Building a fit-for-purpose Australian primary healthcare workforce

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SINCE ADOPTING the Medicare Benefits Schedule as a universal health insurance model, successive federal governments in Australia have grappled with the tension between providing appropriate health services for citizens and the budgetary implications of each occasion of service. A coordinated national approach to medical workforce supply and development was only achieved in 1995 with the establishment of the Australian Medical Workforce Advisory Committee. Since then, legislators have introduced various measures to manage workforce numbers while concurrently attempting to ensure equity of access for demographically and sociologically disadvantaged populations.

The articles presented in this edition of *Australian Journal of General Practice* raise issues that will determine the future role and function for the general practice/primary care workforce in Australia.[1–5] In order to maintain some of the best population health outcomes in the world, what type of workforce should we aspire to? Do we need primary care? If so, how many primary care doctors do we need? What roles could safely be devolved to other service providers, and would they really be less expensive? How should general practitioners relate numerically and professionally to consultant medical services?

Concerns about the provision of services to isolated rural and remote communities encapsulate many of the dilemmas relating to workforce availability and the incorporation of technological innovation. Since the 1990s, rural workforce undersupply has been addressed through the imposition of geographic distribution systems for trainees and overseas-trained doctors. Programs designed to carve out rural and remote practice as a specialist niche area of medicine have developed in tandem with these various distribution levers. Sen Gupta and his colleagues note that evidence of success is patchy at best, with little evidence of long-term sustainability.[3] If indeed there is an irresistible drift of practitioners to larger population centres, and if emphasising the differences (rather than the similarities) in rural and remote practice means that any such rural and remote workforce is passionate but numerically tiny, do we need to develop new approaches to workforce development and distribution across the full span of a medical career?

Beilby correctly warns that the failure to effectively implement and evaluate new technologies, including but not limited to telemedicine, will be a missed opportunity.[4] Simply establishing a video link is insufficient – it is a fundamental principle that doctors delivering services to communities must have a clear understanding of the issues and conditions relevant to those communities.

Sturmberg and his co-authors argue for considering health as a complex adaptive system, requiring a more sophisticated approach to balancing issues of supply, demand and quality.[5] If our workforce training curricula ensure standardisation and efficacy across a defined range of competencies, how do we concurrently develop primary care practitioners who are 'fit for purpose' across the diversity of Australian workplace environments? Should we plan for workforce adequacy or for a redundancy that ensures competition between providers?

A more comprehensive and sophisticated approach to health workforce supply was promised with the establishment of Health Workforce Australia (HWA) in 2009, but the only substantial report to emerge from HWA acknowledged that the predictions made for future workforce sufficiency were based on past patterns of work and did not allow for new models of practice.[6] In the current era of digital disruption and workforce redesign, attempts at planning a future medical workforce can only be a 'best guess'. However, the quadruple aim principles relating to evidence, cost-efficacy, patient-centredness and provider support suggest potential foundation principles on which to build any new workforce programs.[7]

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