

Mr Chris Mitchell

CEO, Health Workforce Queensland



takingaction Divisions of General Practice Network Forum 2004





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Developing a sustainable General Practice Workforce

Divisions of General Practice Network Forum 2004

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GPPHCNT

Rural Workforce Agencies

WACCRM

Health Workforce Qld

NSWRDN

RDWA

RWAV

TDGP

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- Australian Rural and Remote Workforce Agencies Group [ARRWAG]
- RWAs – Common goals and purpose - RRGPP
- ***Attraction, Recruitment, Retention and support of Rural & Remote GPs, their families and communities served***
- Different contexts – State Health, Med Boards, etc
- Different solutions required for different contexts

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- Queensland example of Developing a sustainable General Practice Workforce
- Purpose of the Research
- Why do we have this problem
- What are the Solutions
- Principles to underpin new models
- Research Recommendations

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Solutions for the Provision of Primary Care to Rural and Remote Communities in Queensland

*Copies available from
www.healthworkforce.com.au*

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Research Project Team

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- Col White PhD
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- Nigel Bond
- Chris Mitchell

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Purpose of Research

1. Understand WHY there is a rural and remote medical workforce shortage
2. HOW the shortage impacts on communities and health professionals
3. Examine existing models and identify adaptations to improve sustainability
4. Describe new models for further development

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Working with Divisions & other stakeholder

- Rural and Provincial Divisions
- Rural Training Providers
- Queensland Health
- James Cook University
- QAIHF
- QDGP
- RDAQ
- AMAQ

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Historical Factors

- Until late 1980's size, structure and distribution unregulated by Australian Govts
- Capping medical student intake, 1996
- Reduction in GP training places, 1995
- Immigration restrictions
- Provider number restrictions for OTDs, 1996/97
- Vocational registration, 1996

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Current Factors

Hard Supply Drivers

- Ageing general practice workforce
- Increased participation of women
- Changes in work patterns

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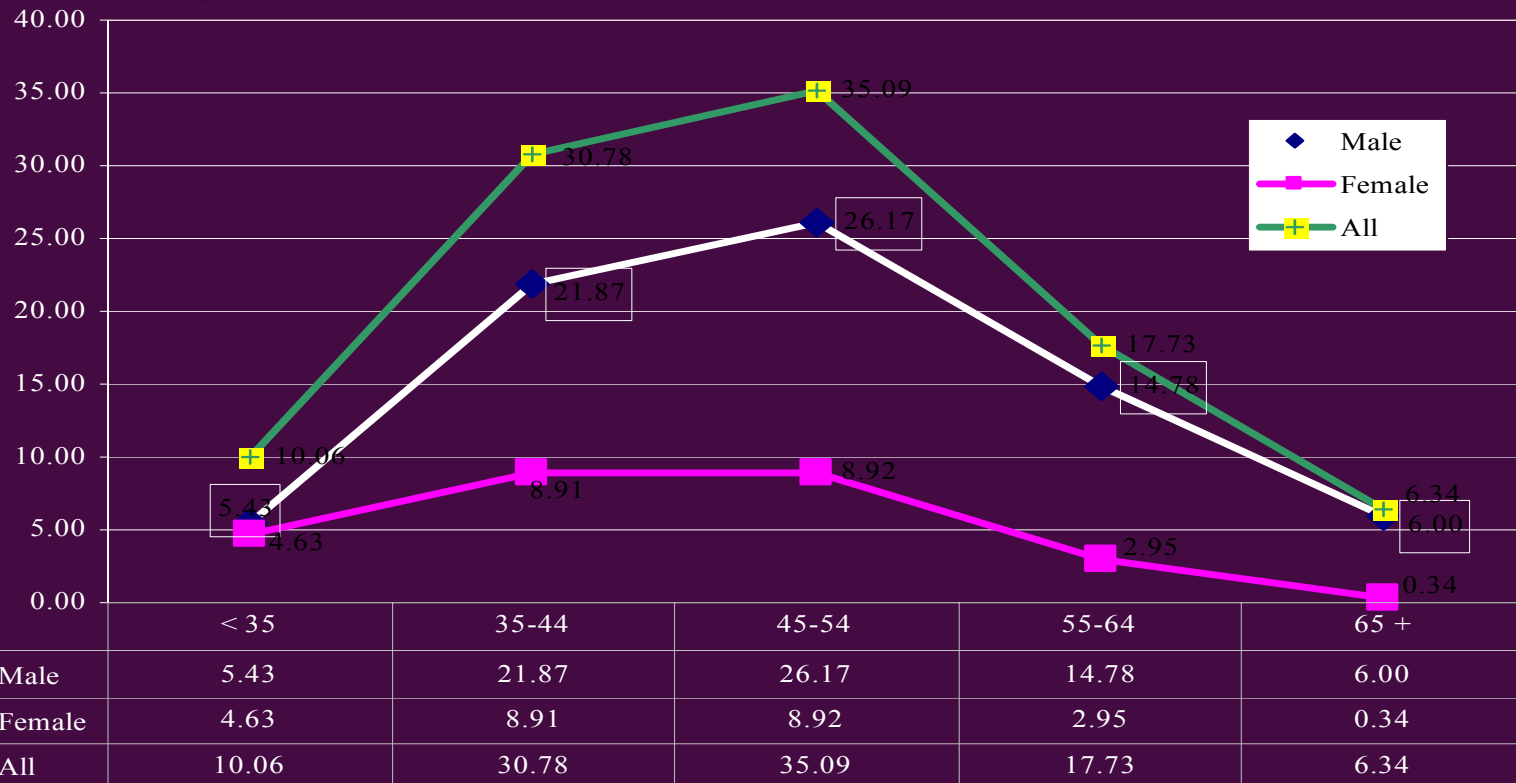


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Percent of FWE by Gender and Age Category (Qld - Apr02 to Mar03) - Total FWE - 3261; N4598



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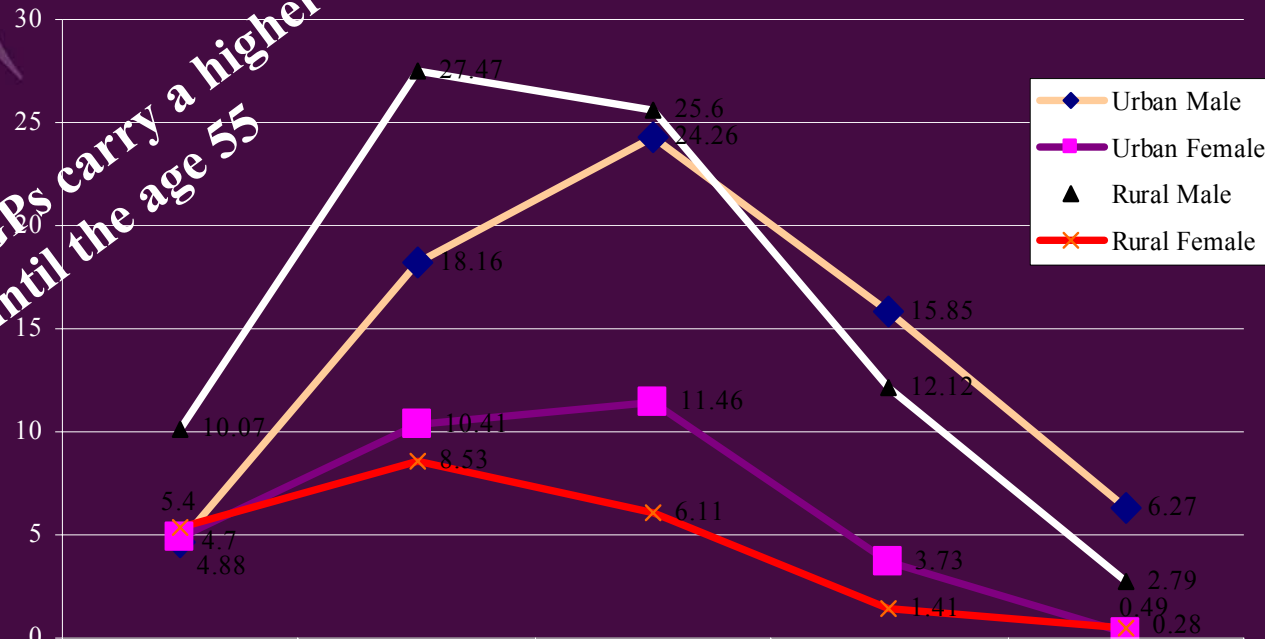
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Percent of FWE by Gender and Age category (Rural vs Urban)

Rural male GPs carry a higher workload until the age 55



	<35	35-44	45-54	55-64	65+
Urban Male	4.7	18.16	24.26	15.85	6.27
Urban Female	4.88	10.41	11.46	3.73	0.28
Rural Male	10.07	27.47	25.6	12.12	2.79
Rural Female	5.4	8.53	6.11	1.41	0.49

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Current Factors

Soft Supply Drivers

- Lifestyle factors
- Changing attitudes to owning and managing a practice
- Poor image of general practice/ rural practice

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Barriers to choosing rural practice

- Long working hours
- Difficulty in accessing leave/ locums
- Lack of part-time or job share opportunities
- Cultural and lifestyle limitations
- Professional isolation
- Lack of employment opportunities for spouse
- Lack of educational opportunities for children
- Travel costs for training
- Isolation from extended family and friends

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Manifestation of the problem

- Decline of rural communities
- Poorer health status of people living in rural and remote areas (independent of indigenous factors)
- Heavy reliance on TRDs (approx 19 % of Qld rural and remote medical workforce)
- High mobility of workforce
- Impediment to continuity of care, preventive medicine, access to care

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Manifestation of the problem

- Orientation to culture and rural/ remote practice
- Does shortage impact on quality – VR and accreditation?
- Negative impact on training
- Loss of procedural skills/ services
- Locums – size of the pool, quality
- Retention of nurses and allied health professionals

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Manifestation of the problem

- Safer Working Hour/European Working Time Directive - 58 hrs to 48 hrs in 2007
 - Impact on Australia's recruitment already
- Queensland Health System Planning & Service Restructure
 - Further downgrading of Qld Health facilities to small communities.

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So what are the solutions?

- Adaptation of existing models
- Practice ownership & systems
- Reduction of After-Hours and On-Call Commitment
- Increased critical mass of doctors to provide procedural services
- Increasing nos. of doctors to service small communities
- Apply the Planning Matrix to Rural Medical Workforce Models in the real world

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Strategies to enhance sustainability of rural practices

- Practice ownership and management
 - Divisions of GP operating a practice management service or operating as a corporate GP service
 - Community Controlled Health Service based on ACCH model

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Reduction of After-Hours and On-Call Commitment

- Telephone triage operated by QAS, Divisions & Family Care Medical Telephone Triage Service
- Integrated after-hours across public/private interface

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Increased critical mass of doctors to provide procedural services

- Health District “employing” local procedural GPs to provide inpatient services eg by cashing out a MO position to a local group practice.
- Targeted recruitment with incentives to procedural doctors for salaried positions.

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Increasing nos. of doctors to service small communities

- Establishment of satellite practices
- Rotation of doctors to small remote communities

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New Models

- Community Medicine Model
- GP registrar across a cluster
- Increasing effectiveness of existing resources in small communities
- Apply the Planning matrix to
 - Small remote & Primary Health Care sites
 - Fruity & Tropical models
- Funding and auspice of the model

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Planning Matrix - Rural Medical Workforce Models: Doctor Professional Factors

Community/ Regional/ State/ National aspects

- Recruitment
- Employment conditions
- Practice Viability/ support
- Relief/Peer Support
- CME/Training
- Specialist and other health professional support

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Principles underpinning new models

- Minimum levels of **service benchmarked**
- Services delivered in context of a **multidisciplinary team**
- **Community participation** in service planning and monitoring of service provision
- **Services match needs and remoteness**

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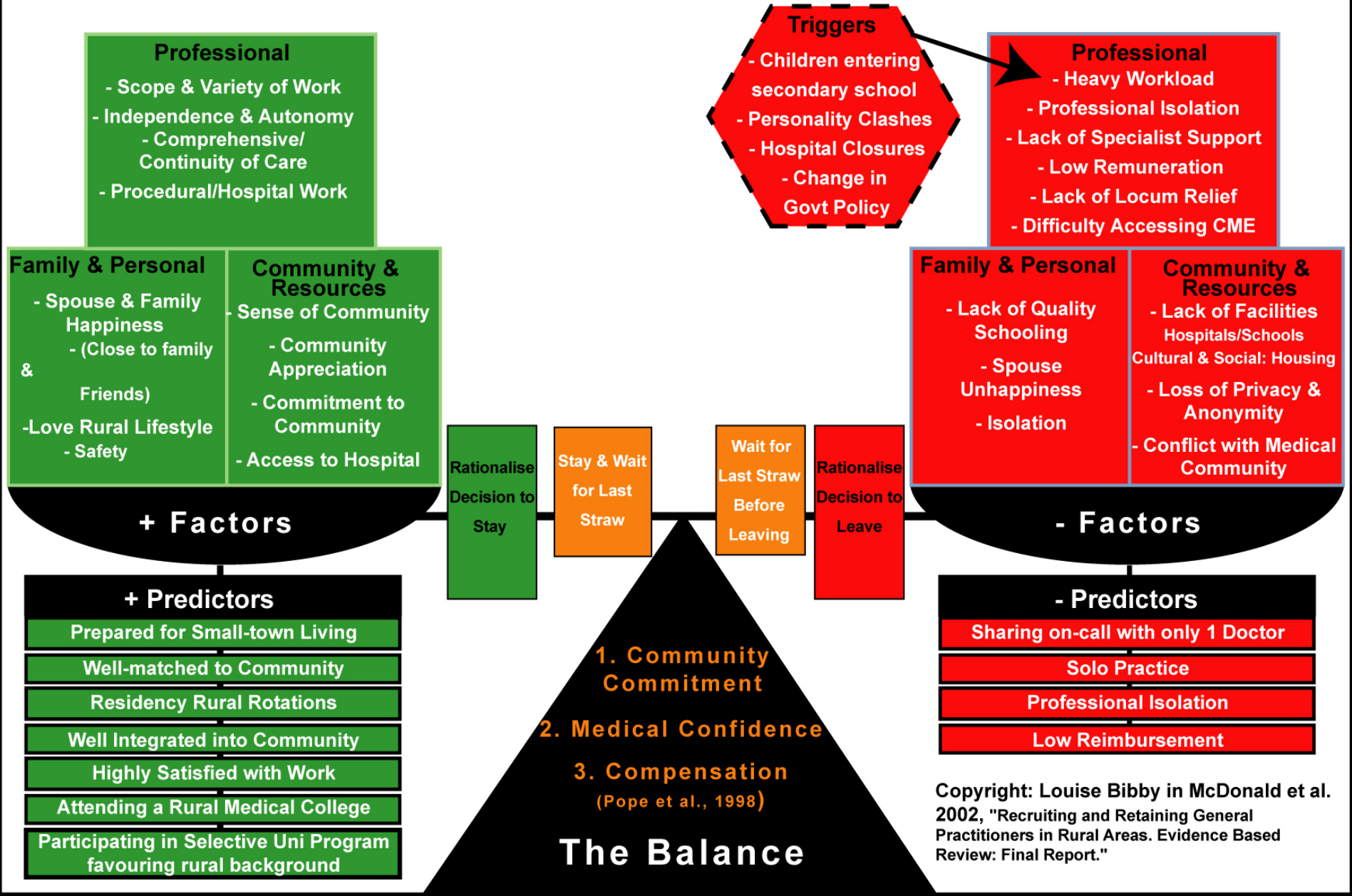
Principles underpinning new models

- **Quality services** maintained by appointment of appropriately qualified and supported health professionals, vocational and professional development, accredited facilities.
- **Culturally appropriate multidisciplinary** service provision.
- Employing agencies **structure remuneration, retention strategies**, CPD , good accommodation and safe working hours.

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The Balance of Retention



Copyright: Louise Bibby in McDonald et al. 2002, "Recruiting and Retaining General Practitioners in Rural Areas. Evidence Based Review: Final Report."



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Recommendations /1

- **Communities are central to decision making** regarding the type and mechanism of service delivery.
- **Equity of access, Sustainability and Quality underpins** restructuring of health services.

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Recommendations /2

- **Removal of artificial boundaries** created by state and federal health funding
 - remunerate hospital nurses to triage and support private GPs in provision of after hours care
 - remunerate Health professionals that support rural GPs by specific item nos. or practice item nos. in rural and remote areas

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Recommendations /3

- **Best Practice recruitment processes**
 - skills assessment and matching of the doctor and family to a community.
- **Length of bonded service** in remote communities to be inversely proportional to remoteness of community.

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Recommendations /4

- Promoting new models that address workload and lifestyle issues.
- Develop mechanisms to **assess aptitude** for rural and remote practice & cross-cultural adaptability of Doctors, Health Professionals and their families

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Recommendations /5

- Increase the size and improve the quality of the **locum pool**
 - Regionally based locums
 - On-site supervision of rural relievers
 - Increased collaboration between Q Health and the QRMSA on locum provision

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Recommendations /6

- Universities continue **preferential selection of rural background students**
- Provision of **increased financial support** to rural practices to undertake teaching of GP Registrars and medical students.

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Recommendations /7

- **Promotion of recruitment and retention strategies** to all members of the multidisciplinary team.
- **Promotion of professional exchange programs** (based on teaching profession) for allied health staff, experienced doctors, and nurses.

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Recommendations /8

- Development of **alternative practitioner models** such as physician assistants to extend care provided by doctors.
- Development of this new profession in Australia – curriculum development and pilot programs, legislation to describe role and responsibility of this new profession.

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Conclusion

So now you;

1. Understand WHY rural and remote Australia's medical workforce shortage has occurred
2. Have Examined existing models and identified adaptations to improve sustainability, and
3. Understand the principles which underpin these models
4. Know the key research recommendations

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Thank You

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