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Capacity census

A pilot study of general practices in Western Australia

The GP Super Clinics that will provide multidisciplinary primary care services are seen as a key feature of the Federal Government's health infrastructure development. They are designed to improve convenience for patients when accessing services – especially patients with multiple comorbidities requiring visits to multiple providers – as well as providing the space and equipment for teaching and research in primary care. In addition, Medicare Locals are seen as facilitating 'investments in primary health care infrastructure, including GP Super Clinics'. Enhancements to existing private general practices to 'support a broader team, teaching or visiting sessions from other health professionals' are also seen as infrastructure development possibilities.[1,2] Although no one model is provided for GP Super Clinics, it is intended that each 'will bring together general practitioners, nurses, visiting medical specialists, allied health professionals and other healthcare providers to deliver better healthcare, tailored to the needs and priorities of the local community'.[3]

In a letter to the *Medical Journal of Australia*, we offered the opinion that many existing community based general practices had the capacity to function as 'de facto super clinics' but failed to receive adequate recognition for this role.[4] We feel that development of this service through a team building model of networking existing community based general practices together with onsite or locally based allied health and specialist services, or through expanding local practices with increased infrastructure support, would complement the planned GP Super Clinics. A similar view was asserted during recent debate in Federal Parliament.[5]

To substantiate this viewpoint, we recently undertook a pilot capacity census study in Western Australia. A 14-item survey of general practice clinics, identified through divisions of general practice or through published online listings, was conducted between February and June 2010. A total of 442 practices were contacted through the practice manager (PM) or principal GP, or through divisions of general practice. Follow up contact was made by telephone 4 weeks after initial contact. A response rate of 38% (168/442) was achieved.

Ethics approval for the study was received through the Human Research Ethics Committee of The University of Notre Dame Australia, Fremantle.

Of the 168 responses, four were excluded from analysis – three as there was substantial information missing and one as it was a special initiative mobile clinic. Analysis was based on 164 responses with urban (metropolitan)[6] practices accounting for 70.7% of respondents. Practice ownership was 82.3% (n=135) private, 10.4% (n=17) corporate and 7.3% (n=12) other (eg. shire or division).

The survey confirmed our initial viewpoint. Twenty-three practices fulfilled our definition of a 'smaller model de facto super clinic' with four meeting our criteria for a 'larger model de facto super clinic' (*Table 1*). This shows that many general practice clinics are already providing, or have the capacity to provide, the aims of new GP Super Clinics but with one important addition – the existing practice locations and primary health care services have responded to local community demands.

Like the primary healthcare workforce, practice premises have been progressively

Table 1. Author criteria for 'smaller' and 'larger' model de facto Super Clinics

Criterion	Smaller (n=23)	Larger (n=4)
Total number of consulting rooms	≥5	≥10
GP full time equivalent (FTE)*	≥2	≥5
Practice manager	≥1	≥1
Practice nurses	≥1	≥2
Allied health services onsite or <5 minute drive**	≥3	≥4
Pathology, radiology or pharmacy services onsite or <5 minute drive	At least two	All
Specialist services onsite or <5 minute drive	≥1	≥1
Teaching medical students, registrars and the Prevocational General Practice Placement Program (PGPPP)	Some undertaken	Some undertaken

* FTE was calculated as two sessions per day or 10 sessions per week with one session equated to 3 hours duration

** Allied health services that were most commonly located onsite or nearby were clinical psychologists/counsellors, physiotherapists, podiatrists and dieticians

evolving both in size and style over recent decades. Some practices are operating at less than full capacity. For example, we found that there were on average 1.83 (standard error 0.8) consulting rooms in practices per full time equivalent GP. We acknowledge, however, that some existing practices lack the capacity to extend services due to limitations with existing physical infrastructure (no capacity to expand due to lack of consulting space at current location, leased premises or absence of freehold) or a lack of financial income to support expansion in less populated areas. Further government support in developing extra facilities in such community based practices would appear to be a logical development, a view also expressed through an Australian Medical Association position statement.[7]

A major aim in the development of GP Super Clinics is to alleviate much of the ambulatory primary care burden presenting to hospital emergency departments. Our study revealed many practices already possess much of the clinical assessment, management skills and equipment needed to undertake much of the nonemergency healthcare demand currently gravitating toward overcrowded emergency departments.

While our study is limited by its response rate and is not a national representative sample, it nevertheless reflects current capacity among the 164 respondents. The evolving nature of modern Australian primary care reveals many existing general practices already provide service delivery and personnel comparable to the proposed GP Super Clinics but with far superior population and geographical spread. To enable equity in access to primary care services, increased support for existing practices will be an essential component of the Federal Government's health infrastructure development plan.

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