The viability of general practice in rural Australia

Practical contributions towards solving the medical workforce problems of rural Australia

> A viable practice is one that meets the particular medical needs of the community by providing appropriate services in a way that takes account of the financial and personal costs to both the practitioner and the community at large.[1]

SINCE 1978, there has been a plethora of inquiries, conferences and symposia on how best to recruit more rural doctors.[2-6] These endeavours have resulted in a series of loosely articulated initiatives such as affirmative medical school entry for rural high school students, scholarships, decentralised medical education and other support mechanisms. It is envisaged that these initiatives will eventually ease the rural workforce shortage and diminish our reliance on overseas-trained locum doctors, many of whom are from underdeveloped countries with doctor shortages of their own.

However, there is not much sense in recruiting and training rural doctors if the conditions under which they are expected to practise are not viable. In this context, two recent reports — *Viable models of rural and remote practice* and *Easy entry, gracious exit* — break new ground in defining the conditions necessary to build and ensure a viable rural medical practice.[1,7]

The reports are based on two separate studies. The larger study, the basis of the viable models report, was initiated and managed by the Rural Doctors Association of Australia, funded by the Australian Government Department of Health and Ageing and carried out under the guidance of the Bendigo branch of the Monash University School of Rural Health. The investigators used a rigorous, triangulated methodology, which included a national survey of all 4403 rural and remote general practitioners in Australia, focus groups and detailed site visits to a representative sample of 53 practices across Australia. There was a 34% response rate (1498 GPs), representing 53% of all practices. And what did the study find?

Demographics: The major finding was the large proportion of ageing and overworked rural GPs, a matter of obvious concern to governments charged with providing healthcare for all people in Australia. Doctors over 50 years of age comprised 40% of the current workforce, and 61% of all rural doctors worked in areas with a shortage of GPs. A quarter of all doctors in the study were trained overseas, predominantly in the United Kingdom, Africa and Asia. Doctors in towns of 10 000–20 000 people need between two and three extra GPs, while those in towns of less than 10 000 people require an extra four to five GPs. Female doctors are now making an increasing contribution to the rural and remote workforce: they comprised 27% of the 1498 doctors responding to this study.[8] Contrary to popular belief, they work the same number of hours as their male counterparts.

This demographic picture has a fluid element, as a third of all rural and remote GPs intend to leave their current practice in the next 5 years. The proportion intending to leave ranged from 31% in the bigger towns to 66% in the more isolated communities.

Capabilities: The ability to cope in depth with procedural presentations and emergencies, both in the consulting room and in the hospital, defines the rural and remote doctor. Over 50% of doctors working in population centres of between 5000 and 25 000 were involved in accident and emergency work outside of their surgery, 22% were doing obstetrics, 12% major surgery and 15% provided general anaesthesia.

Work conditions: Rural and remote practitioners worked an average of 48 hours per week in patient-related activities and 8 hours in non-patient-related activities, mostly patient and

practice administration. The weekly workload consisted of an average of 160 consultations per week, with a mean of 14 minutes per consultation. In addition, the practitioners were on-call one day and one weekend in three. Their vacation time averaged 24 days per year.

Economics: A detailed economic and staffing analysis was performed for 91 of the participating practices. The average full-time rural doctor earned $266 000 per annum from all sources, including hospital work. Of this, 33% was consumed by staff costs and 19% by practice costs. The net taxable income was $127 680, which equates to $47.50 per hour net for a 56-hour week. Half of the GPs surveyed were practice principals and their yearly average profit was $201 000. From this, they paid for motor vehicles, medical indemnity, and continuing medical education. However, a quarter of all practice principals were financially unviable, with a net profit of less than $120 000 per year.

Nearly all practices had a manager, and 72% had at least one practice nurse. In response to increasingly complex regulations and red tape, most managers had resorted to a reactive rather than a strategic approach to management.

Dimensions of viability: Viable models of rural and remote practice identified a hierarchy of three core interrelated dimensions of viability that are amenable to systematic intervention. These are:

- A level of remuneration that reflects rural GPs' skills, workload and commitment;
- A sufficient number of medical colleagues to limit after-hours workload to one night and one weekend in four, as well as adequately skilled locum support to enable annual recreation and study leave; and
- The physical facilities and administrative support to do their job. The habit of state governments of closing country hospital obstetric and anaesthetic facilities has been shown to be a major factor in procedural country doctors leaving their practice.[9,10]

Previously identified family, social and environmental factors were significant, but were found to be dependent on the above three dimensions and therefore less important in a doctor's likelihood of remaining in rural practice.[2-4]

Benchmarks: These data have been used to derive benchmarks for models of viable practice. The authors of the report stress that these benchmarks are not a wish list, nor an ambit claim, and explain clearly how they have reached their conclusions. For example, income benchmarks of $110 per hour are derived from the median incomes of private GPs, government salaried GPs, rates for locum GPs, and the hourly rate paid to GPs engaged in divisional activities.

Other benchmarks cover education, workforce numbers according to emergency and after-hours requirements, and various forms of leave. They also include purpose-built practice premises, a required number of support staff, and business systems which enhance practice management and include broadband internet access. The final chapter of the report illustrates the use of the viability framework in three different geographical locations.

Easy entry, gracious exit complements the viable models report. It is a case study of an innovative model piloted in the towns of Brewarrina, Collarenebri, Lightning Ridge and Walgett in the far west of New South Wales.[7] The unique feature of this model is a third-party provider as the owner and manager of the practice. This relieves doctors of the hassles of being a small-business owner, worried about a low return on infrastructure investment, and allows them to concentrate on practising medicine. In addition, this project is supported by the New South Wales Rural Doctors Network, which provides for safe working hours, regular holidays and promotes a guilt-free "walk-in, walk-out" approach by concentrating on continuity of the practice rather than continuity of the doctor. This model has proven to be an important factor in recruiting and retaining doctors.

Both these reports make major conceptual and practical contributions towards solving the medical workforce problems of rural and remote Australia. They provide clear guidelines for health planners, consumers and medical stakeholder groups on what is required to give their particular geographical area the best chance of obtaining a viable and ongoing medical service.

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