Primary care reform
View from Australia

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Australia and Canada have much in common: remote locations, harsh landscapes, urban consolidation, and sparse rural populations. Both nations view family practice as being fundamental to good primary health care. Although both have been embarking on policies of primary care reform, the reform processes have had substantially different philosophies, structures, and outcomes.

Canadians are proud of their health system. Yet in recent years, the system's universality, comprehensiveness, and accessibility have been shaken by the effects of increasing medical technology, contraction of the hospital sector, an aging population, and widespread physician shortages. All have contributed to a situation where access to care is becoming difficult, health services fragmented, and health care workers increasingly demoralized.[1]

In response, there has been no shortage of proposals for reform, particularly in the area of primary care. Government,[2] medical organizations,[3,4] and health advocacy groups[4,5] have tackled the issue. Most, if not all, have focused on restructuring the organization and reimbursement of family practitioners.[1] Many reform models specify patient rostering and large investments in information technology. With general support from the profession, pilot projects have begun in many provinces to test another common theme: primary care networks (PCNs). These "real or virtual" family practitioner groups are designed to deliver 24-hour primary care to enrolled patients.[6]

Despite two decades of endeavour, no province has implemented meaningful reform.[1] In the same period, Australia has revolutionized the organization and delivery of general practice care.[7] At this time of uncertainty in Canadian family medicine, perhaps something can be learned from the Australian experience.

Australian health system

Since 1974, Australians have had access to universal, taxpayer-funded basic health insurance. This compulsory federal scheme (now called Medicare) underwrites physician fees and provides free public hospital care. Two fifths of the population purchase additional health insurance to cover in-patient care in one of the nation's many private hospitals.

Australian general practitioners (GPs) are gatekeepers for specialist care and deliver most primary clinical services. Although permitted to set their own fees, 40% of GPs choose to directly invoice the government for all clinical services, a process known as "bulk billing."[7] The government returns a predetermined rebate (commensurate with the bulk-billed fee) to patients who have been issued private accounts.

Despite the central role of Australian GPs, the late 1980s saw deep concerns being expressed about their professional role. Isolated from other parts of the health care system, GPs had minimal input into health decision making, a poor academic base, and inconsistent training.[8] Medicare's fee structure encouraged rapid consultations and provided minimal incentives for preventive activities, home visits, or after-hours care.[9] The rural GP work force was decreasing, and many practitioners were withdrawing from hospital and obstetric care.[8]

Australian GP strategy

Major changes followed a 1991 consensus agreement between the Federal Government, the Royal Australian College of General Practitioners (RACGP), and the Australian Medical Association. The resulting "General Practice Strategy" was designed to improve the integration, quality, and comprehensiveness of GP care. General practitioners were given an opportunity to have a stake in the design and implementation of health policy. The strategy included specific initiatives to improve rural and indigenous health and to strengthen the research capacity of primary care. Other reforms have occurred in parallel (**Table 1**).

The most visible sign of reform has been formation of 123 "Divisions of General Practice."

These geographically based organizations represent networks of approximately 150 GPs (range from 12 to 800). The Federal Government provides infrastructure funding to enable divisions to engage in cooperative activities to address health needs at the local level.[10] Divisions are managed by boards elected by local GPs. Standards of reporting were set relatively low at the outset but have steadily increased with time and are now linked with national health priorities and demonstrable health outcomes.[8]

The GP strategy is underpinned by a philosophy of quality improvement for both practitioners and practice. Private general practices are eligible for

Table 1. Australian general practice initiatives, 1989-2000

		OUTCOME	
OBJECTIVE	STRATEGY	LOCAL	SYSTEMIC
Integrate general practice with health system	Divisions of General Practice	Organized links between GPs and local hospitals and community health services	GP-based strategies developed to meet national health goals and targets
		Local public health initiatives using existing GP networks	Change in system from hospital pre-eminence to a better balance with community services
	Primary health care reforms	Patient-based funding of GPs for participation in case-based activities involving other health care providers	National primary health care resource webpage
Improve quality of clinical practice	Vocational registration	Commitment to continuing medical education and practice audit	Improved quality of primary medical services
		Setting qualifications for entry into unsupervised practice	
	Practice incentive payments	Commitment to after-hours service provision • Targeted incentives, eg, immunization rates • Embracing information technology • Rewarding commitment to rural practice • Recognizing medical education commitments	
	Voluntary practice accreditation	Profession-based accreditation process, unrelated to official funds at present	
Redistribute work force	Rural incentives program	Retraining and relocating urban GPs to rural practice	Long-term strategies to attract the right number of appropriately skilled physicians to rural areas
	Rural education program	Medical schools funded to provide rural immersion	
		Rural student clubs funded	
		Student scholarships for repeated immersion in one district	
Improve academic base	General Practice Evaluation Program	Increased GP presence and influence in medical schools	Increased research output
		Development of critical mass of GP academics	Evidence base for strategic decisions relating to general practice
		Improved academic standing of general practice within university	GP input into national strategic decision making
		Improved professional self-esteem	
		Potential for improved evaluation of community- based programs	

blended payments designed to complement traditional fee-for-service income. These "practice incentive payments" reward comprehensive after-hours care, rural practice, teaching medical students, and practice computerization. More recently, the Federal Government has initiated a scheme that pays GPs to provide comprehensive health assessments to elderly and aboriginal patients, participate in interdisciplinary case conferences, and develop multidisciplinary patient management plans.[11]

As in Canada, GPs need approved postgraduate training before registering for independent practice. Continued registration requires proof of participation in continuing medical education (CME), much of which is delivered by divisions. Rural GPs have become eligible for salary subsidies and locum tenens relief, and many are funded to participate in CME. Substantial incentives have become available for urban GPs to retrain before they relocate to rural areas.

The academic base of the discipline has been strengthened in several ways. Government funding of peer-reviewed research and evaluation projects has helped define and articulate the discipline of Australian general practice.[12] University departments have been funded to develop Masters programs in family practice and public health, and numerous doctorate and Masters scholarships have been awarded to junior GP academics.

Outcomes

The GP strategy has had a substantial effect. After years of exclusion, GPs have been invited back into metropolitan teaching hospitals. Funded hospital liaison positions for GPs have improved communication between the hospital and the community. Hospitals have joined GPs in many shared-care initiatives in areas ranging from after-hours access to medical care to care for mentally ill patients. The initiatives have improved continuity of care and convenience and have reduced patient anxiety and postdischarge complications. General practitioners have benefited from a greater sense of involvement, while hospitals have identified improved efficiency and increased capacity.[13]

The strategy has heralded a substantial increase in use of information technology (IT) in general practice. Individual practices received considerable one-time payments in 1998 for becoming computerized. Most divisions facilitate IT consultancy and bulk purchasing services.[10] Among practices receiving incentive payments, 76% use computerized prescribing, and 86% can transfer health data electronically.[14] Coordinated GP-based strategies have helped lift national immunization rates to 92%.[15]

The effect of the Australian GP strategy has been facilitated by circumstance. Unlike Canada, the Federal Government is free to design and implement health policy. Australia's medical work force is plentiful and is not tempted to migrate to a large affluent neighbour. However, several federal policy decisions have also worked against the aims of the original GP strategy. In particular, government limitations on postgraduate training places have exacerbated real GP shortages in less populated regional and urban areas. The internationally respected RACGP postgraduate training program has been dismantled. In its place local consortia will place tenders for educational services from external training providers. Although more than 85% of GPs have joined divisions,[16] considerable resentment has been expressed that the strategy was "funded" through savings resulting from freezing GP Medicare rebates in the early 1990s. Despite quality-linked payments, steady increases in practice and medical indemnity costs and decreasing use of procedures[7] have led to concerns about practice viability.[17] As in other Western countries,[18] dissatisfaction and psychological disability have been increasingly recognized among GPs.[19] While the pace of change is a likely contributor, many divisions have implemented strategies to improve practitioners' health and well-being.[20]

Lessons

The most striking difference between the Australian GP strategy and the published proposals for Canadian primary care reform (apart from degree of progress) is that Australia has nurtured rather than imposed change at the practice level. By contrast, nearly all of the Canadian proposals require family doctors to radically change the style, structure, and financial basis of their practices. Recent proposals strongly advocate that each PCN be staffed by physicians, nurse practitioners, and a range of allied health workers. Many have advocated local fund-holding and the phasing out of fee-for-service payments for family physicians. Patients will be formally enrolled in these fundamentally different practice structures. While we admire the Canadian propensity to subsume individual needs for the greater good, we wonder whether the pedestrian pace of change indicates how the community and their family doctors have taken to such proposals.

Australia's conservatism at the practice level contrasts with a much more radical approach to health service integration. The divisions have

provided common ground for different parts of the health care system to cooperate, interact, and plan for the future. This is facilitated at all levels: from local populations (where four fifths of divisions have formal community liaison structures), to hospitals, allied health organizations, and state and federal governments.

These initiatives have strengthened the role of general practice within the wider health system. Primary medical care has become more community based, has a preventive focus, and yet retains the continuity, comprehensiveness, and patient orientation of traditional general practice.

Although integration is acknowledged in many Canadian primary care reform proposals,[3] its evolution seems to depend on serendipity rather than structure, commitment, and funding. It seems more than likely that "real or virtual" PCNs would be far too preoccupied with the managerial challenges of these new workplaces to be able to cooperate effectively with the community or wider health system. These roles might default to the College of Family Physicians of Canada, provincial medical associations, or university departments of family medicine. Despite the best of intentions, these bodies have neither the capacity, the perspective, nor the mandate to fulfil such tasks.

Integration does not come with a computer network. It does not come when family doctors are "provided" with nurse practitioners. It comes when separate organizations can work together on problems that they are unable to address effectively on their own.[21] It requires planning, nurturing, and time. The Canadian proposals to radically alter traditional family practice without true health system integration are likely to sell family practice short. Indeed, any opportunity for wider systemic reform has been substantially delayed or has even disappeared while the finer details of practice-based reform are endlessly argued.

Australia has discovered that a broad, pragmatic strategy can reward and reinvigorate general practice. Canada's preoccupation with radical, practice-based reform risks dismantling a service that has been a defining aspect of the Canadian health system. It would be sad to see our family practitioner colleagues linked by computer, covering call 24 hours a day, but watching impotently as the rest of the health system passes them by.

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References

1. Rosser W, Kasperski J. Organizing primary care for an integrated system. *Healthcare Papers* 1999;1(1):5-21.
2. Barer ML, Stoddart GL. *Toward integrated medical resource policies for Canada.* Report prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health. Ottawa, Ont: Health Canada; 1991.
3. College of Family Physicians of Canada. *Primary care and family medicine in Canada. A prescription for renewal* [position paper]. Mississauga, Ont: College of Family Physicians of Canada; 2000. p. 1-32.
4. College of Family Physicians of Canada. *Profile of family practice in Ontario.* In press 2001.
5. Rachlis M, Evans RG, Lewis P, Barer ML. *Revitalizing Medicare: shared problems, public solutions.* Toronto, Ont: The Tommy Douglas Research Institute; 2001. Available at: www.tommydouglas.ca. Accessed 2002 Feb 1.
6. Government of Ontario. *Harris launches the Ontario Family Health Network* [press release]. Toronto, Ont: Government of Ontario; March 21, 2001.
7. The General Practice Strategy Review Group. *General practice. Changing the future through partnerships.* Canberra, Australia: Commonwealth of Australia, Department of Health and Family Services; 1998.
8. General Practice Branch, Commonwealth Department of Health and Family Services. *General practice in Australia: 1996.* Canberra, Australia: Commonwealth of Australia; 1996.
9. National Health Strategy. *The future of general practice.* (Issue paper No. 3). Canberra, Aust: Australian Government Publishing Service; 1992.
10. Magarey A, Rogers W, Veale B, Weller D, Sibthorpe B. *Dynamic divisions. A report of the 1997-98 Annual Survey of Divisions.* Canberra, Australia: Commonwealth Department of Health and Aged Care; National Information Service; 1999.
11. Commonwealth Department of Health and Aged Care and the National Information Service. *Primary care initiatives: enhanced primary care package.* Adelaide, Aust: Flinders University of South Australia; updated 2000 Nov 10. Available from: http://www.health.gov.au/hsdd/primcare/enhancpr/enhancpr.htm. Accessed 2001 Aug 13.
12. National Information Service of The General Practice Evaluation Program. *Decade of GPEP projects. 1990-1999.* Adelaide, Aust: National Information Service. Department of General Practice, Flinders Medical Centre; 2000.
13. Lloyd J, Powell-Davies P, Harris MF. Integration between GPs and hospitals: lessons from a division-hospital programme. *Aust Health Rev* 2000;23:434-41.
14. Health Insurance Commission. *Practice incentives program: participation statistics.* Canberra, Aust: Commmonwealth of Australia. updated 2001 Nov 23. Available from: http://ww.hic.gov.au/CA2568D90003F3Af/page/PIP-Statistics-participation?OpenDocument&1=45-PIP~&2=53-Statistics~&3=15-participation~. Accessed 2001 Aug 13.
15. Health Insurance Commission. *Australian childhood immunisation register: coverage.* Canberra, Aust: Commmonwealth of Australia; updated 2002 Jan 18. Available from: http://www1.hic.gov.au/general/acircirgtb04. Accessed 2001 Aug 13.
16. Australian Divisions of General Practice. *Annual report 1999-2000.* Canberra, Aust: Australian Divisions of General Practice; 2000. p. 30.
17. The Royal Australian College of General Practitioners. Wirthlin Worldwide Australasia (Sydney). *State of general practice.* South Melbourne, Aust: Royal Australian College of General Practitioners; 2001; updated 2001 Sept 4. Available from http://www.racgp.org.au/document.asp?id=1814. Accessed 2001 Aug 3.
18. Appleton K, House A, Dowell A. A survey of job satisfaction, sources of stress and psychological symptoms among general practitioners in Leeds. *Br J Gen Pract* 1998;48(428):1059-63.
19. Schattner PL, Coman GJ. The stress of metropolitan general practice. *Med J Aust* 1998;169(3):133-7.
20. Primary Health Care Research and Information Service. *Activities of divisions database.* Adelaide, Aust: Primary Health Care Research and Information Service; updated 2002 Jan 14. Available from: http://som.flinders.edu.au/FUSA/GPNIS/Nisdb/Contents/DIVLIST.HTM#state. Accessed 2002 Jan 31.
21. Gray B. Conditions facilitating inter-organisational collaboration. *Hum Relations* 1985;38(10):911-36.