A physician assistant working in Aboriginal health care—a new approach for Australia

Nanette Laufik1,2
1Mulungu Aboriginal Corporation Health Centre, 2School of Medicine, James Cook University

Introduction
The well recognised maldistribution of doctors in Australia has been much discussed among health professionals, consumers of health care and health care policy makers (1). Undersupply of General Practitioners (GPs) in rural areas including Indigenous communities poses even more complications (2). Training and employment of Physician Assistants (PAs) has proved beneficial to help correct workforce shortages in other countries (3-5). Amplifying and extending the doctor’s role as leader of a functional team that includes PAs is a potential model to help correct shortages in Australia (6).

In 2011 Health Workforce Australia (HWA) was requested by the Australian Health Ministers’ Advisory Council (AHMAC) to provide advice on the potential role of PAs in the Australian context (7). The report, which was considered by AHMAC in February 2012, found PAs can make a significant contribution to addressing a number of key strategies in the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015. It further stated that rural and remote doctors are the strongest advocates for urgent and positive consideration of the PA role. The doctors see PAs as the major solution to the imminent loss in the medical workforce owing to retirement, burnout and unsustainable workloads (8). Further advantages and contributions by PAs based on pilot programs in Australia and experiences in other countries were described in the report. In the context of this paper, specific benefits of employing PAs as part of the multidisciplinary health care team are: the potential for supporting health services for Indigenous Australians and increasing the productivity of doctors and other health professionals by releasing them from routine and repetitive tasks to allow them to work at the top of their licences (8).

The value of PAs in chronic disease care planning in Aboriginal Health Services and other rural settings derives from PAs as a flexible workforce, trained in a generalist model with emphasis on disease prevention and wellness (9); PAs are workforce multipliers who do not replace doctors; they are dependent practitioners capable of autonomous decision-making by delegation which amplifies and extends the role of doctors (4, 8, 10). Delegation of tasks frees the supervising doctor to attend more complex patients and increases time for teaching (11).

A career pathway for Aboriginal Health Workers, similar to that of Native American and Alaskan native Health Workers, is another potential advantage of the PA profession for Australia (1, 11, 12).

Background
In 2009 Queensland Health initiated a pilot program to introduce the PA role to the Queensland government health service. Five American-trained PAs were hired for a 12-month period, four of whom worked in rural settings, two each in Cooktown and Mt Isa. (The fifth PA worked in a tertiary hospital in Brisbane in Interventional Cardiology.)

The PAs in Cooktown primarily worked in the Emergency Department (ED) and Outpatient Clinic. They alternated coverage of the Inpatient Department on Saturdays and Sundays, allowing the weekend doctor to take call and provide supervision from home. This helped to reduce payment of overtime for the doctors who also reported a reduction of fatigue (11). Each PA also worked two days fortnightly at Wujal Wujal Primary Health Care Centre (PHCC). On one of the two days the rostered PA cared for patients with doctor supervision by telephone backup from Cooktown.

The Mt Isa PAs worked in the hospital ED, where a fast track service was commenced that was managed by one of the PAs. This model helped to reduce waiting times in the ED. The other PA eventually...
worked in Normanton and Karumba for six months helping to relieve the workload of the solo doctor there.

A pilot program was also conducted in South Australia in 2009. The focus was on inpatient care in urban settings (13). Independent evaluations and reports of both pilots have been favourable and are available for review (8, 11, 13). Overall reports of the pilot programs concluded that the PAs delivered safe, high quality care, were well integrated into the practice settings and were well accepted by patients and other medical staff (11).

At the conclusion of the Queensland pilot in 2010 one of the PAs commenced employment at James Cook University (JCU)-Cairns to teach clinical skills to 4th year medical students. The remaining PAs returned to the U.S. The PA in Cairns who decided to remain in Australia was anxious to maintain her skills as a PA and sought part-time clinical employment. This paper is a case study of her experience.

**Methods**

In May 2011 the Senior Medical Officer (SMO) of Mulungu Aboriginal Health Service (AHS) in Mareeba, Queensland decided to hire a PA. Mulungu was incorporated in 1995. Like many rural Australian health services, the clinic had ongoing difficulties attracting and retaining enough doctors. A great deal of money was spent paying locum tenens doctors most years. After several discussions the SMO and the PA at JCU-Cairns agreed that it was the right time for a doctor/PA partnership and Mulungu was the right place.

The aim for hiring a PA was to increase the delivery of comprehensive chronic disease care planning and follow up to more patients. For 18 months the doctor/PA team worked together two days weekly in the Chronic Disease Clinic (CDC) along with Aboriginal Health Workers, a Family Support Worker and a Social Worker. Together with the Aboriginal Health Workers the team also increased the number of Health Assessments, also known as Adult Health Checks. The doctor/PA team at Mulungu pioneered a model of utilising the skills of a PA as a health care team member within the Australian Medicare system. The model of patient-centred care primarily focused on patients with chronic conditions most of whom were Type 1 and Type 2 diabetics. Other patient conditions included rheumatic heart disease, chronic pulmonary disease, hypertension, rheumatoid arthritis, and heart failure.

**RESULTS**

**The economics**

By augmenting an established health care team, employment of the PA resulted in increased numbers of patients seen in the CDC. By using Medicare items the model was successful in generating sufficient income to pay both the doctor and PA salaries.

Medicare billing on a typical day caring for an average of eight patients is illustrated as follows:

- 2 patients, new GP Management Plan (GPMP) and Team Care Arrangement (TCA)
  Medicare Item numbers 721, 723 x 2 = $506.90

- 4 patients, GPMP Review and TCA Review
  Medicare item numbers 732, 732 x 4 = $600.60

- 1 patient (of above), Diabetes Assessment, Annual Cycle of Care (Diabetic PIP)
  Medicare item number 2517 = $36.30

- 2 patients, Aboriginal and Torres Strait Island Health Assessment
  Medicare item number 715 x 2 = $416.20

**Total Medicare billing for one 8-hour day = $1560.00**
The PA’s salary of $400/day generated revenue of $1560, based on the above example. On a per annum basis, the salary of $40,000 generated additional revenue of $156,000. Put another way, the PA’s employment was able to justify her position in the CDC two days a week and generate income approximately four times her salary.

On occasion a patient without a chronic condition requested a referral for mental health counselling services. Due to the time-consuming nature of the required care plan the patient was seen in the CDC rather than the Main Clinic:

Mental Health Care Plan (MHCP), consult > 40 minutes:
Medicare item number 2701: $103.50

The time factor
The average total time spent with patients was 40-60 minutes as below:

- Aboriginal Health Worker: 10-20 minutes
- PA: 20-30 minutes
- Doctor: 10 minutes

Whilst the health workers and the PA assessed the patient, commenced the care plan or health check, followed up on previous plans and referrals, and discussed medications, the doctor was able to see other patients and generate more income. The quality of chronic disease care improved at Mulungu as a result of systematic follow-up built into the Medicare scheme: Patients had the opportunity to ask questions and initiate discussions about problems and concerns; had sufficient time for solving problems and formulating solutions; and was effective in preventing gaps in medication regimes and maintaining awareness about upcoming specialist appointments.

Discussion
Though it is difficult at this early stage to measure outcomes, there were increases in preventive screening regarding physical activity and use of tobacco and alcohol, laboratory tests and medication reviews.

Working exclusively in chronic disease care was a role change for the PA. Previous positions were primarily in acute care settings. However, the nature of the PA role is to be flexible and to adapt to the needs of the health care setting and the supervising doctor. Through initial orientation to the electronic record system and by reviewing basics of internal medicine, the PA quickly became part of the team.

The PA’s contribution afforded the doctor additional time for the most complex patients. Complicated and sometimes sudden social and family issues, coupled with serious medical problems, required timely and time-consuming interventions and referrals. Additionally, delegating tasks afforded the SMO more time for other leadership duties including administration, clinic data review and teaching of junior doctors and medical students. The PA also participated in teaching medical students and Aboriginal Health Workers and assisted in orienting junior doctors to the clinic systems. Interactions with Health Workers improved their efficiency and included explanations about drug actions and interactions; interpretation of laboratory tests; planning home visits and patient referrals to specialist physicians, podiatrists, dieticians, dentists and psychologists; discussing strategies for improving patient compliance with oral medication and insulin regimes. In turn the Health Workers’ knowledge about the community and cultural aspects that affected patients was invaluable for the PA.

It was necessary and important that the PA explain her role to each patient being seen for the first time, to every new Health Worker and to other support staff. Feedback from staff and patients confirmed that patients were comfortable being seen by a PA. Staff members who were also patients were willing to be seen by the PA in the clinic, proof of their confidence in the PA’s role as a member of the health
care team. Building relationships through regular three to six month follow up visits benefited both the patients and the PA in understanding how to best manage their diseases.

**Recommendations**

The Mulungu model of a doctor/PA team for chronic disease management can be utilised by others with a reasonable investment of time. Learning the systems required by Medicare for appropriate care delivery and the systems of an individual clinic require a manageable amount of time and effort. This investment by the supervising doctor is quickly reaped in the future through benefits of increased revenue, improved efficiency and more time to devote to other important tasks.

In 2006 the Royal Australasian College of Physicians stated its support for the development of team-based care for chronic disease management. The author discussed task transfer as an evolving way for other care providers to share in taking active roles in patient management. Physician assistants were specifically mentioned along with nurse practitioners, diabetes nurse educators, and Aboriginal health workers (sic) (14). Doctors who understand the benefits that PAs bring to the health care team and who want to progress implementation of the role are advised to contact their government health agencies. Doctors who were eager to employ PAs in the 1960s in the U.S. helped to progress the profession by appealing to their medical boards and legislatures (10). Likewise, being vocal about this innovative role to those who make policy changes is a way to effect change in Australia.

Without professional registration, a PA’s skills are not fully utilised. Registration of PAs would relieve supervising doctors of such time-consuming tasks as ordering tests, prescribing medications, approving refills and making specialist referrals. The pilot program laws authorising limited prescriptive authority remain valid—to progress them to a workable form of registration is the next logical step.

The Australian Society of Physician Assistants (ASPA)—comprised of graduates of the University of Queensland PA Program, students of JCU’s PA program and other stakeholders—have instigated a self-regulatory registration board, reflective of the Australian Health Practitioner Regulation Agency (AHPRA) and Australian Medical Association (AMA) guidelines. Competencies include continuing education requirements with a goal for certification and ultimately for registration with AHPRA. The ASPA guidelines and registration documents are available for review on their website, www.ASPA-australianpas.org.

**Conclusion**

The patient-centred, team-based approach in health care has proved to be effective in chronic disease care. Through collaboration with the primary care GP/SMO and other team members, the PA made a contribution in chronic disease care at Mulungu AHS. The holistic model in which PAs are trained enhances patient acceptance of PAs. The Australian Medicare system for care planning and routine follow up is well-suited to a team model utilising the skills of a PA and is a sound investment for medical practices. The doctor/PA partnership is a non-competitive and efficient time- and cost-saving model. Extending the role of the doctor in Australia by task delegation to the PA improves access for more patients to high quality care. Pilot programs in Queensland and South Australia and decades of experience in other countries have shown this partnership to enhance quality of work life for doctors. Reducing doctor fatigue and isolation and increasing income into practices are key advantages of the partnership. Job satisfaction has implications for retention of doctors, especially in rural and remote communities. Lastly, there is hope that Aboriginal Health Workers who observe the contribution of PAs will aspire to seek training as PAs themselves.
References


