

PIP GENERAL PRACTITIONER TEACHING PAYMENT IS IT TIME FOR IMPROVEMENT?

Submission to the Red Tape Taskforce
November 2003

This paper has been developed jointly by members of the Australian Association of Academic General Practice (AAAGP) and the Federation of Rural Australian Medical Educators (FRAME). AAAGP represents the Departments of General Practice in each Australian medical school. FRAME represents the Rural Clinical Schools and Rural Undergraduate Support and Coordination (RUSC) academics in each Australian medical school. Together, these organisations represent the majority of academic primary care physicians across Australia.

The review of the Practice Incentives Program by the Red Tape Taskforce is timely. This paper provides evidence to support a recommendation that the Undergraduate Teaching component of the PIP not only be maintained, but be increased. It presently represents less than 1% of the total PIP funds, but has been very positively taken up by accredited general practices.

This review presents an opportunity for the quantum of the remuneration to more accurately represent the actual costs to the practice of teaching. It also provides an opportunity for the Commonwealth to reconsider whether this funding could be even more effective if it were made available to the practices through the Universities, thus enabling more accountable contracts to be developed between the Universities and the practices in regards to the outcomes and standards required of the teaching practices.

KEY POINTS

There are a number of key points that this paper makes:

- Commonwealth Government support of undergraduate teaching in primary care is an essential component of Australia's primary care workforce strategy.
- The current \$50 payment per three and half hour session for general practice teaching of undergraduates is inadequate and should be increased to \$100.
- The value of being able to access general practice (GP) teachers in their own practice is substantial, with students gaining important skills in such areas as communication, exposure to management of people with complex multisystem disease and practical clinical training.
- At a time when general practice is being exposed to multiple changes, it is important that GPs who want to teach are retained and adequately remunerated
- There are long-term benefits for the Health System in exposing medical students, in their formative years, to good GP role models. This exposure is likely to lead to more students choosing general practice as a career and, for all students, provide an understanding of the importance of primary care and a generalist approach. Teaching in general practice is a way to influence the culture of medical practice for the next generation towards a primary care model. This is particularly relevant to the rural and outer urban areas.

- Government support for teaching in general practice should be synergistic with other Government initiatives in primary health care, especially the University Department of Rural Health (UDRH), Rural Undergraduate Support Coordination (RUSC), Rural Clinical School (RCS) and General Practice Education and Training (GPET) initiatives. Consideration should be given to broadening the scope of teaching in general practice to include nursing and allied health students.
- Government support for teaching in general practice is a cost-effective long-term strategy for the renewal of Australia's primary care workforce.

At a time when the number of policy initiatives aimed at general practice has increased markedly, patients are no longer admitted to the secondary and tertiary hospitals for long periods of time. As a result, sustainable and consistent access to a broad range of patients who can participate in clinical teaching is no longer available. Most of the people/patients who are suitable for teaching are now found in the community. Therefore the GP setting is now essential for teaching¹.

The benefits of providing access to the general practice for undergraduate and graduate medical students are substantial. Most medical students will end up working in the community and there should be a priority to provide training in these environments in their formative years. Exposure to general practice will allow medical students to understand the value of a doctor who is trained to work with multidisciplinary teams, skilled in chronic disease management and can still call patients by their first name.

There are a number of other arguments about why we need GP teachers. Teaching of clinical skills and communication skills by GPs to students in their formative years at medical school provides a role model that helps balance the specialist based/hospital perspective. A strong general practice is an essential requirement for an effective and efficient health care system. Good communication skills, as seen in everyday general practice (and basically taught by GPs in all medical schools) are essential to reducing litigation. Teaching these skills is therefore a good investment. Students trained in the culture of a tertiary hospital learn the cultural norms of this environment – a rigid hierarchy and inter-professional rivalry; sub-specialisation; expensive investigation and cross-referral; focus on cure rather than prevention and a focus on the patient in an institution rather than the person in a family and community.

Currently there is a \$50 fee paid to the GP for teaching/supervising for a three and half hour session. This paper argues that it is time to consider increasing this fee.

In Australia, the number of practices involved in teaching medical students was:

- Feb 2001 – 12% of 5248 ie. 630 practices
- May 2001 – 7% of 5260 i.e. 368 practices
- Aug 2001 – 10% of 5216 ie 522 practices
- Nov 2001 – 14% of 5273 ie 728 practices
- Feb 2002 - 15% of 4344 ie 652 practices
- May 2002 – 10% of 4482 ie 448 practices

¹ Worley P et al Medical Journal of Australia 2000;172:615-617).

In essence, there are a small number of motivated practices that need ongoing support. The current outlay is \$4 million which is approximately 0.2% of total Medical Benefits Scheme expenditure.

There is a growing discomfort, especially among rural GPs about the amount of teaching they are being asked to undertake. The pressure of time, particularly in areas where there is a shortage of GPs (e.g. in the country and outer urban areas) is beginning to become a greater concern. Increasing problems with morale, widespread policy changes and the current indemnity impasse are other issues that are forcing GPs to look critically at whether they want to keep teaching. To be a good teacher requires time and commitment and GPs need to decrease their consulting to supervise and support students.

In the United Kingdom GPs are paid £119 per session which has been calculated to allow for slower consultation rates and the organisational time involved. This fee is increased where face to face teaching occurs with 4-6 students to £280. In 1991 Australian GP teachers indicated that their day was 1.5 -2 hours longer when they taught medical students in their practice² which is similar to family physicians in the United States³. In the United States the “productivity of teaching physicians was down by 30-40% when they were teaching medical students”⁴. A qualitative study in London concluded that GP educators found that teaching medical students had a positive effect on morale. This improvement in morale was due to a number of factors including peer support, revision of clinical knowledge and skills, more time with patients and an improved image of the practice⁵. The problems these GP teachers faced were much the same as Australian GPs – lack of time and space and “anxieties about adequacy of clinical cover while teaching”.

The cost of providing community based teaching is growing. The Riverland experience has identified that there are recurrent and capital costs that need to be considered in providing high quality teaching in rural general practice. For a general practice experience to have a positive impact on future career choice and practice characteristics, it must be of high quality. Poor experiences in general practice will have a negative impact on students. Good teaching requires time, and whilst the impact of this appears to decrease with extended attachments⁶, there is a considerable cost incurred in the standard 2-6 week rotations that are common throughout Australia. The average length of placement in 1999 was 5.89 days (urban) and 13.78 days (rural)⁷. Placements of this length incurred a recurrent cost of 6-10 patients per day. This is in addition to any recurrent administrative costs such as internet access/phones etc.

Good teaching also requires adequate facilities in the practice. Increasingly, this means that a practice must have a consulting room available for a student to use, and must have an area within the practice that the student can use for quiet uninterrupted study. These are considerable capital expenses for practices and universities to manage.

² Kamien M et al Medical Journal of Australia 1991; 254: 395-400

³ Vinson D, Paden C. Academic Medicine 1994; 69(3): 237-8

⁴ Garg M, Boero J Academic Medicine 1991; 66: 348-53

⁵ Hartley S et al. Influence on general practitioners of teaching undergraduates: a qualitative study of London general practitioners. BMJ 1999; 19: 1168-1171

⁶ Worley P, Kitto P Rural and Remote Health 2001 <http://rrr.deakin.edu.au>

⁷ Strasser R, Worley P, Togno J, Schofield K, Murtagh J, Silagy C. A profile of undergraduate medical student placements and teaching practices 1999 Department of Health and aged Care

Similar recurrent and capital expenses have been noted in the University College of London experience⁸. Clearly, any remuneration for teaching needs to take into account the capital and recurrent costs of student participation in patient care.

What is the correct fee? Aside from the need to pay for the intellectual input of the participating GPs, the fee should also cover infrastructure costs required to teach such as computers, use of dressings, telephone, lighting etc. Currently each participating GP is paid \$50 per session. There has been a suggestion that one normal level B payment per hour (i.e. for a three and a half hour session this would be $\$28.75 \times 3.5$ or \$100.63) would be appropriate. General Practice Education Australia (GPEA) pays GP educators \$204 per three hour session. There is some evidence that teaching costs about 30% of gross sessional fees and \$100 per 3 and half hour session would be about one third of the sessional consulting fee.

There are a number of other issues that also need discussion.

1. Currently a GP can claim for two students per session which is equivalent to \$100 per session. If however a practice takes more than two students and the GP actually stops consulting and coordinates a tutorial, then should the practice be paid more? There is evidence that both models of learning have a place in providing undergraduate teaching.
2. The GPs who are based in marginalised parts of the health system (e.g. remote parts of Australia) have greater difficulty in maintaining practice accreditation, and as such are not able claim the PIP teaching payment. Some of these GPs are excellent teachers and provide role models for students who have a long term interest to practice in these communities. We should have a method to reimburse their involvement and entice them into undergraduate teaching. These practices operate at the margins of the health care system. These often involve local communities and motivated doctors working together to improve health outcomes - this might be a service for the homeless in the city, in a remote Aboriginal community or in a small rural town that has taken on the coordination of its own health service. The educational opportunities are great - motivation to work in areas of need, cross cultural practice and understanding, how to "make things happen". But the resources in such settings are often limited and the service providers almost always have no access to PIP funding due to the difficulties in meeting requirements for accreditation. With a high staff turnover, accreditation is even harder to maintain. Models to enable payments to go to the doctors or their employers working with students in these settings needs to be explored.
3. The issue of accreditation needs to be considered but requires more debate and discussion. Accreditation by peer review may have a role, but this will require a large amount of effort to establish and sustain. At this time we do not have an easily identifiable tool/instrument/questionnaire. Some possible criteria that have been suggested have included:
 - Enthusiasm (for general practice and teaching)
 - Motivation
 - Skills (both clinical and teaching)

⁸ Murray E, Jinks V, Modell M. Community-based medical education: feasibility and cost. 1995;29:66-71

- Personal attributes (as a role model, teacher and coach)
 - The environment in which they work
 - Practice patient profile
4. There is an increasing policy emphasis on a team approach to health care. This is currently not reflected in the education of health professionals. There is the opportunity to change this culture, at an undergraduate level, by providing the capacity for practices to be remunerated for coordinating and providing community-based nursing and allied health students learning in their practice. The current funding model is a disincentive to multi-disciplinary education.

As the pressure grows in general practice to embrace more change and cope with more complex issues, fewer GPs will want to teach. GP teachers are vital in exposing medical students to community based teaching and providing a role model for future GPs. Without GPs supporting medical student education, our future graduates will not be adequately trained and will miss out on this vital exposure. This seems even more important for the rural workforce. If we do not expose medical students to the joys of rural general practice, then how will we entice these students back to the country? If we do not support these GP teachers with an adequate remuneration, then we will lose these excellent educators.

This paper argues for an increase in the GP PIP teaching fee in order to help retain our GP teachers. A doubling of the amount to \$100 per session seems the most ideal way forward.