Harnessing fast and slow thinking to ensure sustainability of general practice and functional universal health coverage in Australia

We must complement simplistic responses to urgent problems with strategic, considered, long term redesign across the whole health system

Universal health coverage (UHC) provides all people with access to the full range of quality health services they need (inclusive of health promotion, prevention, treatment, rehabilitation and palliative care), when and where they need them, without financial hardship.[1] The World Health Organization is explicit that achieving UHC "requires strong, people-centred primary health care".[1] In Australia, Medicare is the financing instrument underpinning our nation's claim to ensuring UHC. Although Australia's health care system compares favourably to other Organisation for Economic Co-operation and Development (OECD) nations on performance metrics,[2] there are relative deficiencies shown by increased waiting times and deferral of care due to cost.[3]

The authors of a recent systematic review of policy and financing challenges to UHC in Australia concluded, inter alia, that the current focus on general practice and voluntary patient enrolment will likely be insufficient to deliver UHC built on lasting structural change.[4] They further argue that successful future reform efforts must simultaneously reduce fragmentation and improve whole system integration. We concur and suggest that a focus on general practice and other primary care mechanisms is a necessary but not sufficient requirement for meaningful reform and redesign focused on UHC in Australia.

If our nation is committed to the attainment of UHC, then how should the whole health system align to deliver affordable, timely access to high quality health services built on a bedrock of holistic primary care but integrated across secondary and tertiary care settings? Primary care is an important foundation for UHC because it provides first contact, locally delivered, person-focused, comprehensive, coordinated and continuing care,[5] and because nations with strong primary care systems achieve better health outcomes and greater patient satisfaction at lower overall cost than United States-type specialist-led models.[6,7] In Australia, general practice is the major provider of medical primary care and is a vital contributor to broader primary health care.

To realign our health system for long term sustainability, we need a shared and widely accepted definition of what we mean by UHC and how primary care, general practice, other medical specialists, disciplines and hospitals contribute. This will require broad and deep consideration of the role of community accountability and the social contract in medicine and health care; of relationships within and across health professions; of how we organise and attend to education, training, and service delivery; and how we prioritise health care needs relative to health care wants. In recent reform documents, these fundamental and complex questions have been given superficial attention, despite their importance for the ongoing sustainability of UHC and the pivotal role of general practice in the Australian context.

Drawing on the cognitive dichotomy popularised by behavioural economist Daniel Kahneman,[8] we suggest that both "fast" and "slow" approaches to problem solving are required to address the complex dynamics at play, and resolve immediate, pressing problems as well as underlying foundational challenges (Box). Fast thinking is instinctive, reactive and often stereotypic; slow thinking operates at a different level and is effortful, directed, strategic and relatively infrequent.[8] In addition to superficial, problem-focused strategies that address discrete and delineated problems, we need deeply considered, thoughtful approaches to the structural and conceptual challenges that underlie our national health system.

During 2022, the challenges faced by Australian general practice led to increased advocacy from professional and consumer bodies[9-11] and to new government initiatives with short delivery timelines. These include recent promises from the Health Minister and First Ministers group to strengthen Medicare via 50 urgent care centres and priority primary care pilots,[12] which can be seen as a fast superficial and highly reactive (fast thinking[8]) response to the urgent challenges in the hospital system. It is intuitively appealing and might, in the short term, take some pressure off hospital emergency departments.[13] Alone, however, this is a simplistic approach that does not account for complexities in shifting demographics, changing burden of disease, or structural inequities in the broader health system. But, perhaps most importantly, it does not adequately accommodate the key principles of high functioning primary care and how they underpin effective UHC.[6]

High level strategic documents from the Australian Medical Association (AMA)[14] and the Royal Australian College of General Practitioners (RACGP) establish a vision,[15] and the *Strengthening Medicare Taskforce report*[16] outlines some reasonable next steps to try to support a failing Medicare. However, the critical slow thinking needed to support complex adaptation and reorientation of the whole health care system is currently missing. We need a higher calibre and breadth of public debate about health care in Australia than is currently occurring. Such debate has been lacking since the last substantial attempt at reform when the National

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Fast and slow approaches to problem solving to resolve immediate, pressing problems and foundational challenges

Current problem-focused thinking (fast thinking)

- Use longer consultation item numbers to appropriately remunerate complex consultations
- Fund urgent care centres through states and territories
- Provide block funding through voluntary patient enrolment for some groups (in the absence of an implementation science approach to the establishment of a complex socio-technical intervention)
- Implement pharmacy prescribing trials

The needed system-focused thinking (slow thinking)

- Engage active debate with our community to develop a shared vision of universal health coverage in Australia across the whole health care system and identify the contributions of different disciplines and sectors and levels
- Consider what social accountability means for medical practice and system organisation and relationships between disciplines
- Develop consensus around how education, training and service delivery can orient towards agreed health care needs and priorities
- Develop models of urgent and extended care within general practice, based on existing models of best practice, and redesign workforce pipelines to support multidisciplinary care teams to work at the full scope of practice
- Enable Primary Health Networks to engage with local practices around voluntary patient enrolment models that would be functional, and support a move to population planning and heath service redesign toward prevention and proactive care
- Implement training pathways for all health care professions that improve integration and understanding of primary health care

Health and Hospitals Reform Commission reported in 2009[17] — many of whose recommendations are echoed in the more recent documents.[14,15] Critically, this time we need to follow debate and vision setting with sustained commitment from successive governments.

We need to address the preoccupation with general practitioner bulk-billing rates in favour of more balanced and comprehensive considerations of access to affordable care that account for community-level equity and professional parity. Despite focused and frequent reporting of declining GP bulk-billing rates, far less attention and concern is directed towards the much lower bulk-billing rates of non-GP specialists (which are more likely to be catastrophically high), with out-of-pocket costs for non-GP specialists and allied health services both higher.[18] The AMA and RACGP have called for greater investment in general practice, beyond the estimated only 6.5% of the total health budget.[19] Will the wider medical profession maintain support for reforms if the solution is to disinvest in procedural specialties and reinvest in lower paid consultation-based specialties including general practice, community psychiatry, paediatrics and geriatrics? How do we reorient our health system to deliver greater global value by shifting our investment profile towards primary care? What are we willing to change as a profession and as a community?

Challenges with attracting and retaining general practice workforce have been well recognised. The decline in Australian medical graduates choosing to train as GPs has been precipitous but is financially rational from an individual perspective.[20] Many proposed solutions to low GP numbers include initiatives to improve team-based care and increase role substitution by nurses and allied health professionals. Irrespective of whether these improve primary care provision, more than the currently reported 15% of Australian medical graduates[21] must choose general practice training if we are to meet the demands of the more than 85% of the Australian population who see their GP at least once a year. Alternatively, Australia will default to a United States-style non-GP specialist-led model. Overwhelmingly, the evidence suggests this would be undesirable in terms of health system cost, outcomes and equity.[2]

Money is only part of the problem, as the limited impact of rural financial incentives on distribution of the GP workforce attests.[22] Rather than just calling for higher Medicare rebates we also need some slow approaches to how we can promote the status and desirability of general practice. Strategies might include reinstating junior doctor placements in general practice; allowing GPs to work at the full scope of their practice with more support for procedural work in urban and rural areas;[20] or developing and supporting portfolio careers, where part-time clinical practice is complemented by reimbursed public health, education, research or policy roles to encourage GPs to use the full range of their generalist skills.[23]

There is broad acceptance that almost exclusive reliance on fee-for-service remuneration does not serve us as well in an era dominated by chronic disease and multimorbidity, where we need to improve preventive, proactive and complex care. Voluntary patient enrolment is often considered part of the solution to improve continuity and enable some form of blended payment[14,15] and has been part of several trials[24] in Australia. However, voluntary patient enrolment is at risk of becoming another simplistic solution emblematic of a fast thinking response, with relatively superficial interpretation and application in Australia. To date in Australia, voluntary patient enrolment is proposed to support resources to enable team-based care (and continuity within the team) and is directed at a specific subpopulation (ie, adults with established chronic disease). However, the intention as articulated in early seminal papers[25] is that enrolment is an essential building block that helps build accountability to community, population planning and equity in high performing health care. A slow thinking approach to implementing enrolment in Australia would include consideration of how to use it to shift primary care to be able to better plan, manage and deliver services for their practice population's needs, not just provide services to patients who have established disease and get an appointment. Enrolment is a facilitator but has complex implications for privately owned practices engaging individual contractor GPs. Staff will all have to develop new skills and shift practice work styles and flows. Slow thinking approaches take time to consider the levers, such as models of capitation payments, training in population planning, skill development in engagement and outreach to community and

primary health networks. Community and patients need to be involved with this shift to mitigate possible perceptions of compromising existing individual relationships with providers or reduction in choice.

Calls for change from professional bodies, politicians and the media bring opportunity but also risk. Meaningful change is hard, and we should not be seduced by the immediate appeal of fast response, falling for the lure of short term "announceable" solutions at the expense of more arduous but fundamental changes. In doing so, we risk avoiding the painful but necessary difficult questions with complex long term solutions and transformative potential. Although rapid solutions are also essential to avoid devastating collapse, they are unlikely to take us closer to the long term aim of sustainable equitable UHC founded on primary care. Slow thinking is effortful, critical, logical and slow. It goes beyond the "what you see is all there is" and requires us to account for complexity, human bias, and uncertainty.[8]

It is critical that we have informed public discussions about what we really value in our health care system, followed by persistent policy commitment and investment over more than a single election cycle. Primary care is a critical foundation for UHC but must function as part of an equitable, sustainable and aligned health care system. Ideally, we should harness the advantages of both fast and slow thinking to achieve optimal outcomes. The time to start is now.

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