phn MURRAY

An Australian Government Initiative

MURRAY HEALTH REPORT

THE IMPORTANCE OF PRIMARY HEALTHCARE

NOVEMBER 2023

Acknowledgement of Country

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us. We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listen to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

OUR COMMITMENT TO BEING AN ANTI-RACIST COMPANY

We aspire to be an anti-racist organisation, embedding cultural humility as a daily practice, to improve health outcomes and health equity in our communities. We recognise cultural humility as a life-long commitment to self-reflection, personal growth and redressing power imbalances in our society.

Message from our CEO

The evidence is clear – a strong primary healthcare system helps keep people healthier and well supported in their communities. And by catching health issues early, primary health practitioners can help people prevent or manage more serious diseases that could result in avoidable hospitalisations.

Even better, the cost to the taxpayer and the community is much lower when illness and disease are managed at a primary level, rather than in the acute hospital system.

But our health needs have changed in the 50 years since our Medicare system was born. Fifty years ago, the average general practice saw a very different cohort of patients, with a different range of injuries and diseases to treat, maybe four or five times a year.

Health problems such as heart or lung disease, or diabetes, were often very life-limiting. Today, with advances in medical care, people are living much longer with chronic diseases and often maintaining a good quality of life.

But the care needs of older Australians can be more complex and their reliance on primary care to stay well has meant that the original Medicare system is no longer fit-for-purpose.

Many people now need longer and more frequent consultations, which is why the introduction of MyMedicare goes part of the way to providing appropriate payments to general practice and other primary healthcare practitioners helping to keep us well.

Despite its importance to all Australians, many of our communities are experiencing a decreasing primary healthcare capacity and people are getting sicker. Without a strong primary health system, the burden of chronic disease and illness is being disproportionately carried by the acute sector.

MyMedicare is one element of the Strengthening Medicare reforms being introduced by the Commonwealth, which will be supported across Australia by Primary Health Networks (PHN).

PHNs play a critical role in addressing gaps, driving innovation and coordinating chronic disease and complex care across Australia's health system. We have always worked to build the capacity of primary care practices and mental health providers, and to help them adopt new models of care and best practice approaches.

Our work also incorporates the development of workforce, as there is a critical need for more good doctors and the most efficient system possible. In this Murray Health Report, you will find more information on our work supporting the existing workforce and innovative solutions to increasing primary healthcare workforce, particularly in rural and regional areas like ours.

We hope we have also given you additional insights on primary healthcare and the makeup and value of general practice - particularly those general practitioners who have made their homes in the communities where you have made yours.

In reality, the term "general" practice is misleading. Our general practitioners are highly skilled specialist generalists – rather than specialising in one body system, they know a great deal about most physical and mental issues.

Please enjoy this report and if you have any comments or questions after reading it, we welcome your thoughts via email to communications@murrayphn.org.au

Matt Jones
Chief Executive Officer

MURRAY HEALTH REPORT

INSIDE:

Each year, PHNs assess the health needs of their communities, to understand primary health priorities in our regions. We work with local providers to commission primary healthcare services to meet these needs, with the shared aim that people in our communities can get the help they need, where and when they need it.

As part of our role, we also link with regional health services and national agencies to build workforce capacity and capability, advocating for resources and encouraging the best and most efficient use of existing primary healthcare clinicians.

We work to develop locally relevant models of care and workforce solutions, piloting locally led programs to find new and innovative ways of supporting our regional communities

The Murray Health Report is published each year to provide information to our communities on what we know to be the health priorities that matter most. Previous editions have focussed on healthy ageing, workforce and mental health. In this edition, we look at the vital role of primary healthcare in our region; the importance of our general practice and allied health clinicians, and how the future of primary healthcare is increasingly one of shared, multidisciplinary care.

The National Skills Commission's 2022 Skills Priority List identified significant key health professional shortages and predicted this would continue at least over the next five years. Registered nurses, general practitioners and specialists are all in particularly high demand.

If you have a young person in your life considering studies in health, this Murray Health Report may provide some background on primary healthcare, which can offer rewarding and sustainable careers, close to where people live.

The importance of primary healthcare

The World Health Organisation (WHO) describes primary healthcare as a whole-of-society approach to organise and strengthen national health systems to bring services for health and wellbeing closer to communities.

WHO says primary healthcare enables health systems to support an individual's health needs, "from health promotion to disease prevention, treatment, rehabilitation, palliative care and more", centred on people's needs and respecting their preferences.

"Primary healthcare is widely regarded as the most inclusive, equitable and cost-effective way to achieve universal health coverage. It is also key to strengthening the resilience of health systems to prepare for, respond to and recover from shocks and crises."

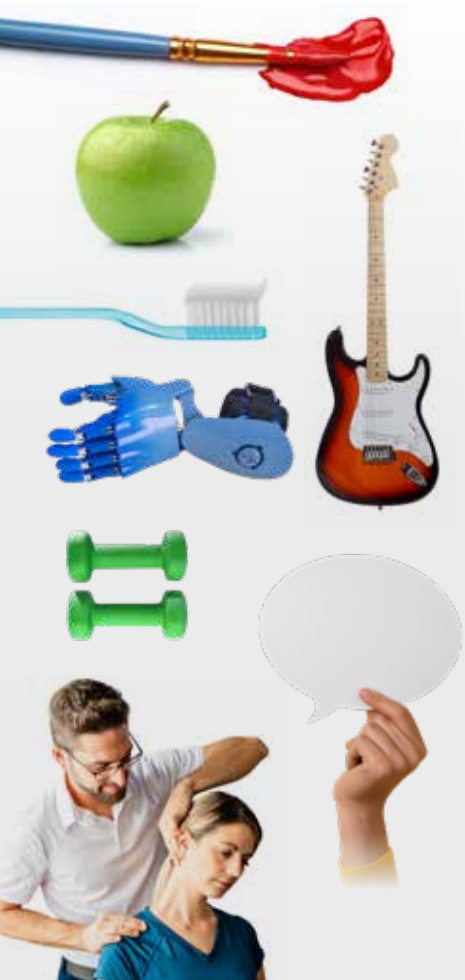
According to the Australian Institute of Health and Welfare (AIHW), primary healthcare is the entry level to the health system and, as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention, to treatment and management of acute and chronic conditions. It generally sits outside the acute hospital system and is delivered in settings such as general practices, community health centres, allied health practices, and also via telehealth consultations, either by phone or video.

AIHW statistics show there were around 270 million Medicare-subsidised primary healthcare services provided in Australia in 2021-22.

As a general practitioner (GP) is usually the first point of contact most people have with the Australian health system, it is not surprising that there were 189 million GP attendances, along with 25 million allied health attendances delivered by practitioners who include psychologists, optometrists, podiatrists and physiotherapists.

Allied health describes a wide range of professions who work alongside other health professionals, such as GPs and nurses, to provide supportive care and therapy that centres on an individual. Allied health professionals are qualified to support and enable the diagnosis of health conditions and provide a variety of services (or "interventions") that can benefit the physical, social and mental wellbeing of people in our community.

In Victoria, allied health incorporates 27 professions and more than 42,500 practitioners, according to the state Department of Health. The department classifies allied health into two broad categories – therapy and science.



Allied health professions

Therapy disciplines	Science disciplines
Art therapy	Audiology
Chiropractic	Biomedical science
Dietetics	Diagnostic imaging medical physics
Exercise physiology	Medical laboratory science
Music therapy	Nuclear medicine
Occupational therapy	Optometry
Oral health (not dentistry)	Orthoptics
Osteopathy	Pharmacy
Orthotics and prosthetics	Radiation oncology medical physics
Physiotherapy	Radiation therapy
Podiatry	Radiography
Psychology	Sonography
Social work	
Speech therapy	
Allied health assistant	

General practice and allied health services are vital to keep people in our community healthy and well.

In 2021-22, 90 per cent of Australians received at least one Medicare-subsidised general practice service, with 37 per cent receiving at least one Medicare-subsidised allied health service. Females were more likely to see a GP than males, and the highest number of services was for those aged 80 or above.

In that year, $17 billion was paid in Medicare benefits for primary care services, including GP, allied health and other primary care attendances.

In the same time period, one in four people delayed seeing a GP for reasons such as service availability or waiting time for an appointment. Almost as many felt they waited longer than acceptable for a GP appointment. Of most concern, almost five per cent of people in rural and regional areas with a long-term health condition delayed or did not see their GP because of cost – a figure that has almost doubled in recent times.

Until the recent Strengthening Medicare changes, our 50-year-old Medicare system was geared predominantly around illness and injury, although our community's needs had changed over that time. People are now living with diabetes, heart and lung disease for much longer than they were half a century ago. The Strengthening Medicare reforms, including increased bulk billing incentives, general practice grants and the voluntary MyMedicare patient registration program, are aimed at improving the Medicare system to ensure it meets universal healthcare goals.

Despite the importance of primary healthcare, there is currently limited public data available for planning and evaluating services for communities. Much of the available information about primary healthcare comes from Medicare data and the ABS Patient Experience Survey, but the AIHW is now working towards improved standardisation, collection and analysis of primary healthcare data.

Australia's 31 PHNs, including Murray PHN, are also playing an important role in both quality improvement and data capture, providing de-identified data from general practice in their regions, across 10 quality improvement measures. The measures are included in the two-year-old Practice Incentives Program Quality Improvement (PIPQI) program.

Further information on other Commonwealth action areas for primary care can be found in Australia's Primary Health Care 10 year plan 2022-2032.

The benefits of delivering local primary healthcare

Around the world, it is recognised that there are many benefits of being able to access effective primary healthcare close to home.

Despite its importance to all Australians, primary healthcare capacity is decreasing across communities and people are getting sicker. Without a strong primary health system, the burden of chronic disease and illness is being disproportionately carried by the acute sector.

The primary care system was shown during the COVID -19 pandemic to be a critical part of a strong health system and local workers were even more important when COVID stopped the traditional migration of health workers to Australia, and we had to be self-reliant.

PHNs were established by the Commonwealth Government in 2015 with the key objectives of increasing the efficiency and effectiveness of primary medical services for patients, improving coordination of care so they can receive the right care, in the right place, at the right time.

In the Murray PHN region, we have major reasons for working to build a stronger primary care system. These include wanting to promote healthy ageing and First Nations self-determination, but also to maximise people's capacity to participate in life, regardless of their socio-economic status or pre-existing health conditions. We also aim to deliver services to people who live in rural and remote areas where access to health services is limited.

To deliver on strong primary care, we need strong rural health teams, consisting of a range of health workers. We know that rural communities have ageing health workforces and the next generation of health workers is more likely to seek metropolitan roles where they can manage working hours and scope of practice.

That said, there are many practitioners who consistently form the backbone of our rural healthcare system. Many have provided years of service and have an excellent knowledge base and capacity to support the next generation of rural health workers and inform local problem solving.

The new Strengthening Medicare measures will help the government to meet its universal healthcare goals. Rural and regional communities that contribute tax to support Medicare should have the same rights to access specialty care which is normally confined to the cities. This is possible by using face-to-face, telehealth and outreach service models as modes of delivery.

At Murray PHN, we work in partnership with community to explore new primary healthcare models that build scale and capacity across multiple communities; models where primary care providers are working in a combination of fee-for-service and bulk billing, but with the inclusion of allied health practitioners and services.

We need our models to be more flexible and make it more attractive for people to come and work in regional areas like ours. And we need funding flexibility so we can make that type of model work well.

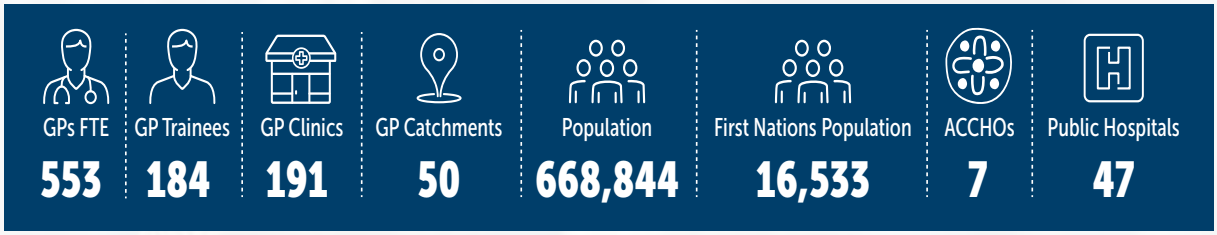
We recognise the value that can be gained when practitioners and communities work together on solutions that can help people in our rural catchment be increasingly able to enjoy health services like those available to people in our major cities.

It is vital to remember that when people whose health issues could have been dealt with at a primary healthcare level do not get the right care, in the right place and at the right time, their conditions can worsen to the point where they need specialist or acute hospital care.

According to the Victorian Department of Health, there were 1.9 million presentations to hospital emergency departments in 2022-23 – a record high, representing a 2.3 per cent increase on 2021-22 and 7.1 per cent higher than 2020-21.

With GP appointments often being hard to access and increased pressure on the system, community members in need of medical attention are forced to seek care elsewhere (hospital EDs, urgent care clinics, pharmacies, telehealth online services), or sometimes not at all, resulting in an increase of presentations at hospitals for people with potentially avoidable conditions.

Murray PHN region contains:



*Full time equivalents (FTE) ** Aboriginal Community Controlled Health Organisations (ACCHOs)

At the 2023 Primary Care Conference in Canberra, RACGP president Dr Nicole Higgins described GPs as the "cost-efficient engine room of the healthcare system."

"It costs the taxpayer $40 to see the GP for an earache, for example. If the same person presents to the ED – it is $600 for an episode of care," she said.

Dr Higgins quoted data from NSW Health that demonstrated that a relationship with a GP practice reduced risk of ED presentations and unplanned hospital admissions. Importantly, a visit to the GP within two days of a hospital admission was followed by 32 per cent fewer readmissions within the first week.

"A cost benefit analysis indicated that there was $1.60 in healthcare system benefits estimated for every $1 spent in the primary care system," she said.

While Category 1 presentations (the sickest people, needing immediate care) have been increasing, there were almost 700,000 presentations last year in Category 4 and 5.

Categories 4 and 5 can often be dealt with by a person's regular GP, an after hours service or a Priority Primary Care Centre (PPCC). In the Murray PHN region, we have PPCCs in Bendigo, Mildura and Wodonga, plus an additional Medicare Urgent Care Clinic (UCC), which offers similar services in Albury and a co-badged clinic (PPCC/UCC) in Shepparton.

PPCCs are being funded by the Victorian Government and delivered in partnership with all six Victorian PHNs. This work includes collaboration on clinical resources to support high quality, safe and consistent services to the Victorian community. PPCCs provide free treatment to patients with urgent but non-life-threatening injuries and illnesses, such as sprains, broken bones, minor burns and mild infections. Locations of PPCCs can be found here.

The Commonwealth Government is also funding Medicare Urgent Care Clinics, which offer accessible, bulk billed services for patients to help reduce pressure on hospitals and emergency departments. Locations of Medicare UCCs can be found here.

The hospital triage system

In emergency departments, you are seen by a specialist emergency triage nurse who assesses how serious your condition is. In Australia, the triage system is used to guide hospital staff to see patients according to how sick they are, allowing patients with life-threatening problems to be seen first.

In general, the triage system has five levels:

Level 1 – Immediate: life threatening

Level 2 – Emergency: could become life threatening

Level 3 – Urgent: not life threatening

Level 4 – Semi-urgent: not life threatening

Level 5 – Non-urgent: needs treatment when time permits

Photographed are Clinical Director, Dr Ferencz Baranyay and Practice Manager, Heather Paterson from Border Urgent Care Centre in Albury

Building primary healthcare relationships

A relationship with a regular, local primary care provider or health service can provide you with both convenience and continuity of healthcare. Your GP or practice team can monitor chronic conditions, provide prevention advice so you can avoid health problems, build your health literacy, and ensure you receive the regular checks and screenings that can keep you well.

If a health issue arises, a positive relationship with a doctor who provides you with regular checkups can make it more likely that any health issue is detected early and treated quickly. A good doctor-patient relationship also makes it easier to raise more sensitive issues, like sexual or mental health.

From a health system perspective, dealing promptly and effectively with health issues at a primary healthcare level is more cost-effective and in the best interests of communities. Public health experts have long noted that local primary healthcare can improve the performance of wider health systems, by lowering overall healthcare expenditure while at the same time, improving population health and access to services.

The MyMedicare funding model is based on the recommendations of the Strengthening Medicare Taskforce. These funding initiatives include changes to MBS funding and additional blended funding through MyMedicare, which aims to strengthen the links between a general practice and its patients. The system is designed to help general practice provide "wraparound care" for patients registered with a practice through new blended funding models - a mix of flexible, lump sum budgets for each registered patient and fee-for-service payments for each visit by that patient. .

From next year, these "blended funding" payments will be provided to support better continuity of care for people with complex, chronic disease who frequently attend hospital. They will also provide incentives for general practice to support regular health assessments, care plans and regular GP visits for people in residential care homes.

You can read more about MyMedicare here.

The system is designed to help general practice provide "wraparound care" for patients registered with a practice through new blended funding models

Affordable primary healthcare

In recent years, the cost of regular healthcare has become unaffordable for many people in our community, particularly those who are unable to access bulk billed services in their area.

We know that the cost of providing chronic disease care has become unsustainable. Without new funding models, such as MyMedicare, the current system of fee-for-service can drive less effective types of long-term care. It can lead to a focus on short-term issues, rather than a person-centred approach with services provided by a range of appropriate health professionals.

For example, people with diabetes may need to visit their GP, but then receive assistance with healthy eating plans, regular blood sugar monitoring, or foot and wound care to keep them well and out of hospital.

We call this team-based care, where GPs work collaboratively with a team of primary health service providers, including nurses, physiotherapists, mental health workers, podiatrists, nurse practitioners, dietitians and others in the field of allied health.

In parts of our region where workforce pressures allow, some general practices have already become multi-disciplinary primary health centres – meaning the practice can also offer a range of the allied health clinical services mentioned. But in less populated centres, it is often hard for all these services to be provided to patients because of workforce issues or lack of funding.

This holistic, wraparound model of care is a feature of the primary healthcare provided by Aboriginal Community Controlled Health Organisations (ACCHOs), which – as their name indicates – are operated by local First Nations communities. ACCHOs deliver person-centred, culturally appropriate healthcare to their communities and the individuals within them.

ACCHOs provide a range of medical services, delivered by general practitioners, Aboriginal and Torres Strait health workers and health practitioners, and other culturally competent healthcare professionals.

MULTIDISCIPLINARY TEAM CARE FOR TYPE 2 DIABETES

When you have a chronic disease, it's important that you are able to get advice from all the health professionals you need to manage your care. In a multidisciplinary team, these health professionals work together so that your care needs are understood by each member of the team.

The following health professionals are just some of the experts who may be able to support and guide you and your family if you have Type 2 diabetes. You may not need all of them, but most people will see at least two or three experts in the chronic disease field.

	**Family doctor/ general practitioner (GP)**	Your GP is your primary carer and plays a central role in assessing and monitoring your health. They help in managing your diabetes, reducing your risk of diabetes-related complications, addressing any concerns and prescribing medicines and additional care needs.
	**Credentialled diabetes educator (CDE)**	A Credentialled Diabetes Educator (CDE) can provide diabetes-specific information and advice to help you stay in the best possible health, including explaining diabetes, teaching you how to monitor your blood glucose levels and helping you with medications or insulin.
	**Accredited practising dietitian**	Having the right nutrition is important to managing your diabetes. An Accredited Practising Dietitian (APD) can offer practical and personalised advice on healthy eating for diabetes, including setting any weight goals or teaching you how buy or order food.
	**Endocrinologist**	An endocrinologist is a medical specialist who treats a range of conditions that are caused by problems with hormones, including diabetes. An endocrinologist can provide expert advice on development of your diabetes management plan.
	**Pharmacist**	A pharmacist can give advice on your diabetes medications, how to maximise their benefit and manage their effects. Together with your doctor, a pharmacist can conduct a Home Medicines Review with you.

	**Podiatrist**	Diabetes can increase the risk of nerve and blood vessel damage to the feet. Regular checks by a podiatrist can determine your risk of developing foot damage and help prevent serious complications.
	**Counsellor, psychologist, psychiatrist or social worker**	Feeling stressed can affect your diabetes and general health and wellbeing. If you're feeling overwhelmed, it's best to talk to a counsellor, psychologist, psychiatrist or social worker.
	**Accredited Exercise Physiologist (AEP) or physiotherapist**	An Accredited Exercise Physiologist (AEP) can help you determine the appropriate exercise and activity plan for you, suited to your health conditions, current abilities, needs and lifestyle. A physiotherapist can diagnose and treat a range of conditions including muscle strains and injuries, incontinence, help with rehabilitation and manage movement, so you are able to function as normally as possible.
	**Optometrist or ophthalmologist**	Most diabetes-related eye diseases do not show symptoms early. If left untreated, they can cause vision impairment or blindness. You do not need to have glasses to see an optometrist for a diabetes eye examination. If you have serious eye issues your optometrist will let your GP know and your GP will refer you to a specialist eye doctor, an ophthalmologist.
	**Dentist**	A dentist who knows you have diabetes should regularly review your teeth and gums. This is important because you may have an increased risk of tooth decay or gum disease, and impaired gum circulation can prevent gums from healing when there's injury or trauma.
	**Aboriginal and Torres Strait Islander health worker**	An Aboriginal health worker can help you with culturally appropriate information and may be able to support you to access the care you need.
	**Family and friends**	Aside from health professionals, your family and friends are important to have in your team. They can provide day-to-day support and assistance in managing your emotional and physical health, and help to provide you with motivation for diabetes self-management.
But the most important member of the team is <u>you</u>. Keeping yourself informed about diabetes can help you make the best decisions about your daily self-care.		

In regional areas like the Murray PHN region, we understand that we need new models of coordinated patient care delivered by a team of health professionals. At the same time, we are working to support local capacity building and effective collaboration that will help build primary and acute service integration at a community level.

We also need to make sure we are considering how to maintain or increase work satisfaction for health professionals in our region. It is important for clinicians to maintain a level of mobility and flexibility to achieve a rewarding career, rewarding employment and work/life balance. We also recognise that aspirations and lifestyle will vary with each stage of life.

If our communities can provide attractive and supportive environments for teamed healthcare delivery, they can enable providers to work collaboratively and to the top of their scope of practice – that is, be ready and able to provide all their skills for the benefit of their communities.

Murray PHN's work in primary healthcare

Murray PHN supports general practice through education, training, resource development and the implementation of digital health systems, to help deliver better health outcomes for patients and business sustainability for primary healthcare providers.

Much of our work is done under the banner of health systems improvement. This funding also enables the integration and coordination of health services in their regions, through population health and service planning and workforce support, including general practice support.

Murray PHN's Quality Improvement Consultants assist general practices to develop meaningful, data-informed quality improvement plans to help keep projects on track and integrated in daily practice. Our consultants also help and guide general practices to access innovative tools and resources to deliver best practice care.

We have significant performance indicators to meet in our work, which covers primary healthcare development; workforce development; digital health, systems and connected care; First Nations Health and Healing; sustainable rural healthcare; and HealthPathways that provide best practice care and local referral options for patients. For more information on our activities, you can read our Activity Work Plan summary.

To ensure that our work as a PHN helps improve the health outcomes for people in our region, to keep people well and out of hospital, we have five guiding principles:

1. Build capacity to enable access to multidisciplinary care
2. Integration of primary care and acute services
3. Team-based employment settings
4. Structural changes to primary care entity ownership
5. Reorganise funding to support care provision

We welcome the opportunities provided by the announced Strengthening Medicare enablers, which recognise the differences in funding and policy based on the place that care is being delivered – metro, peri-urban, regional, rural and remote settings.

Innovation in primary healthcare

With fewer medical graduates choosing general practice as a specialty, regional areas are the first to feel the effect of the GP shortage. Murray PHN is working on new models of care delivery based on connecting fragmented systems, where funding is often split between states and the Commonwealth.

Solutions that enable team-based care and team-based delivery require coordination and the engagement of local communities. Murray PHN has been piloting team-based, locally supported systems of healthcare, including a nurse practitioner project in the Loddon, Buloke and Gannawarra local government areas.

Nurse practitioners have skills, experience and qualifications to provide holistic healthcare and can collaborate with GPs to help prevent disease and promote strategies to improve health outcomes.

They can see people of all ages, diagnose and treat a variety of health conditions, prescribe medications, order x-rays and pathology tests, work with and refer to other health professionals, as well as provide health education to improve health outcomes for patients and the community.

But it is still vital for regional areas to attract and retain a range of health professionals including nurse practitioners, allied health professionals and GPs.

Integrated health networks for community access:

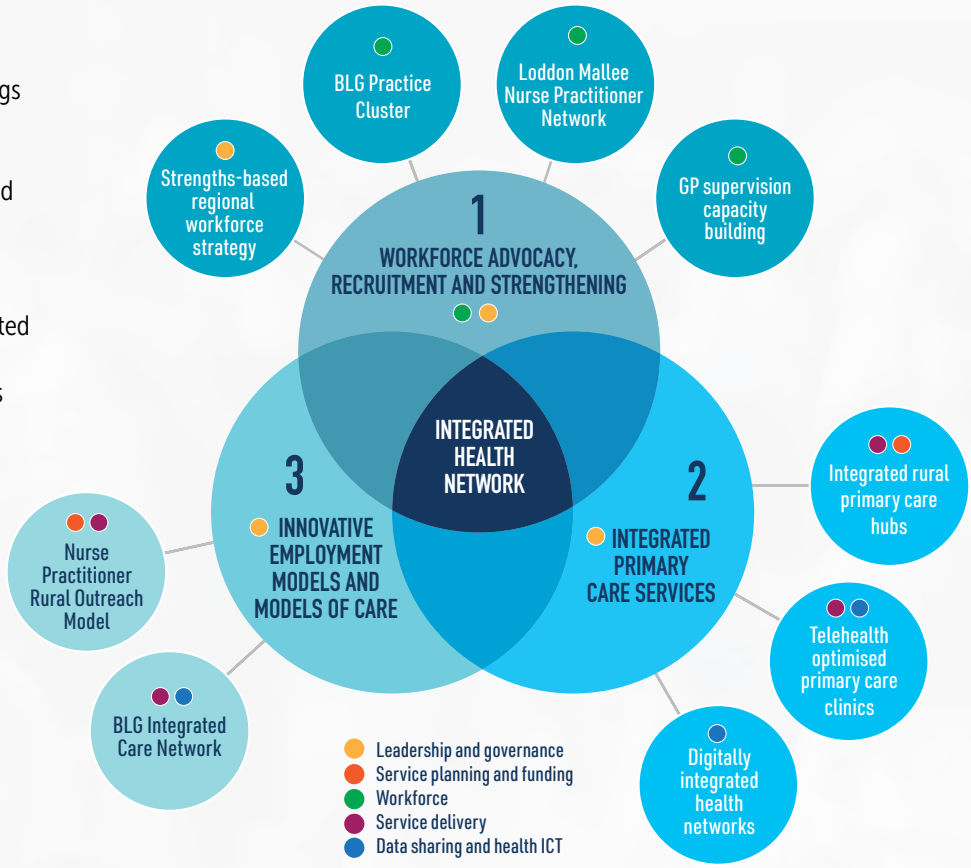
- Prevention, early intervention, wraparound care
- Increasing complexity of health needs
  - chronic disease
  - mental health
  - cancer screening; immunisation
  - acute service discharge back into community
  - community-based coordinated care needed to stop people bouncing in and out of acute care
- Access to high quality patient care, close to home

Nurse Practitioner, Simone O'Brien works alongside Dr Chris Olise to improve healthcare in Boort

The Sustainable Rural Health Project pilot co-design findings have been used to create three intersecting streams of work with a series of proposed models and strategies. The models apply the design principles using a systems perspective, and are interrelated and overlapping to target all health system building blocks for sustainability.

This diagram features the proposed models with descriptions of existing work underway, which can be incorporated into implementation plans and suggestions for additional initiatives and exemplar models to explore.

To learn more, visit: www.murrayphn.org.au/sustainableruralhealthproject



Understanding our GP catchments

In Victoria, we have 153 GP catchments, with 50 of these in the Murray PHN region.

GP catchments are non-overlapping geographical areas established by the Commonwealth in 2019 to support planning and provide government and agencies with a more accurate picture of "functional area" boundaries, showing where patients are travelling to access their GP providers.

GP catchment areas are based on patient movement and on other information, including MBS patient and provider data over a five-year period, population, accessibility and the location and number of GPs in an area.

We know that all catchments have significant workforce need, with two thirds (63 per cent) of Victoria's GP catchments experiencing moderate to high GP workforce need. We also recognise that the GP catchments with the highest workforce need are all located in rural Victoria, in the Murray and Western Victoria PHN regions.

Every one of Murray PHN's 50 GP catchments needs additional primary health workforce capacity, with more than half of these experiencing moderate to high workforce need. We also know that 32 per cent of Murray PHN GP catchments have 3.0 (or fewer) full-time equivalent GPs.

Our work determining the level of need in different areas gives us a starting point for the prioritisation of support across our region – primary healthcare workforce planning.

Primary healthcare workforce planning

Murray PHN's strategic plan 2023-2025 includes developing training partnerships to enhance sector workforce capacity and capability in rural and remote regions.

Our work in this project is based on understanding the data and listening to the lived experience of people involved in the sector.

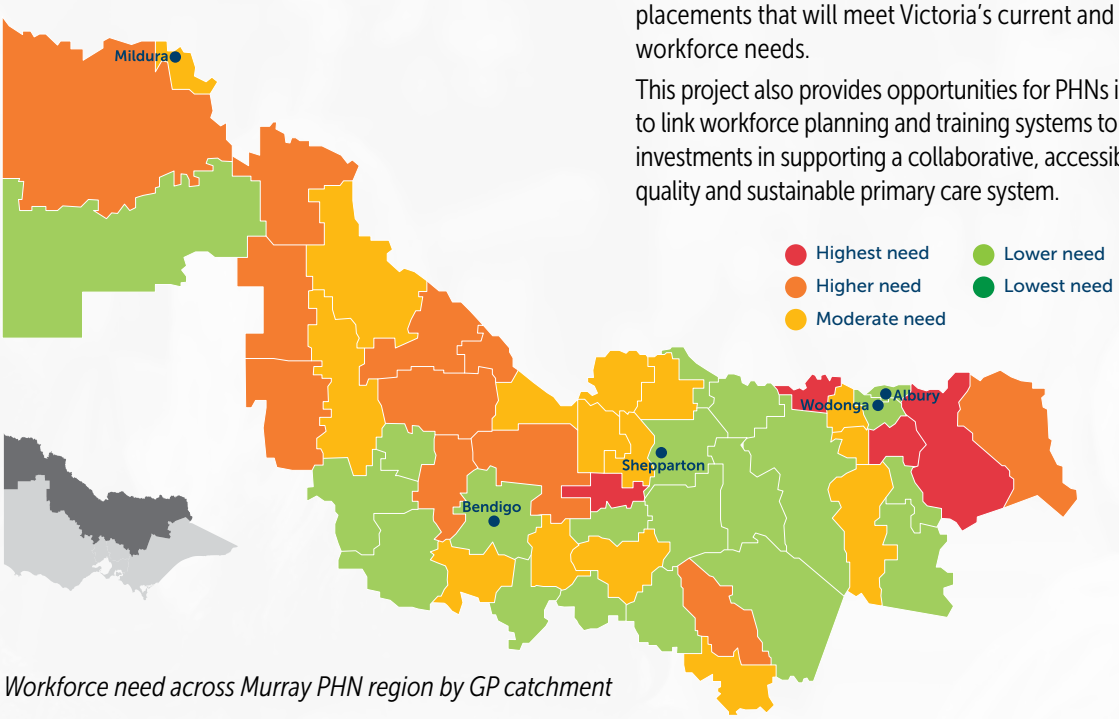
As part of national workforce planning, Murray PHN is leading the Victorian PHN consortium to prepare a range of Australian General Practice Workforce Planning and Prioritisation (WPP) reports for the Commonwealth Department of Health and Aged Care.

The map below shows the areas across the Murray PHN catchment that have the greatest need for GPs based on community needs and access to existing general practice services.

The Australian General Practice Training (AGPT) Program transitioned from registered training organisations (RTOs) to a 'College-led model' in February 2023, overseen by the Royal Australian College of General Practitioners (RACGP) and The Australian College of Rural and Remote Medicine (ACRRM).

The Victorian WPP project supports college planning by providing planning and prioritisation advice on GP training placements that will meet Victoria's current and future GP workforce needs.

This project also provides opportunities for PHNs in Victoria to link workforce planning and training systems to their wider investments in supporting a collaborative, accessible, high quality and sustainable primary care system.



Workforce need across Murray PHN region by GP catchment

Listening to our health professionals

As part of our work on the WPP project, we have met with Victorian members of General Practice Registrars Australia to help us understand issues impacting on the training, attraction and retention of Australian General Practice Training (AGPT) GP Registrars in our GP catchments.

We have also consulted with General Practice Supervision Australia, so we recognise the difficulties and opportunities faced by GPs who are supervising GP training.

Both groups have shared important feedback that will help us give advice to government on the training capacity of Victorian GP catchments.

Issues identified by registrars include high patient waiting periods, multiple roles and long on-call shifts, networking opportunities and limited support that were impacting professional and social integration. Concerns regarding workload, support, compensation and work-life balance were prominent in regional Victoria.

The consultation highlighted the need for community connectors, incentives for relocation, national funding consistency and improved support for registrars. Addressing these findings can contribute to a more sustainable and desirable future for the GP workforce in local communities.

Providing solutions to these issues will require a collaborative effort at national, state and local levels. Murray PHN has worked closely with stakeholders in the region to provide a report to the Department of Health and Aged Care that identifies issues, barriers and solutions to GP training in the Murray PHN catchment. This information will be provided to ACRRM and RACGP to support the prioritisation of AGPT registrar placements in the future.

Murray PHN will also use this information to support organisations at a local level to:

- Develop innovative solutions to increase and improve GP training and supervision
- Increase supervision capacity
- Support new and improved employment models
- Improve access to role models and mentoring
- Fill gaps in rural GP training pathways
- Identify and communicate existing social integration activities and community connectors

The strengths of general practitioners

People sometimes think that medical specialists are more qualified than general practitioners because the word "general" can tend to be misunderstood. In fact, GPs undertake a minimum of three years of supervised training before they can call themselves qualified GPs. Rather than specialising their practice on one bodily system, GPs have to know a significant amount about the entire body and its many systems.

General practitioners are relationship-based specialist clinicians who know that health, illness and disease are experienced differently by each individual patient. According to the Royal Australasian College of General Practitioners, the scope of clinical practice is challenging, spanning prevention, health promotion, early intervention for those at risk, and the management of acute, chronic and complex conditions, whether in the home, practice, health service, outreach clinic, hospital or community.

Generalists support the delivery of integrated, preventative and primary care services across a wide range of community needs, at lower cost, for increased life expectancy.

Despite this, general practice numbers are declining and we are producing an overabundance of non-GP specialists, focused on targeted populations or body systems. This tends to increase the number of practitioners in cities, but often leads to inefficiencies of healthcare in rural and regional areas.

For most graduates, choosing a specialty is a complex process with a number of considerations that are unique to each individual.

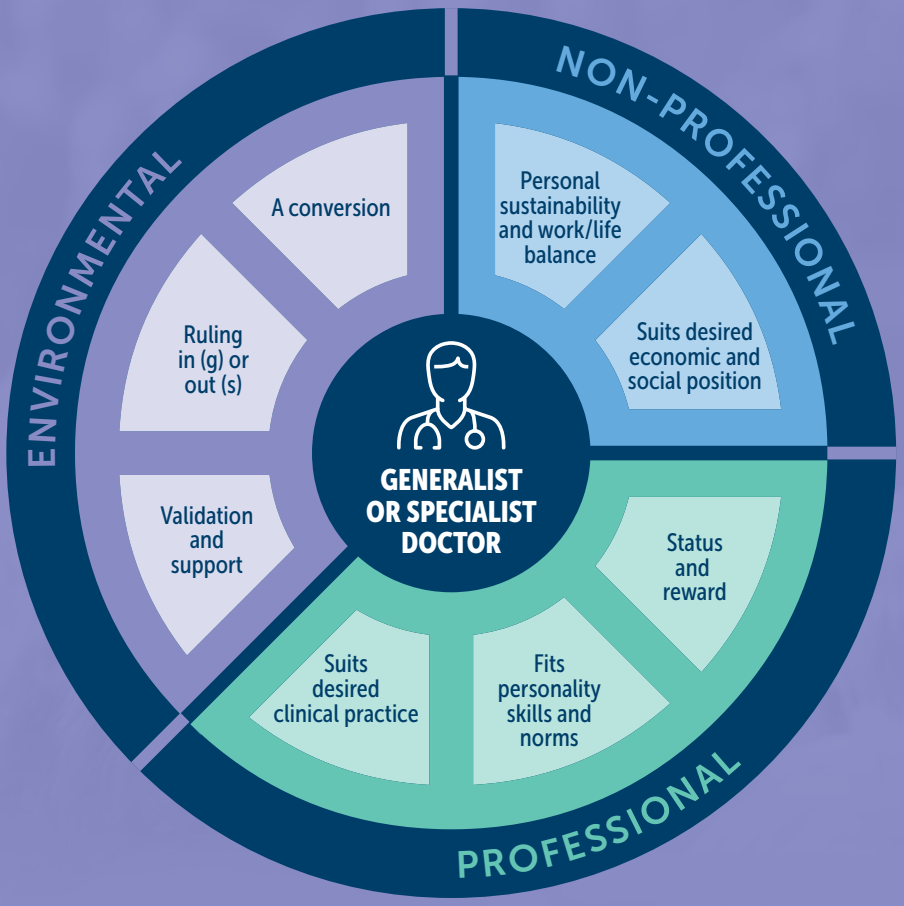
Speciality choice can be both intrinsic - appraisal of skills against specialty; intellectual content; interest in helping people; and extrinsic - work culture; flexible working hours and hours of work.

Compared with other specialties in the research, general practice trainees showed a higher regard for helping people, while fitting their work to their own domestic circumstances. In studies, general practice was also seen to be attractive because of lifestyle, the opportunity for continuity of care, increased procedural skills and work prospects.

Dr Belinda O'Sullivan, Murray PHN's Chief Strategy and Performance is one of four authors of a 2020 study: A realist evaluation of theory about triggers for doctors choosing a generalist or specialist medical career.

Belinda and her co-authors interviewed a range of Australian doctors who had graduated from a large university medical school. Some had chosen a generalist career as a GP or in public health, and others had chosen a specialist medical career.

MECHANISMS TO PRODUCE A GENERALIST OR SPECIALIST DOCTOR - RULING IN OR OUT



The study found that having a primary healthcare role model and a range of clinical experiences may encourage uptake of general practice, even though specialty fields like surgery may be seen to have a higher professional status.

After significant interviews with the doctors, the authors argued that there were eight clear triggers that played into a graduate's choice.

These triggers sat within three main areas of influence – professional, non-professional and environmental. Relevant issues including exposure to options, both clinical and place-based; lifestyle and life stage; a fit with their own skills and perceived career status.

Understanding the importance of these issues, the authors argued, made it possible to tailor both student selection and ongoing exposures to create more generalists.

Dr O'Sullivan believes that key clinical or geographic experiences could trigger "a conversion" to a generalist choice. Strong mentors, being exposed to a range of areas of clinical medical practice, and understanding both the breadth of skills required and the continuity of care opportunities could play their part.

For those of us living in regional or rural areas, we can see that providing graduates with positive and enriching experiences of practising outside major cities can also encourage the consideration of rural generalist careers.

For doctors choosing to be or follow a generalist path, their desired economic and social position was considered in relation to broader social and cultural values. For some, the values they placed on family and within wider society went beyond their professional identity, while others seemed to be more motivated by benevolence than money and power.

Dr O'Sullivan said recent studies indicated that for those who chose generalist careers, their social and cultural interests may be stronger than their economic interest. She suggested more medical generalists may be able to be attracted by enrolling more students who have wider values and social interests based on family, culture and community, rather than would-be doctors motivated by professional identify and socioeconomic gain.

Dr O'Sullivan's study gathered evidence from individual graduates as to the experiences that helped them choose a career as a generalist.

[As a junior doctor] I had trouble choosing one specific specialty... I [hoped I] could have that opportunity to practise some primary health, some hospital health in emergency on the wards, as well as some anaesthetics and giving me that wide breadth.

I did a rural health placement here [regional centre] as a student... I wasn't really interested in being GP probably still at that point... but I was really interested in Aboriginal health... I decided to apply for internship up here... than when I was a resident... I did a PGPPP [general practice rotation] in [remote area]... in a homeland service... which was just incredible.

[General practice]... allowed much more flexibility in the training and taking part-time work, for example, which any of the other specialties didn't allow.

[When a medical student], I was nursed along and shown what the joys of general practice and long-term care in a community were like.

[When a medical student], individuals who were prepared to take me into their personal and family lives, and not just at clinic... as a person, in my early 20s, that had a big impact on my ideas about the world.

WHAT GRADUATE DOCTORS SAY

Sarah Bresnehan, the national chair of the General Practice Students Network (GPSN) recently suggested some answers to reversing the declining trend in students choosing general practice as their speciality.

"How do you increase the profile and attractiveness of general practice to the future medical workforce?" she asked. "The answer is to listen to future GPs, to the students coming up through the pipeline. We know and see the barriers and have effective solutions, so start investing in the most valuable resource within general practice – its future practitioners!"

She cited the importance of quality early exposure to general practice at the beginning of a student's journey before hospital training began. Perhaps a professional peer exchange with existing GPs early on in medical school.

"We all know that early positive impressions of general practice will go a long way to increasing the number of medical students becoming GPs.

"While the GP specialty is at a crossroads, we understand that GPSN has a role to play in strengthening access to primary care in Australia and working with our sector peak partners to uplift the GP specialty. GPSN wants to play a role, and we want to challenge the preconceptions of medical students about the speciality of general practice.

"But the perspectives of medical students must be listened to, otherwise policy makers will continue to invest in initiatives that miss the mark."

The path to general practice

Before you can be a GP, you have to graduate from medical school and work as a junior doctor in one or more hospitals to get some of the skills that will support you as a general practitioner.

Medical practitioners who want to pursue a career in general practice in Australia then apply for the Australian General Practice Training (AGPT) program - a three-to-four-year postgraduate vocational training program. AGPT offers 1500 starting training places each year, and selection is via a competitive, merit-based process.

For more than 50 years, general practice training in Australia has been supported by the Royal Australian College of General Practitioners (RACGP) and, more recently, the Australian College of Rural and Remote Medicine (ACCRM).

When a registrar successfully completes the ACRRM or RACGP Fellowship Training Program through the AGPT pathway, they are eligible to apply to be conferred as "Fellows" of that college and registered as a specialist general practitioner with the Medical Board of Australia.

Since 1 February 2023, this fellowship training is being led by the colleges, which will take responsibility for governance for the administration of the AGPT program.

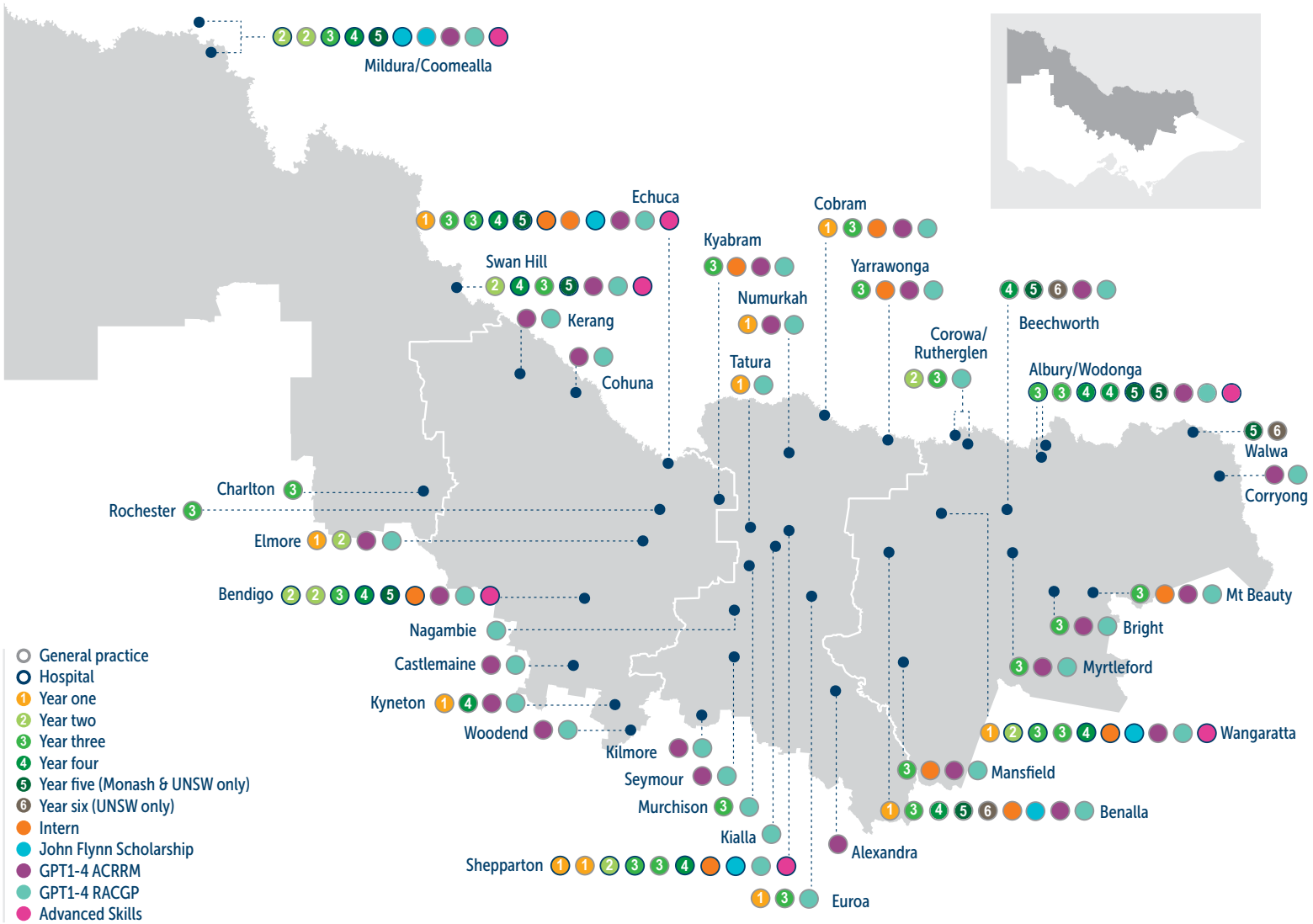
Alternative general practice training pathways also include the Rural Generalist Training Scheme ACRRM Independent Pathway, Remote Vocational Training Scheme and the RACGP Fellowship Support Program.

Simplified GP registrar training pathway (ACRRM/RACGP)

Intern Post Graduate Year (PGY) 1*	Core hospital rotations
	Medicine 10 weeks (minimum)
	Surgery 10 weeks (minimum)
	Emergency medicine eight weeks (minimum)
	Non-core – rotations (2 x 10 week rotations)
	Wide range of hospital rotations e.g. rehabilitation, mental health or general practice rotations
PGY2/PGY3+	Core hospital rotations
	Paediatrics three months (essential ACRRM and RACGP)
	Obstetrics and gynaecology three months (ACCRM essential/RACGP choice)
	Anaesthetics three months (ACCRM essential/RACGP choice)
	Emergency medicine three months (essential ACRRM and RACGP)
	General practice rotation
	General practice 18 months
	Advanced skills – hospital placement
	Selected advanced skill, 12-month hospital placement
PGY4+	Continuation of general practice rotation to achieve 18 months
	Consolidation of skills in general practice and/or hospital
Fellowship	Fellowship exams

**The intern/PGY2 training requirements are current but will change in 2025 due to the review and changes to the National Framework for Prevocational Medical Training*

THE RANGE OF GP/RG RELATED TRAINING PLACES ACCESSIBLE FOR MEDICAL STUDENTS AND GENERAL PRACTICE REGISTRARS (GP/RG CANDIDATES) IN THE MURRAY PHN REGION AS AT SEPTEMBER 2023



The general practice training pathway across the Murray PHN region has been mapped across each of the four regions based on the availability of training opportunities at September 2023. For example, in the North West region of Mildura, there are currently no opportunities for first year medical students.

Medical students interested in settling in Mildura can complete second year training in general practice and the hospital setting in the region, but there are no placements in general practices for third and fourth-year students, only within the hospital.

A fifth year (required by Monash University and University of NSW) can also be done in Mildura, but again only in a hospital setting. Currently, there is no pathway for Victorian Rural Generalist internship positions in Mildura, so medical practitioners need to move out of the region to complete this year, before returning to the region to complete PGY2 (via a John Flynn placement) and then completing AGPT1-4 (via either ACCRM or RACGP) and advanced skills posts in Mildura Base Public Hospital.

Currently, there are end-to-end training pathways in Central Victoria in Echuca (with second year medical students required to travel 30 minutes to Elmore or an hour to Bendigo), or Bendigo (with first year students required to travel from Echuca). In the Goulburn Valley, end-to-end training is only available in Shepparton, while in North East Victoria, full training pathways exist in Wangaratta and Benalla (with only second year medical students required to travel).

How general practice gets paid for keeping communities healthy

Australia's primary healthcare system is a public health system delivered largely by clinicians working in the private sector. Most general practices in Australia are small businesses, and it can be challenging for them to survive on MBS income alone, even with some of the changes now foreshadowed by the Commonwealth Government.

The Strengthening Medicare program will see $5.7 billion invested by the Commonwealth over five years to make it cheaper and easier to see a doctor.

The reforms to Medicare include funding for GPs to have nurses and allied health professionals working alongside them to provide better care to patients. They also include funds to encourage GPs to stay open for longer hours and to connect frequent hospital users to general practice so they can receive comprehensive care in the community.

PHNs will also be funded to commission allied health services to improve access to multidisciplinary care for people who need it most, including those with chronic conditions or who live in underserviced communities.

A key priority in the government's primary healthcare reform agenda is improving digital health, giving health professionals the digital and data tools needed to provide improved care.

PHNs also play an important role in supporting primary healthcare professionals with digital health resources and training.

Understanding health funding

We know that funding healthcare for Australians is a significant part of our national budget, at more than 10 per cent of overall economic activity.

In 2020-21, an estimated $220.9 billion was spent on health goods and services in Australia, according to the AIHW. More than two thirds of this health spending (nearly 71 per cent) was by governments, with more than $70 billion spent on public hospitals and $19 billion on private hospitals. An estimated 15 per cent of the total spending was by individuals.

Since 1984, Australians have had universal access to healthcare through the national Medicare system. People with a Medicare card can get free or lower cost medical services, hospital treatment, many prescription medicines and mental health care.

Medicare is funded through the general Medicare levy, plus a Medicare levy surcharge for higher income earners who do not have private health insurance. The levy is around two per cent of your taxable income, with reduced rates or no levy for people on low incomes.

The Grattan Institute argues that the way we pay GPs is past its use-by date, as it blocks team-based care and keeps appointments to an average of 15 minutes – often not long enough for older or sicker patients.

When someone is unwell, their focus is usually on finding the right health professional to enable them to recover and live their life to the full. The issue of health funding is not relevant to them unless they are experiencing difficulty in finding care that they can afford.

Many people are not aware that some healthcare services are funded by the Commonwealth Government and others by state government. Primary healthcare – mainly GPs, nurse practitioners and opticians – is funded largely by the Commonwealth, while hospitals and hospital services are largely funded by the states.

Increasingly, both levels of government are trying to boost primary healthcare so that people stay well and out of hospital, providing funding to PHNs to make improvements to access, equity and quality.

PHNs work to help integrate health services and patient care pathways, to improve efficiency and effectiveness of services

Fee-for-service/Medicare benefits:

Your refunds from Medicare are based on a schedule of fees set by the government. Some doctors provide services that are bulk billed, which means there is no cost to you as the patient. Other medical practitioners charge more than the set schedule fee and the difference is paid by the patient or their carer. This out-of-pocket expense is called a gap.

Private health insurance:

While many people rely on our public health system for all their healthcare needs, an estimated 55 per cent of Australians choose to take out some level of private health insurance to cover some of the costs of treatment in a private hospital, or extras, including optical, dental, physiotherapy and ambulance. Gap fees charged by doctors can only be covered by private health insurance for treatment in hospital.

Activity-based funding:

A funding method for public hospital services based on the number of weighted services provided to patients and the price to be paid for delivering those services.

Block funding:

Underpins funding for services that are not suitable for activity-based funding, such as small rural and regional hospitals, non-admitted mental health services, and teaching, training and research in public hospitals.

Blended funding:

Is a mix of flexible, lump sum budgets for each patient and fee-for-service payments for each visit.

PHN Practice Improvement Quality Improvement programs:

Provide funding and support to general practice on a local basis to help them undertake continuous quality improvement activities aimed at improving health outcomes for patients. PIPQI activities are designed to implement changes relevant to a particular practice and its patient population.

phn MURRAY

An Australian Government Initiative

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