# General practice ownership in rural and remote NSW:
## its impact on recruitment and retention


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**NSW Rural Doctors Network**
**Discussion Paper**

# General practice ownership in Rural and Remote NSW: its impact on recruitment and retention

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# Abbreviations

| | |
|---|---|
| ACCHS | Aboriginal Controlled Community Health Service |
| AHS | Area Health Service |
| AMA | Australian Medical Association |
| AMS | Aboriginal Medical Service |
| AMWAC | Australian Medical Workforce Advisory Committee |
| AOMS | Australian Outback Medical Services Ltd |
| ARRWAG | Australian Rural and Remote Workforce Agencies Group |
| DoHA | Commonwealth Department of Health and Ageing |
| FWAHS | Far West Area Health Service |
| GP | General Practitioner |
| IMG | International Medical Graduate |
| NSW | New South Wales |
| ODGP | Outback Division of General Practice |
| RARMS | Rural and Remote Medical Services Ltd |
| RDAA | Rural Doctors Association of Australia Ltd |
| RDN | NSW Rural Doctors Network |
| RFDS | Royal Flying Doctor Service |
| RRMA | Rural, Remote and Metropolitan Area Classification |
| RWA | Rural Workforce Agency |
| SACRRH | South Australian Centre for Rural and Remote Health |
| UNE | University of New England |
| VMO | Visiting Medical Officer |

## Summary

Primary medical care in Australia has traditionally been delivered by self-employed general practitioners (GPs) working in small to medium sized practices being remunerated via a fee for service payment model. Significant change has occurred over the last decade, including vocational registration, general practice accreditation, financial incentives to encourage involvement in primary health care and population health activities (blended payments), amalgamation of solo and small-group practices into larger, more efficient business entities, and greater use of information technology. The demographics and attitudes of registrars and younger GPs are also changing, with a focus on access to regional and metropolitan centres, shorter working hours and flexibility, and less commitment to managing the business of general practice. The result has been an increase in the number of larger, more business-like practices benefiting from economies of scale, absorbing the increased burden of business management and often contracting or employing GPs to work in the practice.

In NSW it is recognised at a state and local government level that the traditional GP-owned general practice is becoming less viable in rural areas generally and is probably no longer viable in more remote locations. Continuity of primary care for rural and remote communities increasingly depends on focussing resources on the continuity of medical practices rather than on providing incentives to individual GPs to invest in a small business in the community for the long term. The provision of infrastructure and support services is crucial to establish continuing primary medical care. It is even more crucial in enabling GPs to carry out population health and primary health care initiatives. Co-location with other health service providers can also increase the likelihood of functional primary care health teams.

Divisions of General Practice, local government and RDN have been active in developing a range of models for establishing general practices independently of the individual GPs who do or will work in them. Each has been targeted to suit local conditions, which has contributed to their success. At present such initiatives depend on the good will and expertise of the parties concerned.

Health care policy development needs to take into account this increasing separation of the GP and the infrastructure and support component of general practice without undermining the traditional models of general practice. Financial incentives and payment structures will need to produce arrangements that will both (a) attract GPs into rural and remote service, and (b) support the ongoing viability of the entities that are now tending to supply the necessary infrastructure and practice support services.

# 1. Introduction

New South Wales Rural Doctors Network (RDN) is a Non Government Organisation funded by both the Commonwealth Department of Health and Ageing (DoHA) and the NSW Health Department to facilitate recruitment and retention of doctors in rural and remote New South Wales (NSW). It is one of seven state or territory-based rural workforce agencies.

RDN is a strong believer in community involvement and forming effective partnerships between local health providers and community groups as a means to finding short and long term solutions to medical workforce shortages or incompatability. RDN takes a strategic approach where possible, though is often involved with 'hot spots' - towns where general practice workforce issues have become critical. This can happen where issues build up gradually over a period of months without being addressed, or almost over night when a general practitioner (GP) leaves town with no prior indication.

In 1999 RDN surveyed rural Divisions of General Practice and identified towns with chronic GP shortage and high turnover of locums. Amongst those identified were towns in the Walgett and Brewarrina Shires, which have some of the worst social, economic and health outcomes in NSW[1]. There is a relationship between socio-economic status and health outcomes for most major causes of mortality and morbidity[2]. Non-indigenous Australians living in rural and remote areas have reduced health outcomes when compared to those living in metropolitan areas, and indigenous Australians have by far the worst health outcomes of any group[2]. Improving health outcomes in the more vulnerable areas is often compromised by a shortage of health professionals.

In keeping with RDN's general philosophy and with the *Healthy Horizons*[3] commitment to "worst first", RDN made a decision in 2001 to focus on the north west region of the state. In addition to a low socio-economic status and relatively poor health outcomes, this remote region suffers from chronic health (and other professional) workforce shortages. RDN developed and coordinated an approach to general practice management focusing on the integrity and continuity of the practice. The phrase "Easy entry – Gracious exit" is used to describe the philosophy behind the shift in focus from continuity of individual GPs to continuity of the medical practice, which underpins RDN's approach to developing more effective primary health care in this region.

Australia's health policies are moving towards a population health/primary health care focus, in line with the World Health Organisation's Alma Ata Declaration[4], which raised the profile and importance of primary health care. In this context, the scope and function of a rural general practitioner is described as comprising of three broad components, regardless of the setting[5]:

- All round general practice/family medicine including the provision of primary, continuing, comprehensive, community-based, prevention-orientated care
- A procedural component that includes at least, dealing with emergencies involving resuscitation and stabilisation of the critically ill but often also involves hospital based practice
- A population health focus working with the community to improve the health status in activities ranging from safe water supply and sanitation through to community health education.

Developing enduring general practice structures has potential benefits in attracting an adequate health professional workforce. It also potentially enables more focus on

population health and primary health care rather than just providing reactionary primary medical care on demand.

***This review paper identifies changes to the environment in which general practice operates leading to the need for changes in practice ownership and management. Case studies, including the RDN approach (Easy entry – Gracious exit) are used to demonstrate what can be achieved.***

## 2. General practice in Australia

The history of general practice in Australia is closely linked to the development of health care funding[6-8]. The Commonwealth government directly supports most aspects of primary medical care and non-hospital-based ambulatory secondary care through Medicare and the Pharmaceutical Benefits Scheme. Medibank was introduced in 1975 (and re-launched as Medicare in 1984) as a universal insurance scheme to provide Australians with universal access to treatment as public patients in public hospitals and to free or subsidised non-hospital medical treatment. State and territory governments (with the assistance of substantial funding from the Commonwealth) fund public hospitals and community care. Australians can choose to take out private health insurance (also subsidised by the Commonwealth government) and receive treatment in private hospitals as an alternative to the public system.

The separation of State and Commonwealth funding streams, and hence division of responsibilities, has lead to accusations of cost shifting and tension between successive State and Commonwealth Governments. It is also a potential barrier where initiatives (such as those addressing workforce) require flexible funding or collaboration between providers funded from different sources.

### 2.1 Primary medical care

The majority of primary medical care is provided within the framework of general practice. Under Medicare GPs are rewarded on a fee for service basis, which rewards shorter consultations and high patient throughput. Such a ' reward' system is not very compatible with population health, or with complex care such as that required by older patients and those with chronic conditions. Some primary care is also provided free of charge by salaried doctors in community health settings.

The Commonwealth has not placed a limit on the fees GPs can charge per consultation, but has encouraged bulk billing (charging only the Medicare rebate) to minimise out of pocket expenses for patients. However, the rebate offered under Medicare is no longer an incentive for GPs to bulk bill, and rates for general practice services are declining. Attending a non-bulkbilling GP can cost up to $30/visit (the difference between the charge for the consultation and the Medicare rebate). The proportion of GP attendances bulk billed in the year ending June 2003 was 69.5%[9] and the rate is continuing to fall. Fewer GPs in rural areas bulk bill than do in urban areas and the average out of pocket cost per consultation is generally higher for rural patients. For example, Young and Dobson[10] found that women in rural areas paid more to visit a GP than women living in urban areas.

The majority of GPs work in private practices in the community. They are self-employed, or contracted to or employed by a practice, which is usually a relatively small, privately owned business run by a GP or GPs. The owners of the practice are responsible for the

physical infrastructure, practice management, employment and management of staff and finances, as with any small business. Income is generated through Medicare and other Commonwealth funded initiatives such as blended payments and practice amalgamation incentives (Appendix 1) and through gap payments from patients where the cost of the consultations exceeds the Medicare rebate. Many GPs also provide non-clinical medical services, including population health and administration services[11].

Australia, like many countries, finds it difficult to recruit enough medical practitioners to live and work in rural and remote communities. In December 1998, 15.6% of medical practitioners worked in rural and remote areas, serving 28.7% of the Australian population[6]. In November 2002, there were 3855 GPs working in rural and remote Australia (RRMA 4-7)[*]. Around 28% of those worked in NSW[12]. There are around 130 vacancies for GPs in NSW[13] and a projected shortfall of between 275 and 410 GPs by 2012[14].

## 2.2 Existing models of employment for GPs

Existing models of employment for GPs fit into three main categories, each encompassing a number of variations[6]. The main features are summarised.

### 2.2.1 Small business owners

The majority of GPs are self-employed. Private medical practices differ in size (ranging from 1 to 20 GPs working a variety of hours) and ownership arrangements. Group practices are usually set up as partnerships, associateships or companies, with a practice manager coordinating the practice. Partnerships involve participating GPs sharing income and costs, with profits drawn from a common pool. Associateships are where incomes remain separate, but costs are shared. Companies are formed by a group of GPs as shareholders and directors, which can then employ or contract other GPs. Another form of practice structure is where two or more GPs maintain their own privately owned practices, but agree to co-locate, treat patients from either practice, and share common reception facilities.

The choice of business structure has implications for such things as legal risks, public perception, financing/capital requirements, operating costs and taxation, administration and regulatory compliance requirements, degree of control/independence, desired working relationships with colleagues, career stage and retirement planning. Private practices are found in most towns in Australia, except in very remote locations (for example in the Northern Territory and north west Western Australia) where they are not viable.

### 2.2.2 Contractors (GPs engaged in a practice under negotiated conditions)

***Working in corporate practices:*** Catchlove[15] describes a typical scenario for a corporate practice where:

- A third party acquires an interest in (or establishes) one or more practices
- Whatever the equity arrangements, GPs enter into a contract whereby they assign a proportion of their gross income in return for management of their practice, provision of support services and a good will payment

[*] The Rural, Remote and Metropolitan Areas (RRMA) Classification describes geographic isolation. The seven categories are 1 - capital cities, 2 - other metropolitan centres, 3 - large rural centres, 4 - small rural centres, 5 - other rural centres, 6 - remote centres, 7 - other remote areas. NSW has no RRMA 6 areas.

- The third party then gains access to the flow-on services of the practice (eg pathology and radiology) and may benefit financially from GP referrals
- The practices are merged into a single medical centre, which is generally separately owned by the same third party.

Recognised third parties include publicly listed companies and entrepreneurial corporate groups of doctors. Corporatised practices average 10-12 GPs, contracted to provide services whereby a percentage of their income goes to the company in return for the use of the premises and management facilities. The practices often have integrated referral services such as pathology, physiotherapy, imaging, specialist services and a pharmacy, and offer extended after hours care. Corporatisation is discussed further in Section 7.1.

***Working in privately owned practices:*** Private practices can also contract services of GPs in much the same way as corporate practices. The contracted GPs usually pay a management fee to the practice (though some may work for a salary and are therefore employees). Conditions of engagement are set out in a contract signed by both parties.

#### 2.2.3 Employees (GPs working for a salary and incentives)

Some ***State Health Departments***, particularly the Northern Territory, Queensland and Western Australia, employ GPs to work under specific awards and agreements. They usually receive assistance re-locating, a vehicle for official use and other incentives. As an example the North West Medical Practitioner industrial agreements provide a range of incentives to assist north west employers to attract and retain experienced and qualified medical practitioners in the Western Australian public health system. The Northern Territory government employs District Medical Officers. In rural and remote parts of Queensland GPs may work as Medical Superintendents with rights to private practice. They are employees of Queensland Health, who pay them a salary and may provide them with some combination of the following: accommodation, a surgery, a vehicle, locum relief, award leave conditions and a supportive hospital infrastructure, assistance with medical indemnity cover, a communications package. They usually remain within the community for 6-12 months, though some remain longer.

***Aboriginal Community Controlled Health Care Services (ACCHS), including Aboriginal Medical Services (AMS)*** have provided a mix of primary health care and community development for aboriginal Australians, since the early 1970s. GPs are either employed by ACCHS on a salary, provide sessions for which they bulk bill, or are employed by the community to work under specific conditions with a regular salary as part of a primary health team. ACCHS are usually funded by both State and Commonwealth Governments. In some towns the ACCHS are the only bulk-billing general practices, and thus service both aboriginal and non-aboriginal people.

The ***Royal Flying Doctors Service*** provides medical emergency and primary health care to 80% of rural and remote Australia (7 150 000 $km^2$) using salaried doctors on fixed incomes with specific working conditions, including after hours and organised leave for both recreation and study.

## 2.3 Changes in general practice

Successive Commonwealth governments have implemented changes influencing the way in which general practice is structured and funded[16]. In the last 10-15 years changes have included vocational registration, general practice accreditation, financial incentives to GPs to become involved in primary care and population health activities (blended payments), amalgamation of solo and small-group practices into larger, more efficient business entities (resulting in increased employment of practice nurses and non-medical staff such as practice managers), and optimal use of information technology and information management[6-7,17]. GPs are also asked to provide information to assist Commonwealth departmental assessments, to participate in programs promoting population health, and to respond to a range of Commonwealth government and other surveys. The major reforms are summarised in Appendix 1.

Other significant influences driving change in the general practice environment include changes to the demographics and attitudes of both the GP workforce and the communities they serve, advances in technology (particularly computer applications), changing financial pressures, changes in the role of GPs (such as an increasing involvement with population health and management of chronic illnesses), and workforce shortages. The roles of nurses and other health professionals is also changing to compensate for the shift of treatment and care responsibilities into the community and lack of growth in the number of GPs (more so in a number of overseas countries than in Australia).

Most changes have focussed on efficiencies and accountabilities of the ' business' and not on the additional administrative and compliance activities generated and their impact on self-employed GPs[7]. GPs and their representative organisations have expressed concerns about rising levels of stress and frustration associated with complying with the administrative component of Commonwealth programs. They feel the increased paperwork and conflicting priorities are detracting from the delivery of care to their patients, with little impact on quality medicine[18-19]. The lag in receiving payments can also be a challenge for practices with a high turnover of GPs. The AMA estimates that GPs commonly spend 3-7 hours per week on paperwork[19]. The burden is heaviest in small practices. Practice size (as one element of economies of scale) is therefore a significant factor in attitudes to the quality requirements associated with accreditation.

In July 2002 the Productivity Commission was asked to conduct research examining the administrative and compliance costs associated with Commonwealth Government policies and programs that impact on general practice. They reported that in 2001-02 the estimated incremental administrative and compliance costs resulting from Commonwealth policies and programs amounted to around $13 000/GP/yr[7]. Costs associated with Vocational Registration, the Practice Incentives Program and the Enhanced Primary Care program accounted for over 75% of these costs. Veterans Affairs, Family and Community Services, Centrelink and Pharmaceutical Benefits Scheme authorisations account for less than 6% of costs each. GPs receive government payments that exceed the measurable administrative and compliance costs for most programs. The Productivity Commission also reported that filling out forms accounts for a small share of the measurable administrative and compliance costs, but is a significant source of stress-related and other intangible costs, which are difficult to quantify.

> *Incrementally general practice has accepted more and more bureaucratic requirements for patient management. It remains unclear whether there is an improvement in health outcomes due to this or whether there is an economic benefit*

*in terms of health spending. There is certainly little benefit to the GP doing the work. With good practice support there may be a benefit to the management of an individual practice but this comes at a cost that may not be able to be recouped at this level. GPs need to feel valued for the work they do. Not the forms they fill out*[18].

## 2.4 Another generation of general practitioners

Workforce characteristics, which influence participation in the workforce and hence the number of GPs required to meet the expected patient demand, are changing. The historical view of a male GP working tirelessly for a community for most of his working life is going out of focus. This is well illustrated by the demographics and attitudes of medical students. Of the 604 applicants to the General Practice training program in 2003, 56% were female, 67% were born overseas and 35% did their undergraduate training overseas[20]. In addition, 62% were aged over 30 years, twice as many as five years ago. These figures highlight important shifts (generational change) already noted in the future workforce[21-22]. In addition many medical students are now graduating with a substantial Higher Education Contribution Scheme debt, which must be re-paid to the Commonwealth.

Five of the twelve Australian universities (including the new Canberra Medical School) have introduced a graduate entry program. Therefore many medical graduates are older and more likely to have partners and families. Their partners are more likely to have an established career and they may be less willing to move long distances away from metropolitan centres to train and work. Fewer want to do procedural medicine and work long hours, long term in rural or remote towns.

Thompson[23] observed major differences between the 50 registrars in the Rural Training Scheme in South Australia and the practising rural GPs there in terms of the number of female practitioners, skill levels, emphasis on social and family time, desire for flexible work arrangements and willingness to work in isolated rural environments. Employment for partners was also important and the registrars stated a preference for larger practices within a 300 km radius of Adelaide.

Relative to the past, rural and remote GPs are generally older, more likely to be female, and pressured by the expectation of long working hours (particularly on call and after hours). They are less likely to bulk bill, more likely to be computer literate, less likely to use procedural skills and have more opportunities to work in different ways, for example with Divisions, training consortia, Area Health Services and similar organisations in non clinical roles. They are retiring at an earlier age and are less likely to move to locum or part time work in retirement because of costs associated with indemnity cover[14].

General practice, as a branch of medicine, is seen as flexible enough to allow female GPs to accommodate their family/social and professional objectives[24]. Increasingly, the rural and remote general practice workforce will need flexible working hours to cater for larger numbers of female GPs, who often choose to work part time for part of their career. For example, 87% of female rural GPs in New South Wales surveyed by McEwin[25] in 2000 had children, and 78% of those had the main responsibility for care of their children. More female GPs self-report as working part time (83%), compared with male GPs (17%), though this varies with age. About 63% of younger females (less than 35) work full time compared with 36% of those aged 35-44 years which coincides with a high level of family responsibility[26]. In 1998, for the first time, females represented over 50% of all students commencing a medical degree in Australia[9]. Female GPs tend to be younger (44% of GPs under 35 years are female compared with 13% of GPs aged over 55 years), reflecting the

increasing proportion of females entering medical schools. It is estimated that by 2010 42% of all GPs and 37% of rural GPs will be females[27].

Many of the rural and remote female GPs interviewed by Tolhurst and Lippert[28] indicated that they preferred to work in a group practice with four or more GPs working in a combination of full and part-time positions. Such practice structures were seen to provide more flexible working arrangements that reduced their on-call and other hours responsibilities and their reliance on locums to cover for holidays and other leave. As well as flexibility and shared workloads, female GPs valued the opportunity to work in salaried, assistant or contract positions. Many preferred blended payments, which they felt rewarded their involvement in population health initiatives better than relying completely on fee for service income. Many felt that the business management side of being a practice principal was too time consuming and would impact negatively on family time.

Pope and Deeble[12] identified two types of GPs in their analysis of the Australian Rural and Remote Workforce Agencies Group (ARRWAG) minimum data set. The first is a group of older, mostly male, resident GPs who work relatively long hours and who are likely to have been in rural (and to a lesser extent remote) areas for a long time. They are more likely than other rural and remote GPs to practise advanced procedural skills. The second is a group of transitory GPs who move in and out of rural and remote locations more frequently, often while training. These GPs are more likely to be younger and female, and a considerable proportion have trained overseas. They work fewer hours and are less likely to regularly practise advanced procedural skills, but are more likely to regularly practise emergency care and aboriginal health care.

In future, for a variety of reasons, there is likely to be a more mobile rural and remote GP workforce working fewer hours/GP. This will place more emphasis on the need to recruit additional GPs. Non-financial incentives such as flexible working hours, adequate locum support, less frequent on call work, support for professional development, information technology and administrative support, and different practice models are becoming essential recruitment tools for GPs and for communities.

## 2.5 Another generation of general practices

One of the issues identified as warranting immediate action in the review of the 1992 General Practice Strategy[29] was the need to promote new practice organisational arrangements to encourage efficiency and provide better lifestyle and career choices of GPs. This is happening in response to Commonwealth reforms, economic forces resulting in lower unit costs in group practices and expectations of the new generation of GPs and patients. Practices are under pressure to become larger, to function within accredited guidelines, to move towards a primary health care approach, and to rely increasing on computerisation (Appendix 1). Practice nurses, administrative/support staff and others are regularly employed by general practices. Group practices are more likely to include non-owner GPs who are paid on a percentage of their gross income, or who work for a salary.

The external operating environment has also changed significantly. Divisions of General Practice and Rural Workforce Agencies offer direct support to GPs and practices. Academic support is more accessible with the establishment of University Departments of Rural Health and Clinical Schools, and regionalised postgraduate training programs. There is support for general practice research through the Commonwealth funded Primary Health Care Research Evaluation and Development scheme. As a result the range of professional roles available to rural and remote GPs has increased markedly to include management

roles within expanded practice structures, health promotion, teaching and supervision roles, working for medical-political organisations and undertaking research.

Doran[30] gives a relevant thumbnail sketch of the new style of general practice. She outlines how the Otway Medical Clinic formed by the merger of two general practices. The clinic is housed in modern, comfortable facilities. Staff include a practice manager, a practice nurse, a diabetic educator, an asthma educator, 12 support staff, 8 doctors, one registrar and visiting specialists. Along with this comes a growing stockpile of paper work and pressure to function within accredited guidelines. The practice promotes itself as a private business (rather than the traditional concept of a 'country practice', and charges privately, bulk billing only a few patients. The practice manager estimates that $100 000 was spent to computerise the practice alone. She goes on to say that more could be done.

> *I'd envisage an extensive, holistic health service under the one roof. I would like to see a natural medicine aspect in the clinic, perhaps someone with specialised counselling skills. It's not limited.*

In another example, a group of local GPs in Wollongong have developed a business model for a purpose-built medical and business center to boost profits[31]. They each put up money to build a purpose built facility to house the centre. Participating GPs would enjoy all the benefits of corporatisation, such as top-level administrative support and a secure income, as well as independence and true doctor ownership (which distinguishes this model from a corporate practice where ownership often rests with a large company not professionally involved, Section 7.1). Potential tenants for the centre include X-ray and pathology providers, chemists, newsagents, florists, cafes and health funds.

These are examples of the growing number of larger, more diverse, business like practices emerging as a result of changes over the last 5 to 10 years. However, they are only feasible where the population base is large enough to support them.

## 2.6 Remoteness as a factor in general practice ownership

The economics of general practice and infrastructure requirements make it desirable to have group practices with at least four GPs[32]. Access Economics[33] found that the practice cost per GP fell significantly as the number of GPs increases from one to about eight full time equivalents. During community consultations as part of RDN's workforce planning process, many rural GPs agreed that the ideal size for rural practices is 4-6 GPs[14]. A minimum catchment of 4 - 5000 people is required to support a general practice of 4 or more GPs[32]. However, communities of less than 4000 people also expect resident GP services, leading to a higher proportion of practices with one to three GPs. These smaller practices have higher overheads/GP and face a number of challenges to remain financially viable.

Larger practices have become accredited, and have evolved business and support structures to take advantage of the diversity of income sources now offered by the Commonwealth, including the appointment of practice nurses and other non-clinical staff. Time needed to run the practice, and the overhead costs generated, increase accordingly, as does potential income. One GP interviewed by the Productivity Commission[7] (page xix) stated that he:

> *…does not encounter difficulties when complying with the programs. This is because he is able to rely on systems and procedures developed by the practice administration staff and because the practice employs several nurses…*

Larger practices have the potential to offer a wider range of primary care services, after-hours care from within the practice and a more balanced lifestyle for those who work in the practice, while achieving higher profits through increased efficiency and economies of scale.

In smaller practices, where less staff are employed, accreditation and the subsequent administrative load generated by blended payments are often largely absorbed by the GPs themselves, on top of their clinical load. Traditionally, rural GPs have been unable to take advantage of co-location or share management practice models to alleviate the higher costs of fuel, telecommunications, freight, transport and most commodities[6].

It is possible for practices to link up electronically to form ' distance-networks' , which can facilitate innovations such as shared organisational and staffing arrangements, leading to improved economies of scale and professional exchanges. Other possibilities include facilitating on-call rosters, emergency after hours care for patients and town rosters for sharing anaesthetics and obstetrics after hours.

Such advantages are being recognised in some areas, but are not yet widespread, and do not in themselves reduce the burden of small business ownership sufficiently to make smaller rural and remote practices attractive. Only 4 out of 1347 GPs in NSW (RRMA 3-7) reported working in co-located solo practices and the same in virtually amalgamated practices (RDN Database, 30 November 2002).

Practice size is relevant to financial viability, to enabling GPs to take time away from the practice for continuing professional development and recreation, and to maintain a reasonable after hours roster. Small practices are unable to access adequate local professional support, continuing education and other leave. Only minor changes in workforce structure can have large and compounding adverse effects on supply of medical services.

It is often more difficult and expensive to access quality staff and services, such as practice managers/receptionists, practice nurses, computer support personnel and financial support services in more remote areas. It can also be more difficult for small practices to fund one-off purchases of new equipment and maintain up to date computer and information management technology. These factors tend to be accentuated by increasing remoteness.

In many smaller practices, where one or more GPs have Visiting Medical Officer (VMO) rights, an increasing proportion of the GPs' income is being generated by hospital work. However, the personal cost is high due to more demanding hours, particularly associated with on call and after hours work, and the more demanding continuing professional development required to maintain procedural skills. This has implications for both recruiting and retaining GPs in such communities (Section 4).

> In 1968 the then president of the NSW Branch of the Australian Medical Association[34] said in an address to the annual general meeting that:
>
> *It is apparent that many rural towns are so unattractive, in terms of medical practice, that a doctor must be possessed of almost a missionary-like dedication to remain there. …The small isolated Western town, which could support one doctor, has the least appeal.*

# 3. General practice ownership in rural and remote NSW

The majority of GPs in rural and remote NSW provide primary medical care in their practices as private practitioners. Many also provide in-patient and after hours services in State government funded public hospitals. For their hospital work GPs are paid on a fee for service basis with payment from the local area health service (AHS), according to the Rural Doctors Association Settlement Package (an agreement between NSW Health and the Rural Doctors Association, NSW). GPs working as VMOs in the few towns not participating in the Settlement Package are paid on a sessional basis. Relatively few GPs work as employees of organisations. Those who do are remunerated through a range of different salary/fee for service arrangements. The NSW Government (unlike Western Australia, the Northern Territory and Queensland) does not employ GPs or provide infrastructure for them to work in general practice in more remote locations (Table 3.1).

**Table 3.1 Primary source of income for GPs in NSW compared with other states [Source: Pope and Deeble[12]]**

| | NSW | Tas | SA | Vic | WA | Qld | NT |
|---|---|---|---|---|---|---|---|
| Fee for Service | 60% | 80% | 695 | 81% | 56% | 53% | 29% |
| Private practice salary | 36% | 18% | 27% | 8% | 21% | 20% | 1% |
| Salary – other* | 4% | 2% | 4% | 11% | 23% | 28% | 70% |

* includes state salary with or without rights to private practice, ACCHS salary, non-government salary and local government salary

## 3.1 The general practice workforce

In November 2002 there were 1347 GPs residing and practising in RRMA 3-7 areas in NSW (RDN Database, 30 November 2002). The general practice workforce is reasonably stable with an average of 15.5 years spent in rural practice and the majority of GPs working in RRMA 3-5 areas (Table 3.2). Ninety one percent self report as being vocationally registered, 65% have VMO status and 27% are female[26], though this percentage is steadily increasing, and is expected to reach 37% on a national level by 2010[27]. The average age of the existing workforce is 48 years and they work an average of 46.6 hrs/week in clinical work, including both full time and part time GPs (Table 3.2). The characteristics of GPs differ according to the geographic region in which they work. On average GPs working in remote areas are more likely to be younger males who are more mobile and work longer hours.

**Table 3.2: Characteristics of the NSW rural general practice workforce at November, 2002 [Source: NSW Rural Doctors Network Database, 30th November, 2002]**

| RRMA* | Number of GPs | Female GPs (%) | Average age (years) | Average clinical hours (per week) | Average years spent in rural practice | Number of towns with resident GPs |
|---|---|---|---|---|---|---|
| 3 | 285 | 36% | 47.7 | 37.1 | 16.7 | 18 |
| 4 | 429 | 30% | 47.3 | 44.0 | 15.0 | 52 |
| 5 | 602 | 24% | 48.9 | 52.6 | 15.6 | 139 |
| 7 | 31 | 23% | 42.6 | 54.0 | 8.5 | 16 |
| Total | 1 347 | 29% | 48.0 | 46.6 | 15.5 | 225 |

*No RRMA 6 areas in NSW

## 3.2 Practice size

In December 1999, approximately 19% of Australian GPs worked in solo practices and 66% worked in practices consisting of 3 or more GPs[35]. In November, 2002 in rural and remote Australia (RRMA 4-7), approximately 17% of GPs worked in solo practices[10]. The proportion of GPs working in solo practices varied according to RRMA, with 12% in RRMA 4, 19% in RRMA 5, 10% in RRMA 6 (doesn' t include NSW) and 35% in RRMA 7. The proportion of solo practices in NSW ranges from 22% in RRMA 3 up to 43% in RRMA 5 (RDN Database, 30 November 2002). On average, 38% of GPs in NSW (RRMA 3-7) work in solo practice. There were 73 solo GP towns and 34 two GP towns in NSW (RDN Database, 30 October 2003).

The majority of general practices are solo or two GP practices, regardless of RRMA (Table 3.3). The proportion is much higher in RRMA 7, where only one out of the 21 practices has more than 3 GPs, reflecting the highly dispersed population. The lowest proportion of solo or two doctor practices are in RRMA 3 (58%), followed by RRMA 4 (61%), and RRMA 5 (73%) (Table 3.3). Fewer than 10% of doctors work in practices with more than 6 GPs.

**Table 3.3 Variation in practice size by RRMA in NSW, November 2002 [Source: RDN Database 30th November 2002, size of practice based on head count not on full time equivalents]**

| RRMA | Practice size 1-2 GP (%) | Practice size 3-6 GPs (%) | Practice size >6 GPs (%) |
|---|---|---|---|
| 3 | 58 | 33 | 9 |
| 4 | 61 | 32 | 7 |
| 5 | 73 | 22 | 5 |
| 7 | 95 | 5 | 0 |

## 3.3 Practice ownership and primary sources of income

From a national survey of GPs (RRMA 4-7), 60% reported receiving their primary source of income from fee for service payments, approximately 25% received a private practice wage or salary and 5% were state salaried without rights to private practice[9]. Similar data for primary models of service provision show that 78% of GPs in Australia (RRMA 4-7) are resident GPs and 21% (18% in NSW) provide Aboriginal health services. Practice ownership patterns in NSW show a tendency towards individual ownerships and partnerships with remoteness (Table 3.4).

**Table 3.4 General practice ownership structures defined as % of GPs (head counts) in each RRMA category [Source: RDN Database, 30 November 2002]**

| Practice ownership | RRMA | | | |
|---|---|---|---|---|
| (% of GPs per RRMA) | **3** | **4** | **5** | **7** |
| Associateship | 38 | 33 | 27 | 6 |
| Partnership | 24 | 25 | 29 | 6 |
| Individual | 24 | 29 | 34 | 41 |
| Corporate | 2 | 1 | <1 | 3 |
| ACCHS | 1 | 2 | 2 | 0 |
| Other/Unknown | 11 | 10 | 8 | 44 |

### 3.4 Vacancies

RDN (and its predecessor organisation The Rural Doctors Resource Network) has been advertising GP vacancies for rural and remote practices since 1989 in the RDN Vacancy Booklet. The advertisements are placed by GPs, Divisions of General Practice, local government, Area Health Services, Aboriginal Medical Services, hospitals and individuals. In 1989 there were around 70 advertised vacancies, dropping to less than 40 in 1992. Since then the number has steadily risen to over 100 in 1998, and with the exception of 2001, the number of vacancies has stayed over 100[13]. Since 2000 RDN has also advertised on its website. In November, 2002 there were 130 actual vacancies advertised. An actual vacancy is defined as the number of (currently unfilled) positions that a community can sustain taking into account the workload of other GPs in that town or community and for which recruitment action is currently underway or has been undertaken but was unsuccessful[14].

Vacancies, as a proportion of the GP population were highest in RRMA 7 (40%), followed by RRMA 5 (13%), RRMA 3 (9%) and RRMA 4 (7%). In 2002, 53 GPs who had filled vacancies advertised by RDN were surveyed. Over half were international medical graduates (IMGs), compared with almost equal numbers of registrars and Australian graduates[13]. These proportions were also reflected in the 103 arrivals to rural and remote practice during 2002, (RDN database, 2003). A third were IMGs, and the next largest group (approximately one fifth) were from urban practice. Very few IMGs will buy into a rural or remote practice initially, and neither will registrars (about 12% of new arrivals).

## 4. Barriers to recruitment and retention

The traditional model for general practice is that of small business owners (GPs) working to provide primary medical care. Under this model GPs provide their own practice infrastructure (including buildings, medical equipment and information technology), employ their own staff, and take care of other functions of running a business, such as staffing and practice management.

The most common way to recruit a GP is to identify an individual, provide them with incentives to set up a private business, and retain them for as long as possible by seeing them as part of the community (with personal and professional satisfaction as the major incentives). However, there are many barriers to this process, and these are brought into sharpest relief in smaller and in more remote locations relying on traditional practice structures.

### 4.1 Issues in retaining self-employed practising GPs

The issues that may be faced by self-employed GPs in rural and remote practices are well known[36-38]. They are summarised here as:

- Geographical isolation, which includes distance from metropolitan centres; and can include separation from family and friends, lack of opportunity for spouses to pursue careers, and access to educational choices for children
- High workloads (including frequent after hours and on call commitments)
- Limited availability and high cost of locum cover for leave and short term emergencies
- Professional isolation, due in part to the potential difficulties in accessing continuing professional development (time away from practice, availability and cost of locums)

- Increasing cost and complexity of practice management, and the demands it makes on the GP' s time
- Access to services and skilled personnel in more remote locations.

## 4.2 Barriers for recruiting new GPs

The issues acting against retaining GPs in rural and remote practices (Section 4.1) also act as disincentives (though not necessarily to the same extent) to recruiting new GPs. More recently, practice ownership has also become a barrier to recruitment[29,39]. Issues include:

- The initial capital outlay for an adequate surgery and residence, particularly when there is no guarantee the assets will appreciate in value, or even be saleable in future. Likewise, there is a financial commitment when buying into an existing practice
- The costs of setting up a practice and employing people
- Many small rural and remote practices are only marginally viable, and are therefore not a good investment
- Many GPs are reluctant to be involved in managing a general practice business, which includes employing staff (including other GPs), accreditation, information technology requirements, obtaining incentive payments, taxation issues and many other facets (Appendix 2)
- As the owner of a business, it is more complicated to leave the practice and the community
- IMGs make up a large proportion of the GPs being recruited into rural and remote practice. They almost invariably start out as employees or contractors and are therefore unlikely to buy into a new or existing practice, at least initially. (In 2002, 48% of all new arrivals excluding registrars, were IMGs - RDN database, November 2002).

The business of running a general practice has become more complex, and involves greater outlays and levels of management expertise. To invest in a business, develop business skills and undertake the administrative load necessary for a profitable practice, and maintain the clinical workload in areas of workforce shortage is very demanding. More GPs are seeking flexible working hours which allow them to spend more time with family and friends; and to develop interests in population health and other non-clinical professional interests such as research, medico-political organisations, Divisions, and teaching and supervision. This leaves them with less time for business ownership and practice management. There is a need to provide these support structures in a different way, to free up the GPs time and encourage them to work in rural and remote general practice.

## 4.3 Barriers for the community

Many smaller rural and remote communities struggle to maintain accessible high quality primary medical care. They regularly contend with high levels of GP burnout, practices characterised by high GP turnover and difficulties in attracting locums and new GPs. When a solo GP leaves, the practice entity goes as well if there is no one to maintain the infrastructure, pay the bills, employ staff or maintain the practice records. This is particularly critical where the partner of the GP has acted as the practice manager and where there is a shortage of local skills to link in with to establish a new business (for example, practice management, practice nurses, information technology and financial services). Often in this situation the community has a series of locums providing disjointed, reactionary medical care. More patients either go to other towns or go without

when a practice is vacant or relying on a series of locums. This in turn affects the viability of the practice and the ability to recruit a new resident GP, and can be very costly for communities who become directly involved in the process (Section 5.3).

### 4.4 Overcoming the barriers

The objective of every community is to have continuous, good quality primary medical care delivered by GPs working in financially rewarding, well supported general practices. The benchmark is an accredited, financially viable practice with adequate facilities (including house, surgery and information technology), adequate locum relief for all staff, accessible continuing professional development, adequate administrative support (practice and office management and maintenance of medical records), adequate after hours rosters and robust relationships with the local hospital and other stakeholders. **In many smaller rural and remote communities this can often only be achieved with input from third parties.** Potential third parties include community groups (often led by local government), Divisions of General Practice, Universities, entrepreneurs and State or Commonwealth governments.

In a series of case studies involving communities in all parts of rural and remote Australia, Togno[40] identified two critical success factors for sustainable medical practices. These were community participation and ownership, and an explicit agreement between the community and the GPs regarding the length of contracted service, the range of services provided and after hours availability. The extent to which communities are able to support their health services will depend on the size, resources and priorities of the community.

## 5. Developing new general practice ownership entities

In an effort to overcome barriers, a number of models for re-organising general practices involving local communities, local government, local industry, state health departments and universities are emerging. These are discussed in Sections 5 to 7.

### 5.1 Government sponsored medical services in remote communities

It is widely accepted that privately owned general practice is not viable in very remote communities (for example in remote parts of Western Australia, the Northern Territory and Queensland). In Western Australia, the percentage of GPs in private practice decreases with remoteness, falling to 20% in the Kimberley Division of General Practice compared with 90% in the Southern Division of General Practice[41].

In most places the alternative to private practice is that government, or a mix of government and community, owns the general practice and contracts GPs to provide primary health care as part of a health care team. GPs work under specific awards and agreements, often incorporating flexible working conditions, including job share. For example, Queensland Health employs both Medical Superintendents and Medical Officers with rights to private practice. Both positions have superannuation, recreation, sick and study leave, and the Medical Superintendent also has automatic right to a rent-free house and often a surgery[28]. The Royal Flying Doctor Service also contracts GPs to provide general practice services to some remote aboriginal communities, for example on Cape York Peninsula.

Many remote communities rely on ACCHS (totally or in part) to provide a mix of primary health care and community development, primarily for indigenous Australians. ACCHS are often funded by both the State and Commonwealth governments and are found in all states. GPs are either employed by ACCHS on a salary, provide sessions for which they bulk bill, or are employed by the community to work under specific conditions with a regular salary as part of a primary health team.

In the Northern Territory medical services have historically been provided to many of the larger communities by District Medical Officers who fly in and out on a regular basis. More recently a range of health services funding and management structures have developed, based around delivering primary health care in remote Northern Territory communities, many of which have limited resources to play an active role in governing health services. The major players are ACCHS, grant funded Health Services, Territory Health Service health teams, communities and the Commonwealth[42].

Fee for service remuneration under Medicare does not take into account many of the characteristics of remote practice, such as the need for GPs to practice population health and to provide services which in urban areas can be referred, the on call requirements and the travel distances. Many communities (or regions) rely on pooling funds, including cashed out Medicare payments and other appropriate Commonwealth and State funding to pay their GP salaries[42]. However, even when creatively used and combined with remote area grants, training and relocation grants and continuing professional development support, fee for service payments do not always provide enough to cover the cost of an appropriate remuneration package. Northern Territory Health Services often support GP services by covering practice costs. Communities have also, on occasions, negotiated housing, vehicle costs, private telephone and email costs. Whatever the arrangement, it needs to be transparent. In remote mining communities, mining companies usually step into this role, offering a complete package of incentives to attract GPs.

## 5.2 Community sponsored medical services

In states like NSW, where the government employs very few GPs, other parties are becoming involved (particularly local government) in a variety of ways to ensure their community has access to adequate primary medical care. The most common types of support given to general practices include involvement in recruitment, assistance with infrastructure costs, administration and practice management support, professional support and developing partnerships within the community to encourage long term sustainability of the practice.

### 5.2.1 Recruitment

Recruiting additional or replacement GPs is a vexed issue for many practices and can be time consuming and costly, particularly where the practice is recruiting doctors trained overseas, and where a series of locums provide temporary services. In NSW the majority of GPs are still recruited by individual practices. Support organisations such as Rural Workforce Agencies, Divisions of General Practice and occasionally AHSs, locate and assist in recruiting about half the IMGs recruited into rural and remote practices. For example RDN offers free advertising both on its website and through its Vacancy Booklet, which is widely distributed within the State twice a year. RDN also supports the recruitment of permanent resident overseas trained doctors by screening applicants, assisting with medical board interviews, provider numbers and matching them to a practice.

Community groups (often local government, which has a large vested interest in the process) are also taking a more pro-active role in recruitment by providing resources and incentive packages for incoming GPs. Community groups can also play an important role in orientating incoming GPs and their families, and being mindful of their needs once they are established.

#### 5.2.2 Infrastructure

In many smaller communities there is a shortage of both housing and surgery accommodation. Local government is often called upon to provide the physical infrastructure. The incentive packages put together by communities are usually based around the provision of housing and a surgery, either rent free or at a subsidised rate, which reflects a reluctance by many prospective GPs to financially invest long term in the community they are working in.

It also reflects the high number of IMGs being recruited, who are conditionally registered, and may not be in a position to buy into a practice, at least initially. Increasingly recently qualified Australian GPs may be financially burdened by Higher Education Contribution Scheme debts and other limiting financial constraints.

#### 5.2.3 Administration and practice management support

In many smaller practices there are not enough non clinical staff employed to deal fully with the workload associated with administration and practice management (including maintaining medical records), which then falls to the GP or their family. In areas of chronic workforce shortage, the turnover of GPs and local practice staff, and staff in health bureaucracies makes it difficult to retain corporate memory. Both the Australian Medical Association and the Rural Doctors Association of Australia agree that funded administrative support for GP services with an emphasis on community development is important[5]. This would work best where that support (including practice management and medical record keeping) is independent of the incumbent GPs. Flexible work arrangements, including part time work and job sharing are often the only way skilled staff can be attracted to work in the practice.

#### 5.2.4 Professional support

Adequate locum cover for continuing professional development, leave and other interests, and arrangements to limit after hours work loads are barriers to retaining GPs in smaller communities.

#### 5.2.5 Key partnerships and networks

Evidence suggests that the interaction between the local community, local health services and GP peers has a strong impact on the sustainability of medical services in a community[40]. Community involvement comes as a result of strong partnerships being developed between local interests (communities, government and business) to devise workable local solutions. In the process of developing partnerships local networks are developed, local knowledge and problem solving capacity is increased, skills are strengthened, which provides a sense of ownership (and nurturing) by the community of its local health service. This can make practices more attractive to incoming GPs. A good example is the Walgett Shire Health Forum (Section 6.1).

Partnerships can also be used to garner more resources for the community. Service agreements between community and providers and employment contracts are tools which help to ensure transparency. Flemming *et al.*[43] give two examples of community fora in South Australia designed to build community partnerships. The Hills Mallee Southern Region Rural Medical Workforce Forum and the Penola and District Medical Support Group draw together stakeholders to develop long term strategies for recruitment and retention. Some of the spin offs from such fora are a sense of community ownership and awareness, a multi-system response to problems, shared knowledge base and capacity building.

Roussos and Fawcett[44] have reviewed the use of collaborative partnerships as a strategy for community health improvement and point out the need for broad community engagement. They also outline recommendations for successful partnerships.

In other words *"Stop waiting for the cavalry to arrive from Canberra and the capital city"* (Peter Keynon).

## 5.3 Local government

Local government is the most common vehicle for community involvement in attracting health professionals (usually, but not exclusively GPs), particularly in areas of chronic workforce shortage. This happens in response to community pressure and the potentially adverse flow on effects of inadequate primary medical services to other community activities, and to attracting new businesses and professionals.

Initially local councils were involved in meeting and greeting prospective GPs and their families and assisting them with travel and accommodation to visit the local community. Now they commonly supply subsidised or free housing, a building to house the practice, cars, practice infrastructure and information technology, and in some cases, a guaranteed minimum salary package as incentives for GPs to move to their town and set up a practice. Often shire councils effectively find themselves recruiting GPs into a private business as a community service. The local council is often not the employer and they are not able to grant the GP VMO rights to practise in the local hospital. Initially many councils lacked experience with these issues, particularly where IMGs were being recruited.

In response to concerns by local government Tamworth City Council organised a summit in 2002 to discuss the rural doctor shortage called "Finding a Cure"[45], which passed a number of resolutions regarding community support for and local government intervention in providing medical services. Local government has begun lobbying the Commonwealth government for additional funds to cover the cost of supporting medical services. It believes that such expenditure should be recognised in Commonwealth Grants as it has become a significant and recurring cost in many local government areas.

More recently local councils are also beginning to consider taking on ownership or management of medical practices, either temporarily or permanently, and usually in partnership with other stakeholders. The key is flexibility for both the GP and the community where there is a mutually beneficial outcome. RDN continues to offer advice and support to communities who wish to implement innovative and viable models for sustainable practice. However, the extent to which local government can commit resources to medical services varies according to the viability of the local government itself. Some of

the key issues to be considered when establishing a medical practice are listed in Appendix 3.

Some case studies are presented here as examples of the impact local government can have.

#### 5.3.1 Case Study 1 - recruitment: Dalwallinu, Western Australia[46]

The only GP in the rural community of Dalwallinu in Western Australia left the town early in 1995. Dalwallinu is located in the central wheat belt of Western Australia, 250 km from Perth, and has a catchment population of 2000. The medical practice is a private practice with infrastructure (house, surgery and car) provided by the Shire Council. The Shire and the hospital board combined to recruit a replacement GP.

In the 12 months before a permanent GP was recruited there were 7 locum GPs in the practice. The Shire had to obtain provider numbers, furnish a house, provide a car and transport the locums and their families to and from Perth. Because the shire held the practice and not an incumbent practitioner, the locums became employees of the Shire Council and Council held the provider number to enable the locum to practise. Superannuation and insurance had to be arranged. This process cost the Shire in excess of $20 000. Service provision could also be an issue as the locums have the right to refuse to do hospital visits or outpatient work. And at the same time the community was pressuring the Shire to find a permanent doctor.

Significant issues they faced included; finding interim locum cover, providing a furnished house and motor car, becoming the employer of the locum GP, community reactions, government regulations on recruiting international medical graduates, Health Department restructures and the arbitrary regulations of professionals, and the cost of providing a community service. The State Rural Workforce Agency advertised the position and applied for area of need status, opening the position to an international medical graduate. The immigration procedure, the registration to practise, obtaining a provider number and the information required from both parties is extensive.

#### 5.3.2 Case Study 2: Wentworth Shire, New South Wales

The Wentworth Shire Council owns and operates the local medical practice in Wentworth, and a subsiduary practice in nearby Dareton. Wentworth is in RRMA 7 and has a population of approximately 1500. The Wentworth Shire Council has a population of 7245. The Council built and leases a fully furnished purpose built practice building and employs the practice staff (GP, practice manager/registered nurse, and receptionist) under the same conditions as other Council staff. The Shire also owns the medical records and these will remain with the practice when the incumbent GP leaves. In addition the Shire is responsible for medical indemnity, information technology support, maintenance, human resources and financial management services. The GP has purchased a house and vehicle and provides VMO services to the local hospital. VMO payments go directly to the GP on the usual fee for service basis.

The Council works closely with the practice. A medical service committee meets once a quarter to review the practice, provide strategic direction and address any concerns relating to the practice and its operations. The committee comprises the Mayor, the General Manager, the Director of Corporate Services, two pharmacists and a community representative. The GP and the practice manager also attend. In addition the Director of

Corporate Services with the Council liaises closely with the practice manager in day to day management issues. The practice manager and receptionist come from the regional centre of Mildura (34 kms across the border in Victoria).

#### 5.3.3 Case Study 3: Hay, New South Wales

Hay is located in the Riverina, 726 km south west of Sydney and has a catchment population of around 4120. Following the departure of two resident GPs in 2001, the Murrumbidgee Division of General Practice and the Hay Shire Council formed a partnership to ensure the continuity of general practice services for the town. Hay Shire Council provides a house and surgery rent free and is responsible for employing practice staff. Contracted GPs are required to sign a service agreement allowing Medicare payments to be cashed out and returned to the Division. The Division remunerates the GP locums on the basis of an agreed percentage of their earnings. VMO payments have been negotiated separately with the AHS to ensure that the Division is paid a flat rate in advance for an agreed level of service by the locum. The Division is also responsible for sourcing locums and paying for all expenses associated with the practice. This includes travel and administration, staff, consumables and accounting. The Division is maintaining the locum service with the view that resident GPs will be recruited to take ownership of the practice (pers. comm. J Redway, Murrumbidgee Division of General Practice).

#### 5.3.4 Case Study 4: Coleambally, New South Wales

Following the retirement of the only GP in the small Riverina town of Coleambally (postcode population of 937) RDN and the Murrumbidgee Division of General Practice identified an international medical graduate who was keen to take over the practice. However, due to immigration status, the GP was not permitted to manage a business in Australia. The GP was placed on the Rural Locum Relief Program, sponsored by RDN. The Division managed the practice, assisting with the re-accreditation process and paying for wages, consumables and running costs. The Shire purchased accommodation and a surgery and provided the surgery rent free to the Division. The GP has since been granted permanent residency, and an official hand over of the practice has been completed (pers. comm. J Redway, Murrumbidgee Division of General Practice).

#### 5.3.5 Case Study 5: Moama, New South Wales

Moama (postcode population of 3650) is separated from the northern Victorian town of Echuca by the Murray River. The town has had trouble retaining the services of a GP, and despite its proximity to Victoria, its health services are administered from Deniliquin, approximately 75 km to the north. Murray Shire Council built a combined GP surgery and senior citizen facility in the town, and has since attracted a number of GPs to work there. The Council maintains a landlord/tenant arrangement with the incumbent GPs, but has also provided financial support in other ways, including rent, holidays, furniture, consumables, information technology and recruitment of additional GPs. Since establishing the general practice, a chemist has also moved to Moama. The GP surgery also houses some community health services (pers. comm. G. Murdoch, Murray Shire Council).

### 5.4 NSW Health

In 2003 the NSW State Government put in place an initiative known as the General Practice Employment Entity program designed to attract GPs to rural areas by improving services and infrastructure. A total of 11 rural areas have recently received one off grants up to $200 000 in value. The grants are being managed through partnerships between AHS,

local government and Divisions of General Practice (and in some cases, individual GPs), and are being used for a variety of purposes, including establishing community centres that incorporate general practice services, medical centres and information technology funding. It is anticipated that once established these initiatives will become self-sustaining through fee for service payments and will not require ongoing funding from NSW Health or AHSs.

## 5.5 University teaching practices[47-48]

A network of four University teaching practices has been established in rural South Australia by the South Australian Centre for Rural and Remote Health (SACRRH) and the Adelaide University Department of General Practice in response to the difficulty in recruiting and retaining GPs there. The practices were established at the request of the communities involved, and are managed by a community controlled board or a proprietary company. The concept combines University involvement in running general practices, placements for undergraduate health care students and the provision of multidisciplinary health care. Between August 1995 and October 1999 17 GPs were recruited by the network. Each of the practices is described briefly:

The practice at the Minlaton Medical Centre was established in August 1995 after the Minlaton Hospital closed. The Department of General Practice at the University of Adelaide Medical School offered to recruit doctors, run a general practice and provide a 24 hour emergency service, which is funded separately using a subsidy from the Department of Human Services.

In Maitland the board of the Central York Peninsula Hospital at Maitland approached the University of Adelaide to recruit doctors and establish a university practice. Since August 1997, the University has run a family practice within the Maitland Community Health Centre.

After the only medical practice closed in Roxby Downs, the Port Augusta Hospital entered negotiations with SACRRH to develop a new family practice and recruit GPs. A collaboration was developed between SACRRH, Flinders University and a private urban GP. The group worked to recruit doctors and to establish a management structure for the new practice. The practice started business in May 1998 from a new building housing the hospital, the casualty service, the community health centre and the general practice facility. With a stable practice achieved, the University was able to withdraw from its management role for the practice while still being able to provide academic and information technology support.

After the development of a University Department of Rural Health in Whyalla, SACRRH sought to provide clinical services linked to rural education, training and research activities. A University training practice was established by amalgamating two existing practices under the Commonwealth Government' s GP Links Program. The new practice is co-located with the community and allied health team in the Community Health Centre.

Establishing these practices required a substantial effort. Two key aspects of their success were developing partnerships and ensuring local flexibility. Each of the practices is structured differently because each evolved in response to local reality and need. They are sustainable because they are financially viable (due to a component of external funding), able to attract and retain health care professionals, and integrated by the development of suitable electronic information systems. The heavy teaching commitment in some practices is actively supported and remunerated through sessional appointments.

GPs work in the practices on a fee for service basis but without investing their own capital in goodwill or infrastructure, or making a long term commitment. Locum services are provided, ensuring staff can plan periods of leave and attend continuing professional development courses. Some GPs are also attracted by the strong academic component. Formal collaborations have ensured sustainable workloads, locum relief and a common information technology network. The communities concerned are satisfied with the medical care they receive, and with the additional community infrastructure, employment opportunities and recruitment potential for health care professionals.

The concept of rural academic family practices is not new. In the late 1980s Rosenthal *et al*.[49] developed a collaboration between public and private organisations to provide services in underserved areas in the United States. These practices were more financially viable and also provided opportunities for rural training support.

# 6. Easy Entry - Gracious Exit; the development of RARMS

RDN works with NSW rural and remote communities experiencing medical workforce shortages, both by supplying grants (where appropriate) and facilitating involvement of stakeholders to achieve a common understanding of issues and possible solutions. In the north west of the State, RDN has been involved more than usual, developing a pro-active, community-based approach to attracting GPs and supporting a wider range of medical services, based on a walk in walk out (or turn key) environment. The philosophy of the initiative is defined by the phrase ' Easy entry - Gracious exit' .

## 6.1 RDN involvement in north western NSW

The region (the most remote in the state) is characterised by small communities with large aboriginal populations, including Walgett, Lightning Ridge, Bourke, Brewarrina and smaller towns including Collarenebri, Goodooga, Weilmoringle and Enngonia, which are all RRMA 7). The region is also characterised by high levels of socio-economic disadvantage and poor health outcomes[1], and has a shortage of housing and surgery accommodation and a long term medical workforce under supply. There is an AMS in Walgett and ACCHS in Brewarrina (presently closed) and Bourke, as well as a number of privately owned general practices.

RDN has been involved, both assisting with short term workforce issues and, at a more strategic level, acting as a facilitator to bring stakeholders together and develop common goals to achieve better health outcomes for the region. The focus has been on developing the Far West Area Health Service (FWAHS) Medical Services Plan, population health services, after hours services, aboriginal health and medical workforce planning required to achieve such services.

Traditional recruitment strategies no longer work in the north west. Support (including financial assistance) designed to recruit and retain GPs has been provided from many sources in recent years. The local shires, the Commonwealth Government and FWAHS have contributed to GP housing. RDN has provided relocation, training and support grants and assisted with locums and recruitment services. However, these incentives have failed to deliver an adequate medical workforce. The FWAHS has been pressured to maintain hospital emergency services, and at the same time supply community based general practice services (usually supplied by self employed GPs). They have sometimes

succeeded in finding GPs who are willing to be directly employed (at great expense) to provide both hospital and general practice services, but who are not prepared to run a private practice[50]. This situation has led to a closer working relationship with RDN, focussed on workforce planning and sustainable general practice.

Early in 2000, RDN initiated a meeting of stakeholders with broad regional involvement in the north west. They included Shires, FWAHS, Aboriginal and Torres Strait Islander Commission, the University Department of Rural Health in Broken Hill, the RFDS, and the Outback Division of General Practice (ODGP). The aim was to share knowledge and build a commitment to working together[50]. RDN also held community level meetings, initially in Collarenebri, Walgett and Brewarrina, involving Shires, hospital staff, Aboriginal health service representatives, GPs, ODGP and community members (usually drawn from hospital advisory committees). Walgett and Collarenebri agreed to ongoing joint meetings, and were later joined by Lightning Ridge to become the Walgett Shire Health Forum, which is chaired by RDN. A Brewarrina/Bourke Health Forum was established in mid 2002 with similar intentions.

The involvement of stakeholders and community representatives through the Walgett Shire Health Forum (and more recently the Bourke-Brewarrina Health Forum) has helped to maintain momentum and accountability by service providers, helped identify practical solutions and generated a better collective understanding and awareness of health service and GP recruitment issues. At times the meetings were an effective vehicle to demonstrate to attending Commonwealth or State officials, the strength and legitimacy of health disadvantage in the region and the need for funds, and that there is a community-based mechanism for maintaining interest in project implementation[50].

RDN' s vision was to achieve sustainable general practice by creating and maintaining walk in walk out practices based on the philosophy of ' Easy entry - Gracious exit' , which focuses on the practice and not on the GP. RDN approached the Commonwealth Department of Health and Aged Care (now Department of Health and Ageing) for funding to develop the concept through what became known as the North West project[51]. The key element was to provide housing and practice infrastructure and staff so that GPs could relocate facing fewer barriers (virtually no capital costs, and the opportunity to concentrate more upon medicine and less upon business management responsibilities), and leave free of financial commitments.

Commonwealth funding has enabled RDN to:

- Provide infrastructure for walk in walk out GP environments including furniture for houses and basic surgery fittings (not the buildings themselves)
- Join with UNE (University of New England) Partnerships to provide practice management advice and support
- Develop two way broadband satellite modalities in surgeries
- Obtain legal opinions on a number of issues including GP engagement options and insurance cover

This funding has been crucial in developing the practice entity.

## 6.2 Formation of Rural and Remote Medical Services Ltd (RARMS)

In February 2001 the solo GP in Brewarrina left at short notice. The house and surgery were owned by the Shire Council but, without a GP in residence, there was no one to furnish the house and pay the bills (electricity, phone, rent). More importantly, there was no one to run the practice and employ staff, or to take active responsibility for recruiting a short term locum and a resident GP. RDN negotiated with the Shire, furnished the house and surgery and took on the practice ownership and management (employing the long serving receptionist and a GP locum) as a way to continue to provide medical services in Brewarrina. This was an emergency response to a specific crisis, but it was clear that other towns such as Walgett and Lightning Ridge also had potential workforce crises at hand, and there was an obvious need to restructure the way services were provided to these towns.

In undertaking this role RDN was conscious of a potential conflict of interest with its state-wide role in support, recruitment and retention of GPs. In mid 2001, RDN facilitated the formation of a separate not for profit company to act as a practice management and employment entity. The company, Rural and Remote Medical Services Ltd (RARMS), has Board representation from RDN, Rural Doctors Association (NSW), ODGP, and Walgett AMS, and was focussed on the towns of Walgett, Lightning Ridge, Brewarrina and Collarenebri. Initially RARMS furnished GP accommodation, equipped surgeries, directly employed GPs in Walgett and Lightning Ridge and worked to develop an effective practice management model.

RARMS, as a separate practice ownership entity, became a member of the Walgett Shire Health Forum, and was able to enter into formal partnerships to enable new practice ownership entities to develop[52]. For example, from within the Forum RARMS signed a contract with the Shire for surgery accommodation in Walgett. The Forum also acted as a platform for contracts between the Shire and the Commonwealth Department of Transport and Regional Services to fund GP accommodation. ODGP contracted with the Shire and Department of Health and Aged Care for funds for student/registrar accommodation. Other benefits of the Walgett Shire Health Forum have included; acceptance of the FWAHS Medical Services Plan, discussion and planning of health services around Collarenebri and Lightning Ridge, a more integrated primary health care system, better integration of individual and population health strategies, and an opportunity to draw on the experiences gained from these processes to help other organisations[52].

Perhaps the most important contractual partnership was between FWAHS and RARMS in relation to the supply of 'in hospital" services. Because this had been based on fee for service arrangements it had been difficult for RARMS to give a firm indication of VMO income to prospective GPs. The bundling of 'in hospital' funds into a service contract between RARMS and FWAHS provided income certainty and allowed RARMS to engage GPs on a known salary plus incentives package. Resident GPs now know in advance what their VMO incomes will be for a given number of on-duty days, weeks or months. RARMS negotiated long term contracts with FWAHS to manage ' in hospital' services. Under these contracts doctors are paid for on call regardless of workload, but will do an agreed number of sessions at the surgery as well. These contracts deliver more attractive employment conditions for GPs including reduced after hours workloads (due to the greater availability of GPs), greater income certainty and savings to FWAHS by reducing the number of patients seen at the hospital and increasing Medicare receipts to a more realistic level for the area.

RARMS has evolved due to a number of factors, including changes to medical indemnity. It no longer directly employs GPs, but contracts the provision of practice staff and services for an agreed fee. RARMS provides infrastructure (including fully computerised clinical and management systems) and practice management, offers attractive recruitment packages to GPs to work in its facilities, employs all non-GP staff including practice nurses, manages VMO arrangements and negotiates with other stakeholders. RARMS also ensures manageable working hours and, when required, reasonable access to locums and professional development. GP engagement arrangements have evolved from direct employment or engagement as independent contractors, to the GPs conducting their own medical practices. RARMS provides housing, surgeries, practice infrastructure, personnel and management services.

Brewarrina, Collerenebri, Walgett and Lightning Ridge have all engaged GPs on the basis of walk-in/walk-out arrangements that do not require capital investment or long-term leases for housing and practice accommodation or practice management. The GPs still own their practice, but in exchange for an agreed proportion of Medicare earnings they no longer own many of the issues which traditionally act as barriers for solo GPs, including infrastructure, practice management, and locum cover. The nature of the walk-in/walk-out arrangements varies between towns, though the outcomes are similar. In Walgett and Lightning Ridge RARMS acts as the third party provider, while in Brewarrina it is a Bourke-based for profit company and in Collarenebri it is the AHS.

The GPs have improved access to allied health services and stable relationships with other service providers/managers including the FWAHS. There is also a significant increase in volume and stability of medical services[52]. In 2001 there were 3 GPs in the 4 towns, which have a floating population of between 12 and 14 000 people. In October, 2003 there are 10 GPs, and as yet none of the resident GPs have left the area.

## 6.3 Reflections on the development of RARMS

The development of RARMS was possible because the Commonwealth Department of Health and Ageing (DoHA) was prepared to financially support the initiative. The funding was used to underwrite establishment costs (furniture and equipment) and to assist with the initial cash flow. RARMS has evolved into a not for profit practice management company, and has clearly demonstrated the advantages of focussing on the practice and not the GP as the stabilising influence in providing quality health care to remote communities. This model may not suit all communities or regions, but the ingredients of success are important building blocks for any similar models[53].

The development of RARMS also required a huge amount of energy and commitment, and goodwill from a range of people and services including DoHA and FWAHS. RARMS and RDN staff were familiar with medical issues, had knowledge of the north west and its requirements, knowledge of financial systems, established networks and were very committed to the concept. RARMS has used local management and skills and equipment where possible. Challenges have included a lack of locally available skills, difficulties associated with distance and technology, and the complexities of achieving change when responsibilities are so diffused. Skills shortages include practice nurses, practice staff and information technology skills.

# 7. For - profit ownership entities

Commercial, or for-profit, general practice ownership entities are an alternative to community and government sponsorship. Known generally as corporate practices, they are found mostly in metropolitan and regional centres. There are many possible variations.

Catchlove[15] describes corporatisation as encompassing the concept of changing the traditional ownership and practice structures to improve the profitability of general practice. His description of a typical scenario is that:

- A third party acquires an interest in (or establishes) one or more practices
- Whatever the equity arrangements, GPs enter into a contract whereby they assign a proportion of their gross income in return for management of their practice, provision of support services and a good will payment
- The third party then gains access to the flow-on services of the practice (eg pathology and radiology) and may benefit financially from GP referrals
- The practices are merged into a single medical centre, which is generally separately owned by the same third party.

Recognised third parties include publicly listed companies and entrepreneurial corporate groups of doctors. Corporate practices, which are usually large group practices, enjoy the advantages of lower practice costs per GP, rosters for extended hours, cover for time off from within the practice, and additional services including practice nurses, practice managers to do all the administration, and additional diagnostic equipment[54]. GPs are contracted to provide services whereby a percentage of their income goes to the ownership entity in return for the use of the premises and management facilities. The practices often have integrated referral services such as pathology, physiotherapy, imaging, specialist services and a pharmacy, and offer extended after hours care.

## 7.1 Corporatisation

Prior to 1996, private investment in health care was limited to pathology, radiology and private hospitals. General practices were usually owned by GPs. In 1996 a law was passed allowing third parties to contract doctors[54]. Publicly listed companies, such as Foundation, Endeavour, Primary Health Care/Gribbles, and Mayne Health began actively buying general practices. They paid generously for the goodwill of existing practices, entered limited contracts with the doctors in those practices and relocated some of these doctors to large centres where general practice is linked directly with other diagnostic, imaging and treatment services owned by the corporation[55]. By 2002 approximately 10% of Australia' s GPs were employed by a corporate medical entity. In Western Australia the figure was around 40%[54]. This rapid increase in the number of GPs working as contractors for publicly listed companies (and therefore with no controlling interest in their place of medical practice) gave rise to concerns that they could be compromising their professional independence[55-56].

The rate of corporatisation of general practices has slowed, profits have been below expectations and some corporate practices no longer bulk bill. At the same time, other models of general practice ownership are emerging, which combine the advantages of GPs working together in larger practices with a corporate body providing the organisational framework, but without relinquishing ownership and control. By forming themselves into cooperatives and sharing capital and resources, they are offering services like physiotherapy, radiology and after-hours services just as corporate practices do, but

without the perceived pressure to over-service or refer in-house (Section 2.5). Sprogis[57] sees divisions of general practice as a logical alternative to the non-regional, for profit often publicly listed corporations.

## 7.2 Corporatisation in rural and remote areas

Practice ownership by publicly listed companies is predominantly an urban trend, where it is the most common alternative ownership entity to private ownership. Some companies are seeking to set up corporate medical practices in larger regional centres, such as Dubbo, Orange and Bathurst and the larger centres along the coastal fringe of NSW. This model is not a viable option for smaller rural and remote communities where the populations are too dispersed to support large, high volume practices and secondary referral services.

### 7.2.1 Contracting services

In 2000 the Commonwealth funded seven Divisions of General Practice to conduct feasibility studies into alternative models of corporatisation in general practice. The Whitehorse Division of General Practice (Victoria) carried out a corporation needs assessment with 25 small and solo practices within the Division. From the responses they identified the need to develop and implement new strategies to assist GPs with general practice management and support services. Subsequently the Division employed a Practice Manager Coordinator and a GP Support Medical Practitioner and practices paid for their services. Benefits such as less time spent on business management, increased morale and more viable finances were identified by the GPs[58]. The concept of providing managerial services to private practices for a fee has expanded. A service company has been established as a legal entity for the Division. The company provides practice management and nursing coordination, GP locum support, Whitehorse Home Assessment Team nurses doing health assessments, asthma and diabetes clinics in general practices, specialist information technology technicians and telephone coaching for patients. These services are provided to between 2 and 25 practices within the Division (pers. comm. M. Shearer, Whitehorse Division of General Practice).

### 7.2.2 Contracting GPs

For-profit medical services have developed which contract GPs to work in rural and remote locations. At present, most of these are run by rural or remote GPs. For example, for a time a GP in Bingara ran a for-profit medical service with six GPs, working from two surgeries in two separate towns. The GP income was based on a percentage of their billing and they did not deal with the administrative and business side of the practice.

Another example is the Rivers Medical Group, which is active in Western Australia and Tasmania. It was founded by a doctor to provide (mostly overseas-trained) GPs for small country towns on a short-term contractual basis together with the required infrastructure support[59], p 72).

### 7.2.3 Australian Outback Medical Services P/L

Australian Outback Medical Services P/L (AOMS) was formed in 2001 in response to a doctor crisis in Bourke and Brewarrina. Two Bourke GPs merged their practices and negotiated a contract with FWAHS to provide VMO services to Bourke and Brewarrina hospitals, and later to provide clinical public health services to Brewarrina and Weilmoringle. AOMS then took over the Brewarrina practice from RARMS and provided

practice management, increased continuing professional development, locum support and attractive remuneration for incoming GPs. AOMS also provides medical services to the Bourke Aboriginal Health Service and the Brewarrina Detention Centre. In 2002 they expanded the concept by establishing Australia Outback Locums as a recruitment agency specialising in rural and remote positions, particularly those with Area of Need status, offering transparent packages.

### 7.3 Medical indemnity

Medical indemnity influences the implementation of many innovative attempts to develop rural and remote medical services. The NSW Government agreed to cover medical indemnity for public (and later private) patients in public hospitals where the practice company is owned and controlled by the VMO, which excluded GPs employed by companies such as RARMS. Hence RARMS no longer employs GPs directly.

Medical indemnity is a current and continuing issue, which is still being worked through in the Australian context. The method by which ownership entities engage GPs has a bearing on the degree of medical indemnity risk that will be carried by the entity, and informed advice is essential.

## 8. Overseas experience

The difficulties experienced by Australia in recruiting and retaining an adequate rural and remote GP workforce are mirrored in many other counties. Similarly, the trend away from general practitioners owning and operating their own practices is becoming more wide spread, though manifested differently in different countries. Some examples are briefly discussed to demonstrate the similarity of the issues and the variation of the responses.

***Norway***
In Norway, GPs can choose between 2 types of contract: a contract by which they are paid a salary, and a contract by which they are paid on a fee for service basis plus a fixed grant. Grytten et al.[60] surveyed a representative sample of GPs and found some interesting differences. Salaried physicians tended to be younger than those working on a fee for service bases, and they preferred to trade shorter working hours for higher income. Most were located in rural areas, though they may not want to remain there in the long term. Norway and Sweden are both moving towards capitation-based contracting methods.

***United Kingdom***
Under the National Health Services Plan of July 2000 the United Kingdom has set a target to recruit 2000 more GPs[6]. The development of primary care services is central to the plan, with increased GP numbers and support for single-handed practices via quality-based contracts.

For the first time GPs throughout the UK are contracted to their practice or primary care trust rather than to the National Health Scheme and will have the option of drawing a salary rather than operating as independent contractors[61]. They will also stop having 24 hour responsibility for their patients as out of hours care passes to their local primary care organisation. Shifting the contract from individual GPs to practices introduces new incentives to make greater use of non-medical staff. The prospect of a practice based contract also raises questions about the nature of the contracting organisations, opening the door to new entities, including private companies. Practices may become larger, with sub

specialisation among GPs. The introduction of the new contract is somewhat controversial and the outcomes for GPs are not clear as yet.

***New Zealand***

Until the 1990s the health systems operating in Australia and New Zealand had many similarities. However, during the 1990s the New Zealand system was extensively changed due to funding shortages and threats by GPs to leave rural areas. Different mechanisms of funding, regulation and delivery of services were developed[62,63] and more than 70% of GPs in New Zealand now belong to independent medical practice associations[6]. The independent medical practitioners associations contract collectively on behalf of their members with the national purchaser, the Health Funding Authority. The majority of GPs are still paid on a fee for services basis, but there is an increasing move toward capitation contracts for general medical services.

***United States***

The United States health system differs markedly from Australia' s. It is based on employment-related health cover and underwritten by tax concessions. Almost half the population is inadequately insured[6]. However, like Australia there are physician shortages and incentives to work in areas of workforce shortage.

In 1994, 41% of family physicians in the United States were employees, up from 16% in 1983[64]. The change was driven largely by integration, with many physicians entering into contracts with large health care organisations including physician practice management companies, hospitals and in some cases, physician-owned groups. Throughout the 1990s in particular, these large organisations were competing to buy rural physician's practices and employ doctors, convinced that a broad network of physicians was the key to gaining more managed care contracts[65].

Stensland et al.[66] examined why primary care physicians sell their practices, the majority to non-local buyers. The motivation for selling included managed care concerns, retirement, administrative burdens carried by the practice and financial viability. Those physicians were able to cash in on the high prices being paid for rural practices. Some physicians, particularly those who value the autonomy and relative lack of bureaucracy, went to small group practices. In a survey of community family physicians in North Ohio, Kikano et al[67] found that employed physicians were more likely to be female, in group practice, work fewer hours, and see fewer patients.

After a decade of rapid expansion, physician practice management companies have found that running physician practices wasn' t as easy, or as profitable, as imagined, and many physicians became disillusioned being part of a large organisation and began looking for alternatives[68].

Rollins[69] describes a successful model for a community practice, which meets the needs of both the community and the physicians working there. The practice is located in a small town of 350 people with a catchment of around 2000 people. When the medical services in the town were threatened the community responded by raising additional funds to attract a permanent physician. In fact, they attracted two physicians who work for the community as independent, salaried contractors in the community owned health care facility. Each physician has a guaranteed income, no cash investment, complete autonomy, few administrative worries and, because they share the practice, 6 months off each year. They have not exercised their option to assume ownership of the practice, preferring the existing

arrangements. Community involvement and support is essential for the success of the model.

***Canada***

The Canadian health system is predominantly publicly financed through taxation and services are privately delivered. The provinces control health service delivery[6]. Most GPs are private practitioners working individually or in group practices, which they or their colleagues own. GPs are remunerated on a fee for services basis. As in Australia, reforms are taking place around the distribution and overall size of the medical workforce.

Much effort has gone into documenting the difficulties with isolated medical practice, and the need to make changes to the current system to attract younger physicians. Younger physicians are increasingly unwilling to tolerate the excessive workload and on-call responsibilities that have often led to burn-out of their established colleagues, particularly given the greater emphasis they place on balancing work and family commitments[70].

Results from the Canadian Medical Association's 2003 Physician Resource Questionnaire indicate that 27% of Canada's physicians would prefer to be paid by salary and only 37% now rate fee for service as their preferred payment method[71]. Fifty seven percent of GPs recoup 90% or more of their professional income from fee for service payments. Female physicians and those under 35 are the least likely to do so.

In their submission to the Commission of the Future of Health Care in Canada, the Canadian Association of Internes and Residents supported a variety of reforms to improve working conditions, particularly for rural physicians, in a bid to encourage recruitment and retention[72]. Suggestions included expanding the choice of methods of payments to physicians, particularly those practicing in isolated areas where fee for service payments are not seen as an adequate mechanism for reimbursement, encouraging group practice (allowing physicians to pool administrative and management responsibilities, and facilitate shared call responsibilities) and promoting health care teams. The submission also noted that new physicians are more likely to be attracted to communities where there are group facilities with shared staffing, information systems and administrative support in place. Such facilities are also likely to provide more options for integrating allied health professionals.

More direct reform to general practice ownership was raised at "Forum 99: Searching for Solutions to Physician recruitment and Retention in Southwestern Ontario", a stakeholder meeting where there was public acknowledgment of the difficulties around recruiting an adequate rural physician workforce[73].

Under the heading of rural physician clinical support it was recommended that, regardless of the compensation model, the development of modern, low start-up cost 'turn-key" clinics with nursing, administrative, charting and information technology support, would provide the key infrastructure for the delivery of outpatient health care and encourage integration with allied health care. It was also recommended that such clinics be developed and implemented respecting physician autonomy and independence. This was translated into an action plan to support family doctor services in communities of up to 10-15 000 people by providing attractive group clinic facilities with administration clerical, information technology, and nursing/nurse practitioner support for physicians regardless of the payment model they work under. This initiative would include clerical support grants for family physicians who maintain their own offices.

It was also noted that physicians should have the option of participating in direct contracts in lieu of fee for service, which recognise the unique practice patterns of rural and remote communities, and which would include both monetary and non-monetary measures directed at encouraging recruitment and retention. Direct contract funding should be flexible enough to permit communities to tailor specific elements of their direct contract arrangements to suit community and physician needs and practice patterns.

The need for Government to provide special funding and support for rural practice clinics, including group clinic facilities, clinical support staff and administrative information system support has also been raised in other fora[70].

## Conclusions

It is increasingly recognised that general practice is not a viable business in very remote communities. In these communities most GPs are salaried, either directly or indirectly from the Commonwealth government. This may be through Stage Government appointments (for example, District Medical Officers in the Northern Territory), Aboriginal Medical Services or occasionally through mining companies. It is less widely acknowledged that owning a small business in other rural or remote locations is no longer a sought after option for GPs. Reasons include:

- Poor or negative returns on capital, plus a fear of financial entrapment due to a high probability that the practice will be difficult or impossible to sell at a later time
- Uncertain financial viability of the business
- The increasing burden of administration and practice management on top of high clinical workloads
- The implied long term commitment to one particular location.

Both the characteristics and aspirations of prospective rural and remote GPs are changing. Vocationally registered GPs are increasingly female, born overseas or completed their undergraduate training overseas, older and looking for more flexible working conditions. Increasingly, they are looking to work as contractors or as salaried staff, rather than owning their own business. Almost 50% of the new arrivals in rural and remote general practice in NSW in 2002 were either international medical graduates with conditional registration or registrars. Neither group is likely to buy into a small business in the short term.

The trends observed in Australia are being reflected internationally. There do not appear to be any systematically applied solutions or initiatives to deal with the issues being raised by GPs and their professional organisations and it is being left to individual communities and support organisations to work towards individual solutions.

In NSW it is recognised at a state and local government level that the traditional GP-owned general practice is becoming less viable in rural areas generally and is probably no longer viable in more remote locations. Continuity of primary care for rural and remote communities increasingly depends on focussing resources on the continuity of medical practices rather than on providing incentives to individual GPs to invest in a small business in the community for the long term.

Divisions of General Practice, local government and RDN have been active in developing a range of models for establishing general practices independently of the individual GPs who do or will work in them. Each has been targeted to suit local conditions, which has contributed to their success. At present such initiatives depend on the good will and expertise of the parties concerned.

RDN has developed a guide based on its experience in the north west of NSW[53], which is designed to provide a framework and shorten the process for others who wish to do similar things. Access to resources is critical and at present there is no central mechanism to access the necessary knowledge, money and skills.

These issues are particularly relevant in more remote towns, which support small numbers of GPs working in small practices where they are not in a position to take advantage of the

economies of scale open to larger practices. The provision of infrastructure and support services is crucial to establish continuing primary medical care. It is even more crucial in enabling GPs to carry out population health and primary health care initiatives.

Health care policy development needs to take into account this increasing separation of the GP and the infrastructure and support component of general practice without undermining the traditional models of general practice. Financial incentives and payment structures will need to produce arrangements that will both (a) attract GPs into rural and remote service, and (b) support the ongoing viability of the entities that are now tending to supply the necessary infrastructure and practice support services.

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# Appendix 1

**Commonwealth government changes impacting directly on general practice (1994-2003)[7-8,16]**

| Year | Program | Comments |
|---|---|---|
| 1992 | **Divisions of General Practice** | Established nationally as a joint initiative between the Commonwealth and GPs. The aim was to provide an organisational structure for GPs to work together to improve the quality of health care, promote preventive health care and respond to local community health needs. Divisions are described by Sprogis[57] as regionally based, GP-owned, patient and community focussed, not-for-profit corporate entities. |
| | Programs to address **GP workforce shortages and improve access to quality GP services** | Examples include the **Rural and Remote General Practice Program (RRGPP)** (implemented through Rural Workforce Agencies to target GP shortages and improve access to quality GP services in rural and remote areas), the **Rural Retention Program** (to encourage GPs to remain in rural and remote locations), the **Rural Women's GP Service** (to improve access to female GPs for rural and remote women), the **General Practice Registrars Rural Incentive Program** (to encourage registrars to do some training in rural and remote areas), and **Aboriginal Community Controlled Health Services** (to improve access to primary health services in Aboriginal and Torres Strait Islander communities). **Rural Workforce Agencies** were established in each State and the Northern Territory in 1998 to recruit and retain doctors in non-metropolitan locations; implement the Rural and Remote General Practice Program (RRGPP) and the national Rural Locum Relief Program (RLPP) and promote and support rural workforce activity. |
| 1995 | **Better Practice Program** - a precursor to the Practice Incentives Program. | Aimed to diversify funding for general practice to reward non-volume dependent activity, including long consultations, primary care and population health activities. It also aimed to provide an additional source of funding that discriminated in favour of practices providing high levels of continuity of care in rural practice. Practice and other incentive payments were introduced in parallel with fee for service, producing a **blended payments** scheme designed to remove the limitations of the fee for service payment arrangement which rewards brief and frequent consultations. |
| 1998 | **Practice accreditation** | Introduced to support quality medical care. To achieve accreditation practices must meet standards relating to medical services, the rights and needs of patients, quality assurance and education, administration and the design and fitting out of the surgery. Only accredited practices are eligible for Practice Incentive Payments (PIP). Accreditation usually requires substantial investment of time and money to achieve. |

| | | |
|---|---|---|
| 1998 | **Practice Incentive Program** (PIP) - part of a blended payments approach to funding general practice. Payments made through the program are in addition to other income earned by the GP and the practice (largely patient fees and Medicare rebates). | PIP are financial incentives paid to accredited practices who agree to implement certain practice arrangements deemed to contribute to providing comprehensive, quality and continuing patient care.<br>Practices may qualify for up to 5 elements: Information management, after hours care, rurality, teaching medical students and participating in targeted incentives programs, such as the General Practice Immunisation incentives and the Quality Use of Medicines.<br>By 2002 three additional elements wee added – care planning, practice nurses and extra targeted incentives (asthma, diabetes, cervical screening and mental heath), and about 82% of all general practices were participating[6]<br>Linked to the Medicare Benefits Schedule in 1999 with the introduction of Enhanced Primary Care Items. |
| 1999 | **Enhanced Primary Care**<br>21 new items grouped into three categories of GP activity | A program under which GPs provide specific services associated with preventative care for older Australians and care coordination for people with chronic conditions and complex care needs. The Enhanced Primary Care Package includes 28 Medicare items, which are designed to encourage GPs to work with other health and care providers in multidisciplinary teams on health assessments of older patients, care plans and case conferences between health care and care providers. In return GPs can claim specific Medicare payments. |
| | **Vocational registration and RACGP Fellowship**<br>- encourages GPs to undertake professional training and development. | GPs receive higher Medicare non-referred attendance rebates if they satisfy certain vocational registration requirements or are RACGP fellows. |
| 1999 | **GP Links Program**<br>Commonwealth provided a two stage financial incentive scheme to small practices to encourage physical amalgamation into larger practices | Aims to promote the amalgamation of smaller general practices into larger group practices.<br>Offers two financial incentives to amalgamation: an initial $1 000 to encourage interested practitioners to explore amalgamation feasibility and, should amalgamation follow, $15 000 per practice plus $7 500 per full time GP (up to a total payment of $120 000). Most interest has been from metropolitan practices as the program expects physical collocation of amalgamating practices. This is difficult for rural practices in smaller communities[48]. |
| | **Virtual amalgamation** | Encouraging larger, more efficient practices because:<br>• There are greater complexities and risks of running a small business<br>• Costs have increased and revenue has declined in real terms<br>• Tax advantages have decreased and<br>• Increasing consumer sophistication has required GPs to place greater emphasis on keeping their medical knowledge up to date, providing better facilities and longer opening hours. |

| | | |
|---|---|---|
| | **Information technology and management** | Encouraging uptake, aimed at greater efficiencies. Commonwealth and State putting money into facilitating improved information technology. |
| | **Practice nurses** | The employment of practice based nurses has been advocated as a way to strengthen the GPs role in care planning and coordination and population health. This is seen as being especially important in rural areas where there is an under supply of GPs. |

# Appendix 2

The business of running a general practice comprises activities unique to medical practice and those typical of running a small business (Table A2.1).

**Table A2.1. The business of rural medical practice[74]**

| The business of rural general practice | The business … |
|---|---|
| medical registration<br>provider numbers<br>prescriber numbers<br>DVA registration<br>direct billing private insurance companies<br>blended payments<br>indemnity insurance<br>vocational registration<br>hospital VMO appointment, where appropriate<br>continuing professional development<br>practice accreditation<br>blended payments<br>Medicare fee for service payments | business registration<br>employee contracts<br>PO Box<br>telephones and fax systems<br>security<br>disposals and supplies<br>rent<br>cleaning and maintenance<br>computer maintenance and software contracts<br>vehicle registration and insurance<br>drivers license<br>book keeping and accountancy<br>goods and services tax<br>tax file numbers<br>superannuation<br>banking<br>memberships<br>Business Activity Statements |
| PATIENTS | |

# Appendix 3

There are a number of issues to be considered when establishing a medical practice. They include:

- Provision for appropriate housing, surgery and equipment
- Shifting the focus from the GP to the practice as the enduring feature of health care in the community
- Agreed payment to the GP for a specific set of services rendered and hours worked
- Long term solution to ensure acceptable on-call and after-hours arrangements
- Appropriate professional support
- Agreed time away from the practice with guaranteed locum cover, which provides greater flexibility for other income generation, appointments, holidays, study and sabbatical leave
- Recognising GP' s professional and clinical independence, ethical standards, volume and direction of referrals and need to provide quality medicine to meet needs of the patients, not a third party interest
- Investing locally where possible
- Utilising local skills where possible
- Fostering a collaborative approach between doctor and other professionals including nurses, allied health professionals and the practice manager
- Have a vision for the type of practice required to attract appropriate GPs.