

Viable models of rural general practice

David Mildenhall, Rural Doctors Association of Australia

FACILITATOR: Just while people are moving out could I introduce you to Dr David Mildenhall, who is a procedural GP from WA – and David is here this morning to talk to us about viable models of general practice.

DAVID MILDENHALL: Well, thanks, very much, Jenny, for that introduction. I guess, I do see myself as a rural doctor, not a GP though. The viable models of rural and remote practice was a major undertaking which took about three years, a research undertaking by the Rural Doctors Association of Australia in conjunction with Monash University. Professor John Humphreys injected the necessary academic rigour in order that we had confidence in our results, and I am pleased to see that John's in the audience to day. Do you want to put your hand up, John? I think he deserves a clap because he put a lot of work into this project.

The other person that deserves a special mention is Dr Paul Mara, a rural doctor from Gundagai who, through his firm, Health Connections, put a lot of the nuts and bolts of this project together. Initially, we were going to call this project "Sustaining Medical Practice in Rural Remote Australia", but we thought that rural communities deserved a bit more than just sustenance. Sustenance has got that connotation of struggle, a bit like a felt a couple of years ago after I'd climbed up this hill at Kings Canyon. We thought rural communities deserve something a bit lively, something a bit more viable, a bit like this Northern Territory ... So, hence the term "viable models of rural or remote practice" was born.

The aim of the exercise was basically to determine the building blocks of rural and remote practice and then to take those building blocks and look at them and benchmark them against evidence so that they could be remade into much stronger blocks, each of which we knew were going to be viable, so when they were put together again, we had a viable practice. The principles were that it should be evidence-based, system solutions, rather than project solutions or personality-driven solutions, and accountability should be at the practice level and the workforce level, not at some administrative or process level.

You'll notice that the definition of viability has three key components. It includes the practitioner, the community, and the practitioner's family. The methodology was triangulated. The first arm was a census of all rural remote practitioners in Australia, and the second aim was a series of focus groups of representative doctors that were derived from the first arm, and two special groups: the rural workforce agency focus group; and a salaried doctors group. We didn't want to miss any of the richness of rural and remote practice. There were a total of about 12 to 14 focus groups.

The third major arm was a series of practice visits to 54 representative practices throughout rural and remote Australia and at these practice visits we basically took the practice apart, found out what made it tick, so that we could understand what was happening in the field.

What we are finding. Some of the findings were surprising, some of them were consistent with other smaller surveys. The difference between ours and other surveys was that this was a national project. One in five practices not viable now. Without action, one in two practices not viable in five years. The workforce figures that you'll see on the screen were consistent with perhaps some other smaller projects as well.

In terms of workload, rural and remote doctors worked 56 hours a work, similar to other data, but they did see only 25 patients a day and took nearly 15 minutes to see each patient. Up to an average of two hours a day was spent on other patient-related activities, and up to another two hours on other professional activities such as CME, organisational matters such as divisional work and, of course, practice administration.

We were keen to see what the rural practitioner did, and in two separate parts of the project, we looked quite intensively at what the practitioner was doing. And we defined complexity, relating it to intensity, skills required, responsibility and other supports. We found that the complexity of the consultation did vary with rurality. The more isolated, the more remote, the intensity tended to go up, and there was a correlation there.

But there was something else going on as well, so that within the same strata of communities, such as RRMA 5, some practices, the consultations were more intense than other practices. And we actually found that that was related to whether the doctor, at that consultation, then had subsequent responsibility for the patient. And that, in turn, was related to whether that doctor had hospital admitting rights at the local hospital and performed A and E services.

So, to put that in perspective, for example, if a patient came in that may have had an ectopic pregnancy, and that doctor was then – and his colleagues were responsible for the subsequent management of that ectopic pregnancy in the hospital, then the intensity of that consultation was much, much higher, and the complexity, than if that doctor was in a large regional centre with a staffed regional hospital across the road and could simply refer it across the road. In that situation, the complexity of the consultation dropped considerably.

In terms of economics, in May 2003, the average standard consultation fee was \$32. The bulk-billing and the discounted rate was over 70 per cent. You only read about rural bulk billing in the paper. Rural doctors are part of the community and for philosophical reasons, they may not bulk-bill their patients, but they do heavily discount them, we found. Practice costs were 52 per cent of gross. Net income per principal averaged \$80 an hour in group practices and \$55 per hour in solo practice. And I'd like you to just keep those figures in mind. Additional costs to the doctor often included running a motor vehicle, medical defence and CME.

The viability framework was determined as part of this project. We found that there was an economic dimension, a professional dimension and an organisational dimension, and to have a viable practice, each dimension had to be, in itself, viable. But we also found that the economic dimension was the driver for the professional dimension and the organisational dimension. And if the economic dimension wasn't right, it was hard to get the other two right. I won't go through these, in great detail, as I'll be going over them later and I do want to remind people that these are all on the web.

If we look at the economic dimension, which is about income versus costs and look at the benchmarks around those dimensions, we determine that the hourly net rate for practice principals should be \$110 per hour. This was in, as I said, in May 2003. About 12 months later, the Western Australian government started some co-located bulk-billing clinics with Perth teaching hospitals and they're jointly funded by the federal and the state governments. And in those clinics, the GPs were paid \$120 an hour, plus superannuation, so we weren't far out in our benchmark a year before.

On top of that, we believe that there should be a loading, a rural loading, based on rurality and location and complexity of the consultation, similar to the percentage of the PIP RRMA loadings. And, again, we'll talk about that later, I hope. As well, there should be infrastructure grounds to achieve at least 10 per cent average return on investment so that doctors simply didn't have to walk away from their practices at great capital loss, if they moved away from a

town and couldn't find somebody to replace them. And we all know examples of that and it is a disincentive, as has already been highlighted by the previous speaker, to doctors moving into a town and a problem.

In terms of the professional dimension, it is basically about workforce, and the burden of health increases with rurality and remoteness and the number of doctors needs to be greater. It's also about qualifications, and certainly the ACRRM curriculum provides a sound basis for a rural practitioner. It's also about in-built relief mechanisms so that doctors don't burn out, that they can take breaks and have holidays. The organisation dimension is about practice management and recognising that general practice these days is a sophisticated small business. It's no longer a casual affair and it does require high level practice management and it is also about adequate premises.

So what is the importance of the framework of viability? Just to emphasise, the economic dimension is the driver of the professional and organisational dimension. I think the importance is that it forms a cohesive and evidence-based framework describing what a viable practice is. And policymakers can, in fact, link into this and build policy using the information that we've obtained knowing with confidence that each block will allow a viable practice. It also informs organisations such as RDAA and the AMA to lobby government to have appropriate policy.

But also, individual practices can look at this viability framework and can help build a better practice for the practitioners in those practices. The full report is on the web, it's about 700 pages, got a lot of information in it, I do commend it to you. I'm going to use my own practice as an example of how this viability framework can fit into a real live practice. In 2002, the practice knew it had some major problems.

In terms of the economic dimension, there'd be no contract with a local hospital, a source of 50 per cent of the total income. The state government refused to honour the existing contract. We'd only had a 1 per cent fee increase in the previous five years. The consulting fee income had not kept up with inflation and inefficient office administration led to increased bad debt levels. The cost had increased and there was inefficient management processes occurring. So, as far as the economic dimension is concerned, we knew we had problems. The costs were going up and the income was going down.

Professional. Three of the six partners were due to retire in the next 30 months. We were finding it hard to recruit more doctors. We had a good skills mix, but that was about to change. So we knew that the professional dimension was — we had problems. And, of course, when you get down to three doctors in a six-doctor practice, it means that you can't have the relief that you need. And so often we've seen towns actually lose all their practitioners in this way. Six goes to three, you can't get relief, and then the other doctors burn out and leave.

In terms of the organisational dimension, the manager of 20 years was about to retire. The complexity of the practice had increased: 15 compliance areas, complex income sources. So we wondered what was over the horizon. My wife contemplated this as our permanent future. We looked to the birds for inspiration as well as the tall timber. What was around the bend? Partly serendipity, partly planning. The state government agreed to a new hospital contract. A 33 per cent increase in hospital income which actually was a catch-up with the old — it was what we would have been getting if they'd honoured the old contract with its increases.

But, of course, we had missed out for five years and they didn't give us a catch-up for that five years. Greater office efficiencies led to the stabilisation of costs and improved efficiency of fee collection. So the economics improved. We took on advanced registrar training, actively looking for trainees who showed an interest in staying in the community. We became flexible

in our partnership agreement to allow, for example, maternity leave. We actually recruited two more registrars as partners using this methodology.

The skills mix. One of the new partners was interested in industrial medicine, the other in obstetrics.

The management infrastructure. We recruited a new manager who was an accountant and not just an office administrator, and that led to greatly enhanced management changes – without going through the list, things were looking up. So, using the viable model strain, we were able to show that the economic dimension was fixed. We fixed the professional dimension and, let me say, without the economic dimension being fixed, I don't think we would have attracted our two new partners. They would have gone, probably, to New South Wales where they would be better remunerated. And the organisational dimension also was a key component of making the practice more viable.

I will, briefly, talk about – and I emphasise this is me speaking as Chair of the Viable Models Project Committee, not RDAA Committee of Management, though what I'm going to talk about is probably consistent with their thinking. The stage 1 and 2 reports used an evidence-based approach to recommend a benchmark fee, that we've already talked about, and then a loading, which we've called a rural equity and access loading. The final fees, therefore, are derived from a benchmark fee, plus the loading.

Practice costs – we knew from our research and we knew the benchmark fee. If you adjust that for PIP and annual leave, it means that in April 2004, about \$60 per patient encountered needed to be generated for the doctor, the principal, to take home \$110 an hour. You'll remember that the bulk-billing doctors working in the clinics in Perth were getting, a year ago, \$120 plus super. The solo practitioners in rural and remote Australia were taking home \$50 an hour. In group practice, they were taking home \$55 an hour. In group practice, they were taking home \$80 an hour. How can we ever hope to adjust this workforce crisis where we have these sorts of disparities?

Why rural equity and access loading? Evidence showed the way rural doctors practise – and the complexity of the consultation, as I've mentioned, is linked to rurality and isolation and an X factor which is about the responsibility of managing that patient downstream, which is also directly linked to the doctor having admitting rights to the local hospital and providing A and E services. So it's a lag concept recognising rurality and isolation and the X factor. What loading, we've suggested PIP RRMA loadings because they were formed, initially, on expert advice, they've been accepted by the government and by the profession, and they're simple to administer.

So, for example, in RRMA 5 town, there would be a 20 per cent location loading because you live in a RRMA 5 town, and a 20 per cent X loading or sweat factor if you're doing those more intense work which means that you've got admitting rights to the local hospital and you're using those admitting rights. So the final fee is adjusted by the benchmark fee by the above percentages, depending on location and intensity.

I do commend the full report. It's got a lot of interesting information and I think anybody who's interested in rural practice will find there's stuff there that can be used in their own rural practices, or if you were setting up a model of rural practice, the principles stay the same. Thank you, very much.

PRESENTER

David Mildenhall graduated MB, BS from UWA in 1975 and completed further studies in obstetrics, gynaecology, surgery and anaesthetics. He is also a Fellow of the Australian College of Rural and Remote Medicine. David has been a partner in a group practice in Albany, WA for over 20 years and has executive responsibility for human resources and office administration within the practice. He has procedural interests in anaesthetics, obstetrics, minor gynaecology and GI endoscopy. David has been a strong supporter of professional organisations and is a Past National President of the Rural Doctors Association of Australia. In 2001 David was instrumental in securing funding from the Commonwealth Department of Health and Ageing for the Rural Doctors Association of Australia, to conduct a major research project, and is the Chair of the Project Management Committee.

