

Sustaining Medical Practice in Rural and Remote Australia

A SUMMARY OF THE VIABLE MODELS OF RURAL AND
REMOTE PRACTICE PROJECT—STAGES ONE AND TWO

Funded under a grant from the
Australian Government Department of Health and Ageing

Research team

Viable Models Project Management Committee

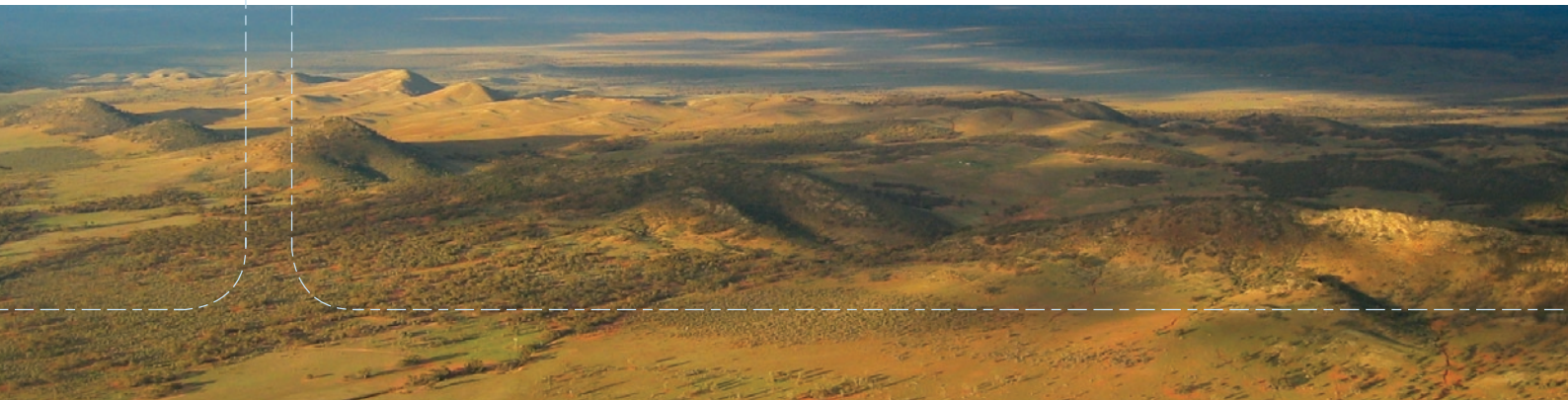
Rural Doctors Association of Australia contact details

PO Box 5361, Kingston ACT 2604

Telephone 02 6273 9303

Sustaining Medical Practice in Rural and Remote Australia

A SUMMARY OF THE VIABLE MODELS OF RURAL AND REMOTE PRACTICE PROJECT—STAGES ONE AND TWO



RURAL DOCTORS ASSOCIATION OF AUSTRALIA
MONASH UNIVERSITY SCHOOL OF RURAL HEALTH | OCTOBER 2003

PREFACE

I am pleased to present this summary document containing the findings and outcomes of the Stage 1 and 2 Report of the Rural Doctors Association of Australia *Viable Models of Rural and Remote Practice Project*.

This landmark study was funded by the Australian Government Department of Health and Ageing in response to the ongoing challenge of recruiting and retaining doctors in rural and remote Australia.

The project has identified and analysed the content, complexity, context and costs—both direct and opportunity costs—associated with rural and remote practice and established the factors that affect viability of practice in these areas.

Rural and remote practice is one of the most exciting, satisfying and yet challenging of all medical disciplines. Doctors work in a variety of communities and practice settings. They practice cradle to the grave medicine and the scope of professional activities across Australia is broad.

The *Viable Models Project* has clearly shown that rural and remote practice is different and that an integrated approach, addressing fundamental structural areas, is required if the problem of medical workforce shortages in rural and remote Australia is to be solved.

There are three key inter-related factors affecting practice viability. These factors, *practice economics, professional issues, and practice organisation and infrastructure*, form the basis of a viability framework.

Minimum requirements for viability and sustainable practice have been benchmarked.

The viability framework and benchmarks identified during this project can be used to inform policy development and monitor practice viability at the local community level.

Achieving these benchmarks will give doctors and their families the confidence that not only is rural practice a worthwhile career choice, but that their skills and commitment will be rewarded adequately; that they will have a practice environment that is efficient, affordable and supports improved patient care and that an appropriate balance between professional and personal life can be achieved.

A complete list of those contributing to the project is listed in the main report. I would like to particularly thank the hundreds of rural doctors, spouses, practices and other stakeholders that have contributed to date in this project, members of the RDAA Viable Models Project Management Committee, Monash University School of Rural Health at Bendigo, the RDAA and the Australian Government Department of Health and Ageing for their support.

David Mildenhall

Chair Viable Models Project Management Committee

KEY FINDINGS

VIABILITY

Today one in five (19%) practices in rural and remote Australia are not viable.

Without action, in five years that number will grow to more than one in two (55%).

Workforce

- 37% of doctors working in rural and remote Australia signalled their intention to leave within five years
- 30% of doctors were trained overseas
- 40% aged 50 years or older
- 61% of doctors reported inadequate workforce in their practices

Workload

On average rural and remote doctors:

- worked 56 hours a week
- during normal working hours saw 25 patients per day in the practice for an average 14 minutes

Complexity

- complexity varied with rurality and practice type
- practices in small rural and remote centres and some larger rural centres typically had greater emergency, on-call and after-hours responsibilities
- practices in small rural and remote centres and some larger rural centres had lower availability of peer support and resources requiring a higher intensity of work for each patient.

Practice Economics

- The average consultation fee was \$32
- Bulkbilling rate 37%
- Discounted rate 35%
- Net income after practice costs per principal averaged \$80 per hour for group practices and \$55 per hour for solo practitioners
- Practice costs were typically 52% of gross
- Additional costs per practitioner include: medical defence, personal professional expenses, and motor vehicles.



WHAT MAKES A PRACTICE 'VIABLE'?

A *viable practice* is one that meets the specific medical needs of the community and takes into account the professional, personal, and economic needs of the practitioners and their families.

The research shows that viability is dependent on three key dimensions. These are:

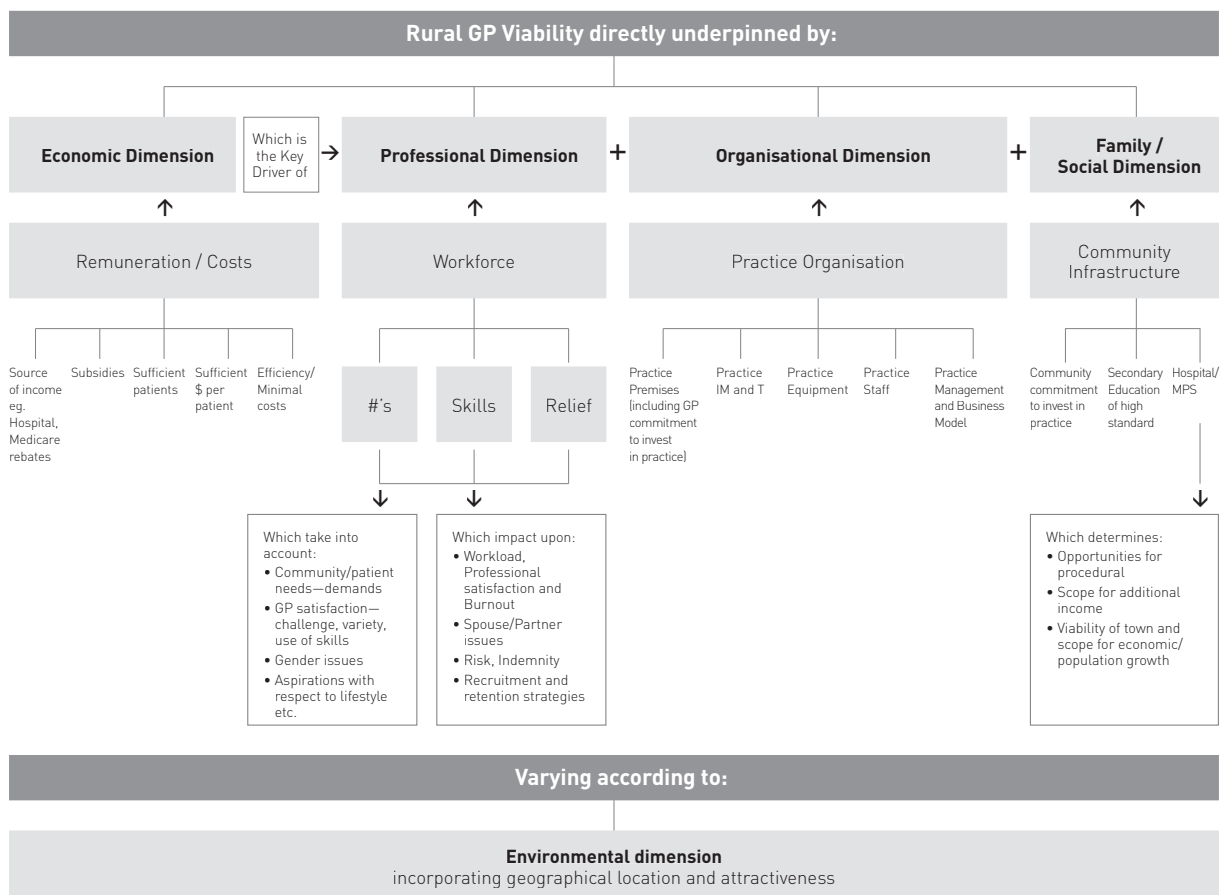
- Professional issues including education, training and skills of practitioners, workforce and workload
- Economic issues including income, practice costs and opportunity costs
- Practice organisation and infrastructure.

Family and social issues were also highlighted in the viability framework and, while important, were shown

by the research to be closely inter-related to the three key dimensions.

These dimensions themselves are inter-related. Within each dimension there are a number of components that have been identified and minimal benchmarks for practice viability determined.

In order for any practice to remain viable into the future, action is required to ensure that minimal benchmarks in all dimensions can be met. Systemic solutions particularly with regard to workforce, practice economics and infrastructure are of overwhelming significance and will need to be applied. The application of the viability framework at the local level will then vary according to practice type and location.



Application of Benchmarks to the Viability Framework	
Practice Economics—Remuneration	
Core remuneration	For practice principals for in hours routine activity, \$110 net income per hour from FFS, Medicare, Private fees and Practice Incentive Payment (PIP) non incentive components. (Net income is gross pretax income less practice expenses).
Rural Grants and incentives	Rural retention grant be retained. Incentive component of PIP and local incentives be retained. Additional fee for service incentives reflecting complexity and isolation.
Hospital	Hospital remuneration remain via State based awards and agreements.
Infrastructure	10% return on investment.
Professional Issues	
Professional education, training and skills	Rural Doctors should be qualified to provide comprehensive care consistent with the core skills defined by the Australian College of Rural and Remote Medicine. All doctors should be involved in 10 days recognised continuing professional development per annum and those in procedural practice should take another five days to maintain procedural skills.
Workforce	In larger centres the current ratio of a fulltime GP per 1000 patients is appropriate. In communities where the practitioner is providing in patient, emergency and after hours services a full time practitioner per 750 patients would be appropriate. In areas of high need and isolated communities a fulltime practitioner per 500 patients may be required to meet community needs in health care.
In hours workload	Number of consultations for a full time equivalent rural doctor should on average be 125 patient consultations a week. Average consultation length 15 minutes.
After hours workload	No more than one in four weeknights and one in four weekends (with compensation in terms of additional time off or remuneration in smaller centers).
Leave	Six weeks annual leave plus one day for each week rostered on call. Two weeks leave for basic skills maintenance with an additional one week for procedural skills. Long service leave—a minimum of 13 weeks after every ten years of service and 2 weeks per year there after.
Practice Organisation and Infrastructure	
Leadership and strategic planning	Minimum documented practice systems including a strategic business plan. Practice manuals should define administrative and operational aspects of the practice.
Staffing	At least 1.5 support staff per full time equivalent rural doctor. Practices should have at least .4 full time nurses and .3 full time practice manager per full time equivalent rural doctor.
Equipment	Equipment should at least meet Royal Australian College of General Practitioner Standards and allow the practitioner to undertake core activities and be appropriately maintained.
Information management and technology	Practices should have a documented information management systems strategy, backup, support, training and maintenance. All rural and remote practices should have broadband internet access.
Practice premises and facilities	Practice premises should reflect local needs and meet building standards for health facilities.

APPLICATION OF THE VIABILITY FRAMEWORK TO LOCAL COMMUNITIES

The following four scenarios show how the integrated viability framework can be applied locally to practices and communities whose viability is at risk.

These scenarios are indicative only and do not relate to any particular individual or practice.

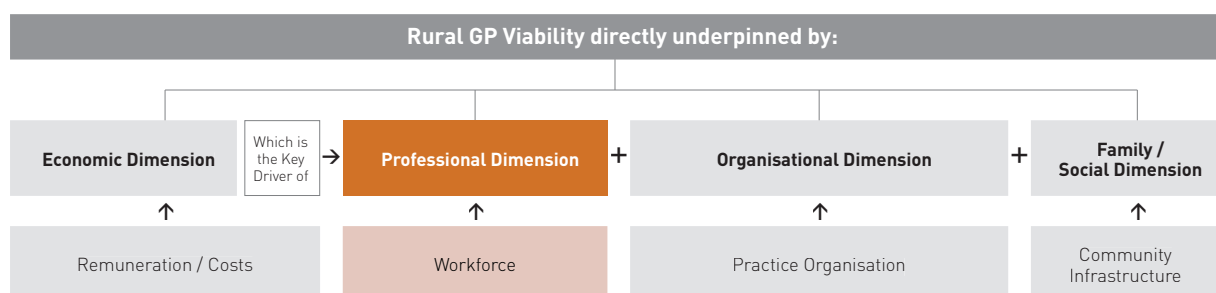
Scenario 1

'Dr Jones' works in a small rural practice in an attractive rural town with population 1300, in Victoria. There is a local 25 bed (12 acute and 13 long stay) hospital in the town. Previously the practice had two doctors working in it, but after working in the town for 30 years 'Dr Jones' colleague retired. A part time doctor works in the practice two days a week but does not do on call or after hours work.

The hospital used to have a theatre for visiting specialists and emergencies and provide a local obstetric service but these have been closed for over 5 years.

'Dr Jones' purchased the practice and premises in 1980. The practice was purpose built in the 1970s and is in need of redevelopment. 'Dr Jones' is reluctant to invest in the premises because he is approaching retirement and cannot find a suitable doctor who would be willing to invest.

The town is 80 km from a major centre and there are no other practices in the town.





Scenario 1 Commentary

Small practices such as this represent the largest challenges and opportunities from a viability point of view. The problems faced can be significant but there is a good chance of developing a truly integrated solution to practice viability.

The key issues for this practice and town are difficulty in recruiting a doctor without certainty over professional activity at the local hospital, the need to upgrade the practice premises and lack of relief for the heavy on call load. The current practice size is too large for one doctor to handle the patient load but too small to provide sufficient income for two or three doctors under current arrangements.

A strategic plan to improve the viability of this practice would see:

- A plan to support the development of the practice infrastructure with facilities for teaching of medical students and GP registrars either through a rural medical infrastructure

development fund guaranteeing a reasonable return on private investment or grant to the practice or community (possibly in association with a hospital redevelopment)

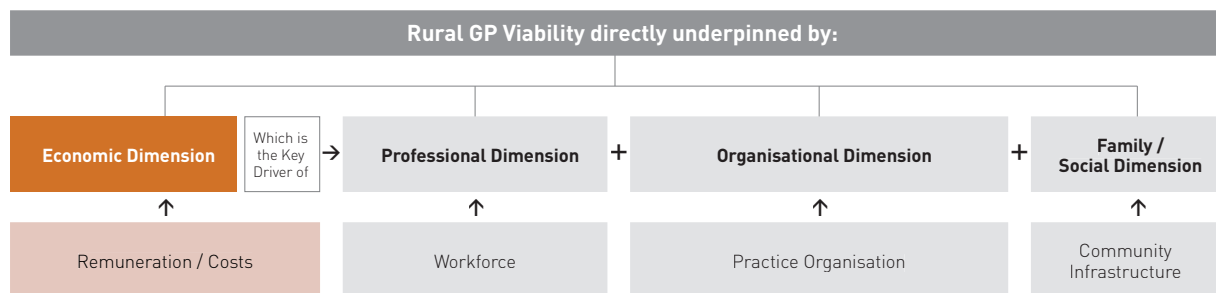
- Improved local procedural (minor or major) facilities to allow extra services to be done locally increasing the community service, doctor satisfaction and practice income
- Attracting a new doctor interested in teaching and research with an attractive remuneration package including recognition of the position by the rural clinical school
- Support from the medical school for teaching students with increased access to student teaching PIP payment
- The practice providing outreach services to a neighbouring town without a doctor
- On call can be better shared but should be supplemented by extra relief or remuneration

APPLICATION OF THE VIABILITY FRAMEWORK TO LOCAL COMMUNITIES

Scenario 2

'Dr Austin' is an overseas trained doctor working with another doctor in isolated remote community with a large indigenous population. Typically turnover of health staff in the community is high. Many patients do not know their Medicare numbers. The practice is not accredited and thus ineligible for entry to the Practice Incentives Program and the benefits of accreditation. The patients that the practice sees present complex problems.

The state government has negotiated an attractive package for medical officers at the local hospital. The doctors work out of the local hospital and undertake outreach services. On call at the hospital is one in two and the hospital doctors would like more time off.



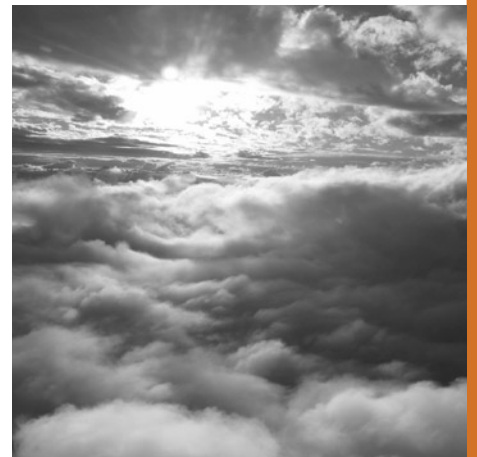
Scenario 2 Commentary

Rural doctors in private practice need to be able to access appropriate Medicare rebates. Remuneration from these needs to provide hourly rates commensurate with that viable in salaried practice.

Results from the project show that a number of practices in rural and remote areas have not been able to access the benefits of the Practice Incentives Program. Accreditation is now a requirement for access to the benefits of the PIP. Patients and doctors in communities where practices are unable

to participate in this program are disadvantaged and these practices should be assisted to achieve accreditation. Infrastructure grants may be required.

Hospital income is an important economic factor for the viability of rural practice. Hospitals should encourage private practitioner participation which can, in turn, help the on call situations in their hospitals.



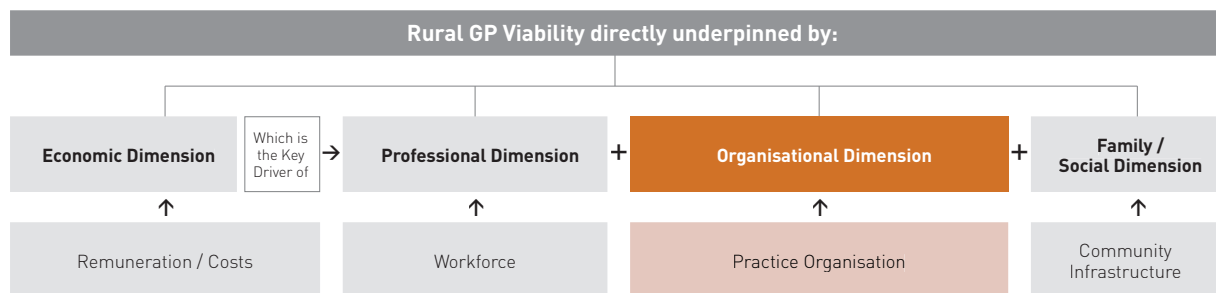
APPLICATION OF THE VIABILITY FRAMEWORK TO LOCAL COMMUNITIES

Scenario 3

'Dr Levien' is a female practitioner working in a small group practice in a medium sized remote centre. The industries in the town are mainly rural. There are four practices in the town and a total of 10 rural doctors, four of whom have advanced skills in obstetrics, anaesthetics, and surgery. All doctors however are

over 45 years of age. The town is also serviced by visiting specialists from the capital city and the hospital is undergoing redevelopment.

All of the practice premises are run down and in need of redevelopment



Scenario 3 Commentary

The key concern in this community is the need for coordinated infrastructure development and practice consolidation to achieve improved workload, service integration and cost efficiencies that can be achieved through amalgamation.

There is a need for adequate numbers of procedural practitioners to share the load and provide workable on-call arrangements.

While all doctors could maintain an independent practice, redevelopment would also allow for amalgamation to provide a focus for teaching medical students and mentoring of rural registrars. Rural

Clinical schools and regional training consortia could be engaged in this. This would act as a succession planning strategy.

A viability profile could be developed to highlight future needs and links established to consortia and bonded scholarship programs to access registrars who may meet the community needs. State/Commonwealth collaborative projects to streamline procedural training places and incentives could be developed to support the practice. The practice should be accredited for rural doctor training and provide training to the Australian College of Rural and Remote Medicine curriculum.



APPLICATION OF THE VIABILITY FRAMEWORK TO LOCAL COMMUNITIES

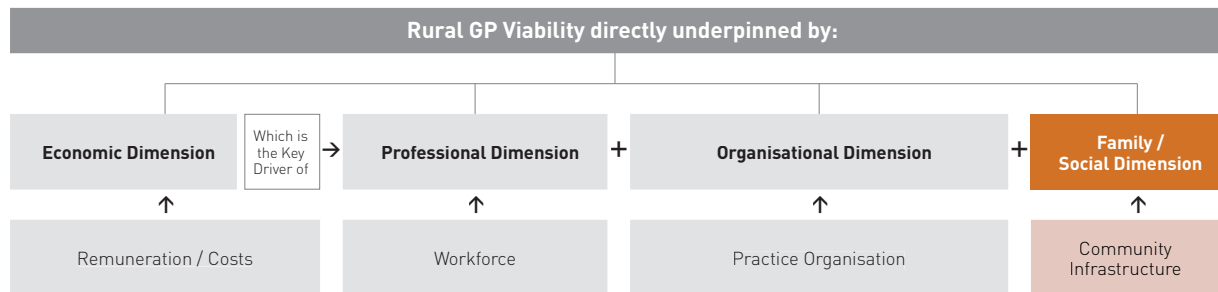
Scenario 4

'Dr Harrold' is the principal of a well-established practice in a rural centre in NSW with a population of 14,000. The town has a strong procedural focus and a well-equipped local hospital.

Ten years ago the doctors built at considerable expense a state-of-the-art medical centre with the idea of attracting more doctors to the town.

The practice is a teaching practice for medical students and GP registrars.

There are not enough doctors in the town and potential doctors are put off by the requirement to buy into the practice and older doctors find they cannot retire because of their unrealised investment.



Scenario 4 Commentary

This scenario highlights the need for all aspects of viability to be addressed. The community has considerable assets and a system that provides a good local service but is vulnerable in future years if the next generation of doctors is not recruited.

Many rural doctors have problems with retirement, particularly given their level of financial commitment to the practice. This scenario identifies the need to

provide some certainty for doctors attracted to the idea of rural practice but concerned at the level of financial commitment required.

The provision of infrastructure grants, guaranteed return on investment and some structural arrangement that provides financial support and guarantees quality and consistency in provision of premises are options for providing support.



KEY RECOMMENDATIONS

1. Measures to increase the viability of rural and remote practices should be set within an integrated and strategic **viability framework**
2. The recommended viability **benchmarks** should be the minimum platform for the development of viable models of practice
3. Based on the evidence of greater **complexity** (and associated increased costs) within rural and remote practice, appropriate differential fee for service arrangements should be implemented to ensure the ongoing provision of complex health care at the local level
4. A realistic and transparent **indexation** of rebates be accepted as the core component of rural practice remuneration
5. The importance of **local hospitals** to GP income, professional satisfaction and support, patient access and community wellbeing should be recognised, and the impact of any proposal to downgrade or close a hospital on practice viability should be considered by the relevant community and professional organisations in conjunction with the appropriate health authority
6. Measures to increase practice viability should enable rural and remote practices to meet viability benchmarks and should facilitate **expansion** of and **collaboration** between existing practices.
7. A small overarching committee with appropriate strategic, technical and evaluative skills be set up to work with RDAA to assist the development, implementation and evaluation of **trials/pilots** of viable models in rural and remote areas
8. A **viability map** of all rural and remote communities should be created. The audit framework developed during the project should be refined to provide the basis for assessment of needs at the local community level.
9. Assistance should be provided to practices to develop vision statements, strategic and business **plans** as the basis for ensuring ongoing practice viability.
10. Further research should be commissioned to investigate optimal measures to support **capital investment** into rural and remote practice infrastructure for the purpose of succession planning, service delivery, and education of medical students and vocational training of registrars. This work needs to include the role of other government departments in providing health and medical infrastructure to avoid duplication.
11. The **recruitment** of overseas trained doctors and temporary resident doctors to rural and remote communities be reconsidered in light of the WONCA 'Melbourne Manifesto' and in view of evidence that failure to address systemic structural problems makes rural and remote practices no more viable for these doctors than for Australian graduates.

SUMMARY

The findings of this study clearly identify that the three key related factors affecting practice viability are:

- Professional issues: primarily supply of appropriately trained rural doctors to ensure that appropriate workloads and adequate relief can be achieved
- Economic issues: adequate rewards to rural and remote doctors for the skills, responsibility and workload
- Practice organisation and infrastructure: the provision of quality infrastructure and management to support professional practice and quality care.

The Viability Model developed during the project:

- forms a cohesive and evidence based framework describing practice viability
- identifies clearly both the systemic and local requirements for a viable practice
- informs both professional and government policy development
- is flexible
- can be used for local risk assessment and action