The Role of GPDV in General Practice Workforce Issues

Final Report

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1. THE GPDV WORKFORCE PROJECT

The Report of the Review of the GP Strategy in 1998 identifies GP workforce issues as a priority for Divisions of General Practice and for State-Based Organisations (SBOs) of Divisions. The Report proposed a role for SBOs in the development of policy on workforce issues, in the collection and analysis of GP workforce data and in collaboration with state and national bodies engaged in workforce planning.

For some time GPDV has been considering how best to take up this proposal and had contemplated employment of a workforce officer whose responsibility would be to implement the role, but it was unclear what the position would actually be responsible for. Some of the lack of clarity related to the role of the Rural Workforce Agency in Victoria (RWAV) which was charged with the responsibility for addressing workforce issues, specifically recruitment and retention of General Practitioners in rural areas. Moreover, rural divisions have been specifically funded for workforce positions which were also intended to address the recruitment and retention of general practitioners in their Divisional areas.

Finally, in early 2001 GPDV contracted The Resolutions Group P/L to work with the State Based Organisation (SBO) to determine its future role regarding workforce issues. The project brief states :

Specifically, the project has been designed to provide :

- **An analysis of opportunities for GPDV to make a valued contribution to GP workforce issues;**
- **Recommendations about roles GPDV should take up in GP workforce issues accompanied by clear indications of stakeholder agreement to such roles;**
- **A workplan of activities to support member divisions in responding to GP workforce issues that could be implemented through GPDV's strategic and business plans over the next three years.**

This final report documents those areas in which GPDV can make a valued contribution to GP workforce issues and details the activities which are most appropriate for the SBO to undertake over the next three years.

The process used throughout the project was planned to ensure that the final recommendations were supported by the various stakeholders. However, it is important to note that while this report recommends to GPDV a number of agreed areas and activities, the final decision about implementation of activities will need to be made as part of GPDV's overall planning. It is likely that when the organisation reviews all of its anticipated work, that some of these areas will pale in significance compared with GPDV's other responsibilities.

2. THE PROJECT PROCESS

The whole project process was designed to be as inclusive as possible of stakeholders. A letter was circulated to all Divisions and other stakeholders. This described the purpose of the project, the proposed methodology and invited Divisions and others to register their interest in being interviewed by the project consultants.

A Project Reference Group comprising representatives from stakeholder groups was established and met twice during the project to review the draft consultation paper and the final report. Most Reference Group members were also interviewed individually during the project. Reference Group members were :

Tony Webb, Executive Officer, RWAV

Dr John Stanton, Manager, GP Unit, DHS

Dr Jill Grogan, Vic Urban rep on ADGP board & ADGP rep on AMWAC, ADGP

Edwina Mason, Manager Workforce Policy, DHS

Karen Large, Assistant Director Primary Health, DH&AC

Annabelle Thorpe, Assistant Director Rural Health, DH&AC

Dr Jeff Jenkinson, Rural GP, WestVic Div

Dr Tali Barrett, Rural GP, Bendigo Div

Dr Chris Watts, Metro GP, Westgate Div

Dr Michael Cross, Metro GP, Mornington Division

A wide range of relevant documentation was collected and read and interviews were conducted with a range of people from the following Divisions which expressed interest in the project..

- Border Division
- Central Highlands Division
- Inner East Melbourne Division
- Knox Division
- Murray Plains Division
- North East Victoria Division
- Westgate Division
- West Vic Division

A consultation paper designed to provide stakeholders with a framework for consideration of the role of GPDV in workforce issues was developed following this work. It was emailed and posted to all Divisions, the Reference Group and GPDV Board members who were all invited to participate in one of two consultation forums held in June to canvass their views.

Readers of the paper were asked to consider the following questions which were discussed at the forums.

- Are the four main topics outlined in section three of this paper capturing the key workforce issues which GPDV should address in the next three years?
- What are the relative priorities among the issues?
- What activities should GPDV use to address each of the issues?
- Who/what other organisation/s needs to be involved in each activity?

Those people unable to participate in the forums were invited to contact the consultants for a question sheet.

There was lively discussion at both forums with participants expanding on the background of and supporting each of the issues discussed and occasionally proposing some further activities.

This report was developed following the consultations and addresses the topics developed through the project. It is important to reiterate that while the areas recommended in this paper are those in which GPDV can make a valued contribution, their importance must be considered as part of the overall responsibilities of GPDV.

3. DILEMMAS ADDRESSED DURING THE PROJECT

3.1 THE TERM 'WORKFORCE ISSUES'

The term 'workforce' is itself problematic. For many people 'workforce issues' have been equated with the shortage of General Practitioners in rural areas of Victoria. This is largely because the specially funded programs with the 'workforce' title are all around the attraction, recruitment and retention of GPs in rural areas. In fact, one consultation forum participant commented that the paper provided a much broader view of workforce issues than the previously held one which really only encompassed the role of the rural division workforce officer.

On the other hand, a broad view of the term workforce issues can encompass a whole range of areas including the preparation for and quality of clinical practice, training, support and supervision, remuneration as well as career development, lifestyle and health of GPs and the numbers and availability of GPs to provide adequate services within various communities including provincial cities, the fringe and areas of lower economic status in metropolitan areas. Aspects of many of these areas are already addressed by GPDV as part of their (support) role, but they have never been thought of or termed 'workforce' issues. Other aspects are more appropriately addressed by other organisations. Examples of these are clinical practice and remuneration of GPs.

It was determined that the areas which would be considered for the project were those which relate to :

- **the structure and function of General Practices and**
- **the distribution of General Practice services in Victoria.**

It was also agreed that the generic term 'workforce issues' would be used as little as possible and that the areas chosen would be named specifically.

3.2. THE RESPECTIVE ROLES OF GPDV AND RWAV

Exploring the role of GPDV in addressing workforce issues is complicated by the existence of another organisation with the term workforce in its title – the Rural Workforce Agency of Victoria (RWAV). It is important to clarify that **the primary role and mission of GPD-V as a State Based Organisation (SBO) and the peak body for all the 31 Victorian Divisions of General Practice**, is to provide support, to develop policy and to represent and advocate for divisions and for general practice. On the other hand, *RWAV's core responsibility is the recruitment and retention of rural GPs and supporting health professionals…(*The Memorandum of Understanding between GPDV and RWAV 2001)

Clearly GPDV has a role and responsibility with all Divisions of General Practice. Because RWAV has a responsibility for a range of areas specifically with rural agencies it does not follow, as some might suggest, that GPDV should undertake the role of the urban workforce agency.

While the roles of the two organisations may overlap on occasion, the rural Divisions interviewed for this project commented on the importance of clarification of the respective roles and the resulting evidence that the two organisations developed strategies to avoid duplication. Where forums or education sessions are being conducted by one organisation for example, Divisions suggested that it would make sense that they were discussed and perhaps promoted by the other, if not conducted jointly, and that time be organised within the session to address any specific urban/rural issues. Some noted that the more recent format for CEO meetings conducted by GPDV provided an excellent example of this.

3.2.1 MEMORANDUM OF UNDERSTANDING BETWEEN GPDV AND RWAV

The Memorandum of Understanding which has recently been agreed by both GPDV and RWAV provides a mechanism to address many of the current concerns of duplication and boundaries for the two organisations. Discussion will need to continue when GPDV moves to implement the activities suggested to address the various issues outlined below.

4. PROJECT FINDINGS AND RECOMMENDED ACTIVITIES

The following issues have been identified through the work of the project – review of documentation and discussions with the Divisions consulted, the project reference group, members of other SBOs, GPDV staff and participants of the two consultation forums.

All the issues relate to the structure and function of General Practices and the distribution of General Practice services in Victoria. Critical to successful implementation of any of the activities is effective communication and planning with a range of organisations. RWAV and ADGP are two of the most important to consider for the following issues.

4.1. SUPPORTING SYSTEM CHANGES IN GENERAL PRACTICE

The effectiveness of systems and roles within any businesses and organisations can benefit from review and adjustment. General Practice likewise can benefit from the opportunity to challenge the assumptions on which many of the current practices are based and explore new ways of addressing old problems. Such assumptions which are relevant to the structure and function of General Practices relate to :

- models of employment of GPs within general practices, and
- the roles of other staff and nurses in particular within general practice.

4.1.1 PROMOTING NEW MODELS OF EMPLOYMENT OF GPS WITHIN GENERAL PRACTICES

During the consultations for this project, some Divisions commented on GPDV providing a valuable role in leading the debate around the roles and relationships possible for GPs in general practice. They noted that apparent shortages of GPs in particular areas can sometimes be addressed by developing new ways of structuring the work of the GP within General Practices to be more interesting, enticing and perhaps more lucrative. Consultation participants also noted that varying and innovative models of employing locums and assistants are also difficult to find and General Practitioners often have little assistance in determining the most effective employment options. They commented that GPDVs statewide overview provided them with the opportunity to explore different models of employment and ways to collect data to assist in future Practice planning, and then to raise the issues as a statewide discussion, rather than providing a focus within one particular Division.

The ADGP General Practice Business Advantage Program (GPBA) provides some opportunities to explore business structures and systems for General Practice and the program continues to be "rolled out" across Victoria. GPDV staff are employed in this program as facilitators but the content and guidelines for the program are the ADGP responsibility. While numbers of people spoke highly of the program, concerns were raised about the limited role which Divisions

currently play in the program and it was suggested that there were possibly ways in which the program could be adapted to allow for the Divisions to build on the program to enable sustainable outcomes for the whole Division.

Some rural Divisions also commented that the GPBA could not be run in their areas because of the numbers required to actually run a program. The General Practitioners in these Divisional areas then missed out on the opportunities provided by the program. However, participants in the consultations suggested that GPDV should be proactive in describing for all Divisions, the effective ways other Divisions had addressed this concern

Possible plan for GPDV to address this issue

Goal : Supporting System Change in General Practice

Strategy : Promote new models of employment of GPs within General Practices

Activities :

1. (Liaise with RWAV to) identify and review the pros and cons of a range of (GP) associate, assistant and locum employment models, and develop a set of resources for Divisions to use in working with their Practices about the most appropriate employment models for their circumstances.

2. Review and document the ways the *General Practice Business Advantage* Program could be enhanced from a Victorian Divisional perspective and represent these issues to ADGP and to the Divisions.

4.1.2 ENHANCING THE ROLE OF THE PRACTICE NURSE

Discussion with different groups, including the Project Reference Group, around the issues of apparent GP workforce shortage, particularly in some areas, led to the question : "Is provision of more GPs the answer?" Are there other models where the GP can be enabled to focus on the work that is the province of the GP alone, while the work which is not the specific requirement of GPs can be undertaken by others? That is, checking the assumption of a GP workforce shortage by reviewing the work of the GP and others within the general practice.

The role of nurses within the General Practice has been the main area which has been explored to date in addressing this issue. Work has been undertaken and models developed in the Monash Division in response to the Enhanced Primary Care items, in Hospital GP Liaison Projects, within Coordinated Care Trials and some models such as that in Central Highlands Division funded for sustainable General Practice. Furthermore, the Ballarat Division has been addressing this issue as part of its role in the Building on Quality Project in which it is participating. The

recent Federal Budget has provided a further impetus regarding the role of nurses in General Practice and there is likely to be some financial support to develop the role, particularly for rural and low socio economic and fringe metropolitan Divisions.

Participants of the forums discussing the consultation paper prepared for this project suggested that GPDV's role was to encourage debate about the role of practice nurses using the models available to stimulate the debate and engage the different stakeholders. Of particular note was the need to show how the practice nurse's role might be enhanced and to address the financial and insurance implications for the Practice of such a changed role. The groups reiterated how it was important for GDV to assist Divisions to share good models across Divisions in order to prevent the duplication of effort which can be a feature of the Victorian Divisional landscape.

The role of the Divisions in supporting the General Practice Nurses was discussed quite extensively and it was suggested that GPDV could usefully assist Divisions in developing strategies to provide the support. This may be in encouraging and assisting Divisions in the planning and facilitation of the Practice Staff Networks which have been developed across the state.

Finally, there was some discussion about the role GPDV should play in encouraging the Australian Nurses' Federation and the tertiary institutions to provide accredited training for the General Practice Nurse.

Possible plan for GPDV to address this issue

Goal : Supporting System Change in General Practice

Strategy : Enhancing the role of the practice nurse

Activities :

1. Promote effective models of practice nurse roles. Document and disseminate the processes and (business) advantages of recent model projects, such as the Innovations Pool funded project that demonstrates enhanced practice capacity where practice nurses implement EPC items.

2. Continue to negotiate with DHS to trial models of nurse positions in practices that link to Primary Care Reform. The aim will be to evaluate the models, document and disseminate the learnings through the Divisions, again to promote creative quality models of effective role and systems organisation.

3. In collaboration with RWAV, develop and disseminate strategies which Divisions can use to provide support to General Practice Nurses in their enhanced role.

4. Initiate discussions with the College of Nursing, DHS and relevant tertiary institutions to encourage development of accredited specialised training for General Practice Nurses.

4.2. ACCESS TO GENERAL PRACTICE SERVICES

"Access" to any services is dependent on the availability of an appropriate service at an appropriate time within a realistic distance. The issue of access to general practice services within a realistic distance has been a key focus of Commonwealth Government policy and has led to the initiatives which the Commonwealth has funded through Divisions and state Rural Workforce Agencies to attract, recruit and retain General Practitioners in rural areas. The PIP payments for provision of After hours Services by General Practices have been designed to address the timeliness of service access.

The issue of access is a workforce issue because it has to do with the types of services provided by the GP workforce, and the availability and distribution of General Practitioners across Victoria, in this case.

While General Practitioners may choose to set up their practices in locations which they prefer, the Commonwealth Government has a responsibility to provide health services to the whole population. Hence, the Commonwealth policy and funding decisions seek to provide mechanisms which encourage the General Practitioner workforce to address the gaps.

While the Commonwealth Government and its various advisory committees have the authority and responsibility in this area, there are some issues which relate to the responsibility of Divisions and hence to GPDV. These relate to :

- the adequacy of the (Victorian) data on which the Commonwealth is basing its decisions;
- issues which are taken into account when determining the numbers (of GPs) required to provide adequate services to a specified population, and
- the timeliness of service availability.

4.2.1. DATA

In order to make appropriate decisions about workforce issues, it is important that the data on which the analysis and management is based is comprehensive and accurate.

There are different databases used for different reasons but all have significant limitations. Of course, the purpose for which the data is collected affects the accuracy of the data for use for other purposes. A listing of many of these databases, their sources, uses and limitations has been developed for this project and is provided as Attachment One.

The State and Territory Rural Workforce Agencies have recently agreed on a minimum dataset and a common set of definitions which will conform with ABS national definitions of full time work, for example. RWAV is currently developing a survey tool which will be piloted prior to sending the survey to all Victorian rural GPs. RWAV will complete the sections of the database with responses based on RWAV's current data, inviting GPs to correct these and complete the other areas. Divisions will be involved in this process to some extent. RWAV must report to the Commonwealth on this minimum dataset by December 31, 2001 as part of the Commonwealth's development of workforce plan for rural Victoria.

Most Divisions collect data about their GPs and can provide a GP profile for their area. However, there have not been any guidelines which would encourage the same data to be collected across the state and so the information collected may not be comparable. It is understood that the South Australian SBO has developed a database which enables similar information to be collected by Divisions and that some Victorian Divisions are currently using this.

Each year all General Practitioners are required to complete an annual registration for the Medical Practitioner's Board. A survey is also to be completed at this time, but completion is not compulsory. The information, however, is used in medical workforce planning by the Commonwealth, even though many acknowledge deficiencies in this data. As the Victorian Medical Practitioner's Act is currently being amended, there is an excellent opportunity for encouraging the Board to be proactive on this issue.

As the Commonwealth (DHAC) is the body which has the authority to make funding decisions in relation to most workforce issues, the issue of which data they will use lies within their bailiwick. However, if Divisions and SBOs are concerned that the data on which decisions are based are not accurate nor adequate, then they have a role in advocating to the decision makers on this issue and in determining the type of data which will be adequate and accurate.

Possible plan for GPDV to address this issue

Goal : Increasing access to General Practice Services

Strategy : Promote the development and use of data which provides a true picture of General Practitioner characteristics and distribution in Victoria.

Activities

1. Represent the issues about adequacy of the data generated from the annual registration process of the Medical Practitioners Board, in responding to the discussion papers currently being circulated about the Medical Practice Act.

2. Research and prepare a paper about the adequacy of and requirements for GP workforce data in Victoria. This paper will be used to provide the collated background information to stimulate discussions with the other SBOs, RWAV, DHS, ACCRM, ADGP, RACGP and DHAC about :
   - the data which will provide the most accurate and comprehensive information for GP workforce analysis and management,
   - how the data will be used, and
   - avenues for collection of the data.

3. Undertake a representation and advocacy role for Divisions about data requirements and the data used in GP workforce planning.

4. Meet with RWAV to consider ways by which the Rural Workforce Agency minimum dataset might be extended across all Divisional areas.

4.2.2. A NEEDS INDEX

Planning decisions about areas of need and appropriate distribution of GP services are largely based currently on parameters of rurality through use of the Rural, Remote and Metropolitan Areas Classification system (RRMA).

This index, used to determine "remoteness", takes into account distance factors (distance from a point in the SLA to the nearest urban centre of a different size) as well as a personal distance factor which relates to population density i.e. the average distance between residents.

RRMA identifies 7 categories

Number	Category
1	Metropolitan – Capital city (statistical division)
2	Metropolitan – other centres
3	Large rural centres
4	Small rural centres
5	Other rural areas
6	Remote centre
7	Other remote centre

Divisions within RRMAs 4 – 7 are provided with a range of funded programs designed to assist them to recruit and retain GPs in their divisional areas to provide general practice services. Some Divisions cover areas which include some RRMA 1 – 3 areas and in most cases they are expected to differentiate in their use of program funding.

In March 1999, the Department of Health and Aged Care Occasional Papers Series No. 6 entitled Accessibility/Remoteness Index of Australia (ARIA) was published. This was proposing a different index (ARIA) which *was designed to be an unambiguously geographical approach to defining remoteness. Socio-economic, urban/rural and population size factors are excluded.*

This ARIA index is currently being used as one component in the implementation of the Medical Specialists' Outreach Assistance Program. However, it is unclear at this stage whether this particular index may be used in future planning about GP workforce distribution, but it is important to note that it is an index which is based solely around geography. Section 5.2 of the paper notes :

The point here is not that socioeconomic factors should not be taken into account in studies of accessibility to individual services. Indeed they should be taken into account in such studies. However it would seem that a general index or classification of remoteness would be more suitable for a wide variety of applications if unambiguously based on the distance people from an area have to travel to obtain services. Since it is recognised that people will differ in their ability to meet these costs, program interventions should target groups as well as areas.

Some Divisions consulted in the course of this project, and especially those on the outer fringe of the metropolitan area and those in areas of low socio economic status argued that there was a lack of general practice services in their areas too, but that because their Divisions fell within the (supposedly) well resourced metropolitan areas, that the lack of GPs was not recognised. One Divisional representative noted that *: AMWAC states repeatedly that high bulk-billing rates are indicative of GP OVERSUPPLY, but our Division has high bulk-billing rates with a GP UNDERSUPPLY. The high bulk-billing Divisions are all in the western and northern suburbs, so maybe it has to do with the socio-economic status of our patients. The west DOES have lower SES and worse mortality and morbidity statistics than the eastern and southern suburbs, but whether this is the only factor is difficult to know.*

Clearly the index, or criteria for determining programs for encouraging appropriate distribution of the GP workforce is an important one. There is often confusion between Commonwealth and State responsibilities and discussions about Areas of Need and Districts of Workforce Shortage. Again it is an issue which is the province of DHAC and its advisory bodies, but it is also an issue which is of importance to a number of Victorian Divisions.

Currently, there appears not to be an organisation other than GPDV which would be the right one for Divisions to approach with such issues.

Possible plan for GPDV to address this issue

Goal : Increasing access to General Practice Services

Strategy : Advocate for development of a measure to underpin GP workforce analysis, which takes account of socio economic factors, age of patients and other health related factors as well as remoteness from general services.

Activities :

1. Prepare a policy paper which discusses the adequacy of the current indices and provides the rationale for use of a new measure, such as a Primary Care Needs Index, considering the pros and cons of its use.

2. Facilitate some (informed) discussions with DHS, other key stakeholders and tertiary institutions about the criteria used to determine needs and share the ideas generated with Divisions.

4.2. 3 AFTER HOURS SERVICES

Provision of After Hours Services – any time outside 8.00 am to 6.00 pm weekdays and 8.00 am to 12.00 noon on Saturdays - is the key aspect addressing the timeliness of access to general practice services. It has been of concern for some time, being addressed in recent years by a range of program developments - as an essential eligibility criterion for GP Recognition, Practice Accreditation and the General Practice Incentive Program (PIP).

In December 2000, the AMA produced a paper entitled 'Out of Hours Primary Care Discussion Paper' which notes that while they agree with the 1996 RACGP Presidential Task Force definition of general practice as 'medical practice that offers primary, continuing, comprehensive whole-person care for individuals, families and communities', it is unreasonable to expect any doctor to be available 24 hours a day. The paper continues, *The AMA interprets the RACGP definition to mean that GPs have a responsibility to ensure that their patients have access to appropriate primary medical care when they themselves are not available. Responsibility includes the establishment of systems to ensure the treating doctor maintains an active involvement in that continuous care.*

General practitioners and their practices have an ethical and professional obligation to provide both continuous access to appropriate care and continuity of care for patients who choose to engage them in their care.

While there is agreement about the need for after hours services, there are numerous barriers preventing the adequate provision in both rural and metropolitan areas. Many of these have been noted in the AMA Discussion Paper and elsewhere. There is a range of models currently being used in after hours services and some initiatives have been specially funded by DHAC as pilot programs in Australia, with one conducted by the WestVic Division in Victoria. The learnings from these pilot programs need to be promoted to other Divisions and General Practices. The recent Commonwealth Budget has provided for quite a sizable expansion of the

After Hours Projects and GPDV, like all SBOs will receive funding from the Commonwealth to employ an After Hours Program Officer.

Any developments of After Hours Programs modelled on the WestVic Division Project for example, will have long term implications for nurse training in general as the role of the primary care nurse is substantially enhanced.

Possible plan for GPDV to address this issue

Goal : Increasing access to General Practice Services

Strategy : Review provision of After Hours General Practice Services and develop strategies for Divisions to increase after hours access for the community.

Activities :

1. (Work with Divisions) to 'audit' the existing after hours service arrangements, identifying both the systems which are working well and clarifying the barriers which exist in Victoria. Some collaboration with RWAV will be useful in developing the audit process as RWAV's draft strategic plan identifies 'promoting innovative models of after hours services' in rural areas.

2. Identify the range of models of after hours primary medical care service provision across the rest of Australia, noting where these models address the barriers which have been identified in particular areas, and disseminate the outcomes of this research to Divisions, working with them to address their local barriers more effectively. Note, this will include identification and promotion of initiatives and opportunities for collaboration with hospitals in the provision of after hours primary medical care.

4.2.4 GENERAL PRACTITIONER SHORTAGES IN LOW SOCIO ECONOMIC, PROVINCIAL TOWNS AND FRINGE METROPOLITAN AREAS

Numbers of those interviewed reported that there are shortages of General Practitioner services in outer areas of the cities which are sometimes lower socio economic areas as well as in provincial towns. While these areas are not considered sufficiently lacking in General Practitioner services to warrant extra Divisional funding for addressing these issues as in rural areas, many Divisions reported the issue as very concerning. While support of Divisions for the recruitment and retention of rural GPs is clearly the responsibility of RWAV, it may be possible for some of the strategies used in rural Divisions to be shared through GPDV to assist the Divisions with GP workforce shortages in their development of creative recruitment strategies.

A further issue in many of the fringe metropolitan Divisions is the limited availability of GPs who are skilled in addressing the language and cultural issues which are relevant to many of the patients in these areas.

Possible plan for GPDV to address this issue

Goal : Increasing access to General Practice Services

Strategy : Assist Divisions with General Practitioner recruitment and retention strategies to address shortages in low socio economic, provincial towns and fringe metropolitan areas.

Activities :

1. (Work with RWAV to) facilitate a sharing of the recruitment and retention strategies developed by the workforce staff of rural Divisions with the Divisions which have General Practitioner shortages.

4.3. PREPARING GENERAL PRACTICE AND GPS FOR THE FUTURE

During the consultations undertaken for the project, there was a significant amount of time devoted to expectations of GPs held by GPs about time commitment, sessional choices and role in practice management. "Real" GPs were thought by some to be those who made a commitment to work full time as a GP in their practice, while others commented on realistic choices which many GPs make about their time committed to their GP work, to other work and to other aspects of their lives. Some of this speculation was focused on the increasing proportion of female GPs.

The community has changing expectations of their health services, expecting them to be as available as other services and there appears to be an increasing demand for requests for female GPs to provide services. On the other hand, many GPs are making lifestyle and family-friendly choices about their careers. Differing sets of expectations around the GP workforce create some tensions within practices currently, between GPs generally and will need to be considered as General Practice develops in this century.

Exploration of the range of expectations within the current and new GP workforce will allow people to consider strategies to address some of the emerging tensions. It is also possible that the outcomes of this exploration will provide materials which will influence future decisions about the General Practice Program.

Moreover, numbers of GPs themselves have commented that their work has not changed over the years. Some are keen to utilise their skills in different ways, perhaps developing a specialty area or exploring different sets of activities which may still be within the general practice ambit.

The Divisional program has provided extensive assistance to GPs in adopting the new information technologies for information management and this has enabled GPs to be at the forefront of health practitioners in adapting to the world of information technology. Moreover, the Divisional program has provided and is providing opportunities for the GP workforce to vary their roles beyond direct patient care. While this opportunity has been seized by many, there are many others who could well find their work is enhanced through further involvement in the

program, especially if they feel well supported in these different roles. During the consultations, people commented on the range of possibilities of working with Divisions and commented on the value of the orientation they had received from GPDV. There were some suggestions that GPDV could further this support by "training" GPs in some of their Divisional roles, such as that of Program Adviser. It is understood that ADGP is developing some further training initiatives for GPs in these roles, so GPDV may be able to utilise these.

Possible plan for GPDV to address this issue

Goal : Preparing General Practice and GPs for the Future

Strategy : Assist Divisions to address issues of change for General Practice and General Practitioners .

Activities :

1. Facilitate collation of existing work and encourage research on expectations of male and female GPs of different age groups about their work and lifestyle.

2. Support Divisions to utilise the outcomes of this research with their General Practitioners. Programs such as GPBA also provide an avenue for inclusion of these materials.

3. Facilitate research into the directions of community expectations about health services and General Practice in particular, and again include discussions of these expectations in various programs as in Activity 2.

4. Where appropriate, represent the issues relevant to the future shaping of the GP workforce to ADGP and the other bodies in which GPDV participates.

5. Explore the various Divisional roles undertaken by GPs and utilise appropriate (training) modules to support GPs in these varied and often new roles. (Note, such roles will include GPs as Program Directors and GPs as research managers.)

4.4. RESPONDING TO EMERGING WORKFORCE ISSUES

Because of its participation in key national and statewide organisations, its liaison with the Department of Human Services, and its relationship with the various Universities where relevant research is being undertaken, GPDV is well placed to be alert to emerging workforce issues. Moreover, in order to have a genuine influence on policy developed at Commonwealth and other levels, Divisions need to be aware that an issue is one they need to know and think about, and they need relevant data to assist them to position themselves, prior to participation in any larger decision-making forums. This may mean that GPDV needs to alert Divisions to the reasons they should "take notice" of an issue well before it becomes commonly talked about and addressed, which is often at a time when decision making is well down the track. One of the consultation forum participants described this as "helping Divisions to interpret the fog and to prioritise

issues to be addressed". It will also mean that GPDV needs to be clear about the criteria for choice of the issues they will address in this way, so they are able to set priorities among competing issues of relevance for themselves.

The issues of Corporatisation and Regionalised Training exemplify this. It was apparent at the recent GPDV conference that 'Corporatisation' is an issue which has been of concern to both Divisions and GPs themselves, but because it was 'new', it was not likely to have been included as a special issue in GPDV's strategic plan even eighteen months ago. However, GPDV has undertaken some work on the issue, explaining the issue for Divisions and circulating a policy paper which was very well received by many Divisions. This type of proactive approach to an emerging issue was noted by many Divisions consulted as one they valued. It would also have been helpful if GPDV had been able to take a lead in encouraging Divisions soon after the regionalised training proposals were mooted, to discuss the Divisional role in participating in and developing the proposal in their regions, encouraging Divisions to be "on the front foot" rather than just responding to what for some, may have been a fait accompli.

4.4.1 CRITERIA FOR SELECTING ISSUES FOR GPDV TO ADDRESS

In order to ascertain whether or not a particular (emerging) workforce issue is one which GPDV should address, it will be useful to apply the criteria chosen for this project. The questions will then be :

- **Does this issue affect the structure and function of General Practice and/or the distribution of General Practice services in Victoria?**
- **Do Divisions have some role to play regarding this issue?**
- **Does the issue have statewide implications?**
- **Is GPDV or another organisation more appropriate to deal with this issue?**
- **If another organisation is most appropriate, is there a role for GPDV to facilitate their participation in the issue?**

If the answers to these questions are positive, then it will be beholden for GPDV to address the issue in some way.

Possible plan for GPDV to address these issues

Goal : Responding to emerging workforce issues

Strategy : Implement strategies to alert Divisions to emerging (workforce) issues and be proactive in addressing the issues.

Activities :

1. Implement GPDV's usual strategies to address the different issues. These will comprise :
   - Undertaking some research to provide an explanation of the issue;
   - Preparing materials for consideration by the Divisions, either at their own meetings and/or at a meeting specially convened to discuss the issue,
   - Preparation and circulation of a GPDV policy and/or position paper;
   - Providing information through the newsletter and weekly information fax sent to all Divisions,
   - Utilising an email discussion group;
   - Use of Quarterly Forums; and
   - Rural and metropolitan teleconferences.

5. PRIORITIES & CONCLUSION

There are numerous ways in which an SBO can support Divisions to address the structure and function of General Practice and the distribution of General Practice Services. Many of the relevant activities may be "picked up" through the regular work of the SBO, but it will be necessary for the organisation to determine the priority of the other issues and the choice of activities to address them. A quick vote amongst the Reference Group members suggested that the priority issues for GPDV to address should be 4.2.1 Data, followed by 4.1.2 Enhancing the role of the practice nurse and then 4.1.1 Promoting new models of employment of GPs within General Practice. 4.2.3 After Hours Services will be picked up immediately through the funding provided by the Commonwealth to the SBOs for a dedicated position.

As noted earlier however, critical to successful implementation of any of the activities is effective communication and planning with a range of organisations. RWAV and ADGP are two of the most important to consider for the issues which have been discussed in this paper.

ATTACHMENT ONE: AVAILABILITY OF DATA ON THE VICTORIAN GP WORKFORCE

Reliable, accurate and up to date data about the workforce profile of GPs in Victoria is required to develop a 'true' picture of the Victorian GP workforce.

Listed below are data collections which include information about the Medical Workforce in Victoria.

1. Annual Medical Labour Force Survey Reports

Data Source:

- An annual labour force survey of all medical practitioners renewing medical registration in Victoria. Medical practitioners do not have to respond to the survey component of the registration.

Data Uses:

- Maintaining a minimum national data set of key baseline medical workforce information for national planning

Data Limitations:

- An average response rate of 80%-90% is usually obtained.
- Local area estimates are generally unreliable as response rates vary greatly between regions.

The AIHW is an independent health and welfare statistics and information agency in the Commonwealth and Family Services portfolio. The AIHW produce the Australian Medical Labor Force Report annually. The data for this report is obtained from the annual national medical labor force survey in conjunction with registration of medical practitioners. The Medical Registration Boards send the questionnaire to medical practitioners.

Information collected by the AIHW medical labour force survey includes respondent age, gender, qualifications, discipline of practice, hours worked, work status and employment setting. The data is collected for all registered medical practitioners including those not in the labour force. An average response rate of 80%-90% is usually obtained.

While the Reports provide good estimates for the States, local areas estimates are generally unreliable.

2. General Practice Activity Survey

Data Source:

- Approximately 100,000 patient encounter records from 1,000 GPs.

Data Uses:

- Develop a picture of GP consultations in Australia

Data Limitations:

- The sample size limits geographic desegregation of the data.

The Bettering the Evaluation and Care of Health (BEACH) survey began in 1998 and collects approximately 100,000 patient encounter records from 1,000 GPs in Australia. The GPs volunteer to participate in the survey. The survey collects information about the content of patient consultations.

3. Medicare Provider Database

Commonwealth Department of Health and Aged Care

Data Source:

- Medicare data on Medicare providers. The data is obtained from the Health Insurance Commission by Commonwealth Department of Health & Aged Care

Data Uses:

- Measures the number and volume of activity of medical practitioners in Australia.

Data Limitations:

- Medicare data cannot distinguish among type of doctor from other medical practitioners (OMP). The data does not identify how many GPs are in other fields such as sports medicine and how many are GPs who do not have vocational registration.
- Hours of work is not collected therefore Medicare income is used as a basis for determining whether a GP is practicing full-time or part-time
- Some of the GPs who are counted as Medicare providers render less than 50 Medicare services in a three month period.
- VMOs are not included in the Medicare data.

Medicare statistics include all practitioners who have billed the Health Insurance Commission for at least one Medicare service during a financial year.

The Commonwealth Department of Health and Aged Care classifies head count of doctors to full-time, part-time and casual categories, on the basis of the Medicare Benefits Scheme fee value of services processed by the Health Insurance Commission in a 12 month period. Hours of work are not collated, Medicare income is used as a proxy to distinguish between full time and part time. For 1998-199 the values used are:

- Casual up to and including $18,017;
- Part-time is $18,018 to $73,240
- Full-time is $73,241 or more.

4. Health WIZ data base (Prometeus Information Pty Ltd)
Division of General Practice data sets (of HIC data) are published in the Health WIZ data base.

Data Source:
- Medicare data, Department of Veterans Affairs data for services provided by GPs and ABS population data.

Data Uses:
- Provides numbers and distribution of GPs to Divisional level

Data Limitations:

- Currency of information - the most current data available from Health WIZ is for 1998/1999.

The definitions used by the Health WIZ for determining GP workforce participation are:
- Full time Equivalent (FTE): the people doing full time work; and
- Full time workload equivalent (FWE) which is the GP workload.

Therefore according to this database one GP could work 80 hrs and be counted as two FWE but one FTE.

Some of the Divisions of General Practice in Victoria do not appear to use the Health WIZ data base to determine the GP workforce profile. Reasons given were that they collected local data themselves which they were sure provided an accurate picture within their Division. This picture was different from that provided by Health Wiz, particularly because Health Wiz data could not take account of the hours GPs provided in hospitals (where they are paid by the State, and could not take account of other factors such as seasonal variations in workforce.

5. GP data (Register) for Hospital Discharge Information
General Practice Division Victoria

Data Source:
- Victorian Divisions of General Practice and collated by GPDV

Data Uses:
- Hospitals can provide patient admission and discharge information to General Practitioners.

Data Limitations:
While GPDV does not collect GP workforce data it has a statewide database of contact details (currently for 4305 Victorian GPs) based on Divisions' data which has been separately validated.

The agreement between GPDV and the divisions that provided the data is that it be used for the sole purpose of hospitals providing patient discharge information to General Practitioners.
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6. Australasian Medical Publishing Company (AMPCo)

Data Source:
- State and Territory Medical Registration Boards
- Workforce surveys on labour force status and practice activity

Data Uses:
- Used commercially as a mailing list

Data Limitations:
- Surveys to update data occur every two years or so
- Response rate to survey is unknown (commercial in confidence)

Medical Practitioners who do not approve publication of their details are not included in the database

AMPCo maintains a national database of all doctors in Australia and produces the Medical Directory of Australia (MDA). The registration details of all newly registered doctors are obtained from the Medical Registration Boards and included in the database.
AMPCo receives feedback about the data, and conducts a full survey before republishing the MDA..

7. Australian Medical Association - Victoria

Data Source:
- Membership data

Data Uses:
- For use by the AMA- Victoria

Data Limitations:
- Approximately 55% of GPs belong to AMA
- Data collected does not provide a picture of the GP workforce in Victoria

Approximately 55% of General Practitioners belong to the AMA in Victoria. The AMA does not collect data which provides an accurate picture of the GP workforce in Victoria.
The definitions used by the AMA for determining GP workforce participation are:
- A full time GP works over 5 sessions; and
- a part time GP works up to five sessions.

8. State Medical Registration Board

All medical practitioners must be registered with the State Medical Board, in the State where they intend to practice. This is a legal requirement.

Data Source:

- The Medical Registration Questionnaire. Data collected includes medical practitioners home location, practice, age, gender and qualifications details.

Data Uses:

- The data includes all medical practitioners

Data Limitations:

- Labour force status is unknown. Doesn't identify whether the GP is presently working in Victoria.
- Address details can be incorrect due to relocation of general practitioners

9. National Population Census and Monthly Labour Force Survey (with quarterly occupation data)

Australian Bureau of Statistics

The definitions used by Australian Bureau of Statistics for employment status are:

- full time employees work 35 hours and over; and
- part time work less than 35 hours per week.

These definitions are very different from the definitions utilised by the Health Insurance Commission therefore accurate comparisons with the Medicare data are not possible.

9.1 National Population Census

Data Source:

- Medical workforce and qualification statistics from 5 yearly census and a private medical practices industry survey
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Data Uses:

- Measurement of long term trends in Australian medical workforce numbers and characteristics. Data available includes for example: country of birth, labour force participation by age and gender, languages spoken at home.

Data Limitations:

- The national census occurs only every 5 years.
- The ABS classify active medical practitioners, who are mainly working in non-clinical areas, as administrators, researchers etc. These medical practitioners are excluded from the medical workforce data but are counted in the AIHW medical labour force survey.
- It is unknown how many medical practitioners are non-respondents to the occupation question in the census.

9.2 Labour Force Survey

Data Source:

- Labour Force Survey conducted by ABS. It is a structured interview of selected Australian households.

Data Uses:

- The ABS reports labour force data every three months for all occupations

Data Limitations:

- The small sample size precludes the data from being useful in GP workforce planning.