# Workforce

## General Practice Strategy Review Report (GPSR)

The GPSR discusses workforce in several different contexts. The meaning of the term is not clearly defined, nor constant in the way it is used in the report.

It arises in chapters on:

- Micro-economic reform (12)
- GP careers, lifestyle, education and training (13)
- Rural and remote settings (17)
- Divisions (27)
- SBOs/RWAs (28)

Much of the discussion is in the context of rural/remote areas, but some issues in the rural/remote chapter are common to metro and rural practice. This briefing paper focuses on three issues that are common to both metro and rural settings: area classification systems; micro economic reform and workforce data.

## Area Classification Systems

The RRAMA classifications are criticised in the report for assuming heterogeneity in communities & not taking account of medical need in specific areas, nor that the availability of other health services varies in different settings, and that GPs practise in different ways, providing different services in different areas. This also applies to metropolitan areas with different demographics.

The proposed ARIA classification may well have the same failing.

*Possible role for GPDV: to investigate ARIA system and advocate for change if necessary.*

## Micro Economic Reform

Workforce is relevant here, as particular structures of general practice have the potential to address particular workforce problems e.g. locums, after hours, part-time/flexible work, and participation in other non-patient activities to enhance practice, like research, training etc. GPDV has put the position that a clearer statement of objectives of the government's amalgamation program, based on evidence, would be necessary for an amalgamation program to succeed in addressing workforce issues (or addressing patient care, or addressing whatever other objective the government may have in mind).

As GPs are aware, the amalgamation program has been launched without any of this work taking place, and therefore without any ideal practice size being nominated.

GPDV's (and DH&AC's) position on amalgamation is that agreements are a matter for individual practices to negotiate with the DH&AC. GPDV's members have not requested any additional representation, nor support, beyond the provision of the DH&AC information.

*While there may be a role for GPDV in research, in collaboration with a university or research centre, into what an optimal practice size may be to achieve some of the objectives listed above (and listed more fully elsewhere) the board considers that it is not a priority for GPDV.*

## Workforce Data

The GPSR report's position is that AMWAC/AIHW data "is not always consistent with local experience" and therefore data should be collected locally through division, then RWA then SBO. The Rural Workforce Agencies are to collect data where a division is unable to.

The report states that SBOs and RWAs should disseminate an agreed minimum data set for GP workforce. Development of the data set "would need to involve AMWAC and AIHW" (p.166).

Collection of this data at the local level ***may*** be the most appropriate way of collecting it, but this is not necessarily so. The expertise of someone with detailed and substantial experience in large-scale data collection (e.g. AIHW) would be useful to work through this. As it stands, it is possible that this is a case of "seems like a good idea" on the part of the Review Group, which did not specifically include anyone on the basis of their expertise in this area.

Establishing a process that involves data entry at multiple sites and aggregation of data at various levels (practice, divisions, RWAs, SBOs, ADGP, DH&AC) may increase the likely margin for error, along with the administrative costs. GPDV has previously suggested, regarding other types of data (e.g. immunisation data) that this type of model may also place a significant burden on divisions which may or may not have the expertise and resources to carry out the work.

A parallel with the GP Computing Group springs to mind: the GPCG recently decided that as some of the ACIR data was unreliable or incorrect, the solution would be not to identify and remedy the problems, but to abandon the system and establish another one, where practices collected data, which is then collated by divisions, SBOs and finally collated nationally.

## Existing Sources

Before deciding on what needs to be done to improve the data available to workforce planners, it is essential that the existing sources of data be examined. Some of the existing publicly funded sources are listed below. (This is not a comprehensive list).

- AMWAC and AIHW reports use Medicare data and labour force survey data (from questionnaire distributed at time of registration). AMWAC's work forms the basis of medical workforce policy.

- Health Wiz is currently being expanded to include GPs by postcode (based on Medicare data).

- The Commonwealth is one of the funding bodies for the BEACH project, which investigates the content of a large sample of general practice consultations.

- The Commonwealth funded a Practice Profile Study (undertaken by Campbell Consulting) which published a final report in December 1997.

- At the same time, one interpretation of the GP Strategy Review Report suggests that the Commonwealth is funding each Rural Workforce Agency (RWA) and each State Based Organisation of Divisions (SBO) to separately collect additional workforce data.

- In Victoria, the Act governing the Medical Practitioners Board is currently being revised. We understand there may be a possibility that data collected annually for the purposes of GP registration will be made available for other purposes in the future.

## Discussion

While there may be problems with the different sources of data, it seems only common sense to endeavour to alter data collection and analysis procedures so that the existing data is reliable and useful. Certainly there may sometimes be a case for setting up a new data collection system, but only where the existing systems are unable to meet a specific set of needs. Duplication of data collection systems is expensive, time consuming and may well lead to two (or more) sets of unreliable data. We are unaware of any documentation of the following:

- why the existing data cannot meet the needs of the RWAs and SBOs

- why the existing data systems cannot be altered so these needs are met

- why a new system must be established

- why that system would function best if divisions are involved at the point of data collection

- any justification for a different system in each state, and within each state a different system for metropolitan and rural GPs.

This is not to deny that problems exist with the current data sources. AIHW for instance, collects data on the whole medical workforce, not only GPs, and it may well be that some more work is needed to address problems specific to GP workforce data. The use of different definitions in different data sources may make it difficult to draw general conclusions based on these sources. A comprehensive review of the advantages and disadvantages of current data sources would require particular expertise in data systems and statistical analysis, which is why this paper does not enter into such a review. (An initial reading of some of the workforce reports has identified some areas for further investigation.)

*Possible role for GPDV: to review the existing data sources on GP workforce for Victorian divisions, their usefulness and shortcomings, to provide a basis for investigating how the existing data can be improved, to make it reliable and useful for general practice, and to develop a recommendation on whether a new data system needs to be established.*

## CONCLUSION

GPDV's general position on divisions' participation in data collection is that:

- the purpose of data collection must be clearly articulated **before** data is collected
- it must be useful to the GP in the practice
- divisions should not be collecting data that appears to place them in the role of government (e.g. data that shows whether GPs are eligible for PIP payments)
- it should not duplicate other sources of data.

Collation of workforce data would meet the first three criteria. What needs to be decided is whether we could more usefully have input into other, existing data sources and collection systems, to make them more accurate, rather than establish an additional, separate system.

If divisions are to be involved in data collection, the agreed minimum dataset to be disseminated by RWAs and SBOs, recommended in the GP Strategy Review Report must be developed (in collaboration with AIHW and AMWAC) before any database is developed. If this is not done, the data being collected in each state will not be comparable.

GP workforce planners need to know:

- GP to population ratios, by state and by different regions in the state
- how many GPs are working full-time/part-time
- how many are needed
- what they are spending their working time doing.

In the widest sense of the term "workforce," GPDV provides a range of services to its member divisions (both metropolitan and non-metropolitan) to assist them to better support their practices, e.g. through information and support on accreditation, IT, amalgamation, practice staff training, immunisation, etc.

GPDV also has an obligation to represent its members' interests by helping to ensure that accurate workforce data provides the basis for government policy on GP workforce. In so doing GPDV must have regard for the proper expenditure of public funds and ensure that money is not spent on work that duplicates work already done.

**It appears that the first step must be a review of the existing GP workforce data sources for Victoria, their usefulness and shortcomings, to provide a basis for investigating how the existing data can be improved, to make it reliable and useful for general practice, and to develop a recommendation on whether a new data system needs to be established.**