Primary Health Care - 2010

1. Preamble

1.1 This Position Statement examines the role of general practice in the delivery of primary care services in Australia.

1.2 The AMA has developed this Position Statement as a vision for general practice and primary care into the future. It will be updated regularly to reflect changes in the delivery of primary care in Australia.

2. Definition of Primary Care

2.1 The World Health Organisation (WHO) Alma-Ata Declaration defined primary health care (PHC) as incorporating curative treatment given by the first contact provider along with promotional, preventive and rehabilitative services provided by multi-disciplinary teams of healthcare professionals working collaboratively\(^1\).

2.2 Primary care is socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation, and involves collaboration with other sectors. It includes the following:

- health promotion
- illness prevention
- care of the sick
- advocacy
- community development\(^2\)

2.3 The AMA endorses these definitions because they envisage a balance between curative services and promotion, prevention and rehabilitation - a balance that is often misunderstood by supporters of a non-medical approach to PHC.

2.4 "International studies show that the strength of a country's primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. This relationship is significant after controlling for determinants of population health at the macro-level (GDP per capita, total physicians per one thousand population, percentage of elderly) and micro level (average number of ambulatory care visits, per capita income, alcohol and tobacco consumption). Furthermore, increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending."\(^3\)
3. Definition of General Practice

3.1 “General practice is the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities. General practice involves the ability to take responsible action on any medical problem the patient presents, whether or not it forms part of an ongoing doctor-patient relationship. In managing the patient, the general practitioner may make appropriate referral to other doctors, health care professionals and community services.

General practice is the first point of contact for the majority of people seeking health care, and often therefore the first point of referral. In the provision of primary care, much undifferentiated illness is seen; the general practitioner often deals with problem complexes rather than with established diseases. The general practitioner must be able to make a total assessment of the person's condition without subjecting a person to unnecessary investigations, procedures and other treatment. General practice has a core set of clinical characteristics and practices, unique within medicine. These characteristics and practices are defined by the General Practice curriculum.

Surrounding this well-defined set of core clinical characteristics and practices, there are significant variations relating to the demands of particular clinical contexts, and to the special skills of individual practitioners. Context demands generally reflect both geography and particular populations. The variable demands of clinical contexts extend, for example, from remote rural contexts with high Aboriginal populations to outer metropolitan areas with high levels of chronic illness and/or refugee populations, and inner-city groups with high rates of HIV, Hep C and D&A problems. General practice training is intended to equip its graduates with both core clinical skills and the ability to assess and address the learning needs arising from differing clinical contexts over a professional lifetime”.

3.2 The AMA defines practices staffed by general practitioners who spend less than half of their patient contact hours providing general practice care, as defined by the RACGP, as special interest clinics as opposed to general practices.

3.3 As ownership and make-up of general practices changes, clinical sovereignty of general practitioners must continue to be a core, non-negotiable principle of the Australian health care system. GPs must be allowed to independently care for their patients in the most appropriate manner, free from commercial influence.

4. General Practice and Primary Care

4.1 General practice is pivotal to the success of primary health care (PHC) in Australia. PHC is not a substitute for general practice. Nor can it be implemented as a complementary system. Primary health care must be delivered through general practice.

4.2 The World Organisation of Family Doctors supports this view. In a 1991 statement titled The Role of the General Practitioner/Family Physician in Health Care Systems, general practice was described as the “central discipline of medicine around which medical and allied health disciplines are arranged to form a cooperative team for the benefit of the individual, the family and the community.”
"High quality primary health care depends on the availability of well trained general practitioners or family physicians as members of health care teams in the community."\(^6\)

"Internationally, there is an increasing emphasis on the importance of general practitioners as lynchpins in the health system. As generalists in the community, general practitioners have a first contact, longitudinal and comprehensive perspective of patients’ complaints, and are therefore recognised as crucial stakeholders in the delivery of agreed national policy."\(^7\)

"General practice is widely regarded as being at the heart of both the primary health care system and the health system overall. GPs play a crucial role as ‘gateways’ to the rest of the medical system: in this role they have a profound influence on both health outcomes and health expenditures. The role of the GP is becoming increasingly important as the population ages and there are consequent increases in the burden of chronic disease requiring continuing long-term care."\(^8\)

"The role of the general practitioner gives an indication of the breadth of the primary care services provided and the degree of uniformity in the services. In industrialized countries, the GP is the only clinician who operates in the nine levels of care: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, terminal care and counselling."\(^9\)

### 5. Primary Care Teams

5.1 Australia’s population is growing older and the incidence of chronic disease is rising. Primary care has been demonstrated as one of the most effective ways to deliver health services and Australia must continue to embrace and strengthen this model.

5.2 An effective way to deliver primary care is through primary care teams. These teams allow patients access to a broad range of professional expertise and can help improve access as demand for care grows.

5.3 General practitioners are the only clinicians appropriate to lead the primary care team, bringing experience and training in whole-patient, multi system continuous care. GPs are the only primary care health professionals who can take responsibility for diagnosing, treating and managing care.

5.4 It is the GP’s role to assess the patient, make a diagnosis, and determine how their management can be best supported by other members of the primary care team or through referral.

5.5 The AMA believes the Medicare Benefits Schedule must be structured to support and encourage this model of primary care.

5.6 Without a “team” approach to care and an appropriate team leader, Australia risks creating a fragmented health system that fails to provide patients with continuity of care.

5.7 The AMA supports a team-based approach to patient focused primary care with the general practitioner at the centre of the team.
5.8 The key to safe practice in any model of care is that non-medical health professionals work in an interdependent, co-operative relationship with medical practitioners.

5.9 The AMA believes that an emphasis on substitution of tasks away from medical practitioners to other health staff can lead to diminished quality and safety outcomes. AMA accepts there is greater scope for team-based models of care under the control of the medical practitioner.

5.10 There are significant limitations on the extent to which tasks can be taken out of the hands of medical practitioners or away from their supervision. These limitations include the inability of lesser-trained groups to appreciate the complexity of medical decision-making and treatment options. Many local signs and symptoms are indicative of more general disease and selective training in a particular disease, organ or tissue fails to adequately prepare the treating practitioner to recognise the broader disease involved. Further, even if appropriate treatment is initiated it is even less likely that non-medical practitioners will have the education or expertise to recognise, diagnose and manage complications of their therapeutic interventions.

5.11 Therefore the AMA does not support the "independent" nurse practitioner as reflected in the variety of State/Territory legislated roles for nurses where levels of independence remove the general practitioner as central to delivery of primary care.

5.12 However, General Practice Nurses (GPN) make a valuable contribution to the profession of general practice and, while their role is complementary to that of the general practitioner, it is integral and adds value to the delivery of primary health care services in the general practice setting.

5.13 Within a practice, a positive and constructive relationship with general practitioners, based on mutual professional respect, establishes a GPN as an indispensable member of the health care and administration team.

5.14 The role of the GPN will vary according to the specific needs of the practice, the qualifications and specific skills of the GPN, and the needs of the local community that the practice serves.

5.15 The AMA is of the view that the establishment of clear and agreed practice protocols, particularly those related to clinical care, must form the basis for the role of the GPN within the practice.

5.16 For the primary care team model to be successful, strong communication channels between general practitioners, pharmacists, allied health providers, community nurses, general practice nurses and specialists must be developed and maintained. These channels must allow GPs to provide information to all professionals involved in the care of the patient and receive timely reports from each of these providers. (For further detail - refer to the AMA Position Statements on General Practice Nurses and Independent Nurse Practitioners and the AMA Submission to the Productivity Commission Review of Health Workforce.)

6. Access

6.1 Australian general practice is central to our primary health care system and provides the point
of access for patients into the system. General practice must remain the gatekeeper to secondary medical care, ensuring an economically sustainable, high quality health system. General practice must be affordable and accessible to all Australians.

6.2 The underlying strength of general practice resides with the GP’s capacity to form an ongoing relationship with the patient that produces the personal knowledge and mutual confidence necessary to ensure appropriate services. General practice is also closely involved in the local community. This role is facilitated by its proximity to places where people live and work.

6.3 The AMA supports a primary health care system that provides equity of access to quality care for all Australians regardless of their race, sex, religion, socio-economic status or location.

6.4 General practice is often the only available source of care after hours or in specific locations. The Government must ensure that there is robust support for general practice in these areas.

6.5 The AMA acknowledges the enormous potential that rapid advances in e-health and telecommunications technology have to improve patient access to general practice and other GP coordinated primary care services. With the right supporting infrastructure, including high speed broadband, new innovative models of care delivery such as 'virtual clinics' will become a feature of general practice.

6.6 There is no single model of virtual clinic and these will evolve according to local community need and the available primary care infrastructure. For example, virtual clinics could involve the provision of some aspect of patient care via the internet or other means and/or greater integration of services that different primary care providers deliver in collaboration with GPs. Without limiting the options available, it is clear that support for virtual clinics could be directed towards investment in areas such as:

- Stored e-health record;
- Improved telephony systems;
- Video consultations;
- Centralised or shared patient booking systems;
- Web based service delivery.

7. Advocacy

7.1 The general practitioner plays a pivotal advocacy role for all patients and helps them access the care they need in an increasingly complex and confusing system.

7.2 The general practitioner/family physician serves as the advocate for the patient regardless of the level of care within the system that the patient requires. Advocacy includes helping the patient and/or family to take an active part in the clinical decision-making process. Advocacy by the general practitioner/family physician also includes working with government and private authorities to maximise equitable services to all members of society.
7.3 As well as receiving care, patients look to GPs to explain and interpret what often appears to them as a jumble of services. GPs act as the coordinator and interpreter of care for the patient over time and across services.  

7.4 For disadvantaged or disempowered patients, the GP is ideally placed to facilitate their access to other services and assist them in navigating the health and welfare system.

8. Quality and Safety

8.1 Every member of the primary care team must practise according to the principles of evidence-based medicine (EBM). In addition, they should practise according to profession-set standards, be appropriately accredited and undertake continuing professional development.

8.2 General practitioners have a commitment to quality care and attempt to practise on the basis of their knowledge of the most effective management strategy for a particular condition.

8.3 “In the last few decades the amount of information concerning available treatment and management options for many conditions has increased exponentially. This development has particular relevance for general practice given the breadth of conditions managed.”

8.4 EBM is a useful tool for assessing the value of specific clinical interventions on the basis of rigorous and systematic evidence. Clinical guidelines based on EBM should not be used to prescribe interventions but should augment clinical skills and experience.

8.5 “It is essential that clinical research address the broad range of questions relevant to general practice and that the use of EBM is critically assessed within a general practice setting.”

8.6 The AMA supports an evidence-based medicine approach, which entails the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

8.7 General practitioners work to a very high level of standards that have been developed by the profession and over 85 per cent of general practices are accredited. This demonstrates general practitioners’ strong commitment to providing safe, quality care to patients, as the quality of Australia’s health care is partly dependent on the structure and organisation of practices.

8.8 The AMA supports a system of general practice accreditation that is independent of Government, is under the effective control of actively practising general practitioners, and is a voluntary, educational and supportive process.

8.9 Continuing professional development helps general practitioners update and maintain their skills and knowledge, particularly as new evidence from rigorous research mandates changes to standard practice. The AMA supports Continuing Professional Development (CPD), which is integral to the definition of medical professionalism, in line with the following principles:

- that it be directed and supervised by the profession;
- that it be needs based;
- that it be interactive;
• that it be relevant to the practice setting;
• that it be part of a multi-faceted program; and
• that it include individualised learning. (For further detail - refer to the AMA Position Statement on General Practice Standards.)

9. Workforce

9.1 General practitioners must be at the centre of primary care. Therefore, the general practice workforce must be adequate and sustainable.

9.2 Doctors are attracted to general practice because of the breadth and diversity of work, being part of the community, providing continuity of care, teamwork, lifestyle benefits, and the flexibility of a portable, dynamic and fulfilling medical specialty.¹⁷

9.3 General practice must continue to be an attractive vocation in the future.

9.4 Initiatives that would impact on general practice workforce include improved remuneration, infrastructure support, a final round of grandfathering for eligible non-VR GPs, and improved training and career pathways.

9.5 The growing acceptance and development of GP-led primary care teams will also impact positively on workforce. In a team environment, GPs will have more clinical and administrative support. This will allow more patients to be cared for by the team under GP supervision and provide the GP with more time to spend with patients.

9.6 The AMA believes strategies must be developed to rebuild value in general practice businesses. There must be a clear financial benefit to owning and running a general practice. If this can be achieved, more doctors will be attracted to general practice.

9.7 The changing lifestyle and work patterns of general practitioners must be considered and reflected in general practice training - both in terms of training numbers and delivery of training.

9.8 Australia must increase its medical workforce through training of an adequate number of local students, but this is a long-term proposition. However, Australia must strive to reach this goal in order to reduce its reliance on overseas trained doctors. In an environment of increasing global competition, attracting sufficient numbers of International Medical Graduates (IMGs) will be increasingly difficult in the future. In addition, there are ethical questions around Australia utilising IMGs when they are needed in their countries of origin.

9.9 In the short-term, initiatives must be developed to encourage general practitioners to delay retirement. More doctors staying in the workforce longer would result in a significantly larger workforce.¹⁸

9.10 Ensuring all areas of Australia have a viable general practice workforce will be partially addressed through increased workforce numbers and support for primary health care teams. However, initiatives to attract GPs to areas experiencing shortages will be required.
9.11 The early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enrol in medical schools are the most likely of all initiatives to increase the workforce in these areas.

9.12 Proper medical infrastructure, a strong training experience, and access to community and professional resources, and continuing medical education are essential to the provision of a rewarding professional and personal experience.

9.13 Consideration must be given to the needs of not only the medical practitioners, but also their families - particularly with respect to access to employment opportunities, healthcare, safe work practices, education, and social amenities.

9.14 Appropriate remuneration and incentives are essential to attract and retain medical practitioners.

9.15 A significant reduction in general practice "red tape" would also positively contribute to workforce issues.

9.16 In addition to general practice workforce, governments must consider initiatives to improve the workforce numbers of other primary care providers such as allied health professionals and general practice nurses. (For further detail - refer to the AMA Position Statements on Medical Workforce and Training, Overseas Trained Doctors and Regional/Rural Workforce Initiatives.)

10. Funding

10.1 General practice in Australia is funded by a variety of mechanisms. The main source of general practice funding is fee-for-service, under which patients pay for the service they are provided and seek a rebate from their insurer. The universal insurer for general practice services in Australia is Medicare.

10.2 Medicare is currently designed to provide patient rebates for care of illness rather than prevention of illness. The AMA believes the Medicare system must move away from this purely disease based model and embrace the provision of "wellness" services.

10.3 To enable true equity of access for all Australians, Medicare must properly value the provision of general practice care. Patients, particularly those from disadvantaged groups, must not face unreasonable out-of-pocket costs because Medicare fails to insure patients appropriately.

10.4 A restructured Medicare Benefits Schedule (MBS) would encourage GPs to spend longer with patients providing quality care. This would allow GPs to better facilitate and integrate care, provide preventive and public health care, and manage chronic illness.

10.5 The MBS must also be appropriately indexed to keep pace with any increase in the cost of providing general practice services.

10.6 Australia enjoys one of the world's best health care systems and any move away from fee-for-service as the foundation of health financing will be to the detriment of individual patient care and
choice. Other funding mechanisms being implemented in other parts of the world and considered in Australia, such as fundholding, carry the risk of health rationing. It is only through fee-for-service that patients can be assured of uninterrupted access to services. Fee-for-service must remain as the cornerstone of general practice funding.

10.7 Remuneration of primary care activities must be for the service provided at the GP's instigation, not based on who provided the service. This will allow the general practitioner to determine which member of the primary care team is best placed to provide the care and the patient to access the care they need and deserve.

10.8 The Medicare Benefits Schedule must be restructured to allow general practitioners to delegate activities to the most appropriate member of the primary care team, while maintaining responsibility for supervising and managing total patient care. A structure that rewards service would strengthen the primary health care team. For example, general practice is a good place to undertake public health activities because 85 per cent of the population attends a general practice every year and because these activities can be integrated with total patient care. However, a GP may not be the best person to carry out all of these tasks. Many public health activities may be more efficiently undertaken by a general practice nurse.

10.9 As primary health care teams grow and general practitioners are asked to provide more training for our future doctors, consideration must be given to establishing a funding mechanism that supports the development of practice infrastructure.

10.10 GPs must be supported in upgrading and expanding their facilities in order to provide patients with the safest, highest quality care. (For further detail - refer to the AMA Position Statement on "Fundholding" and "Private Health Insurance and Primary Care Services".)

11. After Hours

11.1 The AMA supports the right of all Australians to timely, appropriate primary medical care. It is, however, unreasonable to expect any doctor to be available 24 hours a day.

11.2 GPs and their practices have an ethical and professional obligation to ensure that their patients have continuous access to appropriate care and continuity of care. GPs' responsibility lies in ensuring patient access to after hours care. However, they cannot be personally responsible for providing round the clock care.

11.3 Increasing demands for out of hours care during the past two decades have placed the system of 24-hour care of patients by GPs under considerable strain. It is acknowledged that patients in some areas of Australia experience difficulties in accessing effective after hours primary health care due to a number of factors. These include an inadequate after hours workforce resulting, in part, from inflexible remuneration for GPs; insufficient patient education and awareness of available services; and inappropriate usage of hospital emergency facilities for primary after hours care.

11.4 The AMA believes the Medicare Benefits Schedule must recognise the cost and value of quality after hours services and enable GPs to establish sustainable mechanisms for the provision
of this care. The AMA has determined that any period outside 8.00am to 6.00pm on weekdays is considered after hours and this must be reflected in the MBS.

11.5 In the health care system, nurse operated telephone triage systems using computer-assisted protocols are increasingly common. The AMA objects to the establishment of a call service unless GPs are involved in its management, including developing protocols. In addition, the role of existing medical deputising services needs to be recognised. (For further detail - refer to the AMA Position Statements on “After Hours Services” and “Call Centre Triage and Advice Services”.)

12. Preventive Medicine

12.1 Primary care services can be optimised to improve delivery of preventive health care in Australia.

12.2 Preventive medicine includes the prevention of illness, the early detection of specific disease, and the promotion and maintenance of health. This can include population health initiatives such as immunisation and screening programs and helping patients quit smoking and address risk factors like weight.

12.3 Evidence-based periodic health examinations, which might include laboratory tests or imaging, should be undertaken for individuals and groups, timed according to the risk factors, including psychological and social factors, relevant to the individuals concerned.

12.4 The restriction of Medicare benefits to therapeutic medical services ignores the economic benefits, to the individual and to society as a whole, of preventive medical services. Recent additions to the Medicare Benefits Schedule have enabled GPs to provide health assessments to certain small, targeted groups of patients. However, for preventive health to be truly effective these "wellness checks" must be available to all Australians regardless of age, sex or risk factors.

12.5 The ability to deliver preventive health care will be even more vital as the prevalence of chronic disease grows.

12.6 The World Health Organisation (WHO) projects that in high income countries, including Australia, deaths from chronic disease will increase 11 per cent, including a 53 per cent increase in deaths from diabetes. WHO believes at least 80 per cent of premature heart disease, stroke and type 2 diabetes and 40 per cent of cancer could be prevented through interventions that lead to healthy diet, regular physical activity, and avoidance of tobacco products20.

12.7 Research into chronic disease by the Australian Institute of Health and Welfare (AIHW) in 2001 clearly demonstrates that prevention would have a significant impact on the risk of chronic disease in Australia. The AIHW report concluded "primary prevention, based on attention to both behavioural and biomedical risk factors, is a central part of chronic disease control. However, attention to these and other factors should also be a focus of care in those who already have chronic diseases - that is secondary prevention of various risk factors. The scope of prevention in the context of chronic diseases therefore is wide and includes effective management".21
12.8 Public health activities targeting chronic disease prevention are of value both to the individual and to governments.\textsuperscript{22}

12.9 Due to the large proportion of the Australian population that attends a general practice at least once a year, there is substantial opportunity for GPs to observe and influence the lifestyle risk behaviours of their patients.\textsuperscript{23}

12.10 Recognising the pivotal role of general practitioners in recruiting people to preventive health programs, the AMA believes there is a need to evaluate the full benefits of GP-based health screening consultations.

12.11 GP-led primary care teams are well placed to offer ongoing management of patient risk factors and deliver public health education to large groups of patients. (For further detail - refer to the AMA Position Statement on Preventive Medicine.)

13. Aboriginal and Torres Strait Islander Health

13.1 There are a significant number of Australians who, for a variety of reasons, are disadvantaged in terms of health care. All of these groups deserve assistance and support. However, the health of Aboriginal peoples and Torres Strait Islanders must be made a priority by government.

13.2 Aboriginal peoples and Torres Strait Islanders suffer a disproportionate burden of illness and social disadvantage when compared with the general population. Life expectancy at birth remains 20 years less than that for non-indigenous Australians and the gap has not closed. The percentage of the Aboriginal population expected to live to age 65 is less than in many developing countries.

13.3 Ensuring appropriate utilisation of well-managed comprehensive primary health care services is crucial to the improvement of the health of Aboriginal and Torres Strait Islanders. There is currently a significant annual shortfall of spending on Aboriginal and Torres Islander health in the primary care sectors. Funding for Aboriginal and Torres Islander primary care must be increased. (For further detail - refer to the AMA Position Statement on Aboriginal and Torres Strait Islander Health)

14. Training

14.1 Australian Medical Workforce Advisory Committee research clearly demonstrates that there is currently a general practice workforce shortage in Australia.\textsuperscript{24}

14.2 Australia must work towards a training system that produces enough new general practitioners per year to meet this demand. This will require an increase in training numbers. An expansion of training numbers has already begun and this creates its own issues that must be addressed. In particular, the quality and safety of medical training during undergraduate, prevocational and vocational training must be maintained.

14.3 Consideration should specifically be given in planning to the following issues: infrastructure, resources and adequate clinical exposure required to deliver training to increased numbers of medical students and doctors in training; recognition and remuneration for all clinical teachers; adequate supervision at all levels; use of alternative settings including private hospitals and
community settings (such as rural and urban general practices); efficiency and effectiveness of training; and capacity of the system to absorb additional trainees whilst maintaining a high quality of clinical care. (For further detail - refer to the AMA Position Statement on Prevocational Medical Education and Training)

15. Research

15.1 Traditionally, there has been limited research into general practice specific fields. Research into other medical disciplines is produced at a significantly higher rate than for general practice. This must change.

15.2 "Primary care research is the missing link in the development of high quality, evidence based health care for populations." 25

15.3 General practice is a distinct medical specialty and requires its own specific research. Findings from other medical research cannot simply be transferred to general practice.

15.4 Research improves patient care, is important for teachers of general practice and stimulates intellectual rigour and critical thinking. 26

15.5 In addition, efficient and effective primary care will produce a more affordable health care system. General practice is the medical component of primary care. 27

15.6 More support must be provided to general practice research in order to improve primary care and patient health outcomes. In particular, general practitioners must be assisted to undertake research.

15.7 A robust general practice research discipline will provide general practitioners with new, exciting opportunities to explore their field of practice and produce cutting-edge findings that will assist the profession improve the services they provide.

15.8 Strengthening general practice research will help make general practice a more attractive occupation as it will provide increased opportunities for career growth and change. (For further detail - refer to the AMA Position Statement on Health and Medical Research.)

16. Doctor Health

16.1 Medical practitioners have an above average health status that is similar to others in advantaged socio-economic groups. Some issues of concern, however, include higher than average rates of suicide, stress, depression, substance abuse and violence.

16.2 The health and safety of general practitioners must be a priority for all stakeholders. General practitioner health can impact on workforce and quality and safety of patient care.

16.3 The AMA believes all general practitioners should have access to programs and support designed to improve their health and safety. There are already a number of very positive initiatives designed to assist GPs care for their health and safety. However, all GPs need to be aware of the help available and have access to support when it is needed.
16.4 The Royal Australian College of General Practitioners and Divisions of General Practice around Australia have developed successful programs to assist GPs who have health problems. These must be further developed and supported by the profession and Government.

16.5 Peer support programs and access to other forms of mental health care must be made more readily available. For example, the Doctors' Health Advisory Service (DHAS) is a telephone service providing first point of contact for doctors or family members in crisis. Callers are directed to appropriate primary care or psychiatric service providers. The AMA believes projects such as this must be encouraged and sustained.

16.6 Long hours and an inability to take adequate sick leave, holidays and meet family commitments put great strain on some general practitioners.

16.7 Initiatives are required to ensure general practitioners are not required to work unacceptably long hours and can take an extended break from their workplace when required.

16.8 All GPs need access to their own general practitioner and must be encouraged to seek care when it is needed.

16.9 Australia's GPs must be assisted in protecting themselves against the risk of violence. The AMA believes general practices must be supported through the provision of an infrastructure payment that will enable them to improve security measures. (For further detail - refer to the AMA Position Statements on Personal Safety and Privacy for Doctor, and Health of Medical Practitioners.)

17. General Practice Organisations

17.1 There are a wide range of organisations that support general practice in Australia. Each of these groups plays a role in shaping general practice and assists general practitioners provide quality care to patients.

17.2 The AMA is the peak medical organisation in Australia representing the profession's interests to Government and the wider community. The AMA advances the professional interests of doctors and the health of the community.

17.3 As a member based organisation, the AMA's policies and positions are based on consultation with its medical practitioner members and independent from influences associated with Government or other external funding.

17.4 Others organisations have their own distinct role in helping general practice, doctors and patients.

17.5 The Royal Australian College of General Practitioners is committed to ensuring high quality clinical practice, education and research for Australian general practice.28
17.6 The Rural Doctors Association of Australia advocates for quality medical care for Australians living in rural and remote communities and on behalf of practitioners working in those areas.29

17.7 Divisions of General Practice are local organisations, funded by the Australian Government’s Department of Health and Ageing to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals.30

17.8 Many other organisations contribute to general practice in Australia in terms of recruitment, quality and safety, education and training, and political representation. These include the Australian Rural and Remote Workforce Agencies Group, General Practice Education and Training, General Practice Registrars Association, Australian General Practice Accreditation Limited, Australian Medical Students Association, Australian College of Rural and Remote Medicine, General Practice Accreditation Plus, Australian Association of Practice Managers and the Australian Practice Nurses Association.

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