VICTORIAN DIVISIONS FORUM

Workforce: Supporting the divisions' role

May 2007

Report to Divisions

25 of the 30 Victorian divisions (12 rural, 13 urban) attended GPDV's Forum on 20 May to revisit the theme of workforce and to discuss an appropriate focus for the GPDV workforce position. Participants included 28 GPs and 6 division CEOs, as well as representatives from DoHA state office (Dianne Petchell); RACGP (Dr Philip Hegarty, Victorian State President) and Melbourne University Department of General Practice (Dr Kathryn Robertson). Kris Honey of KNH Consulting facilitated the discussion.

BACKGROUND

Workforce issues have been a constant theme in the divisions program, although, in the early years, they were seen as primarily rural. In 2004, when GPDV held a forum on the coming workforce crisis, there was growing recognition that outer metropolitan areas and the Western suburbs of Melbourne also experienced great difficulty in attracting an adequate supply of GPs. Since then there has been ever greater publicity given to problems of health workforce shortage (not just of a GP shortage) across the board and many strategies have been introduced to overcome the problems: overseas recruitment, introduction of the practice nurse program, increase in training numbers, focus on patient self-management.

The board of GPDV recently decided to create a new position to provide a strategic statewide approach to workforce and, linked to that, GP education and training. It will analyse workforce issues from a statewide perspective to help in finding solutions for all Victorian divisions and will focus on the connection between GP education & training and solutions to workforce issues, including the broader leadership role in the Divisions Network at practice, divisional, state and national levels.

PRESENTATIONS

Introduction – Bill Newton

CEO, GPDV

In 2000, GPDV commissioned a report on its role in workforce. The board accepted the Report's conclusion that workforce was a rural issue and that SBOs and metro divisions were not funded to do this work. For a number of reasons, the board recently revised that view. It now sees workforce for the statewide issue and has allocated a position to this work.

Given the limited resources available, GPDV is concerned to focus on things that it can most effectively address with divisions and is seeking the views of divisions and other relevant organizations on an appropriate role. It is also concerned to define the workforce trends that should influence the focus of the role and the relevant matters for advocacy. In particular, is the workforce shortage a 10-year crisis that will be resolved by the emergence of the large numbers of GPs from the new undergraduate positions recently funded **OR** is it a permanent ongoing crisis?

Workforce trends & division responses:

Dr Catherine Joyce, *Senior Research Fellow in the Department of General Practice, Monash University*

Catherine Joyce defined the workforce trends that illustrate that Victoria is experiencing a real decline in workforce supply at the same time that there is a definite increase in demand. There has been no change in the number of GPs per 100,000 population since the early 1990s but the hours worked have declined and there is a large cohort approaching retirement. At the same time the population is ageing and the prevalence of chronic disease is increasing.

The medical workforce supply typically follows a boom/bust cycle and although we are in the 'bust' phase, the numbers in training suggest that by 2011 Governments may start to talk about 'the impending oversupply of GPs'. But due to the long-term shortage it may take up to 10 or even 15 years to feel the full impact of the increased student numbers. The 1995 quota for intake into GP training was 400. Recently this quota has been increased to 600 but the target of

600 has still not been met. Further, this number does not bring GP numbers to the same level as those of early 1990s so the effects of the caps are still being felt.

The challenge is to break the boom and bust cycle and to develop an approach to planning that provides for an appropriate match of supply and demand over time.

One of the problems with our approach to planning is that we usually ask the question (during the bust phase): 'how do we meet the demand for more GPs?' The only way to answer that question is to look for more GPs. If we ask 'How do we meet the demand for primary health care?' then we start to think about who else can do the work, we start to review the organisation of work and we can also think about self-management.

Current Training Arrangements in Victoria: Workforce supply & demand: Dr John McEncroe

Chair, Victorian Metropolitan Alliance & GPDV Board Member

Dr John McEncroe presented the projected figures for numbers of GPs in training and numbers of undergraduate medical students in total based on research undertaken by Australian General Practice Training.

The key messages are:

At present, 155 places are allocated per annum to general practice registrar training in Victoria. There are large numbers of medical undergraduates coming through in the next several years. These will need access to training places in general practice. Victorian Regional Training Authorities have estimated they could offer a total of 252 places by 2010 if the cap were lifted. Apart from the need to create these places there is an urgent need to create the capacity to provide the supervision and to undertake the work to attract undergraduates to general practice in the first place.

In order to ensure undergraduates are attracted to the GP program, it is vital they are given a positive experience. There is evidence that the quality of training at the practice level is variable and there is a need for a substantial investment in training GP supervisors and in accrediting certain practices as training practices. The problem is that this extra demand is being placed on practices during the time of lowest workforce supply.

Divisions need to support their practices (a) to have the systems and staff available to free up limited GP time for supervision; (b) to develop the supervision skills required. They also need to work with regional training authorities and universities to assist in the identification of and support for appropriate practices.

Even so, without further investment by both levels of government it is unlikely that general practice will be able to cope with the expected increase in the numbers of students needing training places. The federal government has to be put under pressure to increase the numbers for undergraduate teaching. The fact that GPs are poorly paid for supervision is a major part of the difficulty in finding teaching practices. Another difficulty is the lack of an extra room in most practices to undertake the teaching.

If public hospital internees are to spend a term in general practice, then state government has a role and should be approached to support the infrastructure and other resources required.

PLENARY DISCUSSIONS – KEY POINTS

Dr Philip Hegarty noted that general practice is not a career of choice. In the last five years of GPET only 25% of medical graduates opted to become GPs so 'the profession is not winning the hearts and minds of students'. And in the next 5 to 10 years it is not going to. There will be a small uplift. There will be double the number of interns in 5 years but the vast majority will become specialists.

It is vital to ensure there is a positive experience in the undergraduate years, in prevocational training. General practice must be sold as a worthwhile career.

The major source of growth in general practice in the recent past has been the recruitment of women but women are now choosing emergency medicine, anaesthetics, and geriatrics. The reason appears to be because general practice is undervalued and underpaid. The relative value study 10 years ago showed this.

Other participants confirmed that after students attend general practice for training they report that the supervisor advised them not to undertake general practice as a career. The role of training authorities and divisions in selecting and training appropriate GP supervisors is vital. Equally important is advocacy for changes that make general practice a more attractive career option.

The compulsory rural experience was also raised as an obstacle to recruiting GPs. Some argued that either all specialist areas should have that requirement or none. To single out general practice has the effect of limiting the number of applicants.

In general, substantial work needs to be undertaken to alter the perception that general practice is the default option when a student cannot gain access to another speciality.

A related matter was the nature of the work that falls to general practice. 'I'm expected to do stuff specialists have walked away from. There are no general physicians any more. I do the general physician work in a 15-minute consultation. At the moment, everyone else is shaping what the GPs do. We're being left with the bits no-one else wants to do.'

SMALL GROUP DISCUSSIONS – KEY POINTS

What are the practice support implications for divisions in responding to the workforce and training matters raised in the presentations?

Divisions must support practices (a) for training GP supervisors and (b) to set up effective practice systems

How do we use teams to ensure that the most appropriate health professional is available for each given task?

- Need to address problems of fee-for-service model in context of integrated team
- Need clarity of role of team members and need to ensure GPs are used for their complex diagnostic skills
- Clarify medico-legal implications of team.

How should divisions work with the training networks ie what kind of relationship and for what purpose?

- Training providers include universities and teaching hospitals (PGPPP)
- There is a role for divisions as a broker between GPs and training providers
- The focus should be on supporting the relationship between training authorities and practices
- It should become the norm for training authorities to communicate with practices 'via the division'
- At present, divisions do not necessarily have the capacity to undertake the role.

What are the messages for advocacy at division and GPDV level?

National & state

- Advocacy at both levels of government and to AGPN to get funding into practices for
  - Infrastructure
  - Training
- Strong role for divisions in forming and maintaining relationships, supporting practices, advocating for local workforce issues, engaging community and business support. Time-consuming and costly role. Divisions need funding for this role.
- Message re value of general practice, especially to DHS
- Very good research at Monash and General Practice Education and Training (GPET) should be used to lobby government
- Policy to deal with workforce. End boom/bust model
- Build on local knowledge and expertise of divisions

Local

Lobby local members of parliament, local press, local community groups.

Support/assist

- Lobbying
- Funds to do lobbying

Marketing of general practice

Presentations will be available on GPDV website at www.gpdv.com.au.

NEXT FORUM

The next Forum for the Chairs of Victorian divisions will be held on Sunday 19 August 2007