It's Different in the Bush: a Comparison of General Practice Activity in Metropolitan and Rural Areas of Australia, 1998

Dr Richard Madden, Associate Professor Helena Britt, Professor Ian Wronski

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Thank you very much. To the Council of the National Rural Health Alliance and the organising committee, thank you very much for allowing us to have this launch as part of this conference. What we’re launching is a special report on differences between rural and urban areas in GP activity, “It’s Different in the Bush”. I’m Richard Madden, I’m the Director of the Australian Institute of Health and Welfare. Jill’s just given a nice advertisement of independent authorities in the health and aged care portfolio and we’re another of them to produce information on the Australian health and welfare system which is independent and objective.

There’s a little slide here of our values, of how we do our business: objectivity, independence, respect for privacy and confidentiality, accessibility, client focus and people, people within the Institute. And that guides the work of the Institute and also the work of our collaboration with the University of Sydney which I’ll talk a little bit more about. I’m here to introduce two speakers to you, one of whom is Professor Helena Britt who is the Director of the General Practice Statistics and Classification Centre as we style our collaboration with the University of Sydney, and Professor Ian Wronski who is Executive Dean of the Faculty of Medicine, Health and Molecular Sciences at James Cook University.

And I’m sure he’s well known to you all as President of the Australian College of Rural and Remote Medicine. After the launch there’ll be an opportunity for the media to talk to the three authors — Graham Miller and Lisa Valenti are the other two authors with Helena, and they are also on the platform.

This study is the first of its kind for 10 years and it comes at a time when interest in rural and remote Australia is at a high level across the country and particularly politically. We at the Institute and the University trust that reports such as this one will give a greater insight into the issues that are related to rural health in Australia and give everybody an objective basis for that discussion. Now, this report comes from the BEACH Survey which is the survey of patients who attend general practice and their consultations. There’s been a bit in the media recently about this general topic, so I wanted to make a few comments about BEACH and to distinguish BEACH from other collections of patient information which have been mentioned in recent days.

This is a national survey and is funded jointly by government and several pharmaceutical companies, but wait there’s more. AIHW has been very grateful for all
their support. BEACH provides information on the characteristics of patients who go to GPs, their reasons for attending and the actions taken or recommended by the GP. BEACH data, and this is the law, BEACH data is collected under the Australian Institute of Health and Welfare Act.

The collection process, storage and release arrangements have been approved by the Institute’s and the University of Sydney’s Ethics Committees and are fully in accord with the Privacy Commissioner’s guidelines for medical research. Further, the data are collected under the auspices of the AIHW and so are covered by the Privacy Act and the Information Privacy Principles. Names and addresses of patients are not collected.

All output from the survey is unidentifiable and data is only collected on one in 1000 GP consultations. An information sheet is provided to patients before their consultation with the doctor who participates in the survey. Anyone who does not wish to participate can indicate that to their doctor. AIHW welcomes the opportunity provided by BEACH to inform the Australian community on what is happening in general practice while ensuring the patient’s privacy is fully protected.

I’m relying on Helena, by the way, to explain the acronym BEACH to you. Well, with that introductory set of comments about where this data comes from and the high quality and protection that’s afforded to those whose data is included, let me hand over to Professor Helena Britt of the General Practice Statistics and Classification Unit to explain to you some of the content of “It’s Different in the Bush”.

**HELENA BRITT**

Thank you, Richard. Distinguished guests, ladies and gentlemen, thank you for sharing this occasion with us. It was actually ideal to finish it just in time.

“It’s Different in the Bush” does report comparison of general practice activities in rural and metropolitan areas of Australia. As Richard said, it’s the first study of its type for almost a decade and we, in fact, conducted the last one. It’s a secondary analysis of data from the BEACH program, continuous national study of general practice activity.

BEACH is unusual because of the funding arrangements of government and industry, but it works very well. (Their names are supposed to be appearing over there but I think you can only see some of them,) About 1000 GPs participate in the BEACH program each year. They’re randomly selected from the Medicare records and each records details about 100 consecutive consultations. The survey period, though it’s different in the bush, was two years, April 1998 to March 2000.

It involved over 2000 GPs and over 200,000 encounter records. The GPs were grouped according to rural, remote and metropolitan area classification by practice postcode. To simplify comparison and ensure sufficient sample size the RRMA categories were grouped into three strata, and I’ll discuss this later. “Metropolitan” included RRMA 1 and 2, the “Large Rural” sector RRMA 3 and 6, that is the rural and remote centres, and the “Small Rural” included the small rural centres, other rural and other remote areas.
There were no significant differences in the distribution by RRMA of the BEACH GPs compared with all GPs across Australia. In the short time available today I will have to concentrate on the differences between the groups, rather than the many similarities, but I will also touch on a couple of results from 10 years ago. In 1990–91 only one in eight rural GPs was female. Rural GPs were older, more likely to have graduated overseas and more often in solo practice.

Now, one in four rural GPs are women, still less than the one in three in metropolitan areas but a great improvement. Compared with metropolitan GPs, rural GPs were younger and more likely to have graduated in Australia and there’s no longer a significant difference in the proportion in solo practice though there is some difference. These changes may be due to a combination of the increasing feminisation of the GP workforce and the wide range of government initiatives recently instituted to encourage young GPs to rural areas.

There was a significant difference between the strata in the distribution of activity in terms of the number of A1 items of service claimed in the previous quarter and these align with the number of sessions per week of clinical activity reported by participating GPs. Rural GPs tended to the middle of the range in terms of the number of A1 Medicare items and these results were validated against Medicare data for the total GP population.

However, A1 items we know make up a lesser proportion of the rural GP’s clinical workload. Rural GPs do more non-A1 Medicare work, they do more non-Medicare paid, that is paid by State government departments etcetera, and they do more indirect encounters where the patient is not seen but a service is provided. Now, putting all that together there’s a mean A1 items of service, mean other Medicare items, mean services paid by other sources and mean indirect encounters.

At the end of the day there was no significant difference in the total service provision levels, or busyness as it’s often called, between the strata. There was also no significant difference in the number of encounters that involved Medicare item numbers for obstetrics, operations or anaesthetics. However, there were large differences in the proportion of GPs involved, claiming at least one obstetrics item number or at least one in the area of operations.

And anaesthetics, those item numbers were definitely only the province of GPs in the small rural areas. Busyness, a funny issue. Let’s think about after-hour services. One in five metropolitan GPs said their practice provided all their patient after-hours care, compared with 40 per cent in large rural areas and even more in small. Some GPs in all strata did some of their own mixed with other types of service while permanent co-operative arrangements were far more common in the rural strata.

This means that over 80% of rural practices are providing part or all of their after-hours care for their patients, double the proportion of metropolitan areas. It’s notable that 56% of metropolitan practices relied totally on deputising services. I thought, “Well at least they can go home and have a glass of wine.” Use of computers in the practices. Eighty per cent of GPs reported their practice uses computers in the practice but use for clinical purposes was considerably higher in rural areas, particularly in the Large Rural strata.
One-third of computerised metropolitan practices only use them for administrative practices. Let’s turn to the patients. Ten years ago rural GPs saw more male than female patients, now there’s no significant difference in a gender distribution seen in the three strata. However, in small rural areas the patients are older than those in other strata, they are therefore more likely to hold a health care card or a vet affairs card and they’re far less likely to be from a non-English speaking background.

While encounters with Indigenous people occurred at four to five times the rate in rural areas, the small sample size rendered this difference of no statistical significance. While we’re talking about patients let’s look at their risk behaviours. In both rural strata, a significantly greater proportion of patients reported at-risk alcohol intake levels. The level of patient obesity and overweight increased steadily with rurality, as did the proportion of patients who were past or current smokers.

And while we can hardly regard the at-risk behaviour in metropolitan areas to be of a satisfactory level it would seem that rural GPs are in an ideal position to intervene in regard to their patient’s health behaviour and have a positive effect on the overall health of their communities. Now, the morbidity managed at the consultations, respiratory problems and upper respiratory tract infection in particular decreased in relative frequency with increasing rurality.

This difference was also apparent ten years ago and reflects overall rates of presentations of minor acute illness, they’re definitely less in rural areas. For the first time we found that depression was significantly — and that difference is quite considerable — more often managed in large rural towns and this was reflected in higher prescribing rates for antidepressants. This is probably worthy of further investigation. Hypercholesterolemia was less often managed in large rural areas, remember that’s where they’re overweight and drink a lot.

Skin problems, particularly solar keratosis and malignant neoplasms, were more frequently managed in rural areas as they were ten years ago. And as ten years ago again the pre- and post-natal care remained a more common issue in rural areas, but particularly in the Small Rural. There was no significant difference between the strata in the overall rate of prescribing, though GPs in metropolitan areas did advise more over-the-counter drugs, perhaps aligning with a higher presentation of minor illness. However the amount of advice and counselling provided by GPs decreased steadily with rurality, particularly counselling about nutrition and weight.

It is of some concern that in areas where weight and at-risk alcohol consumption are high, advice of this type is low. As I said earlier, there is a chance here to effect change. That was advice and counselling.

Procedural work was more frequently undertaken by rural GPs, in particular excisions reflecting the high rate of management of skin problems and repairs and fixations. Pathology order rates increased steadily with rurality, particular orders for EUCs, FBCs, and for haematology, and this suggests that rural GPs may be taking greater responsibility for working up the diagnosis prior to referral.

In summary, this study has demonstrated that it is different in the bush, that there are real differences in the characteristics of rural GPs and their patients, in the problems
managed, in the management techniques adopted. However, by far the majority of these
differences are in the small rural areas, not in the rural remote centres of Australia.
Most differences are also of a lesser magnitude than they were 10 years ago, perhaps
reflecting the overall change in the face of Australian general practice.

There are some methodological issues that need to be considered. In representing
general practice on a national basis, quite correctly we have very few participants from
the remote areas. The 139 GPs from rural centres have a far greater influence on the
results for Large Rural than do the activities of the nine remote centre GPs. Likewise,
encounters from the 15 GP participants from other remote areas in Australia will have
little impact on the description of activities of the Small Rural stratum. If we are truly
to describe general practice activity in remote Australia it is essential we conduct a
parallel study in which these remote GPs are over-sampled. There are only about 150 of
them so such a study would require their full group support and co-operation.

The second issue is one of classification. The Small Rural stratum included many
coastal towns, pleasant places to live with a growing population of retirees. The
influence of the data from these areas is likely to have softened the differences that
would otherwise appear. We need to work with geographers to define the small rural
areas of interest with isolation level in mind and look specifically at their practice
patterns.

Finally some thank yous. This study would not have been possible without the
tremendous efforts of current and past members of the total BEACH research team, this
is only three of us; the financial support of the Government and industry groups in the
BEACH consortium; the co-operation of the GP branch of DHAC in the drawing of
samples and comparative totals of GP data; the contribution of the College, the AMA,
and the Australian divisions of general practice through their participation on the
BEACH Advisory Board.

We are delighted that Mark Robinson has recently agreed to join the Board on behalf of
ACRRM. Last but not least without the considerable time and effort put in by the 2000
GP participants this study could not have been undertaken. On behalf of the authors and
generally the GPSCU, thank you all. We hope the results will be useful to the
profession of general practice. Thank you.

THE CHAIR

Thank you, Helena. Now I would like to introduce Ian Wronska. I’ve already said that
he is President of the Australian College of Rural and Remote Medicine as well as
being Executive Dean of the Faculty of Medicine, Health and Molecular Science at
James Cook. Ian has been involved in rural and remote medicine for over 25 years. He
spent 10 years in Broome, ending up as Director of the Kimberley Aboriginal Medical
Services Council. He then became Director of the Anton Briel Centre for Tropical
Health and Medicine at James Cook University before becoming Head of the School of
Public Health and Tropical Medicine and moving on to his current position. I won’t go
through his qualifications and memberships because there are far too many of them. Let
me just introduce Ian. Thank you very much.
Thank you very much, Richard. I’ve got the signal so we’d better move along. I’m really pleased to be part of the launching of “It’s Different in the Bush” and congratulations do go to the authors, Helena, Graham, and Lisa, and I think also for the AIHW and those parts of Sydney University that have been involved in maintaining this database for such a long period of time. I think also we ought to send a vote of thanks to the public and private funders for supporting the work and maintaining an important part of the national health efforts information landscape.

The quality of Australia’s health information has improved substantially over the last few years. Information provides a major foundation, not the only one, for policy decision making revision. Communities have learnt that resources go to what’s measured and therein lies some of the rub for rural communities. Statistical methodologies are not good at dealing with small numbers so it’s easy to lose data from the need to aggregate and not everything that is important is easy to measure.

This data set is an analysis of doctors who are vocationally registered or are able to use the vocationally registered Medicare item numbers and between April 1998 and March 2000. It does provide an important snapshot of general practice activity though, of course, does not include doctors who non-VR Medicare items.

Overall it suggests a positive impact of a number of government strategies in relation to the rural medical workforce and it paints a picture consistent with a substantial medical procedural deskilling amongst rural practitioners and arguably amongst other things in the context of small hospital closures, increased barriers to access to larger hospital practice and soaring medical indemnity costs. Despite these homogenisation trends, rural and remote docs still appear to do more after hours work, more procedural work, more non-Medicare related work.

They spend more time working up their own patients who present later. They see many more Indigenous people and are trying to find efficiencies through the use of modern technologies including IT. In addition, practice patterns operating in areas of workforce shortages may differ more than is evidenced by Medicare billing. Involvement with State health facilities is one. Load in areas of workforce shortage, load may need to be shared with other health providers. Many rural practitioners have a population in health role and an emergency care role.

All this goes to support the authors’ call for a more comprehensive study of rural and remote medical practice in particular. I believe this is an important continuing data set and an important report, and I recommend it to you. Thank you very much.