Meeting Australia's Emerging Primary Care Needs by Nurse Practitioners

Michael A. Carter, DNSc, DNP, Eileen Owen-Williams, DNP, PhD, and Phillip Della, PhD, RN

ABSTRACT

Australia is experiencing challenges in developing the workforce to meet emerging primary care needs and has attempted to address these challenges by producing more physicians. However, new medical graduates are selecting specialty practices rather than primary care. Nurse practitioners (NPs) provide primary care in other countries, whereas Australia's nurse NPs are primarily in hospital-based, specialty practices. Lessons learned from the United States' experience can position NPs as a solution to the emerging Australian primary care shortage.

Keywords: Australia, Medicare Benefits Schedule, nurse practitioners, Pharmacy Benefits Scheme, primary care

Australia has a keen interest in assuring the best health care possible. The National Healthcare Agreement in 2012 states that the Australian health system should "provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country."[1(pA-2)] The basis for the delivery of this broad approach to care is a robust primary care delivery system. The Australian Medical Association says that primary care providers are expected to diagnose and treat a wide variety of acute and chronic health conditions as well as serve as the referral source for specialty care.[2]

Australia reports problems with an unequal distribution of primary care doctors, with the majority located in urban, affluent areas and lower numbers and poorer doctor/patient ratios in rural, poor areas.[3] The challenge is meeting the increased need for primary care services in the setting of a coexisting decrease in traditional primary care providers' availability.

There are a number of factors that have led to the increased need for primary care providers, including higher rates of chronic disease in an aging population of Australians.[4] There have been increases in type 2 diabetes, dementia, and arthritis in Australia.[4] Recent Australian initiatives, including patient-centered care, increased demand for after-hours care, inclusion of the social determinants of health, and increased demand for health promotion and disease prevention, act to increase the need for primary care provision.[4] These health care needs are paired with a shortfall in the number of general practice doctors due to aging and retirement and a marked decrease in the proportion of medical school graduates who elect primary care practice after completing medical school.[5]

PROBLEMS WITH THE OLD MODEL OF CARE DELIVERY

Primary care in Australia is commonly provided by a general practitioner (GP) in private practice, and payment is usually made by the patient, with a portion reimbursed to the patient by the Medicare Benefit Schedule (MBS). Some patients have additional private insurance to help offset the difference between the GP charges and the Medicare payment. The Australian Medicare payment structure is based primarily on the time the GP spends with the patient.

A challenge with this model care is the increased complexity of the conditions being treated in primary care, leading to an increase in the number of patient encounters for chronic illness and comorbid conditions.[5] The time-based model of care payment is most cost effective for the GP when the health

condition is a self-limiting acute illness. Chronic illnesses require that the patient self-manage the condition with the consultation of the primary care provider. This means that sufficient time must be allocated during the visit to evaluate the problems and select the best treatment from a range of treatments for the specific patient—with the consideration of individual preference, culture, health literacy, available resources, and other patient-centered care characteristics. These visits must be scheduled at regular, frequent intervals. Substantial patient education is required and the coordination of the care provided by a number of other providers is critical to high-quality outcomes. All of these issues act to increase the time needed for each visit and the frequency of visits. Chronic illness management requires that each primary care provider cares for fewer patients, further increasing the need for additional primary care providers.

Australia's Health Workforce Series[5] provides useful information concerning primary care physicians in the country. Over the past 20 years, there has been a substantial decrease in the proportion of Australian medical school graduates selecting primary care. This decrease has been coupled with other changes in primary care practices. Australian doctors are working fewer hours than in the past and the range of services that they provide has decreased, with many primary care physicians no longer providing surgical or obstetrical services to their patients.[5]

Nearly 25% of the physicians in Australia are over age 55, and a substantial number will be retiring in the next decade.[5] Australia has increased the number of medical schools and class sizes but has not been successful in meeting the primary care demands of the country. There has been about a 25% increase in the number of primary care physicians in Australia over the past 10 years as compared with the 47% increase in all clinical physicians.[5]

One of the approaches that Australia has used to make up for the shortfall in doctors is to import doctors who have obtained their medical education in another country. Clearly, there is the draw of a substantially different economic picture for many doctors from low-resource countries. Yet, is this the best policy for sustaining a health care system for the future? This policy is short-sighted and immoral, often leaving the developing countries with an increased medical workforce shortage.[6,7]

Currently, 26% of all doctors in Australia have received their primary medical education in another country,[5] compared with 25% of all doctors in the US.[8] Almost 40% of Australian visas are granted to doctors from lower resource countries. About one third of the GPs in Australia were trained overseas.[5]

The World Health Organization has developed a global code of practice regarding the international recruitment of health personnel.[9] Both Australia and the US have signed this agreement. One of the key areas of this agreement is that resource-rich countries should educate and retain their own workforces. Rich countries become a substantial drain on low-resource countries when they become destination countries. There are substantial moral and ethical questions that arise when resource-rich countries develop health workforce plans that rely on the recruitment of health personnel from other countries as compared with domestic training. Yet, this is exactly what the Health Workforce Australia plan has done.[5]

Australia has an alternative in place using existing, educated health workforce personnel who are citizens of the country, are culturally similar, speak local dialects, understand the health system, and are distributed throughout the country. The full deployment of nurse practitioners (NPs) can help Australia to meet the looming primary care shortage.

THE CASE OF US NPs

The case of NPs in the US is proposed for consideration to influence Australian policy. The role of NPs was begun in the US by Loretta Ford and Henry Silver in 1965 to provide primary care to children.[10] Children were not receiving the care needed and these 2 pioneers believed there was a better way than to rely only on physicians. The early NP programs taught diagnostic skills, including history-taking, physical examination, differential diagnosis, laboratory testing, and radiography. These skills were combined with medical diagnosis and referral systems. Studies showed that these new NPs were well prepared to provide primary care.[11]