Is there a blueprint for replicating new general practice entities in rural Australia?

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Background

Australia, along with many other countries, has a chronic shortage of medical professionals, particularly in rural and remote areas. Recruitment and retention of new general practitioners (GPs) is increasingly difficult, particularly where primary medical care is delivered by self-employed GPs working in small to medium sized traditional practices being remunerated under a fee for service payment model (Medicare).[1]

Significant changes have occurred to the business of general practice, including vocational registration of GPs, accreditation of general practices, financial incentives to encourage involvement in primary medical care (blended payments) and greater use of information technology. In addition, the majority of GPs entering the workforce are now Generation Y (born after 1981), or overseas trained doctors, who have different needs and attitudes towards general practice as a career, and towards business ownership.

Nationally, the cohort of GPs aged 55 and over comprises 86% of males who work an average of 49.3 hours per week providing routine clinical services (not including hospital work, teaching, supervision or other medically related pursuits).[2] In comparison, the cohort of GPs less than 40 years of age comprises 57% of males. Those aged between 35 and 39 are working an average of 47 hrs per week providing routine clinical services. Females in this age group (37% of the group) are working an average of 32.4 hours.

Young GPs appear wary of long medical and business management hours they perceive to be associated with rural practice and are less interested in practice ownership. They are saying that they prefer working in group practices where they have defined hours, no responsibility for business management and good incomes, which encompass portability and flexibility. 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. Younger GPs are more likely to see rural health as part of their working life, not necessarily their whole life.

In this environment, continuity of primary care increasingly depends on focusing on continuity of practice rather than on providing incentives to GPs to invest in small business in the community and remain there for decades.[3] Third party input towards providing infrastructure and support services is crucial to establishing the continued delivery of core local services. Although long term sustainability is unclear, different service models, involving practice nurses and allied health professionals working with GPs, are being trialled. It is important to identify commonalities and define key characteristics to assist effective development and implementation of new general practice entities and models of service delivery. Is there a blueprint for replicating managed general practice entities in rural Australia?

Aim

This paper examines the range of characteristics which contribute to the successful establishment of new models of general practice in rural communities, with specific reference to three General Practice entities and associated service delivery models.

Method

New managed practice entities in Tamworth, Cessnock and in north west New South Wales (NSW) were chosen. Two of the three practice entities have been evaluated. Steering committee members, staff and key stakeholders were interviewed as part of these evaluations. One model was auspiced by a Division of General Practice, one by a university and the third by a newly established not for profit structure.[4] The three managed practice entities are described in Table 1.

Table 1 A comparison of three managed general practice entities in NSW

Practice entity	Rural and Remote Medical Services (RARMS)	Cessnock Uni-Clinic	Peel Health Care
Location	Two remote locations in north west NSW	Within the grounds of Cessnock Hospital—a semi-rural town of ~45 000	Tamworth, a regional town of ~40 000
Board Structure	Not for profit—3 Directors nominated by RDN, plus Outback Division of General Practice and Rural Doctors Association, NSW	Corporate entity wholly owned by The University of Newcastle	Not for profit company wholly owned by the North West Slopes Division of General Practice
Employment arrangements	GPs conduct own practice and pay management and facility fees. Other staff employed by RARMS	GPs, nurses and allied health staff salaried	GPs contracted on percentage. Nurses salaried. Allied health professionals private or employed by the Division
Billing	Bulk Billing	Bulk Billing	Private Billing
Integration with other services	Employing aboriginal health nurses and practice nurses	Working with community health	Expansion of premises with increase in private allied health
Workforce numbers	3–5 GPs at two sites Practice nurses at both sites and an aboriginal health worker at one site	5–7 GPs, 3 nurses, 1 women's health nurse, 1 midwife, part time mental health nurse, 1 dietitian	4 FTE GPs , 1.5 practice nurse, 12 sessions by allied health

Essential and desirable criteria for establishing managed practice entities in rural areas were identified and described.

Findings

Nine criteria were identified as being essential to the development and implementation of managed practice entities:

- develop a sound business case
- identify and engage a local champion
- involve stakeholders with resources
- develop clearly defined financial and clinical models of governance
- agree on a model of service delivery
- ensure compatible IT systems
- develop the practice entity to run independently of individuals
- implement responsive financial arrangements for staff
- local flexibility.

All three managed practices were initiated in response to workforce crises. None the less, it is essential to develop a sound business case, which demonstrates need as well as financial viability, in order to engage stakeholders and consult with the community. It is essential to have a local champion who is passionately committed to the project, can put time and energy into it, but who is not indispensable to its development. Local health services need to be engaged in a co-operative way to ensure ongoing community commitment to the project and the local champion has a role in this process. The project needs to engage stakeholders with influence, a local track record and other resources, including money to support the project.

Governance is a critical issue, and needs to be worked out at three different levels; the management and financial level, clinically (who is clinically responsible to whom, who deals with issues of clinical competence, who owns the medical records) and from a human resources perspective (for example, method of payment and co-ordination of leave within the practice). Related to this is agreement on the model of service delivery to be adopted by the practice, and on the expected outcomes. For example, will the practice keep its books open to all comers or will it target some groups in the community, and what happens when capacity is reached. Will the practice bulk bill all or some patients, or none and how will it engage and integrate with other health service providers? This will in turn be reflected in the information technology systems used by the practice, which need to ensure the continuity of information between practitioners within the practice and ideally also allow transfer of clinical information between the practice and other health providers such as the local hospital.

To be relevant to both practitioners and to the community it is essential that the operation of the managed entity be independent of any individuals, including management staff and practitioners. This ensures continuity of primary health services to the local community. At the very least it ensures continuity of medical records.

GPs and other health service providers like to know what remuneration packages come with 'the job'. In a managed entity this can include things like accommodation, motor vehicles, relocation allowances, contracted minimum incentive payments and cashed out Visiting Medical Officer contracts. Where recruitment is more difficult, remuneration packages need to have a short term pay off.

As well as the essential criteria, there are at least four desirable criteria for establishing managed entities:

- a sense of humour
- a core of skilled local practitioners
- continuing to put energy into established linkages
- building in evaluation during the development stage.

It is desirable to have local knowledge present—a core of skilled practitioners—who can manage outsourcing of other skills in an appropriate way, and who can continue, along with other stakeholders, to put energy into maintaining and building established linkages. In all three examples at least one GP was already present in each of the locations before the managed practices were established. Evaluation should also be built into routine practice to enable continued improvements to the managed practice and keep it 'customer focused'.

Conclusions

Rural communities invest a large amount of time, resources and energy into delivering primary medical care. Generational change is one of the drivers for the need to develop new practice and service delivery models. A blueprint for replicating new practice models in rural areas could save communities much time and effort by mapping key pointers to success. While differing community needs remain essential drivers, there are some common lessons which can be used to inform and support sustainable rural practice models. Both essential and desirable criteria have been discussed, including the need to always maintain local flexibility. These new managed practice entities can act as platforms for

integration of primary health care services. The way this is done is the next big challenge for primary care. The essential and desirable criteria outlined here (the blueprint) are equally relevant to this challenge.

References

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Presenter

Jenny May has over 20 years' experience as a GP in rural and remote Australia. She is currently the Rural Doctors Association representative and Deputy Chair of the National Rural Health Alliance. In this capacity she has been involved in numerous committees and working parties around rural health issues. Currently she represents the NRHA on the Mental Health Council of Australia. Within RDAA she is involved in the Female Doctors Group, and has represented RDAA in forums around cervical screening. She represents RDAA Women's Group on the National Rural Women's Coalition. She is an examiner for RACGP and currently works in a new practice set up by North-West Slopes Division of General Practice. Through this model she is exploring usage and upskilling of practice nurses. Her job funded by PHCRED encompasses support of research and evaluation activities in primary health care particularly involving Divisions of General Practice, regional GP training providers and CPD delivery. She is currently involved in an evaluation of the GP workforce in Tamworth as part of the wider evaluation the UDRH is doing for the new Division Managed Practice. She is also studying for a Masters of Health (Social Science) and has a research interest in looking at the economic, clinical and social viability of rural health facilities. Her interests include women's health, mental health and the development of rural general practice models.