Coordinating rural divisions: The workforce window

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Abstract

Divisions of General Practice have been established to alleviate the professional isolation which general practitioners face by being excluded from involvement in other parts of the health care system. Divisions facilitate the development of local communication networks and cooperative activities which improve the integration of general practice with other elements of the health system.

Coordination of communication is one of the strengths of divisions at the local level and Rural Divisions Co-ordinating Units at the State level. This strength is being effectively utilised to target general practice workforce issues. Given the significant proportion of general practitioners in the medical workforce, particularly in rural and remote areas, this has implications for broader medical workforce issues.

Australia faces a maldistribution in its general practitioner workforce, with an excess supply in urban areas and a significant shortfall in rural and remote areas. Since 1995–96, the General Practice Rural Incentives Program, which targets the recruitment and retention of rural doctors, has devolved funding to the Rural Divisions Co-ordinating Units to coordinate the statewide provision of practical assistance to rural general practitioners, through their divisions, in relation to continuing medical education and the provision of locums. There is potential to build on the successes of these initiatives and also to work with urban divisions through the state-based organisational structures which are currently being developed.

At the time of writing this paper, divisions are consulting with each other and also State and federal health departments to develop new general practice support structures. These structures are to include state-based umbrella organisations incorporating both support functions for divisions and rural workforce initiatives.

Introduction

This paper outlines the development of Divisions of General Practice in Australia, with a particular focus on rural divisions and Rural Divisions Co-ordinating Units (RDCUs). While providing a background to the divisions and RDCUs, the paper refers to the current and potential roles of RDCUs with respect to workforce issues. One purpose of this paper is to highlight the fact that coordination of communication is one of the strengths of rural divisions and RDCUs and that this strength is being used, through the General Practice Rural Incentives Program, to address general practice workforce issues. These issues are also relevant to an examination of the future roles of RDCUs and the development of state-based support structures for divisions and rural workforce initiatives. This was outlined in the February 1997 discussion paper by the Federal Department of Health and Family Services, *Support and Co-ordination Structures for Divisions of General Practice and GP Workforce Initiatives*. Before introducing divisions and RDCUs, the paper will give some basic definitions and a background to the Australian medical workforce.

Background

There are various definitions of a general practitioner (GP), and this reflects both the perceived role of the GP and also the purpose for which the definition was developed (Department of Health and Family Services 1996). A widely used definition of a GP adopted by the Royal Australian College of General Practitioners is a medical practitioner who provides primary, continuing and comprehensive care to individuals, families and their communities. Macklin (1992, p 8) stated that 'General practice looks after the medical needs of most of the people (of Australia) most of the time — over 80 per cent of the population visit a GP at least once each year'. The role of the GP in Australia has altered in the 1990s with the introduction of vocational registration, Divisions of General Practice, accreditation, better practice payments and more emphasis on preventive medicine and continuing medical education. The 1994 estimates of the total number of GPs and medical practitioners providing GP services in Australia are about 23 000 actual numbers or 15 300 full-time

equivalents. The 1994 estimates of the total number of practising clinicians in Australia are about 40 859 actual numbers and 37 300 full-time equivalents (Australian Institute of Health and Welfare 1996). GPs are the largest single grouping within the Australian medical workforce and therefore trends and structural imbalances in the GP workforce affect the broader medical workforce. The focus of this paper will be on the GP workforce and the strategies employed, through the divisions/RDCU framework, to address the recruitment and retention of doctors to rural and remote areas.

There are many patterns evident in the Australian medical workforce data. These include a sustained growth in Australian medical graduates over the past 20 years, the increased input of 'Temporary Visa Doctors' from overseas and an increasing proportion of female medical graduates (Macklin 1992). Despite these trends in the medical workforce generally, it is widely acknowledged that the GP workforce is in considerable oversupply in urban areas of Australia, with significant supply shortfalls in rural and remote areas (Macklin 1992; McEwin 1995). The urban excess supply is estimated at 4400 or 2900 full-time equivalents and the rural supply deficit is estimated at around 500 or 445 full-time equivalents (Australian Institute of Health and Welfare 1996).

In Australia, about 28 per cent of the total population resides in non-metropolitan or rural areas and these areas are served by about 20 per cent of the available GP workforce and 10 per cent of specialists (Kamien 1995). There have been attempts in recent years to define a 'rural GP' in an effort to address the acknowledged undersupply of medical practitioners in rural areas. Procedural skills are often cited as a major difference between urban and rural GPs, as there are proportionately fewer procedural GPs in urban areas compared with rural areas. However, rural GPs are not a homogeneous group and not all rural GPs require the same level or mix of procedural skills. Furthermore, although a minority, there are some urban GPs who do have high levels of procedural skills (McEwin 1995).

The results of a survey commissioned by the *Medical Journal of Australia* in 1993 to describe the work undertaken by GPs working in rural areas of Australia and then make comparisons with the work of GPs in urban areas concluded that rural GPs were, in general, undertaking more hospital work and utilising procedural skills more often than urban GPs. In the main, these skills are in anaesthetics, emergency medicine, obstetrics and surgery. The practice of procedural medicine occurs in rural areas to a greater or lesser degree depending upon local requirements (for example, distances to large base hospitals and the availability of specialists).

Hoyal (1995) identified some of the social, personal and professional causes that have been responsible for doctors leaving rural general practice. These include issues like partner's employment or career prospects, social networks and children's schooling. The Rural Medical Family Network was established through the General Practice Rural Incentives Program in 1994 for the support of the families of doctors in rural areas (Cotton 1996).

The National Health Strategy Issues Paper No 3 (Macklin 1992) described many of the developments, trends and structural factors in the medical workforce and identified a series of challenges for Australian general practice. Many of these challenges were addressed through the General Practice Strategy which is outlined here.

The General Practice Strategy

In December 1991 the Australian Medical Association, the Royal Australian College of General Practitioners and the Federal Government entered into discussions on general practice under the broad themes of workforce and standards. A group, then known as the General Practice Consultative Committee, comprising senior representatives from each of these three bodies, presented a reform strategy for consideration by the profession (of general practice) and the Government. The aim of the strategy, presented in *The Future of General Practice: A Strategy for the Nineties and Beyond*, was to provide a framework to allow general practice in Australia to 'reassert its role as the cornerstone of Australia's health care system' (Macklin 1992).

The proposals in this General Practice Strategy included recommendations, or 'General Practice Reforms', to address the oversupply of medical practitioners in metropolitan areas and the undersupply in rural areas (the General Practice Rural Incentives Program), the introduction of vocational training and registration for GPs, accreditation, remuneration issues and the introduction of funding for formal networks (divisions) of general practitioners. The General Practice Strategy was officially launched with the Federal Budget in August 1992.

The background to the General Practice Strategy is now historic, but nonetheless provides the framework within which a number of developments have been occurring. Divisions of General Practice are one dynamic aspect of the General Practice Strategy reforms.

What are Divisions of General Practice?

Divisions of General Practice are federally funded 'grass roots' local networks of GPs. There are approximately 110 Divisions of General Practice in Australia and almost half are groupings of GPs working in rural areas. These networks can apply to the Divisions and Project Grants Program (which is part of the General Practice Branch of the Federal Department of Health) for administrative and operational funding, known as infrastructure funding, through a local GP management committee. This funding can then be used to maintain a corporate office base with employed staff, to provide remuneration for GP involvement in a range of activities and to develop and promote a local GP network to respond to both community and GP needs.

The overriding aim of the Divisions and Project Grants Program has always been the improvement of health outcomes for patients. This is being made possible through divisions because they encourage GPs to work together and link with other health professionals to improve and extend the delivery of primary health care. Divisions of General Practice also provide a mechanism to address many of the underlying structural weaknesses of Australian general practice, including quality of care, integration, access and overall efficiency.

Divisions can also apply to the Divisions and Project Grants Program for project funding. Project activity has become increasingly significant to divisions, both in terms of GP involvement and from a divisional resource point of view. Through projects, GPs have become exposed to new patterns of work and remuneration. They have become involved in innovative models of health care delivery in association with other health care providers (for example, projects on cardiac rehabilitation or disease prevention involving dietitians, projects on asthma or diabetes management or palliative care involving nurses and/or specialists). In addition, many GPs have learnt new skills as project managers.

The implementation of projects through divisions has meant that GPs have been given opportunities to trial new ideas, work with allied, public and community health professionals, become involved in health education strategies, work with disadvantaged target groups and improve their communication and linkages with hospitals and specialists. Projects, in areas such as cardiac rehabilitation, diabetes management and palliative care to name a few, have encouraged more GPs to become involved in their local divisions. Many projects have addressed the delineation of shared care between GPs and specialists, particularly in urban areas. The publication *Summaries of Divisional Projects 1993–1996* by the National Information Service of the General Practice Evaluation Program summarises projects funded through the Divisions and Project Grants Program.

The Federal Department of Health defines divisional boundaries on a geographical basis. Over 80 per cent of the geography of Australia now includes 'catchment' areas for Divisions of General Practice. The boundaries of divisions often correlate with the administrative groupings of local health services. The size of divisions, in terms of GP numbers, ranges from about a dozen in rural divisions where there are few GPs covering huge geographic areas, to over 400 in high density metropolitan areas. Large rural divisions include about 150 GPs within their boundaries. At the end of 1996 there were over 110 functioning divisions claiming membership of over 70 per cent of working GPs across Australia. The mean population of divisions is 152 920 (Department of Health and Family Services).

Table1: Potential and actual GP membership for Divisions of General Practice by State and Territory, Australia, 1996

State/Territory	Estimated potential GP membership	Actual division membership (%)
NT	155	77
ACT	350	91
Tas.	481	70
WA	1 447	70
SA	1 801	82
Qld	3 466	64
Vic.	5 585	77
NSW	6 718	69
Total	**20 003**	**72**

Source: Figures provided by the Divisions and Project Grants Program, General Practice Branch, Department of Health and Family Services 1996. Not published.
Note: Estimated numbers are the potential number of GPs eligible for membership within division catchment areas. These numbers are based upon the number of GPs working within division boundaries.

Table 1 gives a breakdown of division membership by States and Territories. The membership of rural divisions is estimated at about 80 per cent, compared with 70 per cent for urban divisions. Approximately 25 per cent of GPs work in non-metropolitan areas.

The funding allocations for the Divisions and Project Grants Program have grown from $1 million in 1992–93 to approximately $76 million in 1996–97.

What are Rural Divisions Co-ordinating Units?

Having introduced divisions, it is now appropriate to move to the next level of coordination and describe the Rural Divisions Co-ordinating Units (RDCUs). Before doing that, the distinction must be made between rural and urban divisions. The term 'rural divisions' refers to Divisions of General Practice which have a majority of GPs working outside the metropolitan areas. These divisions are in coastal, inland and remote areas and include small towns as well as major provincial centres.

The RDCUs were established for the purpose of coordinating the activities of rural divisions and hosting a communications network for rural divisions. Commonly agreed objectives for all RDCUs are:

- to facilitate the coordination of communication across rural divisions
- to coordinate rural activities and projects across rural divisions
- to assist rural divisions to become established
- to support rural GPs in areas not covered by divisions or rural GPs in urban divisions.

The membership of each RDCU comprises the rural divisions in that State. The rural divisions influence the direction of their RDCUs through a board or management committee. The number of rural divisions in each State are: New South Wales (17), Victoria (15), South Australia (10), Western Australia (5), Queensland (5) and Tasmania (3). There are two rural divisions in the Northern Territory which obtain limited support from the South Australian RDCU. There is one urban division in the Australian Capital Territory.

The RDCUs were not part of the Government's original master plan for Divisions of General Practice. By way of history, the Rural Doctors Association of Australia, which is the major industrial organisation for rural doctors, played a significant role in the establishment of RDCUs which followed 15 to 18 months after the establishment of the first divisions. During 1993 the Rural Doctors Association of Australia and its state-based affiliates joined the Federal Department of Health in discussions concerning the special needs of rural divisions. The outcome of these discussions was that the department agreed to provide an extra 25 per cent to the infrastructure budgets of rural divisions (called rural loadings) to compensate them for the disadvantages they suffer (compared with urban divisions) regarding isolation and distances from capital cities and major resource centres. This money was not paid directly to GPs but to the office infrastructure of the rural divisions. A further step in the negotiations between the department and the Rural Doctors Association resulted in an agreement to

designate a proportion of the funding to be paid directly to rural divisions as rural loadings to establish state-based RDCUs. This initiative was to further address some of the isolation problems for rural doctors caused by distance and geography by establishing a communications and support network for rural divisions.

The original role envisaged for the RDCUs did not directly target general practice workforce issues. The RDCUs were established primarily to facilitate networking and communication between rural divisions and their members. This core objective has been broadened into a number of functions which include:

- representation and advocacy for the purposes of liaison with other bodies as directed by rural divisions
- the selection of representatives from rural divisions to attend meetings on behalf of the rural divisions in their State
- the promotion of project implementation in rural divisions and the development of statewide rural projects
- the provision of a communication conduit between peak bodies, such as the State health departments, and the rural divisions
- liaison with other organisations, community groups and individuals about how the needs of rural divisions can be incorporated into their own activities
- the development of policy in consultation with rural divisions.

Since 1995–96 the role of RDCUs has been expanded to include strategies which are aimed at addressing workforce issues. This has evolved in three main ways. Firstly, workforce issues have been placed on the agenda for discussion by rural divisions and this has occurred through both informal meetings and formal workshops (New South Wales Rural Divisions Co-ordinating Unit 1994, 1996). Secondly, RDCUs have been awarded funds (known as the Continuing Medical Education/Locum Grants) under the General Practice Rural Incentives Program to target workforce issues. Thirdly, RDCUs provide representatives to the General Practice Rural Incentives Program Support and Assessment Panels which are responsible for assessing applications from doctors for relocation and training grants and also remote area grants.

Therefore, although not originally envisaged in the General Practice Strategy or through the negotiations with the Rural Doctors Association of Australia which led to the establishment of the RDCUs, the RDCUs have become delivery mechanisms for part of the General Practice Rural Incentives Program. In 1995–96, two years after their establishment, the budgets of the RDCUs included both Divisions and Project Grants Program funds and General Practice

Rural Incentives Program funds. Before further exploring the current and potential roles of the RDCUs in relation to workforce issues, it is necessary to briefly overview the General Practice Rural Incentives Program which, like the Divisions and Project Grants Program, is funded through the General Practice Branch of the Federal Department of Health and Family Services.

Federal workforce strategies

As part of the 1992 General Practice Strategy (General Practice Consultative Committee 1992), the Federal Government established the General Practice Rural Incentives Program to encourage doctors to relocate from adequately serviced areas to rural and remote areas where there is a shortage of doctors. The program was also designed to support medical practitioners already working in these rural and remote areas. It was originally known as the Rural Incentives Program, and since 1995 has been referred to as the General Practice Rural Incentives Program, in acknowledgement of the fact that it specifically targets the recruitment and retention of GPs.

The objectives of the General Practice Rural Incentives Program, as cited in the *Guidelines for Continuing Medical Education and Locum Support Grants 1996–1998* (General Practice Rural Incentives Program 1995), are:

- to improve access of rural and remote communities to GP services
- to assist in the delivery of high quality GP services by supporting appropriate training
- to foster recruitment and the retention of rural and remote GPs.

The General Practice Rural Incentives Program has had an annual budget of approximately $15 million over the 1995–96 to 1997–1998 funding triennium. Approximately $5 million per year has been allocated to RDCUs in total as Continuing Medical Education/Locum Grants in recognition of the difficulties faced by rural GPs in gaining access to appropriate continuing medical education and in obtaining relief for other leave. The amounts allocated to each State (out of this $5 million) are determined by a formula, known as the Rural, Remote and Metropolitan Area Classification, which takes into account factors such as demography and population densities across defined areas in each State. (This formula was developed by the Department of Primary Industries and then Department of Human Services and Health in 1994.) The Continuing Medical Education/Locum Grants are aimed at enhancing educational and professional opportunities for GPs in rural and remote areas and providing both practical and financial assistance in procuring locums. In the guidelines for these grants, the

Federal Department of Health and Family Services cites research which has 'suggested there is a link between retention and the access to relief for maintaining skills and having leave' (General Practice Rural Incentives Program 1995).

Rural Divisions Co-ordinating Units: Current and future workforce roles

Workforce issues have become increasingly relevant to the functions of the rural divisions and of RDCUs. In part, this has occurred as the roles of the RDCUs have matured and developed beyond their basic establishment phase. Through the application of General Practice Rural Incentives Program funds (known as the Continuing Medical Education/Locum Grants), RDCUs have demonstrated an ability to use their coordinating role to address workforce issues facing the profession of general practice. In some States, RDCUs use all of these funds to coordinate statewide workforce strategies which address both locum and continuing medical education issues and also provide practical and financial assistance to doctors requiring relief. In other States (for example, New South Wales) the RDCU devolves a proportion of the central funding to individual divisions to coordinate local workforce strategies such as continuing medical education events and the procurement of locums. At the national level, RDCUs meet regularly, sharing experiences and learning from one another. Much of this has occurred through the network of RDCUs called the Australian Rural Divisions. The way in which the General Practice Rural Incentives Program is delivered by RDCUs, and the strategies employed, vary across the States and are, to a large extent, a result of inter-state differences, history and numbers of rural divisions.

RDCUs use the divisional framework in each State to implement and coordinate statewide workforce strategies. These include locum schemes which deliver locums to GPs in need, arrange urban/rural 'swaps' and develop and coordinate publicity and advertising to attract more doctors to rural areas. On the continuing medical education side, the strategies include investigation and implementation of the application of information technology to deliver education to doctors in rural and remote areas and the organisation of continuing medical education meetings, workshops and practical upskilling courses. The grants also provide subsidies for GPs in rural and remote areas to contract with locums and attend continuing medical education events. In many cases, individual rural divisions are also attracting locums through urban divisions with whom they are establishing positive relationships. A commonly expressed

view is that there will be opportunities for urban and rural divisions to work together to address GP workforce issues once the new State structures are established (Department of Health and Family Services 1997).

In 1996 Mandala Consulting Pty Ltd was contracted by the Department of Health and Family Services to undertake a review of all RDCUs and to evaluate the extent to which the objectives of the RDCUs had been efficiently and effectively implemented. The consultants undertook a survey of divisions regarding their views on the effectiveness of RDCUs. Divisions cited the coordinating of continuing medical education and locum services under the General Practice Rural Incentives Program as a key area of satisfaction in this survey (Cotton & Worley 1996).

Mandala Consulting Pty Ltd concluded that there was potential for an expanded workforce role for RDCUs by facilitating a concerted, coordinated and efficient approach to issues of common concern, including recruiting, retaining and supporting GPs in rural and remote areas of Australia. These strategies include initiatives such as those which involve upskilling, mentor programs and working with Rural Medical Family Networks. The consultants further recommended that this could be undertaken by:

- administering the General Practice Rural Incentives Program Support and Assessment Panels (for relocation, training and remote area grants)
- identifying and targeting rural communities in need of GPs
- liaising with community representatives, consumers and providers
- monitoring movements within the rural medical workforce.

Both Mandala Consulting Pty Ltd (Cotton & Worley 1996) and the General Practice Branch of the Federal Department of Health and Family Services (1997) have acknowledged the important interface between the General Practice Rural Incentives Program and the Divisions and Project Grants Program which is now being enhanced by the RDCUs, specifically through the application of the Continuing Medical Education/Locum Grant funds (Cotton & Worley 1996).

Workforce strategies: Coordination and communication

One of the great strengths of divisions and RDCUs has been their ability to coordinate communication and activities. Effective coordination involves the existence of open, two-way communication channels. At the local level, rural divisions facilitate communication between GPs. This is brought about through divisional newsletters, meetings, educational events and teleconferences. Many

GPs, who previously felt isolated, now have a sense of belonging to a local network of GPs called a Division of General Practice.

At the State level, RDCUs facilitate communication across rural divisions. This occurs both vertically and horizontally. Rural divisions communicate (vertically) with their RDCU, which provides resources, support and advocacy. The divisions communicate (horizontally) with each other as a result of the communication network developed by the RDCU. This also occurs through newsletters, meetings, workshops, educational events and various forms of electronic communication.

Coordination is a strength of the RDCUs and this strength is now being applied (through the Continuing Medical Education/Locum Grants) to effectively address GP workforce issues. Over time, this may have a ripple effect, expanding to other areas of the medical workforce. In addition, because of the part that they are now playing in workforce issues, RDCUs are becoming more proactive in participating in other workforce strategies and initiatives such as those involving high school students, medical undergraduates, local governments and community organisations. This occurs, for example, in New South Wales in conjunction with the Rural Doctors Resource Network (1997).

Conclusion

The critical shortage of doctors in rural and remote areas of Australia is often described as a 'workforce crisis'. Rural divisions have taken up the challenge of coordinating networks of GPs working in diverse rural and remote communities. Coordination has become one of the strengths of rural divisions and RDCUs. Their next challenge will be in relation to the way in which they can use this capacity and work with their local communities to address the important issues of recruitment and retention for the GP workforce in rural and remote areas of Australia.

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