community health centres or corporate providers are the only options available for this type of work in general practice – but neither really provide a private practice model in a team setting.

According to the AMWAC report, for example, GPs are more team-focused than previously – a trend which is likely to continue into the future. Increasingly, GPs are working in group practices and as members of primary care teams –

[30] AMWAC, *The General Practice Workforce in Australia.*
[31] J. Charles, H. Britt and L. Valenti, 'The evolution of the general practice workforce in Australia, 1991–2003', *Medical Journal of Australia,* 181 (2), 2004.
[32] AMWAC, *The General Practice Workforce in Australia.*
[33] AMWAC, *The General Practice Workforce in Australia.*
[34] AMWAC, *The General Practice Workforce in Australia.*
[35] J. Charles, H. Britt and L. Valenti, 'The evolution of the general practice workforce in Australia, 1991–2003'.
[36] AMWAC, *The General Practice Workforce in Australia.*
[37] C.M. Joyce and J.J. McNeil, 'Fewer medical graduates are choosing general practice: a comparison of four cohorts, 1980–1995', *Medical Journal of Australia,* 185 (2), 2006.

for instance, with practice nurses and a host of allied health professionals, including diabetes educators, podiatrists, physiotherapists and social workers.

For some time the Australian Medical Association has called for better links between general practitioners and other allied health professionals.[38]

As noted above, practice ownership has become much less attractive than previously. According to AMWAC, GPs are put off by the increasing complexity of owning a practice – for example, by the red tape, OH&S regulations and other requirements of running a small business. Many GPs surveyed for the AMWAC report said that they had not 'trained in medicine to become an accountant'.

Rather, GPs want to work in environments where time with their patients is maximised. Increasingly, they also want employment arrangements which don't tie them to a particular practice in a particular location for life.

And even for those that do want to commit to working in a particular area, many GPs want more flexible working arrangements than working in small general practices allows. AMWAC notes that female GPs work approximately 70 per cent of the hours worked by their male colleagues, but that there is also an increasing tendency for male GPs to also reduce the average hours they work per week (in keeping with the demand for a better work-life balance).

Training the general practice workforce of the future

To ensure the sustainability of general practice into the future, there is a need to ensure that general practice is an attractive career proposition for the large crop of new doctors who will be graduating from our medical schools over the next few years.

This requires ensuring, as far as possible, general practices are places where young or newly graduating doctors want to work. It also requires ensuring that doctors are exposed to general practice settings as early as possible in their training. The available evidence suggests that when this occurs, and when the training experience is positive, doctors will be more likely to return to general practice as a career.

Similarly, the available evidence suggests that students who experience positive placements in rural areas are more likely to practice in rural areas. This will be particularly so if practice arrangements are sufficiently flexible – for example, to enable easy buy in and out for young doctors who may not want to buy into a small practice for their whole career.

According to the Australian Medical Students Association (AMSA), one of the most effective educational models in primary care is 'supervised autonomy', where students have their own rooms and resources but work under the supervision of a qualified clinician.[39] But general practices often need infrastructure and other support to be able to accommodate students in this way – for example, in the form of capital to build extra rooms and consulting space.

At the same time as we need to be ensuring general practice is an attractive career proposition for medical students, it is also the case that, given the large crop of medical students that will be going through and graduating from our

[38] AMA General Practice Key Health Strategy Proposal, December 2002.
[39] Australian Medical Students Association, *Medical Education in General Practice: A Way Forward,* Media release, 17 July 2007.

universities over the next few years (the medical student population will more than double over the next five or so years), ensuring good quality clinical training for our doctors – at both undergraduate and pre-vocational levels – will not be possible if we continue to rely on public hospitals alone.

Without adequate health and medical infrastructure in rural and regional areas, there is little hope of enticing desperately needed doctors, nurses and other health professionals to small rural and regional communities.

The primary care system of the future

As Labor has already made clear, we believe the best way to equip the health system of the future to deal with the key challenge of the growing burden of chronic disease is to re-invigorate the role of the primary care system.

A new approach to frontline care should be focused on building on the strengths of the current primary care system, while addressing its problems and ensuring we are able to successfully meet the health challenges of the future.[40]

There is now international evidence to demonstrate that health systems focused on primary care and preventative health care achieve better health outcomes, including lower death rates from chronic diseases like heart disease and cancer, and lower overall cost than health systems which are focused on acute hospital care.[41]

This is because systems oriented towards primary care are likely to be better equipped to manage chronic disease, provide better continuity of care and tend to provide a greater population health focus, greater accessibility for patients, and a greater patient focus.[42]

Given the international evidence, it would seem that Australia is poorly served by having no national strategy for primary health care and no comprehensive approach to more effectively harnessing the benefits primary care could provide for prevention and better management of chronic disease.

A more holistic model of primary care would include a greater focus on health promotion and illness prevention, and better coordination between privately-provided GP services, and community health services run by the states and territories.

The health system of the future needs to focus on:

- providing more health services in the one place, to ensure greater convenience for patients in their local communities and more support to keep people healthy;
- improving access to health services for working families;
- providing a focus for integrated health care teams to come together in the one place and provide better services to patients outside hospitals; and
- getting doctors and health professionals into the communities where we need them.

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[40] J. Doggett, *A New Approach to Primary Care for Australia,* Centre for Policy Development, June 2007.
[41] J. Doggett, *A New Approach to Primary Care for Australia*.
[42] J. Doggett, *A New Approach to Primary Care for Australia*.

As part of this challenge, there is also a need to ensure that general practice remains an attractive career path for newly graduating doctors and other health professionals.

Greater investment in primary care services in the community will also help take the pressure off public hospitals. We know that 500,000 hospital admissions each year are for conditions that would be better managed in the community.

Reforming the health system to meet these challenges of the future requires national leadership. This requires, for example, overcoming the tendency to see the growing problem of hospital demand as a problem only for the states and territories.

This is why Labor has committed to making the next Australian Health Care Agreements *Preventative Health Care Partnerships* with the states and territories.

A Rudd Labor Government will provide the kind of leadership that is required to equip the health system for the future.

Labor's *GP Super Clinics*

A Rudd Labor Government will re-invigorate the primary care system to deal with the challenges of the future by investing $220 million to establish *GP Super Clinics* in areas of need.

Labor's *GP Super Clinics* will provide a new way of delivering the next generation of frontline primary health care services to the community.

They will deliver a solution to important long-term challenges facing Australia's health system:

- our ageing population
- the explosion of chronic diseases like diabetes and obesity
- growing pressure on hospitals
- time poor families who need easier access to health care in their local communities
- getting doctors into the communities where they are needed.

Labor will provide capital funding for the establishment of *GP Super Clinics* around the country, in areas where access to primary health care services is poor and need is high.

Labor's *GP Super Clinics* will provide the infrastructure for GPs and other health professionals and services to come together in the one space – to facilitate multi-disciplinary team work and provide a greater focus on chronic disease prevention and management.

Labor's *GP Super Clinics* will provide space and training facilities for medical students and trainees.

And Labor's *GP Super Clinics* will provide greater convenience and better access to services for patients.

What services will Labor's *GP Super Clinics* include?

Labor's *GP Super Clinics* will be health centres incorporating privately practising GPs and a range of other health service providers and services.

They will be tailored to the needs of local communities, and a centre could include some of the following characteristics:

- a group of five or more privately practising GPs;
- after hours care, with a link in to the relevant state or territory health call centre help line;
- facilities for regular services provided by other allied health professionals, including physiotherapists, dieticians, podiatrists and specialist care for seniors;
- a psychologist and relevant mental health support programs including drug and alcohol counselling;
- consulting rooms for visiting medical specialists;
- on site practice nurses to provide vaccinations, assist with preventative tasks and health screening, take pathology samples and under take other nursing tasks;
- facilities for running regular chronic disease management programs and community education (including diabetes, obesity, asthma and smoking cessation programs); and
- clinical training facilities for medical students, prevocational doctors and GP registrars.

Some clinics may include diagnostic services (x-ray and pathology). Ideally, a pharmacy would also be located on site or nearby.

In rural areas the clinics could provide a base for tele-health services to improve access to specialist services not available locally.

Labor will work with the states and territories to identify areas most in need of services, as well as areas which would benefit from co-location of state-government funded services, such as:

- ante-natal and post-natal clinics;
- public dental clinics;
- hospital outpatient services, such as day procedure and surgery facilities, cancer services, including chemotherapy, and renal dialysis;
- community care services like HACC;
- screening and prevention programs such as Breastscreen; and
- hospital in the home services.

The exact configuration of services will depend on the needs of the local community. Local involvement from health professionals through to councils and area consultative committees will be encouraged. They will respond to community based solutions for better service delivery.

Labor's initiative means that funds will be available for local solutions that tackle a range of identified community health service needs.

In providing a space for a range of health professionals to come together, the Clinics would provide patients with an integrated primary health service and help families get more of the help they need, in the one place, when they need it.

People will still be able to choose their own doctor: *GP Super Clinics* will not be an equivalent to the UK's NHS that requires patients to enrol at a clinic.

Where will Labor's *GP Super Clinics* be located?

The factors that will be taken into account in deciding where clinics will be located will include:

- areas where there is currently poor access to services, in particular doctor shortages and subsequent under-utilisation of Medicare services, including low Safety Net benefits
- areas where there is currently poor health infrastructure
- areas where a *GP Preventative Health Clinic* could help take the pressure off local public hospital services
- areas with high levels of chronic disease and/or demographics with high needs, such as large numbers of children or elderly.

These criteria mean the Clinics are most likely to be located in regional towns and outer metropolitan areas – which are currently poorly served, particularly by Commonwealth funded services.

Some *GP Super Clinics* could provide outreach services, for example to smaller, nearby areas not large enough to be the base for a Clinic in their own right.

Who will run *GP Super Clinics?*

Once areas for the location of *GP Super Clinics* have been identified, tenders to build and run the services will be offered.

The tender process will be open to local consortiums, including local councils, existing practices looking to amalgamate, health professionals and Divisions of General Practice.

Tenderers will be required to seek input from local health professionals and the local community, such as from local councils and health consumers.

Ensuring community and consumer input in the design and management of *GP Super Clinics* will ensure the services remain responsive to community needs and priorities.

What funding will be provided?

Capital funding will be provided for each *GP Super Clinic,* depending on the needs of the local community and whether the particular clinic is being purpose-built or an existing facility upgraded. In most cases it is expected that funding provided will be between $1 million and $10 million, however, in some cases up to $25 million in funding will be considered depending on need.

Significantly smaller amounts will be considered for projects that meet some of the identified health needs of communities – such as practice upgrades to provide training facilities, estimated by the National Rural Faculty of the Royal Australian College of General Practitioners, to cost around $50,000 in most cases.

Additionally, small recurrent funding streams will be provided to each *GP Super Clinic* to assist with the costs of administrative support such as providing

central billing, shared health records, and practice managers. Recurrent funding could also be used to employ practice nurses.

The recurrent support packages will be tailored to the needs of each individual *GP Super Clinic* and will be in addition to all existing incentive programs.

Doctors will be eligible for incentives of up to $15,000 to re-locate to a *GP Super Clinic,* in addition to incentives available under existing programs including:

- the More Doctors for Outer Metro Areas program, which provides relocation incentive grants of up to $40 000
- the HECS Reimbursement Scheme, which provides HECS remissions for doctors working in rural, remote and some regional areas
- the Training for Rural and Remote Procedural General Practitioners Program, which provides up to $26 000 per financial year for training in procedural and emergency medicine under
- the Practice Incentives Program, which includes rural loadings to some rural practices and funding of up to $40 000 per year to employ a practice nurse or allied health worker (depending on location and practice size).

Under Labor's policy, allied health professionals will also be eligible for re-location incentives.

GP Super Clinics will not act as fundholders for MBS or PBS funding – consumers will retain their current access to these programs. In fact, by locating clinics in areas which are currently poorly serviced, access to these services will be enhanced for those communities currently missing out.

Existing bulk-billing incentives will be in place and providers in *GP Super Clinics* will be encouraged to bulk bill. Tenderers who propose to provide bulk-billed services will be preferred.

How Labor's *GP Preventative Health Clinics* will help families

Labor's *GP Super Clinics* will make health care more accessible and more convenient for individuals and families, by providing local health services together in the one place assisting busy, time-poor families – particularly in regional areas and fast growing outer suburbs that tend to be under serviced by health professionals.

Labor's *GP Super Clinics* will improve chronic disease prevention and management, helping to keep people healthy and stabilise health conditions that require multidisciplinary care. .

Labor's *GP Super Clinics* will also help attract doctors, specialist and health professionals to communities where they are needed most – particularly assisting families in rural and regional Australia who want high quality health services where they live (and their children to be able to train and work in the region).

Case Study 1

James has just been diagnosed with depression and mild schizophrenia. James lives in regional New South Wales and would usually have to travel to Sydney to get the specialist mental health services he needs.

However, with a *GP Super Clinic* nearby James travel time is drastically reduced. His GP and the team at the Clinic (including a psychologist) manage his care on a week to

week basis and every month a psychiatrist from Sydney visits the Clinic and checks on James' progress along with other patients at the Clinic.

A tele-conference link at the Clinic allows for remote consultations if they are needed between monthly visits.

James is able to have all the treatment he needs for his condition close to home. He will not have the inconvenience or expense of travelling to Sydney. This helps him to manage his condition much more easily than he otherwise would be able to.

Case Study 2

Jenny and Nathan's 5 year old daughter Ruby has a health check up with a school nurse when she starts school, as part of Labor's *Healthy Kids Check* policy.

The school nurse notices that Ruby has some breathing difficulties. She suggests Jenny and Nathan take Ruby to her GP for a follow-up appointment.

Jenny and Nathan take Ruby to see their GP, who is located at their local *GP Super Clinic.* The GP diagnoses Ruby with a mild case of asthma. The GP prescribes Ventolin, but also suggests Jenny and Nathan attend one of the asthma information sessions conducted regularly at the *GP Super Clinic*.

There Jenny and Nathan learn more about Ruby's asthma, the factors that can set it off, and the ways they can help Ruby manage her asthma so she is less reliant on her medication, but also less likely to end up back at the doctor's or worse, in hospital with an asthma attack.

Case Study 3

Maria has been feeling tired and run-down for months and goes to see the GP at her local *GP Super Clinic*. She runs some tests and discovers Maria's blood sugar levels are higher than normal – she is diagnosed as being pre-diabetic.

Maria doesn't think she can do much to prevent getting diabetes but is persuaded by the doctor to see the dietician while she is there at the *GP Super Clinic.* Because it is all at the one place, Maria agrees to sign up to a diabetes prevention program run through the Clinic.

Maria did not know before she started the diabetes prevention program that being overweight could increase her risk of diabetes. She also hadn't realised until her sessions with the dietician that some of the foods she was eating regularly were making her put on weight.

After six months of attending the diabetes prevention program and a few one-on-one sessions with the Clinic dietician, Maria has lost a little weight, her blood sugar levels at back at normal levels, and she feels great.

Case Study 4

Dr Lana Jennings has just completed her two year internship at a regional hospital.

Dr Jennings wants to become a GP and practice in a rural or regional area, but doesn't want to buy into a small rural practice she may not be able sell later on if she decides she doesn't want to stay in the one place for her entire career.

Dr Jennings decides to take up a rural GP training place with Regional Training Provider. The training place is based in a *GP Super Clinic,* which is ideal for Dr Jennings.

Training in the GP Super Clinic exposes Dr Jennings to the experience of working in a multi-disciplinary team which she would not get at many other private practices. She discovers she loves working in a rural setting and stays for many years.

She enjoys the flexibility of the structure of the practice which allows her to work elsewhere for a short period or take time out for children without losing an investment in a solo practice like some of her colleagues.

A national approach to primary care

As part of our *National Health Reform Plan*, a Rudd Labor Government will ask the *National Health and Hospitals Reform Commission*, to be established within 100 days of taking office, to identify strategies to better integrate primary care and other health services.

As noted above, in addition to Medicare-funded GP services, state-government run community health centres provide a range of primary health services – such as child and maternal health services and health screening.

But a lack of integration between these prevention and screening services and treatment services means that people often fall through the cracks.

Poor integration between Commonwealth-funded primary care services and state and territory-government funded services – both community health services and hospitals – is one of the key areas of inefficiency and duplication in the current system.

A Rudd Labor Government will also seek to identify ways of consolidating and better integrating existing state-government run community health services and Commonwealth-funded GP services

This process will not involve cutting funding to existing state programs, or altering existing Medicare fee-for-service arrangements.