Primary Health Care – 2021
July 2021

1. Preamble

1.1 This Position Statement examines the role of general practice in the delivery of primary care services in Australia and in line with the *Delivering better care for patients: The AMA 10-Year Framework for Primary Care Reform* serves as a vision for general practice and primary care into the future.

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 health-care 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 microlevel (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 provides comprehensive whole-patient medical care to individuals, families and their communities. Services provided may be for care that is urgent or routine, for minor or complex health issues and includes preventive care, diagnosis of undifferentiated illness, the management of acute and chronic illness, palliative care, where the biological, psychological, and social factors relevant to the patient's care are taken account of. Care is often longitudinal with the majority of patients having a preferred practice and a preferred GP[4].

3.2 General practice is the first point of contact for the majority of people seeking health care and as such is often the first point of referral for diagnostic, other specialist and allied health services. General practice plays a central role in the coordination of patient care.

3.3 The AMA defines practices where less than 50% of practice's general practitioners clinical time (ie collectively), where less than 50% of the services for which Medicare benefits are claimed (from that practice) are special interest clinics as opposed to general practices.

3.4 As ownership, structures 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 any commercial influence.

4. General Practice and Primary Care

4.1 General practice is the cornerstone of, and pivotal to the success, of primary health care (PHC) in Australia. PHC also involves care delivered by nurses (such as general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and aboriginal health workers. This care, while a valued contribution and one that works better in a collaborative model with general practice, supports but is not a substitute for GP care.

4.2 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 and safe services. General practice is usually the first point of call by the community for primary care services, as such general practitioners are deeply entrenched in their communities and cognisant of community and service need in the areas that they work.

4.3 A review of the international literature over many years, as evidenced below, has clearly demonstrated the important role of general practice within the health system. A role which governments need to incorporate into health policy design for effective health service delivery to the community.

General practice is 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."[5]

"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. 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.

5.3 General practitioners are the only clinicians appropriate to lead the primary care team, bringing experience and many years of training in whole-patient, multi system continuous care. As a result of this extensive training, 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 to non GP Specialist services.

5.5 The AMA believes primary care funding must be structured to best support and encourage a GP led collaborative model of care.

5.6 Without GP led team based care, Australia risks creating a fragmented and siloed health system that fails to provide patients with continuity of care and poorer health outcomes.

5.7 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 and fragmentation of care and the patient journey. AMA accepts there is greater scope for team-based models of care in collaboration with the medical practitioner.

5.8 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 non-medically-trained health practitioners to appreciate the complexity of medical decision making and the available investigative 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 health practitioner to recognise the broader disease involved. Further, even if appropriate treatment is initiated, it is even less likely that non-medical practitioners will recognise, diagnose and be able to manage complications of their therapeutic interventions.

5.9 Therefore, the AMA does not support the "independent" health worker, for example nurse practitioners as reflected in the variety of State/Territory legislated roles for these nurses and where varying levels of independence remove the general practitioner as central to delivery of primary care.

5.10 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.

5.11 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.

5.12 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.

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

5.14 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, the 10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors, and the AMA Submission to the Department of Veterans' Affairs Review of Dental and Allied Health Arrangements.]

6. Access

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

6.2 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, socioeconomic status or location.

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

6.4 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.

6.5 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, 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
- Clinical software with integrated virtual care systems
- High speed, consistent and reliable telecommunications connectivity.

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 and often 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.[10]

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.[11]

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 safely and according to the principles of evidence based medicine (EBM). In addition, they should practise according to profession-set standards, be appropriately credentialled have a defined scope of clinical practice and commit to undertake continuing professional development and upskilling.

8.2 A review of the literature provides many examples as follows where quality and safety issues are paramount in the primary care setting:

> 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.[12]
>
> "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."[13]

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.[14]

"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."[15]

8.3 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.[16]

8.4 General practitioners work to a very high level of standards that have been developed by the profession and over 80 per cent of general practices are currently accredited against these standards.[17] This demonstrates general practitioners' strong commitment to providing safe, quality care to patients.

8.5 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.

8.6 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 The general practitioner workforce must be adequate and sustainable to ensure community need is met.

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.[18]

9.3 Government investment and training policies must be directed in such a way that General practice must continue to be an attractive vocation into the future.

9.4 Initiatives that would support an adequate and sustainable general practice workforce include improved remuneration, improved models of funding to support quality and seamless care, infrastructure support, prevocational exposure to general practice, equitable remuneration and employment conditions for GP trainees improved training and career pathways and upskilling opportunities.

9.5 The growing acceptance and development of GP-led primary care teams will also impact positively on workforce. In a collaborative 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 greater capacity to provide comprehensive patient care.

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 so more doctors will be attracted to practice ownership and a long career in 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 ensure its medical workforce through the training of an adequate number of local students to meet workforce needs and address maldistribution. Australia must strive 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 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. Initiatives to attract and retain GPs to areas experiencing shortages must remain a continuing focus of policy decisions.

9.10 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[19,20,21].

9.11 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.

9.12 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.

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

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

9.15 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 the Medicare program.

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

10.3 While retaining fee-for-service as the predominant funding mechanism, the AMA believes there is significant scope to better support holistic care and improve patient outcomes through a blended funding model incorporating incentives, grants, block and pooled funding mechanisms.

10.4 An enhanced blended funding model that supports value based care over volume based would better support GPs, team care, and general practices in the provision of holistic, collaborative care that is efficient, well targeted and patient-centred.

10.5 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. 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.

10.6 In developing a blended funding model, it must include a mix of fee-for-service and non fee-for-service funding, and must be designed so the risks commonly associated with the funding mechanisms utilised are offset. For example, fee-for-service funding can encourage overservicing, capitated funding can encourage "cherry picking" and block funding can cause care to be rationed.

10.7 To enable true equity of access for all Australians, the care provided in general practice must be properly valued and funded. The AMA has constantly advocated for 16% of total government expenditure on health be directed to funding general practice care.

10.8 Where providing quality care requires spending more time with a patient the GP attendance items in the Medicare Benefits Schedule (MBS) must be structured in a way that progressively devalues GPs time.

10.9 Indexation of the MBS must keep pace with any increase in the cost of providing general practice services. Over the years the indexation of the MBS has been inadequate against increases in Average Weekly Earnings and the Consumer Price Index, and at times have been frozen, cumulatively devaluing patient rebates, Patients, particularly those from disadvantaged groups, must not face unreasonable out-of-pocket costs because Medicare fails to insure them appropriately.

10.10 Government funded remuneration of primary care services must be for a service provided at the GP's instigation as part of the patient's treatment and or management plan. This will ensure GP centrality to patient care, delivering improved care coordination and timely access to clinically appropriate services as required for quality patient care.

10.11 Funding streams that support greater utilisation of the general practice health care team must be developed and implemented to enable general practitioners to delegate activities to the most appropriate member of the team, while maintaining responsibility for supervising and managing total patient care. A structure that rewards provision of quality care and improved health outcomes would strengthen and support care collaboration, working to scope of practice, and efficient use of resources. For example, general practice is a good place to undertake population health management 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.

10.12 As primary health care teams grow and general practitioners are asked to provide more training for our future doctors, funding mechanisms that appropriately resource and support general practices and GP supervisors and mentors are essential. This could include infrastructure grants, support payments and incentives.

10.13 GPs must be supported in upgrading and expanding their facilities so they can 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 The AMA acknowledges the role of Medical Deputising Services in supporting general practices in providing their patients with access to after hours care. The AMA supports this role where Medical Deputising Services complement and operate in collaboration with general practice.

11.3 It is acknowledged that patients value access to medical care in the after hours period but 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 busy GPs being fatigued at the end of their long working days, inadequate remuneration; and insufficient patient education and awareness of available services; all of which contributes to and results in inappropriate usage of hospital emergency facilities for primary after hours care.

11.4 The AMA believes the Medicare Benefits Schedule (MBS) must recognise the cost and value of quality after hours services and enable GPs to establish sustainable mechanisms for the provision of this care. While the AMA defines after hours as any period outside 8.00am to 6.00pm on weekdays, the AMA believes that at a minimum the after hours period for in-room consultations under the MBS must be brought forward to start from 6pm on weekdays and 12 noon on Saturdays. This alignment of the after hours period with that for Medical Deputising Services under the MBS would support general practices in extending their hours of operation to enhance patient access to care.

11.5 Patient’s access to care in the after hours period is greatly advanced through access to telehealth consultations.

11.6 In the health care system, nurse operated telephone triage systems using computer-assisted protocols are increasingly common. These services can be a useful part of an integrated system supporting GP after hours services, but are not a substitute for GP care. Triage services must be able to support patient access to GP

care when required. Triage services must operate on the basis of GP-endorsed protocols and must have stringent quality assurance measures in place. [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 to combat the prevalence of chronic disease.

12.2 Preventive medicine includes the prevention of illness, the early detection of specific diseases, 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 other risk factors for poor health and chronic disease development.

12.4 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 products[22].

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".[23]

12.8 Public health activities targeting chronic disease prevention are of value both to the individual and to governments.[24]

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.[25]

12.10 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.

12.11 Blended funding arrangements that support the flexible and efficient provision of preventative care in general practice should be implemented.
[For further detail - refer to the AMA Position Statement: Doctors and Preventive Care.]

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 significantly less than that for non-indigenous Australians and indigenous Australians can expect to die around 10 years earlier than non-indigenous Australians[26]. The percentage of the Aboriginal population expected to live to age 65 is less than in many developing countries[27].

13.3 Aboriginal peoples and Torres Strait Islanders experience a higher prevalence of risk factors for chronic disease – diabetes, mental health conditions, smoking, overweight and obesity and harmful drinking levels – which persistently contribute to poor health outcomes for Aboriginal and Torres Strait Islander people[28].

13.4 Access to culturally safe comprehensive primary health care services is for improving Aboriginal and Torres Strait Islander health[29].

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 (see also AMA Vision for GP training)

14.1 Despite graduating record numbers of medical graduates,[30] there has been a decline in the number of medical graduates entering specialist general practice training compare with other specialties, and an ongoing maldistribution of the general practice workforce across inner and outer regional areas[31]

14.2 Action that produces tangible outcomes is urgently needed to encourage and support medical students and doctors in training to pursue a career in general practice to meet workforce and community demand. Pathways must be developed to provide access to a positive rural and general practice training experience, beginning in medical school, and continuing into prevocational training.

14.3 The following considerations are essential to develop a viable training pathway: adequate infrastructure, resources and the clinical exposure required to deliver training to 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); and the efficiency and effectiveness of training.

14.4 The AMA supports a well structured, planned and systematic transition to College led training that provides those aspiring to be the GPs of the future some certainty of their future training including a training model that provides a quality learning experience that supports the registrar to achieve specialty Fellowship.

14.5 Employment conditions for GP registrars should be comparable to non-GP registrars in order to sustain General Practice as an attractive vocational pathway for prevocational doctors. An employment model that allows GP registrars and supervisors to focus on the learning experience rather than being influenced by service delivery and business arrangements is desirable.

[For further detail - refer to the AMA Position Statement on Prevocational Medical Education and Training and the AMA Position Statement Medical Workforce 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."[32]

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.[33]

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.[34]

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.

15.9 The Australian Primary Healthcare Institute should be reinstated and a minimum of 8 percent of National Health and Medical Research Council funding should be dedicate to general practice research. [For further detail - refer to *Delivering better care for patients: The AMA 10-Year Framework for Primary Care Reform*.]

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 and be aware of programs and support designed to improve their health and safety.

16.5 Peer support programs and access to other forms of mental health care must be readily available.

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 General practitioners must have access to flexible working arrangements to ensure they 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. Access to infrastructure grants would assist general practices in ensuring a safe workplace appropriate security measures in place.

[For further detail - refer to the AMA Position Statements on Personal Safety and Privacy for Doctor, and Health and Wellbeing of Doctors and Medical Students.]

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