THE AUSTRALIAN NATIONAL UNIVERSITY

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

RESPONSE TO *TOWARDS A NATIONAL PRIMARY HEALTH CARE STRATEGY: A DISCUSSION PAPER FROM THE AUSTRALIAN GOVERNMENT*

APHCRI

February 2009

ANU COLLEGE OF MEDICINE BIOLOGY AND THE ENVIRONMENT

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BACKGROUND

The Australian Primary Health Care Research Institute (APHCRI) was established in 2003 provides national leadership in improving the quality and effectiveness of primary health care through the conduct of high quality priority-driven research and the support and promotion of best practice. APCHRI is funded through the Commonwealth Government's Primary Health Care Research, Evaluation and Development (PHCRED) strategy. The Institute's research focuses on important questions relating to the organisation, financing, delivery and performance of primary health care, including its interaction with public health and the secondary and tertiary health care sectors. Since its inception APHCRI has funded 13 streams of research and more than 50 individual projects and has an explicit commitment to improving the translation of research into policy. Recent APHCRI streams have included Sustainability of Primary Health Care Innovation, Chronic Disease Management, Primary Health Care Workforce, and Drivers of Successful Primary Health Care. APHCRI has been highly effective in funding research that is of direct policy relevance for Australian primary health care. APHCRI is pleased to have the opportunity to translate this research into evidence based options for the future of primary health care in Australia. (See Appendix 1 for an overview of some key APHCRI funded projects on workforce. All other project research outcomes can be accessed at http://www.anu.edu.au/aphcri/index.php)

SUMMARY OF KEY ISSUES AND PROPOSED ACTIONS

ACCESS TO SERVICES

1. The Commonwealth should take responsibility for the delivery of all primary health care services.

2. The outcomes from the consultations about a National Primary Health Care Strategy should be integrally linked to the National Health and Hospital Reform Commission's work and to that of the National Preventive Health Taskforce.

3. Regional level organisations, which are not necessarily based on current divisions of general practice boundaries, need to be developed so as to gather population based data and to deliver primary health care that meets the needs of population groups. There needs to be trained population health staff linked to a national public health institute.

4. Clear strategy and governance frameworks, to meet the needs of specific populations at a local level, need to be developed through regional organisations where comprehensive population based data can also be collected to inform service priorities.

5. Consumers at a local level need input into the organisation of primary health care so that their needs are better met.

6. Investment should be made in eHealth models that are proven to be effective in improving access and provide cost effective treatment.

SERVICE DELIVERY

7. Funding needs to be provided for primary care practices and practitioners to be involved in research and to further develop research capacity in primary care.

8. There will need to be recruitment strategies, including possible incentives, given to incentives for patients from specific populations who are prepared to enrol.

9. A data collection and public reporting framework needs to be developed at regional levels about how well general practices coordinate care, how well they perform in enabling timely access and how care can be delivered to improve patient outcomes.

10. A National Centre for Quality Improvement should be established to support quality improvement in primary health care.

11. Linkages between services need to be strengthened to ensure efficient and effective service utilisation and minimise service duplication.

WORKFORCE

12. The education and training of health professionals for a role in primary care needs to be quality assured and underpinned by inter professional learning and better targeted for multi professional care and population health outcomes. Organisational development techniques can be used to train clinical leaders and to develop teams.

13. The establishment of inter professional teamwork in primary health care, so as to improve patient care, will require investment in education, training and organisational development and the development of good communication across disciplinary boundaries.

14. Clinical placements in primary care need to be adequately supported and funded and curricula reviewed for primary health care content.

15. Core competencies for primary health care professionals need to be developed if primary care teams are to work together effectively.

FUNDING

16. The current funding system underpinning primary health care needs to be reviewed to enable greater flexibility in meeting both episodic care and provide a greater capacity to address the needs of particular populations and, in particular, those with chronic and complex conditions.

17. Appropriate measures of service outcomes should be developed and with appropriate incentives incorporated into service funding. In particular, measures to address current gaps in prevention and management of complex and chronic conditions are needed.

INTRODUCTION

This paper acknowledges the significant contribution the *Towards a National Primary Health Care Strategy* document makes to the development of a comprehensive and sustainable primary health care system in Australia and agrees that a robust, sustainable and high quality primary health care is at the heart of the Australian health system.

This paper reports on a roundtable held by APHCRI on 17th February 2009 with key stakeholders, researchers and practitioners in primary health care (See Appendix 2). Participants were encouraged to use their individual expertise and the recent APHCRI and international research base to build a vision for the future of a primary health care strategy in Australia. The discussion had three goals:

- To examine any links between this document and the interim National Health and Hospitals Reform Commission Report (NHHRC) issued on 16th February 2009
- To review and respond to key questions in *Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government* (PHCS) and
- Based on APHCRI evidence to make recommendations to the Reference Group on key issues raised in the PHCS document

SECTION 1

SYNERGIES WITH THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION INTERIM REPORT

The NHHRC interim report provides a sharp focus on four main areas:

- Taking responsibility for health by individuals
- Connecting care in a patient centred way
- Facing inequalities in access to primary care and through acknowledging the social determinants of health
- Driving quality performance across clinical and governance domains of primary care.

It also makes key proposals for the funding and delivery of primary care to help address these key areas. A comprehensive PHCS should underpin these proposals and

the emphasis on primary health care in the NHHRC report points to the need to review and renew primary health care in Australia. The key ingredients of such renewal should be based around measurable population health outcomes, enhanced system performance and a highly skilled multidisciplinary health workforce. The PHCS could provide and operational plan to link in with the NHHRC interim report and develop the Australian primary health care system. It is important that this strategy is integrally linked to any outcomes and actions arising from the NHHRC

PRINCIPLES

APHCRI notes that the Government's priorities for a primary health care strategy include the following:

- Better rewarding prevention.
- Promoting evidence-based management of chronic disease.
- Supporting patients with chronic disease to manage their condition.
- Supporting the role GPs play in the health care team.
- Addressing the growing need for access to other health professionals, including practice nurses and allied health professionals like physiotherapists and dieticians.
- Encouraging a greater focus on multidisciplinary team-based care.

APHCRI considers that a primary health care system built around the elements set out in the Task Force discussion paper around access, service delivery, health workforce and fiscal sustainability/cost-effectiveness would be able to meet these priority objectives.

SECTION 2

RESPONSE AND RECOMMENDATIONS TO KEY TOPICS IN THE PHCS DISCUSSION PAPER

ELEMENTS 1-4: ACCESS TO SERVICES

If Australia is to provide a comprehensive, quality assured and well co-ordinated national primary health care system, funding and priorities need to be administered and co-ordinated from one source. The Commonwealth government should take responsibility for setting policy and funding primary health care services.

This is not to say that the Commonwealth should operate primary care services such as those currently operated by states and territories. Contracting arrangements with governments and other providers against specified service and outcome criteria should be explored.

Recommendation 1: The Commonwealth should take responsibility for the delivery of all primary health care services

Recommendation 2: The outcomes from the consultations about a National Primary Health Care Strategy should be integrally linked to the National Health and Hospital Reform Commissions work and to that of the National Preventive Health Taskforce.

There is a need for good population data to help explain why some populations do not access primary care. Although a number of groups, including Divisions of General Practice, gather population based data and other potentially useful information, the data are not well utilised across the health care sector to ensure appropriates services are delivered to meet the needs of populations and are not centrally available to support planning and resource allocation. Resource allocation should be linked to population data through a needs based funding mechanism. Such a mechanism would be underpinned by robust centrally available population based data. To enable patient

centred care and choice for patients, patients need to be given options for accessing care so that they engage with the health services they need regardless of geographic location or ability to pay. There needs to be a national chronic disease surveillance system and expertise is required at regional level to use these data for designing interventions. The regional organisations should be co-terminus with LGA and other boundaries and include a strong local consumer focus.

Recommendation 3: Regional level organisations, which are not necessarily based on current divisions of general practice boundaries, need to be developed so as to gather population based data and to deliver primary health care that meets the needs of population groups. There needs to be trained population health staff linked to a national public health institute.

Recommendation 4: Clear strategy and governance frameworks, to meet the needs of specific populations at a local level, need to be developed through regional organisations where comprehensive population based data can also be collected to inform service priorities.

Recommendation 5: Consumers at a local level need input into the organisation of primary health care so that their needs are better met

If the Commonwealth was to take over responsibility for primary health care this would facilitate the development of population based maps for flexible needs based funding. Whilst it may not be possible to deliver comprehensive primary health care services and related support services to all geographic locations in Australia, populations could be better served by access to eHealth resources, particularly as the national broadband network is rolled out across the country. This would also facilitate a 'stepped care' model where people can access health care information and certain healthcare services via the telephone, the web and/or through Telematics. This would aid remote diagnosis and health decision making. Geographically diverse populations, as we have in Australia, require a mix of services that are accessible through various means, are responsive to their needs and provide high quality care over time. There is good evidence that web based brief interventions work, particularly in mental health care.

Recommendation 6: Investment should be made in eHealth models that are proven to be effective in improving access and provide cost effective treatment

A greater focus on preventive health care, including healthy lifestyles and health education is required in primary health care services. The most important development to support this will be the implementation of electronic health records. This will allow performance measurement which can be linked to remuneration. (See Appendix 1)

ELEMENTS 5-7: SERVICE DELIVERY

Developing an evidence-based research culture in primary health care, translating evidence into practice more systematically and supporting health care professionals' involvement in research innovation is vital to the development of a comprehensive and quality assured national primary health care system and to efficient service delivery. APCHRI, through the PHCRED strategy, has made a significant difference to the research culture and evidence base in primary care in Australia. Nevertheless, are significant challenges are yet to be addressed when engaging with health professionals working in primary care to develop a research culture. Research activity by primary care practitioners is not currently funded and this is a barrier for practice based research activity.

Research active and knowledgeable primary care practitioners are needed if research evidence is to systematically be translated into practice. Funding bodies, such as the NHMRC, have a role to play in providing adequate funding for practice based research projects and in supporting the building of relationships between practitioners and researchers and in rewarding practitioners for research involvement.

Recommendation 7: Funding needs to be provided for primary care practices and practitioners to be involved in research and to further develop research capacity in primary care

We concur with the NHHRC recommendations for young families and people who have chronic and complex conditions to have the option of enrolling with a single primary care service. In addition there is a need to target appropriate services for young people, in particular, adolescents between the ages of 14 and 24. This group faces a

number of risks and, while the barriers to them accessing care are well understood, evidence based strategies for addressing these barriers are poorly recognized and implemented in mainstream primary care. There are a range of other vulnerable groups, including people with intellectual disabilities and multiple co-morbidities whose needs need to be addressed.

Recommendation 8: There will need to be recruitment strategies, including possible incentives, given to incentives for patients from specific populations who are prepared to enrol

Whilst there is a need for better co-ordination of care, the particular professional who undertakes this role is context dependent. There is a need to train and educate clinical leaders and teams using real problems in real-time. These techniques are in use in the USA and UK. (See Appendix 1)

For instance, there is evidence practice nurses have the latitude to generate an environment of team work and team co-ordination. However, current funding models in primary care do not allow for team work and team development. Also, innovation of service delivery and co-ordination require research models to be developed and tested in primary care settings. For this to be successful practices will need to be funded to research and innovate and to develop a continuous quality improvement cycle in primary care practice. Work needs to be undertaken to gain a better understanding and evidence base for continuous quality improvement. The Audit and Best Practice in Chronic Disease (ABCD) project which aims for quality improvement in Indigenous primary health care provides a model for the development of a national quality improvement initiative in Australia. The Primary Care Collaboratives is another model of continuous quality improvement.

18. ***Recommendation 9: A data collection and public reporting framework needs to be developed at regional levels about how well general practices coordinate care, how well they perform in enabling timely access and how care can be delivered to improve patient outcomes.***

Recommendation 10: A National Centre for Quality Improvement should be established to support quality improvement in primary health care

Primary health care services need to be better linked and co-ordinated and be patient centred. The United States in particular has developed methodologies for implementation of research findings that mean the time from clinical trial to widespread use is now under five years. (See Appendix 1))

Recommendation 11: Linkages between services need to be strengthened to ensure efficient and effective service utilisation and minimise service duplication

ELEMENTS 8 AND 9: WORKFORCE

The current fee-for-service model which increases activity but is not related to outcomes creates workforce problems. Not only does it increase activity but it does not provide an incentive for teamwork or skill mix. APCHCRI has good evidence on the health workforce in Australia (see Appendix 1). The research has shown that approaches to improving primary health care workforce numbers in Australia require a broad range of strategies. Researchers reaffirm that a well developed primary health care workforce is necessary for good quality patient care. The research indicates that aspects of primary health care do not necessarily need to be delivered by general practitioners. However, expanded roles for other generalists should be considered in the context of best practice patient care and developed through closer working relationships between health care professions.

Practice nurses could be given more responsibility and have their role extended to take a more active role engaging with, and teaching, patients about self-management. In rural areas new medical workforce roles, like physician's assistants, could be working alongside GPs and nurses doing some procedural tasks at both hospital and primary care levels.

Continuing professional development (CPD) and opportunities to maintain a strong knowledge base, develop further skills and meet with other professionals in a learning environment contributes to a GP's commitment to rural towns. CPD is one of a 'package' of components that keep GPs in rural and remote Australia – including spousal and family support, the ability to access locums and medical team work.

A common thread in many of the APHCRI reviews is the need for adequate quality assured training, sensitive development of roles, mutual trust and respect between team members leading to effective communication and collaboration amongst the primary care team.

Recommendation 12: The education and training of health professional for a role in primary care needs to be quality assured and underpinned by inter professional learning and better targeted for multi professional care and population health outcomes.

Education and training classically is not enough. Attention needs to be paid to organisational development in primary health care. (See Appendix 1)
The 'future Australia' will need to make best use of the workforce it has and facilitate effective teamwork and rational use of limited workforce resources. Career pathways need to be flexible and allow evolution over time to reflect the changing needs of both the individual within them and of the health care system they serve. Undoubtedly there will be different mechanisms for retention of staff in the next generation.
For those already committed to primary care, retention is increased by a number of factors which include: recognition for the wide ranging, challenging and vitally important role they play, professional satisfaction and variety, adequate and flexible continuing education, realistic expectation that holidays can be taken and locum support found, and financial reward**.**
For the current primary health care workforce and those training in the future, it is vital that career development exists through structures and training pathways that enable career development. Generation Y graduates value flexibility and the capacity to change – the financial burden of buying the physical structure of a practice may be seen as unattractive and restricting, particularly as it adds to the significant debts accumulated during training. "Difficult-to-staff' regions may need to consider providing the infrastructure of practice which would allow medical practitioners, nurses and other allied staff to more easily move into (and out of) an area. This will need to be underpinned by clinical leadership and organisational development

Recommendation 13: The establishment of inter professional teamwork in primary health care, so as to improve patient care, will require investment in education and training and the development of good communication across disciplinary boundaries

Measures have been put in place to increase the number of medical and nursing graduates – it is now vital that the proportion of recent Australian graduates who

choose to work in primary care is increased. To do this it is imperative students are exposed to positive community-based clinical environments throughout their training and the primary health care focus of early postgraduate experience is increased. Clinical training in the community must be effectively funded, both to allow development of infrastructure but to also realistically cost the teaching commitment in the community. This will require a shift from the hospital systems in which the majority of nursing and medical clinical placements are completed, to the primary health care system. Some promising programs such as the PGPPP for medical graduates should be continued and new programs for nursing established. Nursing curricula need to reflect the central place of primary care and prevention in patient well being and focus on these areas more fully. Nursing curricula are currently heavily focused on the acute sector to the detriment of primary care and prevention.

Recommendation 14: Clinical placements in primary care need to be adequately supported and funded and curricula reviewed for primary health care content

The future education of the primary health care workforce should actively facilitate the development of functional primary health care teams. A starting point would be to increase inter- professional health care education and clinical placements. This is currently extremely difficult to achieve due to poor vertical integration of undergraduate-postgraduate training as well as almost no horizontal integration of medical, nursing and allied health training. Improving integration will be an additional cost to universities which provide medical and nursing training. First steps forward should include supporting the development of inter-professional primary health care organisations and providing targeted funding to universities to improve integration.
It is important to remember that there are existing functional multidisciplinary team models (like Aboriginal Controlled Medical Services, Primary Care Collaboratives) in the Australian primary health care system. Australia needs to learn from these and build scalable models of primary health care teams. One size will not fit all, and these models should be flexible and variable depending on local needs and resources. These could include co-located teams (eg GP Super clinics) or locally supported networks of providers funded on performance and clinical outcome; and instituting a quality assurance framework to provide the framework for funding.

Recommendation 15: Core competencies for primary health care professionals need to be developed if primary care teams are to work together effectively

Through a small number, perhaps six generic core competencies, it would be possible to change the way of working for an entire generation in training as well as those who train them.

ELEMENT 10: FUNDING

The funding system that supports primary care in Australia rewards patient throughput rather than health outcomes. It has become overly complex and bureaucratic and is ill equipped to deal with populations with chronic conditions and to support service co-ordination. Patient enrolment can be beneficial for patients who are at risk, who have high needs and where continuity of care is fundamental to their long term health needs. Models developed overseas to reward quality should be assessed in terms of their transferability to the Australian context.

Recommendation 16: The current funding system underpinning primary health care needs to be reviewed to enable greater flexibility in meeting both episodic care and provide a greater capacity to address the needs of particular populations and, in particular, those with chronic and complex conditions.

Recommendation 17: Appropriate measures of service outcomes should be developed and with appropriate incentives incorporated into service funding. In particular, measures to address current gaps in prevention and management of complex and chronic conditions are needed.

SECTION 3: SUMMARY AND CONCLUSIONS

Current attention to primary health care in Australia, and the reviews that are being undertaken, provide an opportunity for Australia to develop a primary health care services based on best evidence, staffed by the best trained health professionals and focussed on the patient and on population health outcomes. It also provides the opportunity to develop a funding framework that supports quality outcomes rather that

patient throughput. There is now the opportunity to develop a consistent approach and to link implementation across all the reviews being undertaken. If a comprehensive primary health care strategy is to be implemented in a timely manner, a timeframe for action needs to be developed, responsibility for carriage of the strategy identified, resources assessed and allocated and appropriate organisational structure for implementation put in place.

This submission provides key recommendations and fundamental pre-requisites for renewing and revitalising primary health care in Australia that is underpinned by good evidence and supports a National Primary Health Care Strategy.

APPENDIX 1:

SUMMARY OF THE APHCRI EVIDENCE BASE ON WORKFORCE

In 2006 APHCRI commissioned "Stream Six – Workforce" and funded nine research teams to examine how to increase general practitioner (GP) numbers, how to optimise the workforce that exists and the place of generalism in primary health care. This research provides a good foundation for looking at changing roles in general practice and thinking about what primary health care teams might look like in 2020. The following is a brief summary of the major outcomes of the research and is reproduced from the APHCRI Dialogues of 2008 available on the web at: http://www.anu.edu.au/aphcri/General/aphcri_dialogue.php .

Professor Jane Gunn's team undertook to answer one of the big questions in general practice – what is "generalism" and what will it look like in the future? The team developed a conceptual model that outlined the key personal and work characteristics and knowledge frameworks that are particular to generalists. Generalist are often reflexive and interpretive individuals who share biographical as well as biotechnical epistemological frameworks and this, combined with their community-orientated and patient-centered approach to doing, mean that generalists have the potential to deliver 'health for all'. Gunn and colleagues believe that generalism is a professional ideal worth understanding and striving for.
Professor Gunn looked at the primary health care team in 2020 and called for policy which "increase(s) the importance and status of primary health care generalist workforce through career pathway development and remuneration, among other facilitators".

Professor Jill Thistlethwaite used a systematic review and targeted interviews to establish how to entice more medical graduates into general practice. She concluded that the profession needed to improve its image with medical students and those thinking of studying medicine and be more flexible in training and working hours to attract young professionals.

Her research showed medical students are influenced by a number of factors when making a career choice, including work/life balance opportunities, experiences during training and at medical school, and their personality.
With increasing numbers of women in medical training and choosing general practice the solo General Practitioner model is becoming increasingly unattractive. Professor Thistlethwaite's work suggests funding maternity leave and developing more salaried positions and a greater emphasis on team working would tip the balance in general practice's favour.
While these solutions might result in more GPs in the cities on Australia's eastern seaboard, areas of need and rural/remote communities may well still struggle to fill the workforce void. Rurally bonded medical graduates will soon start coming through the system, but how many will stay - and for how long - is less certain. On all projections rural and remote Australian workforce solutions are still desperately needed.
Professors John Humphreys and John Wakerman examined the issue of continuing professional development (CPD) to discover if opportunities to maintain a strong knowledge base develop further skills and meet with other professionals in a learning environment contributed to GPs commitment to rural towns. They discovered that while CPD was a contributing factor, it was one of a 'package' of components that kept GPs in rural and remote Australia – including spousal and family support, the ability to access locums and medical team work.

Dr David Perkins et al, considered the wider roles of medical practitioners in building a sustainable workforce into the future. Looking specifically at generalism in primary health care mental health they concluded that generalists across the health spectrum, not just GPs, have a role to play.
The report noted international evidence that endorses increasing the range of elements of care provided by non-GP generalists, with appropriate supports. GPs would then be helped by other generalists to provide elements of care where they are more effective, but encouraged to share or delegate care, which can be provided effectively by other generalists.

Professor James Dunbar and his co-authors considered general practice as an organisational structure, considering how organisational development could be applied to general practice, particularly in the care of chronic disease. Professor Dunbar argues that performance in health care organisations is linked to leadership, culture, climate

and collaboration and these features need to be a key part of any reform or change agenda in primary health care. He also noted that unless organisations are willing to change, attempts to influence clinical practice change remain ineffective.
The Dunbar team believes that an organisational development approach in primary health care will lead to better health outcomes for chronically ill patients by improving team work, communication, integration and co-ordination and by facilitating the creation of clinical networks across organisational boundaries. With this in mind in order to see patient health outcome benefits, Australia's workforce solutions need to be part of a broader change in the system and organisation of primary health care.
The research showed that approaches to improving primary health care workforce numbers in Australia require a broad range of strategies. Researchers reaffirmed that a well developed primary health care workforce is necessary for good quality patient care. The research has indicated that aspects of primary health care do not necessarily need to be delivered by general practitioners. However, expanded roles for other generalists should be considered in the context of best practice patient care and developed through closer working relationships between health care professions. Generalists, of many forms, have an important role to play in Australia's health care in the future.

Professor Nicholas Zwar has examined the use of teams in two APHCRI research streams. Looking at chronic disease management in 2006, Professor Zwar found that patient self-management was a potent tool in managing chronic illness and combined with a multidisciplinary team approach, will improve physiological measures of disease. In his Stream Six work, Professor Zwar looked at optimising skill mix for the care of older Australians and concluded that there are particular roles that primary health care nurses can successfully adopt. These include pro-active patient follow-up, general patient consultation and support, care planning and goal setting. Professor Zwar cautions that the expansion of nurse roles needs to be developed through improving inter-professional trust and handled with sensitivity.

Professor Helen Keleher's research on community nursing suggests the role of practice nurses should be expanded and the profession given a clear career pathway and training. Most practice nurses come into the profession via hospital work and the training in the tertiary environments is not always compatible with work in the primary health care sector. Clear role delineation of the primary health care/general practice

nurse may help attract nurses to the sector in the face of declining overall workforce numbers.

Professor Keleher's research affirms that primary health care nurses have a role to play in chronic disease management and that, within their scope of practice, they can achieve similar patient health outcomes to doctors. Professor Keleher states 'Nurses working in primary health care can help address workforce shortages, improve access to health care and contribute to the management of chronic conditions and illness prevention."

Professor Dennis Pashen looked at the expanding role of generalists in rural Australia given that both nursing and GP numbers are at a crisis point in many rural communities. In his review Professor Pashen concludes that: "greater investment in primary health care and 'generalist' medical services maybe more cost effective, efficient and equitable for rural communities compared with specialist and sub-specialist medical service providers". He notes Queensland has developed specific training and career pathways for 'rural generalists' which reflects the importance of broad procedural and cognitive skills and is supported with attractive remuneration. In an effort to support existing generalists Professor Pashen suggests that mid-level practitioners such as physician assistants, practice nurses and nurse practitioners are part of the solution because "they can extend the reach and enhance the viability and sustainability of rural and remote medical generalists."

The use of other medical professionals to supplement general practice care for mentally ill patients – particularly those suffering from depression and anxiety – was examined by Dr Grant Blashki and his team from Melbourne. They concluded there was good evidence for GPs providing problem-solving therapy for depression, good evidence for psychologist delivered psychotherapy and good evidence that collaborative, multi-professional approaches to depression care are superior to treatment as usual for depression and some other illnesses.

These reports indicate that good patient health outcomes for elderly Australians, those with chronic and/or mental illness and patients in the bush are possible with the evolution and adaption of the roles and responsibility of the primary health care team. Practice nurses could be given more responsibility and have their role extended to take a more active role engaging with and teaching patients about self-management. In rural areas new medical workforce roles like physician's assistants could be working

alongside GPs and nurses doing some procedural tasks at both hospital and primary health care levels.

A common thread in many of the reviews is the need for sensitive development of roles, mutual trust and respect between team members leading to effective communication and collaboration amongst the primary health care team. How best to achieve this might be the next important question to address in the evolution of primary health care multidisciplinary teams.