



THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

The Supply of General Practitioners in Outer Metropolitan Areas

On 31st March 2003, the RACGP's Council endorsed a Position Statement on The Supply of General Practitioners in Outer Metropolitan Areas.

Aim

To describe the RACGP position with respect to the supply of General Practitioners in outer metropolitan areas.

Introduction – workforce shortages, generally

Workforce shortages are becoming a problem across every location of Australian general practice. Shortages in some rural and remote locations have been evident for some time.

While this Position Statement focuses on the issues for outer metropolitan areas, many of the challenges and solutions apply across other areas; and their implementation should not be constrained to outer metropolitan areas.

In addressing the challenges, the RACGP will not compromise its longstanding position on the safety and quality of general practice care; nor the integrity of the craft of general practice. Reliance on overseas-trained doctors and nurse practitioners is not acceptable to the RACGP. It is not acceptable to use nurse practitioners or practice nurses as a substitute to providing effective access for the community to General Practitioners (GPs), nor to use practice nurses as gatekeepers to GPs.¹

Consumers do not wish to see nurses in place of doctors, have nurses reduce their access to doctors, or for nurses to be responsible for diagnosing 'life threatening or serious conditions'.² Consumers, although having misconceptions and gaps in their knowledge around the actual and potential roles of nurses in General Practice, see nurses adding value to General Practice by carrying out a limited number of roles.³

The RACGP maintains its position of 12th December 1999 on Nurse Practitioners.⁴ There is a small amount of evidence that nurse practitioners can provide care that leads to increased patient satisfaction and similar health outcomes when compared with that from a doctor.⁵ However, this research has not been undertaken in the Australian context, none of the studies reviewed was adequately powered to detect rare but serious adverse outcomes, and there are a number of methodological limitations in those studied. Any extension of the role of practice nurses or nurse practitioners must follow the results of robust Australian research.

The solutions to achieving appropriate access to general practice for patients in Australia cannot rely heavily on overseas doctors, whether or not they train in Australia. Australia has an ethical obligation to contribute to the overall supply of doctors, proportionate to its demand for doctors. Policies that would have create strong incentives for GPs in poorly serviced countries to migrate to Australia are not acceptable.

Any immediate, medium or long-term redistribution of the GP workforce cannot aggravate the shortage of doctors in other areas, particularly rural and remote locations. Governments at all levels must take a number of steps, in partnership with the profession and affected communities, to address these problems.

The solution needs:

- Short-term approaches (1-3 years)
- Medium-term approaches (3-5 years)
- Long-term approaches (7-10 years).

Outer metropolitan areas, specifically

There are grave shortages of GPs in a number of outer metropolitan areas. There are also shortages of doctors from other medical specialties in many of these areas.

The shortage of doctors compromises access to general practice (and other medical specialties), and thus compromises the health of people who live in these areas.

This shortage results in increased workload for these GPs, and contributes to the lowering of GP morale and disenchantment with the profession. These factors correlate positively with intentions to leave the profession.⁶

Shortages in the availability of GPs in outer metropolitan areas are the result both of a number of trends (e.g. as a change in the attitude of doctors to working hours and population settlement), and of deliberate government policy (e.g. the level of intake into general practice vocational training).

The challenges to be faced vary according to the location. In some locations there are practices which could be assisted to grow. In other areas of recent population growth, it is necessary to establish practices. Because they are not sensitive to local issues and based on formulae with which the RACGP disagrees, current Government definitions of 'area of need' (for example) are inadequate. This results in some GPs (and their patients) who have equivalent need, being disadvantaged under the application of current Federal Government policy. The workforce that might provide an immediate boost to general practice in outer metropolitan areas is likely to come from a number of different areas. There are likely to be doctors, including doctors in hospitals, who have some experience in general practice who could develop general practice skills and be assessed for Fellowship of the RACGP. There are likely to be doctors who are not currently working, and who would join the workforce given appropriate support. As a last option, it might be possible to encourage doctors who work in areas of relatively good GP:patient ratios

to relocate. There is a risk that this approach will result in a later shortage in such areas ('over-correct' in the longer term).

Care must be taken that the provision of any incentive to practice in an outer metropolitan area does not result in relative disadvantage to GPs who decided to provide care through practices in these locations prior to the establishment of such incentives.

Any incentive to work in outer metropolitan areas must adhere to the principle of ensuring 'safe hours' of work, as outlined in work such as the AMA's Safe Hours Project.⁷

Short-term approaches (1-3 years)

"Area of Need" definitions used by State Governments and "Workforce Shortage" definitions used by the Commonwealth Government need to be revised. The resulting definitions need to be simpler, more readily understandable to local communities, and more flexible. The flexibility needs to ensure that the variation in local factors can be accommodated.

Consideration needs to be given to the role of Divisions of General Practice in the collection and analysis of nationally comparable, local data on workforce issues. This data could be used to inform decision-making.

There is sound evidence about the disincentives doctors face in working in outer metropolitan areas.⁸ The College believes that initiatives aimed at increasing the number of doctors for these areas should be built on that evidence. The disproportionately high overhead costs of part-time work need to be addressed.

A support program run through the RACGP, providing professional, clinical, educational and personal support for GPs is required.⁹

In using the \$80M committed in the 2002 Federal Budget to address the challenges in outer metropolitan areas, the government needs to introduce incentives such as those outlined below:

- 1. Re-entry incentive**

An incentive for GPs lacking confidence in their skills to return to general practice after time away from the profession, who could attend a skills refresher course at no cost to the GP. The course would be similar to the General Practice Recognition Education Program (GPREP), but be much shorter in duration.

- 2. Incentive for increasing general practice participation**

An incentive for GPs who increase the number of sessions they work per week above their usual level. This incentive would be a single, probably quarterly payment similar in concept to the Rural Retention Payments, although the incentive is tied to increasing the number of sessions, rather than specific location or time in the area.

- 3. Support Staff Incentive**

An incentive paid to practices to assist GPs delegate greater amounts of administrative work and/or focus on clinical outcomes, by delegating work to either a practice manager or practice nurse. This incentive would be an extension to PIP Practice Nurse

incentive. Practices may share the practice manager or practice nurse with other practices.

4. **Practice Infrastructure Incentive**

An incentive paid to practices to improve equipment or facilities required for additional GP needs and/or patient workflows. This incentive is similar to the infrastructure grants to nursing homes, with no real precedent in general practice.

5. **Practice 'establishment' incentive**

An incentive for GPs to establish a new, or join an existing, practice in an outer metropolitan area. This incentive is like GP Links (practice amalgamation) in structure, but is similar to the first home owners grant. However, GPs who have owned practices in the past, could still apply. The impact of this is likely to be longer (three, rather than one year to fruition).

Overseas Trained Doctors (OTDs) who wish to practice unsupervised general practice require support to reach this goal. The Federal Government should give consideration to providing financial support for the preparation for assessment for the FRACGP.

Should the Government provide incentives based on the willingness of OMPs to move towards the FRACGP, the Government must also rigorously audit compliance with any requirement to be assessed for the FRACGP.

The training of any doctors (including registrars from other medical specialties) in general practice settings, is only acceptable where that training meets the standards required by the relevant Medical College(s).

There is no discernible educational basis for requiring vocational trainees to undertake a rotation in an outer metropolitan area, and thus no educational basis on which to make such a rotation compulsory.

The AMA's recent Work-Life Flexibility project¹⁰ has identified an increasing need across all post-graduate training programs to incorporate flexibility. Measures that support the need for a larger general practice workforce in outer metropolitan areas, but reduce flexibility, are not acceptable.

Vocational training opportunities meeting the RACGP's educational standards need to be provided to doctors whose personal circumstances make the travel time or relocation requirement an unreasonable burden. These doctors need an appeals process and the opportunity to work in areas of medical service need (e.g. Aboriginal Medical Services).

All sites for general practice vocational training in outer metropolitan areas must meet the RACGP's standards. Disproportionate use of Subsequent GP terms in outer metropolitan areas, as a mechanism to overcome problems with capacity in training posts is not acceptable.

Unless the need for GPs in outer metropolitan areas is met, general practice supervisors who, by the very nature of their presence in these areas, can be expected to have high patient loads and substantial work pressure must be provided with a high level of support.

Compulsory rotation of vocational trainees is likely to damage the perception junior doctors have of training.

The non-GP capacity of general practices must be strengthened, in particular the availability of practice managers and practice nurses. Research about the appropriate role for practice nurses and nurse practitioners must be commissioned such that any further development of their role is underpinned by robust research in the Australian context.

There is a benefit to medical specialists in other crafts, and subsequently to the community, of exposure to general practice. Subject to mutually agreed processes between the Medical Colleges, under which vocational trainees in other crafts can undertake a component of vocational training in general practice, the RACGP supports the establishment of accredited training posts for registrars in other specialties in general practices in outer metropolitan areas, with supervision by accredited general practice supervisors. Any initiative that results in incremental growth in the number of training posts for other medical specialties, other than those determined through national workforce requirement analysis (e.g. the work of the Australian Medical Workforce Advisory Committee – AMWAC) is unacceptable. As a result, the use of Commonwealth funding for 'backfilling' hospital positions (effectively increasing the FTE training program) is not acceptable to the RACGP.

Medium term approaches (3-5 years)

The Federal Government must raise the number of GP vocational training places. The AMA has estimated that the places need to increase from 450 to 600 per year.¹¹ The RACGP endorses this position as an interim requirement, and seeks to work closely with Government in determining the need for the GP workforce.

There needs to be a sustained effort to improve self-management skills of people, particularly people who have chronic illnesses, as this will contribute to managing the overall demand for GPs.

Long-term approaches (7-10 years)

There should be an increase in the number of Australian medical school places to account for changes in attitudes to working hours, and trends in the characteristics of students entering medical schools.

There is a risk that a program of incentives to practise in outer metropolitan areas will create or aggravate a problem in providing access to GPs in inner city areas. As a result, any incentive arrangements must be carefully monitored for unanticipated adverse consequences.

The RACGP supports supervised pre-vocational placements; and sees General Practice as having the capacity to provide such placements in outer metropolitan areas only when the overall supply of GPs has risen to adequate levels.

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