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#### Title

The role of the general practitioner in the Australian approach to HIV care: Interviews with 'key informants' from government, non-government and professional organisations

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## Key messages

- In Australia, HIV care is partly provided by skilled medical practitioners with a 'special interest' in HIV medicine working in private general practice
- Advances in HIV treatment and demographic and geographic shifts among people living with HIV and the general practitioner workforce are testing the sustainability of this approach
- Professionals holding senior roles in organisations that influence Australian HIV care policy identified strengths and challenges facing this role for general practitioners
- They recommend that general practitioners need flexible models of training and accreditation, support in strengthening relationships, and assistance in achieving service accessibility

## **Abstract**

Objectives: HIV care is provided in a range of settings in Australia, but advances in HIV treatment and demographic and geographic changes in the affected population and general practitioner (GP) workforce are testing the sustainability of the special role for GPs. This paper explores how a group of 'key informants' described the role of the GP in the Australian approach to HIV care, and conceptualised the challenges currently inspiring debate around future models of care.

Methods: A thematic analysis was conducted of semi-structured interviews carried out in 2010 with 24 professionals holding senior roles in government, non-government and professional organisations that influence Australian HIV care policy.

Results: The strengths of the role of the GP were described as their community setting, collaborative partnership with other medical and health professions, and focus on patient needs. A number of associated challenges were also identified including the different needs of high and low HIV caseload GPs, the changing expectations of professional roles in general practice, and barriers to service accessibility for people living with HIV.

Conclusions: While there are many advantages to delivering HIV services in primary care, GPs need flexible models of training and accreditation, support in strengthening relationships with other health and medical professionals, and assistance in achieving service accessibility. Consideration of how to support the GP workforce so that care can be made available in the broadest range of geographical and service settings is also critical if systems of HIV care delivery are to be realistic, cost-effective and meet consumer needs.

## INTRODUCTION

The advent of HIV infection challenged the design of health systems in every part of the world. In Australia, the population of people living with HIV is relatively small [1] and the effective delivery of HIV treatments has in most cases transformed care needs from acute to chronic. However, the number of people infected with HIV is gradually increasing each year, and new infections are being seen in a growing number of heterosexual men and women, in addition to the main affected population of gay-identified men or men who have sex with men [1-2]. People living with HIV are also moving increasingly away from the main urban centres, which is testing the current approach to providing HIV care around the country [3-4].

This care is currently provided in a range of settings, including public hospital outpatient units, sexual health centres and specialist HIV clinics, but a particular feature is the role of the skilled and accredited medical practitioner working in private general practice [5-7]. General practitioners (GPs) have been providing care to people living with HIV since the start of the epidemic [8], and many of those GPs have developed and sustained a 'special interest' in HIV medicine [article in press] and have been accredited as 's100 prescribers' (ie. authorised to prescribe HIV medications as regulated by the 'Section 100' Highly Specialised Drugs Program), particularly those working in 'high caseload' practices in the large capital cities which care for many people with HIV infection [9].

This role for GPs has been recognised as contributing to Australia's comparative success in HIV prevention, treatment and care [7, 10], and enabling the development of close and trusting relationships between GPs and the populations most affected by HIV in Australia [5, 11-12]. However, advances in HIV treatment and ongoing demographic and geographic shifts among both the affected population and the GP workforce are testing the sustainability of this approach [3, 7, 13]. Ongoing reform of the health care system has also led to changes in how GP services are delivered and accessed including, for some high HIV caseload practices, the decision to move from 'bulk-billing' (ie. no out of pocket costs for patients) to charging a 'gap fee' (ie. patients pay the difference between the total cost of the consultation and the government reimbursement).

Profession, government and community concern has been expressed about whether sufficient numbers of new GPs are taking up prescriber training to enable HIV care needs to be met in the coming years. For example, Australia's Sixth National HIV Strategy (2010-2013) has recognised recruitment and retention issues among the s100 prescriber GP workforce [10], and in response to this and a range of other issues facing HIV health systems in Australia, the Australasian Society for HIV Medicine and the National Association of People Living with HIV/AIDS conducted a collaborative project in 2009 on *Models of Access and Clinical Service Delivery for HIV Positive People Living in Australia*, from which the final report claimed that:

... to comprehensively address Australia's health workforce problems (and therefore address HIV workforce issues) will require a grand plan and cooperation across all levels of government and the private sector. This is unlikely in the short term, so we are left with considering what has been effective and applying that or testing models that have shown some promise [7: 33].

In other comparable international contexts, the 'reincorporation of primary care providers into the spectrum of HIV care' [14: 1] has become an explicit interest of policy debate regarding the changing needs and contextual conditions of contemporary HIV health systems. Supporting access to quality HIV care is deemed to be important both for equity and to prevent the serious personal and system costs of inadequate HIV care and treatment, particularly late entry to HIV treatment [15].

This paper contributes to these debates by considering how a group of policy ‘key informants’ described the strengths and challenges associated with the role of the GP in the Australian approach to HIV care, and what this might suggest about ways forward in both Australia and comparable health service settings in other developed nations.

## METHODS

This paper reports on semi-structured interviews conducted with senior professionals working in government, non-government and professional organisations which influence the ongoing review and development of HIV health care policy in Australia. Ethics approvals for the study were received from the National Research and Evaluation Ethics Committee of the Royal Australian College of General Practitioners and the Human Research Ethics Committees of participating universities.

Semi-structured, face-to-face (14) and telephone (10) interviews were conducted between February and April 2010 with a range of professionals who were purposively recruited by the study investigators on the basis of their expertise in relation to this topic. Before the start of each interview, written consent was secured from the participants who were interviewed face-to-face, and verbal consent (following a structured protocol) was obtained from the participants interviewed by phone. All participants were offered AU\$150 reimbursement.

More men (17) than women (7) took part in interviews and five self-disclosed as HIV positive. Professional backgrounds included medicine (10), allied health (3), community sector (3), public sector (3) and ‘other’ (5). The setting in which they were currently employed or engaged was split across the non-government (10), government (7) and professional education/training (7) sectors. Scope of interest in relation to HIV was mostly state-level (12) and national (9), and three participants were focused on particular affected populations.

Analysis of the deidentified transcripts followed the Braun and Clarke [16] guidelines for thematic analysis which involves an inductive, constant-comparative approach to identifying recurrent themes and divergent variations, assisted by the qualitative analysis software NVivo 9.

## RESULTS

Many dimensions of the role of the GP in the Australian approach to HIV care were described by this group of key informants, including the following strengths.

The *community setting* in which much HIV care is provided was described as a special feature of the Australian response – at least among developed countries – particularly because of the role that GPs have played as HIV medication prescribers since the introduction of antiretroviral medications:

[N]o other place in the world allowed general practitioners to do this level of work and to get this special authority for the prescribing. ... And I don’t think we would have come as far with clinical care and management if we hadn’t have had a system that allowed people outside of the hospital base to do this work ... I think the strength of the response but also the health of this community has been linked to the fact that we had general practitioners allowed to deliver that care. [KI\_03; non-government organisation]

As noted here, the belief was consistently expressed across these interviews that GPs had played an essential role in the HIV response, and that their role could be (at least partly) recognised for contributing to the relative successes of HIV prevention and treatment in Australia. Reasons posited for this included that GPs were able to build trusting relationships with their HIV positive patients as

they could see them regularly and over a long period of time, and that GPs were better placed to provide a 'whole-person' approach to care, which is broadly believed to improve outcomes.

Another strength of the role of the GP in the Australian response to HIV care focused on their effective *collaboration across professions*. It was broadly assumed that people living with HIV benefited immensely from the close working relationships that GPs were able to establish with other health and medical professionals who provided specialist or allied health expertise and support:

[W]e've traditionally had very good shared care arrangements [with] tertiary providers ... But [GPs] do not have the time to help people [living with HIV] sort out the plethora of issues that they present with. And they do need ... particularly nurses to help them ... [and to] provide a liaison [with] allied health services but also the health promotion programs and the community based organizations. So [there is a] hope that that nurse led model... will attract more GPs into the area. [KI\_18; government organisation]

This quote acknowledges the strength of the team-based approach to HIV care that is believed to have characterised the Australian clinical response to the epidemic, with the GP conceptualised as central to that approach. However, it also recognises that GPs need a whole range of supports in order to provide effective multidisciplinary and 'interprofessional' [17] care, and that the recruitment and retention of GPs in this area is likely to be very much dependent on ensuring that opportunities for collaborative sharing of clinical roles is supported and grown.

Finally, a *focus on patient needs* was also described as a key strength of the role of the GP. HIV community or consumer advocates have actively shaped debates around appropriate and effective ways to support people living with HIV infection, and this 'partnership' with government, research and clinical sectors has ensured that health service decisions have remained (at least relatively) responsive to patient needs over time:

[G]enerally people with HIV ... have a very high level of trust for their GP ... So for people then to agree to have more of a shared care type of a model between, not between primary and acute care but between two different types of primary care practitioners, that could be a bit of a challenge ... But I do think that, you know, with workforce issues and workforce shortages in primary care, these issues need to be considered and addressed. [KI\_08; government organisation]

This quote demonstrates the emphasis in these interviews on ensuring that HIV health systems are always designed around patient needs. The current debates around how to strengthen care models in this sector are mentioned here, focusing on the impact on patients of the proposal to recruit more GPs and other primary care professionals into the care of people with HIV through a 'shared care' arrangement with experienced s100 prescriber GPs.

While these 'strengths' were consistently voiced, this does not mean that GPs were viewed by these key informants as holding a straightforward or uncomplicated position within this health system. A number of associated challenges were also described.

The recurrent 'challenges' related to the number of patients with HIV infection that a GP needs in order to justify the time it takes to keep their clinical skills and knowledge in this area up to date. This issue is described in shorthand as *caseload*, and has significant implications for the engagement of GPs in HIV as an area of special interest:

[I]f you have a high caseload, it can really colour your view of the world. However, you do need a minimum amount ... to ensure that you give the appropriate treatment because you need to maintain your skills ... [A]nd it's hard for people in rural and remote areas in this situation because they might only have one or two patients ... Whereas if you work in a clinic that has a lot of patients, you can usually ask other people to, you know, two heads always sort out the problem ... And I certainly think there is a healthy number of cases ... The 'Goldilocks' number ... Not too many, not [too few], just right? Yeah, I'd just say fifteen to twenty five percent, if I had to put a number on it. [KI\_12; professional organisation]

This quote emphasises the different experiences of GPs working in high HIV caseload practices (mostly in the central metropolitan areas of the largest capital cities) alongside several other prescriber GPs with whom one can share the load, compared with those working in isolation in low HIV caseload practices (mostly in regional areas, but also in non-HIV-specialist GP clinics in urban areas). This quote is particularly interesting for how it frames these issues not only as a system challenge that impacts on patient need but also as potentially threatening to the health and wellbeing of the individual GP.

Another challenge identified here is the *changing expectations of professional roles* that are described as a feature of general practice and primary health care more generally, but particularly of the 'interprofessional' [17] dynamics within the Australian approach to HIV care:

[GPs], for a lot of specialists, are seen as general practice. General practitioners are not general practice anymore. Every single general practitioner has to specialise in some way. And so there is this mismatch ... And I think it's not a HIV-specific thing. I think it's evolved because of what GPs are now forced to go through ... Sorting out how an individual with HIV is co-managed, I think is quite important ... [but] the second issue for me is ... how these doctors between themselves handle their relationships and treat each other. [KI\_06; professional organisation]

Two main issues are being negotiated in this quote. The first relates to the debates arising within the medical profession around how to conceptualise and value the specialist expertise held by GPs with a particular 'special interest', of which HIV is a good example [article in press]. The second relates to the ways in which clinicians approach their interactions with other health and medical professionals. For this key informant, the relational aspects of HIV care are critical to achieving quality in care delivery.

The final issue described as a challenge for the role of the GP in the Australian response to HIV relates to *barriers to service accessibility* for people living with HIV.

[The Australian response to HIV care] has been based through the GPs, predominantly, and more or less out there in the community ... It's been very good for the people who need care and treatment, it's been much better for the clinicians who provide it, and it's been much better for the budgets ... Perhaps where that breaks down a little is where you get out of Sydney and go to the rural and regional areas ... So how they get access to clinical care out there is a problem ... [which] needs a lot of creative thought about how we might secure those same excellent outcomes for the next twenty five years. (KI\_23; non-government organisation)

This quote is focused on clinical service access issues for people living with HIV in rural and regional areas, but access was also raised as an issue in terms of cost, the limited availability of appointments (particularly in high HIV caseload practices), and the physical accessibility of clinics in terms of

location and building design. These debates suggest that as the needs of people with HIV change through ageing, geographical spread, and shifts in demographic characteristics (particularly gender, sexuality and ethnicity), the protection of both HIV care accessibility and quality is likely to become increasingly difficult.

## CONCLUSIONS

In our interviews with senior professionals who influence HIV care policy in Australia, the strengths of the role of the GP in the Australian approach to HIV care were described as their community setting, collaborative partnership with other medical and health professions, and focus on patient needs. However, they also identified a number of associated challenges particularly organised around the different needs of high and low HIV caseload GPs, the changing expectations of professional roles in general practice, and barriers to service accessibility for people living with HIV.

There are limitations to our analysis, particularly in that we do not include first person accounts from HIV clinicians (they comprise the second part of our study), and we are focused on the role of the general or 'family' practitioner, which is not necessarily a typical role in other HIV health systems. Nonetheless, we believe it is valuable to consider both the strengths and challenges of the Australian approach, which has been lauded for its successes, but is nonetheless now facing a range of new and continuing pressures on the delivery of HIV clinical services. We also believe that understanding how health service issues are conceptualised and framed by policy key informants can reveal important dimensions of the ways in which health system reform is undertaken.

Our results suggest that there are indeed many benefits of delivering HIV care in primary care settings, particularly if that includes a central role for a GP (or equivalent clinical position). However, our analysis also suggests that the ways in which GPs are engaged and supported as part of that system of care requires considerable attention and flexibility. In particular, the systems through which GP participation in HIV care is regulated and supported must take better account of the different needs of high and low HIV caseload clinicians. Pilot projects are being rolled out in various geographical and service settings around Australia to explore new ways of responding to this issue, including pairing experienced and inexperienced GPs in formal 'shared care' arrangements [18].

The need for multidisciplinary and 'interprofessional' approaches to HIV care delivery is also important. Our key informants believed this was an essential aspect of quality care, particularly as the population of people living with HIV age and their clinical and social needs continue to diversify. However, GPs in particular are seen to require support in developing and strengthening relationships with other health and medical professionals, and in ensuring that the complexities of delivering effective HIV care in primary care settings does not further exacerbate issues with recruitment and retention among this workforce.

Finally, while it is clearly important that the design of an HIV health system be responsive to the changing needs of people living with HIV, our analysis suggests that one of the most important issues for patients is service accessibility. As noted in the US context, supporting access to quality HIV care is important to both protect equity and prevent the serious personal and system costs of inadequate HIV care and treatment [15]. Careful consideration of how to support the GP workforce so that care is available in the broadest range of geographical and service settings is critical if proposed changes to the current systems of HIV care delivery are to be realistic and appropriate to both costs and consumer needs.



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## **Competing interests**

None declared

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## **Contributions**

CEN was responsible for the original study concept and funding application, recording most of the interviews, and conducting the analysis and first written draft of the manuscript. JDW and MK were the most senior members of the research team, providing oversight of the study concept and funding application, data collection and analysis procedures, and redrafting of the manuscript. PC, RR and SK also provided expert contributions to the study concept and funding application, data analysis and manuscript preparation with particular contributions relating to their areas of expertise in (respectively) consumer representation, historical perspectives, and social research methodology. All authors contributed significantly to the content of the manuscript.

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