



INTRODUCTION

General practice holds a very special place in Australian society. There is a long tradition of the local family doctor being an important member of local communities – city and country.

In recent times, that key role and the ability to sustain a general practice have become strained and pressured. We have seen communities, especially rural communities, lose their family doctors. We have seen family doctors burdened with administrative red tape. There have been changes and reforms – not all of them good.

Now, amid a significant period of health reform, general practice once again faces new challenges.

GP Super Clinics, diabetes care plans, Practice Nurse incentives, after hours funding, Medicare audits, collaborative care arrangements, GP workforce shortages, new training places, infrastructure funding,

Medicare Locals, and the ever-present red tape. There are winners and losers in any reform process. Individual general practices and family doctors are being affected in different ways by the changes.

So, what does the future hold for general practice? In this Special Feature, we have sought a range of views, including from the Health Minister and the Shadow Health Minister.

The views expressed in this Special Feature are the views of the authors and their organisations, and not AMA policy except for AMA contributions.

The future of general practice is a huge issue for the medical profession and the Australian community. Australian Medicine wants to hear your thoughts on this important subject. Please send us an email to ausmed@ama.com.au



Doctors to benefit from reform to the health system

BY HEALTH MINISTER NICOLA ROXON



As Minister for Health and Ageing, I am excited to be working with the AMA during such an historic time of change. This is a time when the Government is implementing our plan to deliver better health and better hospitals for all Australians.

The foundation of that reform lies with better primary care, and strengthening the lifeblood of our health

system – our doctors.

We need more doctors, particularly in rural, regional and remote areas, to meet the increasing demands of our ageing population.

This Government's ambitious reform agenda includes training record numbers of doctors in the coming decade to take the burden off our hardworking General Practitioners.

Medical students and junior doctors will have the opportunity to take up one of the 600 extra GP training places and there will be 680 more specialist doctors trained over the next decade.

We know investing in General Practice to do what it does best – keep Australians healthy and out of hospital – is smart health policy.

That's why the Government is providing more training, more locum support, better incentives for GPs to employ practice nurses and extra funding to help patients with chronic conditions. We are also determined to introduce a national e-Health system to assist doctors in modernising the delivery of patient care.

Key among the reforms is funding to help GPs employ practice nurses, freeing GPs to do more of their important work caring for patients. It is expected that more than 4,500 GP practices will benefit under the new program.

GP practices also have the opportunity to upgrade and expand their existing facilities through around 400 infrastructure grants. Grant guidelines are now available, with applications now open. In addition, existing practices could become one of around 23 new GP Super Clinics providing coordinated GP and primary care.


The Government will also establish a network of primary health care organisations - Medicare Locals - across Australia, including funding to improve access to after hours care. Medicare Locals will have strong links to local communities, health professionals and service providers, enabling them to respond more effectively to local needs. The first Medicare Locals are expected to commence operations in mid 2011.

The Government is also investing more to improve care for patients with chronic conditions, starting with people with diabetes. The new \$449.2 million voluntary program, starting in 2012-13, will help patients to receive coordinated and continued care by having their health condition managed by one general practice, where and when they need. We look forward to working with the profession on the detailed implementation arrangements for this policy.

Our ambitious health reforms would not have been possible without the feedback we received from the nation's doctors and representative groups. I now look forward to continuing to work closely with you as we begin the next stage of health reform – implementing it in our GP practices, GP super clinics, emergency departments and hospitals on behalf of all Australians.

These extra investments in primary care and general practice have been made possible thanks to a strong economy and decisive action during the global financial crisis.

There's never been a better time to work in the health system, and I thank you for your hard work and commitment to improving that system.

To find out more about how the Government is delivering better health and better hospitals visit www.yourhealth.gov.au 

The Future of General Practice

BY SHADOW HEALTH MINISTER PETER DUTTON



As the Parliament closed for the winter recess in somewhat dramatic circumstances, one of my last duties in Canberra was to receive a petition. Twelve thousand Australians had signed this petition calling on the Parliament to ensure their right to have access to a family doctor.

Twelve thousand signatures is not an insignificant number and it signals a concern in the community about what is happening in health. The signatories indicate they believe seismic changes are underway – that the days of the family GP are under threat.

It's fair to say general practice exists today in a very challenging situation.

The face of general practice has changed rapidly over recent years, but apart from consolidation and corporatisation new issues are now in play under the guise of 'health reform'.

Labor's so-called 'reforms' remain largely opaque, for instance there is absolutely no detail apart from lots of spin and branding of 'Medicare Locals' and what they will mean for the delivery of primary healthcare. (if, of course, the 'reform' path staked out by Kevin Rudd remains on course under Julia Gillard)

More concrete is the threat posed to existing practices by the introduction of GP 'super' clinics. There's been a failure to deliver on the promise to open 31 of these facilities, but the contracts are signed and they are coming.

Of the three that are open, a few things are clear. These clinics are offering services that are already available through most general practices. They are opening in competition and mostly in close proximity to existing GP surgeries. This is government subsidised competition which will undermine existing services.

We know that, at least one, has been given special treatment in terms of access to overseas doctors while existing practices have been

denied. The threat they pose to the viability of other practices, the livelihoods of other doctors hovers, as yet unquantified.

Another unknown is the plan for enrolment of diabetes sufferers and capitated payments for their treatment. This is a dramatic departure from the fee-for-service model that has served Australians well and one that should worry the profession.

Both the 'super' clinics and enrolment are drawn directly from the British health model and it is one that we do not want to emulate in Australia.

The challenges don't end there. Talked-up have been new upfront incentives to employ practice nurses, not mentioned is the loss of practice nurse MBS item numbers from 2012. Still to come is the widening role of Nurse Practitioners and the development of walk-in nurse centres.

The Coalition remains steadfastly committed to the primacy of general practitioners and if elected at the coming election will ensure that doctors remain front and centre of healthcare in Australia. The general practice should remain at the core of the health system.

We firmly believe that when patients present with a medical condition their expectation is to see a doctor, preferably a doctor they know and one that knows them – a family doctor. The doctor-patient relationship is paramount. Any moves to undermine it should and will be resisted. 🌐

The Essence of General Practice

DR BRIAN MORTON



The essence of General Practice is continuity of care, that professional relationship with the patient (and family), the efficiency of general practice care vis a vis cost and the undifferentiated medical presentations that characterise general practice consultations. General Practice is hard; it is poorly remunerated for the responsibility, intensity and expectations of all from government to patient to peers.

It does however have its rewards that keep us there. For me it's the challenge of diagnosis, the variety of conditions to manage and most of all the relationships with patients and families from the newborn to those at end of life.

So why is General Practice always under attack? Why does everyone else want to do our job? Why do they think they can do it better? Why don't they understand the job entails a wholistic approach to the person not just the disease?

Reform is scary because it challenges our beliefs and training. The driver for reform of health care is primarily cost and perceptions of inequality of access for all Australians and if you are a cynic ideology. The challenge is to objectively assess whether the system is broken and needs fixing or whether the system simply needs enhancement and the settings are fundamentally correct.

The evidence is that the community and both sides of politics accept the universality of access that is Medicare (eMJA 2000). The



evidence is that Australia is at the top of the tree in managing chronic care and life expectancy in OECD comparisons (AIHW Tuesday 24 June 2008). The percentage of GDP spent on health sits in the middle of comparative OECD countries (AIHW Tuesday 24 June 2008). Cost issues related to technological advances, an aging population and increasing demands for access to care should not devalue the quality and system that is delivering outcomes that are the envy of the world. Clearly the system is not broken but the bits that don't work well need fixing.

General Practice sits at the centre of the reform initiatives in primary care with expectations that don't match the rhetoric. General Practice's capacity to respond is strangled by an impediment of excess bureaucracy and red-tape. The administrative system that has failed our public hospital system is threatened as the solution for community care.

The first skirmish in the battle for primary care reform is the Diabetes Plan. The greatest concern is the requirement for voluntary enrolment and the implications of capitation and denial of Medicare entitlements. Is the enticement of a fistful of dollars a short term gain but well deserved for General Practice or a bribe leading to the demise of fee for service? Will the plan enhance better care through access to allied health in the Medicare Locals or will the locals simply be salaried competition to General Practice.

We know from research commissioned by AMA that 88% of patients have a regular Family Doctor; the bulk billing rate is above 70%; patients make active choices about access; 96% of patients think time with a GP is important. The average age of General Practitioners is over 50yrs of age.

National Conference called on Federal Council to re-examine voluntary enrolment. There are obvious questions to ask and answers which will enable AMA to respond appropriately. There is an elephant in the room, however, and that is which generation should have the loudest voice? Should we listen more carefully to the future and what weight do we place on the past lessons of history? 🌐

Brian Morton is the AMA Federal Council member for General Practice Craft Group



Innovation and growth in clinical training will be integral to Health Reform

PROFESSOR JUSTIN BEILBY



The broad and comprehensive input gathered from clinicians and people and communities across Australia as part of the National Health and Hospitals Reform Commission (NHHRC) deliberations has provided a broad and exciting framework for a redesigned health care system. The Commonwealth, States and Territories have now agreed on a way forward. Health, National

Health and Hospital Networks will be created and nationally funded and locally run. In parallel, Medicare Locals will be established which will evolve from current Divisions of General Practice. In a further positive step the Commonwealth will take over funding and policy control for the aged care sector and look to integrate these three disparate elements. Health Workforce Australia (HWA) has been established with number of broad aims of fostering workforce innovation and establishing new training infrastructure in new "greenfield" sites as private hospitals and aged care. HWA will also aim to create Integrated Regional Training Networks to "coordinate" local clinical education and training.

There is no doubt that we all need more detail about how these new entities will interact. Local alignment will be crucial with the Hospital Networks, Medicare Locals, Aged Care and Training Networks overlapping and working in some sort of partnership. Establishing these partnerships will be a challenge and require sustained patience, visionary leadership and appropriate policy and funding levers and must have clinician and academic input. Involvement of the latter two groups will provide the much needed "reality testing" of any new policy or health service changes.

Reform of the workforce training is a crucial element in a redesigned health system. The University sector which trains the future health workforce has been under-funded for a number of years and is struggling to cope with the increase in medical, nursing and allied health students, particularly with accessing clinical training sites. New resources are urgently required. HWA has recently called for initiatives for the establishment of new clinical infrastructure sites for undergraduate health students. In South Australia, these new funding initiatives have led to increase communication between a multitude of local health providers and the University sector, aimed at building innovative education and training options. The energy is infectious. Creating new quality training environments outside of the traditional sites will be an important lever to draw these "new" organisations together.

One of the strengths of our current health system is our quality clinical training program – through undergraduate to postgraduate. The planned doubling of general practice placements from 600 to 1200, increase in number of medical training placements in specialist rooms in private, community and rural settings and increased options for junior doctors to work in general practice will create much needed options for teaching and learning in a broad range of settings. As these new sites are established, the University, Postgraduate Training

providers (e.g. GPET and the Regional Training Providers) and Specialist Colleges need to work efficiently to establish a quality clinical teaching framework that embraces such key elements as supervision, infrastructure and student focus.

The NHHRC argued that we needed to create "an agile and self improving health system for long term sustainability". In other words a health system that will continually improve and innovate and, as new research and knowledge is found, quickly integrate this in to every day care for people. This vital aim will not occur unless we have enough trained workforce to deliver daily care, with time to further develop their skills and knowledge. ☘

Professor Justin Beilby is Executive Dean for the Faculty of Health Sciences, Member of the Executive of Medical Deans of Australia and New Zealand Inc and former Commissioner for National Health and Hospitals Reform Commission

Primary Health Care Reform and Chronic Disease – What does the research tell us?

PROFESSOR MARK HARRIS



The rise of chronic disease in the Australian population has been a major stimulus to health system reform. Cardiovascular disease and diabetes account for the majority of the chronic disease burden and this places a disproportionate load on the community and the health system¹. These conditions and their risk factors are common in general practice², however

there is evidence that between 30-50 percent of patients do not receive optimal prevention or management of these conditions³. Disadvantaged groups have the highest burden of chronic disease and are more likely to be in the group who receives sub-optimal care.

The challenge therefore is do something to address this burden through prevention, early detection, effective ongoing management and to address the gap between current and optimal practice. Of course there are numerous barriers to achieving this, both on the part of patients, community, providers and health services^{4,5}. The chronic illness model provides a framework for understanding how we can more effectively intervene to address these barriers through patient self management education, developing effective patient care teams, use of information technology and decision support, and strengthening links between health services and community organisations⁶.

How does the health reform seek to address these? Previous research has demonstrated that structured multi-disciplinary care for patients with chronic diseases in general practice can improve health outcomes. Creating teamwork across providers, who are in different locations and organisations is very difficult⁷. The referral pathway is inherently complex and the communication and continuity of care prone to failure. So we have seen projects at both national and state levels to create more integrated primary health care services collocated under one roof (eg GP Super Clinics)⁸. This seems like an obvious solution to providing better access to a range of providers, however the larger the service the less

patients feel they are receiving personalised continuity of care and the harder it is to create effective team communication and effort to improve quality of care⁹. Some of the most responsive services are small practices.

So how do we proceed? Primary health care needs to be organised to provide multi-disciplinary team care, however this must be structured in such a way as to provide personalised care and allow for more effective communication and continuity between providers. This may mean that services should be medium sized rather than very large or at least arranged in a hub and spoke model with clusters of smaller teams. Teamwork needs to be facilitated – putting people in the same building does not necessarily create a team. Whatever the model, we need to evaluate its effectiveness in providing better quality of care for all groups and reducing the burden of chronic diseases in the community. 🌐

Professor Mark Harris is the Executive Director of the Centre of Primary Health Care and Equity at the University of NSW

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Investing in the future of general practice

DR CHRIS MITCHELL



The Royal Australian College of General Practitioners (RACGP) has welcomed the recent focus and investment by the Federal Government into general practice, with more than \$2.2 billion committed in new programs for general practice and general practice related services over the next four years.

Our current general practice workforce is ageing, with the average age of vocationally recognised GPs now over 50 years and at the same time,



GP supply is falling. The significant increase in GP training places was very welcome, but to fill these places general practice will need to be better recognised and rewarded in comparison to other medical specialties. Continued investment in general practice is critically important to ensure that there is a future for primary care in Australia

Health reform must be about improving our patients' health outcomes and experience of the health system. The RACGP wants reform that provides direct investment into general practice infrastructure, rebates that support teams and teamwork in general practice, subsidies for general practice and community training, information technology that supports the work we do and that connects us with the extended primary health care team, public health, mental health, and sub-specialty services and funding for research into what really works in Australian general practice.

Unless we fundamentally change from a hospital to a community-focused approach, health costs will continue to spiral and patients will continue to follow the money into secondary care, rather than being treated in the general practice and community sector. It is far less expensive - when safe to do so - to deliver care in the community and the evidence is clear that more GPs and better resourced general practices will lead to better health outcomes, enhanced health prevention, better management of chronic illness and lower rates of unnecessary hospital admissions.

We need investment that builds upon existing services and arrangements and we must ensure that services work with, not around, general practice. Investments for general practice nurses throughout Australia has been welcomed, however better results could have been achieved with better consultation with the profession. While real and meaningful consultation is also needed around the 'diabetes program' and the 'superclinic' initiatives.

Australia has developed a general practice system which has come to be regarded as a world leader. Our model, based on whole person, continuing, comprehensive and coordinated care, has produced international benchmark results. We enjoy the 3rd longest life expectancy and the longest productive life expectancy in the world.

While there has been a lot of talk about the need for a health system based on primary care, there has been little acknowledgement



of the fact that much of the evidence base that supports this change is built on the evidence from general practice and family medicine.

Most people still don't understand what general practice offers unless they have experienced a major life challenge and need the coordinated, filtered and comprehensive care GPs provide.

The evidence of the benefit of general practice is abundant and unmatched by any other medical specialty or primary health care sector.

As Australia struggles to cope with an ageing population, as well as an ageing GP workforce, and an increase in chronic disease, more demands will be placed on our health system. If we are committed to making the health system work better, we need to start with investments into general practice and the community sector. 🌐

Dr Chris Mitchell is President of the RACGP and the immediate past Chair of the RACGP National Rural Faculty. He was a member of the RACGP National Expert Committee on Standards for General Practices contributing to the successful RACGP Standards for general practices (3rd edition). Chris has been a rural general practitioner in northern New South Wales for 20 years and has an appointment at Ballina Hospital.

The national health reform process — a missed opportunity for rural practice

BY DR NOLA MAXFIELD



Look at the national health reform outcomes through rural-tinted glasses and one thing is clear — most governments and policy-makers are still struggling to get their heads around the critical issues on which the future of rural general practice hinges.

Rural doctors face two key challenges. First, they need the right clinical skills if they are to confidently treat all the conditions that come through their door, and they also want to see better financial and professional recognition of these skills. Second, they need the right support to ensure their practice remains financially viable.

Unfortunately, neither of these areas was addressed through the recent reform process.

Unlike their suburban counterparts, a rural doctor usually has to provide both primary and secondary care to their community. To do this, they need a wider skill-set than that typically associated with office-based general practice, and they often also need skills in at least some of the areas of obstetrics, anaesthetics, surgery, emergency medicine, acute mental health and Indigenous health.

In effect, this means that a medical workforce has to be custom-built for rural Australia — yet while the recent reforms have pleasingly delivered more medical training and pre-vocational places (including in rural areas), they haven't delivered the real incentives that are then needed to entice young doctors to rural areas and recognise additional training in advanced rural medicine. (The success of Queensland's

Rural Generalist Pathway in building a well-trained rural medical workforce has been a glimmer of hope in that state at least.)

Similarly, when it comes to supporting the financial viability of rural practice, most governments continue to do little.

Like any small business, rural practices need to make a profit both to survive and to encourage further investment, particularly from the new generation of doctors.

Yet the recent health reforms have demonstrated little understanding of the financial and clinical pressures impacting on these practices and why they are unique businesses needing unique supports. In fact, some of the reforms could actually harm rural practices. For example, some practices could receive less support under the Federal Government's new support for practice nurses measure once the removal of MBS nursing items, associated bulk-billing incentives and PIP payments is taken into account.

So what is needed? Many of these problems could be addressed by implementing the Rural Rescue Package advocated by the Rural Doctors Association of Australia, the AMA and the Australian Medical Students' Association to entice more doctors to the bush. This would be implemented via rural loadings on Medicare rebates so rural doctors and rural practices would be much better supported.

Also required is better support from the Federal and State governments for a rural generalist training pathway so we have a future medical workforce that is designed for rural communities and the primary and hospital care they require.

At the end of the day, real measures are needed now to ensure that rural communities will benefit from a viable medical workforce and viable rural practices into the future. Sadly the health reform process represents a missed opportunity in this regard. 🌐

Dr Maxfield is President of the Rural Doctors Association of Australia.

General practice: Our future

TIM BROMLEY AND AMY SCHIRMER



Recent announcements by the Federal Government have reinforced general practice and primary care as essential facets of our healthcare system. Within universities and

medical schools, there is a growing interest in utilising GPs for preclinical tutoring as well as placement opportunities, particularly as student numbers increase and the need for innovative spaces rise.

However, medical schools vary considerably in the amount of time students spend in the general practice setting and student opinion on this focus varies. Some students are happy to be immersed in this field, however others dislike that other career aspirations seem to be discouraged. Regardless, most would agree that a well-rounded experience is critical and that whatever the level of focus, it is essential

that any exposure be positive.

From a student perspective, the evolving nature of general practice is exciting, so long as flexibility forms part of its essence, indeed, the first comment by many medical students when considering general practice as a career relate directly to GP's working conditions. For instance, the amount of hours worked in a day, part-time versus full-time, overtime and out-of-hours requirements and the flexibility of these arrangements are all important. Healthcare reform must ensure these options are supported. Students today are looking for a more sustainable work-life balance than their predecessors. Further, the ability to alter the intensity of training is an incredibly enticing prospect to many students who may desire international travel, locum work or family life. Given the large increase in female medical students, it is this last point that is most pertinent - students today do not want to miss out on family life, and this desire will impact heavily on career choice. Additionally, the capacity to invest and buy in to the practice or work as an employee offers the choice between solidity and gaining a stake in the practices activities, or leaving the business management to employers and gaining flexibility in working location.

The second characteristic to consider when tailoring general practice for today's medical students is the medical workload. In light of increasing specialisation, general practice appears to be solidifying itself in community-based, comprehensive primary healthcare within a multi-disciplinary team. GPs are becoming less involved in hospital care, but this decrease should not be mandatory or bring with it a decrease in procedural opportunities for GPs. Future reform should ensure there remains ample opportunity for GPs to develop and utilise a procedural skill set. Without providing a broad scope of practice for a diverse cohort of students, general practice will fail to present as an attractive career option to enough students and doctors. The challenge will be to define to prospective GPs what their future career will look like, or to provide a structure in which these doctors can tailor their individual practice.

While the variety of general practice attracts many students, failure to provide these students with protected boundaries may leave them feeling lost. Proper education of medical students regarding the activities of GPs is the responsibility of many stakeholders and one that must be taken seriously if medical schools are to produce enough GPs into the future. 🌐

Tim Bromley is the Rural and Indigenous Officer for Australian Medical Students' Association and Amy Schirmer is the Treasurer for the Australian Medical Students' Association.



General Practice: the next steps

DR RICK FIELKE



These are interesting times for the trainee and even more so for a GP registrar. The health policy and reform agenda has in recent times focused increasingly in health arenas that will directly impact on us as the future of General Practice. The impact will be felt directly and indirectly, with the development of primary health care organisations through to the collaborative care models with other health disciplines and reform of the methods by which chronic care is managed.

The policy reforms go hand in hand with the changing demographics of the profession, which has been discussed extensively elsewhere, to change the where, when, who and how general practice is to be practiced. As a trainee involved in the AMA, and a GP registrar, often it can be difficult to provide commentary on the reforms facing the way we work. The reason for this is that the landscape within which we deliver care is being challenged in many different ways in a very short period of change. However, the way in which I resolve this is to consider why I *chose* general practice as a career and how I want to practice in the long term to provide the care I believe my patients deserve.

The emphasis on chose above is an important one. I have chosen to undertake General Practice and the reasons for this are multifactorial. The primary reason remains that I am attracted to the long-term therapeutic relationships that are developed between a patient and their family doctor. The challenge of managing a paediatric patient (and their parents/carer), diagnosing and excising a skin lesion, treating the hypertensive, diabetic geriatric patient, or the antenatal care of a young mum, whilst educating the next generation of doctors is a significant part of the appeal that has drawn me to the world of General Practice. General Practice is an opportunity to provide this care with a unique understanding of the local context within which I will ultimately practice.

To this end the dream I envisage is working in a vertically integrated practice where I am ultimately practicing medicine as a GP involved in the supervision and training of registrars, junior doctors, and medical students who are consulting in parallel to me, with the supervision commiserate to their level of training. A collaborative model of care exists within which the practice nurse manages a well-defined scope of presentations to the practice. I will be working within a team of like-minded General Practitioners who would share my ethos and understanding of the delivery of healthcare. Where the family doctor is, and remains, the primary point of care integrating input from a multi-disciplinary team and other medical specialties into a management plan that is appropriate for each unique patient.

The perspectives of general practice and the reasons for choosing this training program will vary. The challenge for the profession is to ensure that the future landscape of primary care and General Practice is flexible and strong enough to allow us to practice medicine with



the freedom necessary to meet the health care needs of our individual patients. This requires a strong voice not only from the current General Practitioners but a strong voice from registrars to ensure the future of General Practice is a future within which we want to work. 🌐

Dr Rick Fielke is the AMA(SA) Doctors-in-Training Chair

General Practice – An Economic Perspective

BY ROGER KILHAM

What light, if any, does economics throw on the current wave of primary health care reform? Put very crudely, economics is about maximising welfare. Resources are scarce, and the wants and needs of individuals and governments are unlimited, so goods and services have to be rationed (price rationing, non-price rationing). The need to ration pervades all thinking about payments systems.

What do we economists see when we look at General Practice as a discrete part of the health services industry? Key observations include:

- It was once entirely a cottage industry, but is now changing;
- There is an ageing workforce, which is increasingly more female and this equates to lower lifetime hours of work;
- Static workforce despite a growing and ageing population (there is growth in GP training numbers but a lag before they will have effect);
- Workforce shortage and maldistribution;
- Very highly subsidised (90 per cent for services billed to Medicare, higher again when other GP payments are taken into account);
- The bulk billing rate has been rising even though annual indexation is skinny;
- GPs are reluctant to impose patient gap charges;
- There is an increasing burden of compliance (via interventionist programs);
- General Practice is pushed aside/excluded by the hospital sector/medical specialists; and
- There is increasing competition from nurses and other paramedical professionals.

We economists look at these factors against the backdrop of the major themes of the Government's broad health reform strategy, which include:

- Big challenges from the growing burden of chronic disease and the need to refocus on prevention;
- The need for appropriately skilled workforce and infrastructure;
- The need regional integration of primary care services;
- The need for information and technology;
- The admission that Medicare remains a fundamental tenet but fee-for-service is not always the most appropriate financing tool; and
- The need for tools to measure system performance.

Looking at payments systems, fee for service is the patient-friendly option for General Practice because it empowers patients at the expense of control of medical benefit outlays. It encourages productivity, and it gives providers an incentive to keep practice costs low but not at the expense of quality improvement. It is, however, dogged by a first-dollar insurance system.

The capped payment is the taxpayer-friendly option. Capped payments empower governments (or the budget holders they may engage) to determine priorities and the quality of services provided, but at the expense of patient choice.

They facilitate budget discipline. You can cap an entire budget or cap individual patient entitlements.

Capped payments can be used to help disadvantaged sub-groups who don't get much access under fee-for-service but, when applied mainstream, they create all sorts of equity problems.

The Government puts a lot of money into primary care and considers this entitles it to ask questions, seek greater accountability, and always be suspicious of what is going on out there in the health economy.

The economic and clinical efficacy of fee-for-service looks quite sound but the Government is always looking for other options to blend into the mix. This is despite the fact that the nation gets excellent value for money from GPs.

No matter the number of reforms you grudgingly accept or the number of controls you grudgingly tolerate, there are always more of the same in the pipeline. Perhaps it is the everlasting dynamic of General Practice.

Every reform of the past 20 years is supposedly about quality. Does this mean the quality is suspect? At face value, the Government thinks so. Of course, it might simply be a sugary coating for an unpleasant pill.

Doctors know they are making a difference and that quality is improving year on year, but there is no easy way to prove it, particularly to the Government. Most quality improvement flows from the highly trained workforce going about its normal business and not because of Government health reforms. But the Government wants to claim any credit.

Don't despair. There have been some significant wins in recent years as a result of a sustained and fairly unified campaign by the medical profession – Medicare Plus, GP workforce, Practice Nurses. These are all good for GPs but additionally some, such as practice nurses, are genuine health reform and take the heat out of moves to create separate primary care streams.

To assure the future of General Practice, the Government needs to hear your ideas over and over until they adopt them as their own. For that, General Practice needs the unity that has eluded it. You need good policies, you need your patients on your side, and you need endless patience as well. 🌐

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