GPs – Deal or No Deal?

General Practitioners in Aboriginal Community Controlled Health Services in NSW

March 2010

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List of Acronyms

AH&MRC	Aboriginal Health & Medical Research Council
ACCHS	Aboriginal Community Controlled Health Service
AMA	Australian Medical Association
AON	Area of Need
ASGC – RA	Australian Statistical Geographic Classification – Remote Area
COAG	Coalition of Australian Governments
DGP	Division of General Practice
FTE	Full Time Equivalent
GP	General Practitioner
GPET	General Practice Education and Training
PGPPP	Pre-vocational General Practice Placements Program
MBS	Medical Benefits Schedule
MSOAP	Medical Specialists Outreach Assistance Program
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OTD	Overseas Trained Doctor
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
RDN	NSW Rural Doctors Network
RLRP	Rural Locum Relief Program
RRMA	Rural, Remote and Metropolitan Areas
VMO	Visiting Medical Officer

GPs – Deal or No Deal? General Practitioners in Aboriginal Community Controlled Health Services in NSW

Executive Summary

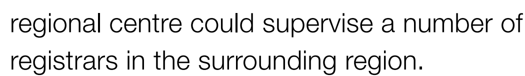
The project *“GPs – Deal or No Deal?”* was initiated by the Board of the Aboriginal Health and Medical Research Council of NSW in response to difficulties experienced by Aboriginal Community Controlled Health Services (ACCHSs) in recruiting and retaining general practitioners (GPs).

The project aimed to develop strategies to improve recruitment and retention rates of ACCHS GPs in NSW and to offer a guide to appropriate salaries and conditions of employment for GPs. Fifteen ACCHSs (representing 43 percent of ACCHSs with GPs) across NSW were surveyed in depth. Fourteen site visits were undertaken and one telephone consultation conducted. Mainstream GP earnings and incentives were examined and many stakeholder representatives were consulted. The published and unpublished literature was interrogated.

The findings revealed that ACCHSs in NSW (rural and urban) have a GP vacancy rate of 25 percent – twice the vacancy rate of mainstream rural general practice (no vacancy figures are available for urban general practice). Overseas trained doctors (OTDs) are over represented in rural and remote ACCHSs (where more than 50 percent of the GPs are OTDs) highlighting the importance of effective orientation and cross cultural training programs.

Remuneration packages offered to ACCHS GPs vary considerably across NSW with some being more beneficial than others. This leaves some ACCHSs in an uncompetitive position when attempting to recruit GPs. Additionally, there has been very little data available to assist ACCHSs to decide what might constitute an “appropriate” or “reasonable” salary package. GPs and locum agencies have been in strong bargaining positions and there is little consistency in employment and contractual arrangements. The ACCHSs surveyed are on the whole paying their GPs salaries that are comparable to mainstream general practice earnings (for similar work). They have had to do so to be competitive. Salaries are not based on any particular award and are higher than the OATSIH “nominal” funding allocations for GPs. As mainstream GP earnings have been increasing, so too has the amount of money ACCHSs have had to spend to maintain their general practice services. There is, however, strong evidence of the return on investment in primary care and agreement that GPs are vital members of the team.

Male and female GPs work in ACCHSs in equal numbers although OTDs are more likely to be male. Sixty four percent of the GPs work fewer than eight sessions a week and have flexible working conditions. GP registrars are a good source of future recruitment but many ACCHSs experience difficulties in providing the required level of supervision required for registrars and lack the space to accommodate them. A “regional and roaming” GP supervisor model is recommended whereby a GP in a



regional centre could supervise a number of registrars in the surrounding region.

It is not only very difficult for ACCHSs to recruit GPs, it is also very challenging to obtain GP locums. This report recommends the establishment of locum services that are reasonably priced and able to meet ACCHS demand for services. Further recommendations are made that are aimed at developing a solid and sustainable general practitioner workforce in NSW ACCHSs.

ACCHS are increasingly required to demonstrate business acumen in maximising Medicare revenue without compromising patient care. This report recommends strategies that include seeking funding for a Medicare Enhancement Program Officer within the AH&MRC and the establishment of a Practice Managers Network for the exchange of information and to showcase local initiatives.

The *“GPs – Deal or No Deal?”* project, while addressing the concerns of the AH&MRC Board and Member Services that remuneration packages offered to ACCHS GPs vary considerably across NSW, has looked beyond that to focus on ways in which a sustainable ACCHS general practitioner workforce can be developed. The report contains sixteen recommendations.

Recommendations

Recommendation 1:

It is recommended that ACCHSs offer GPs remuneration packages that are on a par with mainstream general practice earnings and that ACCHSs in NSW establish a consistent approach to terms and conditions of employment for their GPs. A schedule of annual GP salaries by ASGC-RA locality is available separately as a guide for ACCHSs and is based on current ACCHS GP earnings in 2009 and ballpark mainstream earnings.

Recommendation 2:

It is recommended that AH&MRC (in partnership with other State and Territory Affiliates) consider sustainable financial models of general practice within ACCHSs including the proportion of an ACCHS budget that would ideally be spent on GP services.

Recommendation 3:

It is recommended that an officer within the Member Service Support Unit of AH&MRC assumes responsibility for assisting ACCHSs with GP recruitment initiatives.

Recommendation 4:

It is recommended that AH&MRC develops a marketing strategy to attract GPs to work in ACCHSs in NSW. The marketing project would be developed in association with ACCHSs and would build upon materials already available.

Recommendation 5:

It is recommended that a second AH&MRC/NSW Rural Doctors Network GP Issues Workshop be held in 2010 to develop and show case strategies aimed at improving the recruitment and retention of GPs to ACCHSs.

Recommendation 6:

It is recommended that GPs in ACCHSs be encouraged and supported if they wish to apply for Visiting Medical Officer accreditation with the Area Health Services and that this option be promoted (if appropriate) when ACCHSs are recruiting GPs.

Recommendation 7:

It is recommended that the dedicated GP Workforce Officer in AH&MRC (see Recommendation 3) approach the NSW Local Government and Shires Association of NSW to present at the 2010 Shires Association NSW Annual Conference (to be held from 31st May to 2nd June). The aim would be to forge a closer relationship with local councils to encourage them to offer incentives to GPs in ACCHSs, similar to those offered in mainstream general practice.

Recommendation 8:

To promote shared GP recruitment initiatives across a regional network ***it is recommended*** that a pilot GP recruitment project be funded and established in the BIla Muuji area. This would build upon and further develop the shared efforts of ACCHSs within this region. The pilot project would run for 12 months and be evaluated at the end of that period. The pilot would be managed as a vertically integrated model with short and long term GP recruitment strategies introduced. These would involve medical student placements, support for pre vocational doctors through the Pre-vocational General Practice Placements Program (PGPPP), increased GP registrar placements and additional support for overseas trained doctors in the Bila Muuji ACCHSs. Marketing and locum programs would be introduced, Councils and other

organisations would be approached to offer support to ACCHSs (housing etc) and partnerships between ACCHSs and other stakeholders (Divisions of General Practice, Regional Training Providers etc) could be strengthened.

Recommendation 9:

It is recommended that AH&MRC and the NSW Rural Doctors Network work together to consider if the RDN GP Locum Service could be extended to provide GP locums to ACCHSs for short periods where there is no incumbent GP.

Recommendation 10:

It is recommended that AH&MRC explores the options of increasing the access of ACCHSs to reasonably priced GP locums and that these options include an examination of different models such as an AH&MRC locum service, an urban – rural partnership, and fly in – fly out GP locum service models.

Recommendation 11:

It is recommended that AH&MRC and the NSW Rural Doctors Network conduct a one-day workshop introducing the Australian health care system and cultural awareness of Aboriginal health issues to overseas trained doctors interested in ACCHS practice.

Recommendation 12:

As the GP vacancy rate in ACCHSs in NSW is twice that of rural NSW as a whole, ***it is recommended*** that AH&MRC lobbies the Department of Health and Ageing to provide additional incentives for overseas trained doctors to work in ACCHSs by reducing the length of time that provider number restrictions apply if a doctor works in a NSW ACCHS and meets other eligibility criteria.

Recommendation 13:

It is recommended that AH&MRC seeks funding to develop a "Regional and Roaming GP Supervisor Scheme" whereby GPs in regional centres provide supervision to GP registrars in ACCHSs in the region.

Recommendation 14:

It is recommended that research is conducted examining the reasons why GPs choose, or choose not to, work in Aboriginal Community Controlled Health Services. The findings will inform recruitment strategies aimed at attracting GPs to practice in ACCHSs.

Recommendation 15:

It is recommended that a Medicare Enhancement Program Officer be appointed in AH&MRC to provide information to ACCHSs on all Medicare related issues. The officer would work closely with the chronic disease team in the AH&MRC. The primary focus of the position initially would be to conduct Medicare audits with ACCHSs to streamline Medicare practices and operations.

Recommendation 16:

It is recommended that AH&MRC establishes a network of ACCHS Practice Managers.

1 Background and Context

1.1 Aboriginal People in NSW

There are 145,000 Aboriginal people living in NSW, representing 2.2 percent of the total NSW population and 28.7 percent of the total Aboriginal and Torres Strait Islander population across Australia (Australian Indigenous HealthInfoNet, 2009). The Far West of NSW has the highest proportion of Aboriginal people per population (Primary Health Care Research and Information Service. 2006-2007).

That Aboriginal people in NSW suffer from much poorer health than the non Aboriginal population is well documented (Population Health Division, NSW Health, 2008. p60). Many Aboriginal people suffer chronic diseases, many of which are preventable. Aboriginal and Torres Strait Islander people live on average about 17 years less than non Indigenous Australians (Hoy, 2009, p542). Access to primary healthcare remains poor (Oxfam Website http://*www.oxfam.org.au/explore/indigenous-australia/close-the-gap* accessed 20th October 2009).

It is also recognised that there has been significant government under spending on Aboriginal health relative to need. Despite morbidity rates 2.5 times higher than non Indigenous people MBS expenditure is estimated to be 45 percent of the non Indigenous average. For the same period it was estimated that for every dollar spent on non Indigenous Australians, $1.17 was spent on the health of Indigenous Australians – significantly less than need would indicate (Deeble et al, 2008).

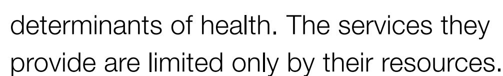
1.2 Aboriginal Community Controlled Health Services

Concern about Aboriginal people's access to mainstream services, which were perceived as racist, discriminatory and expensive (where they existed at all)[1], led to the establishment of Aboriginal Community Controlled Health Services to provide primary health care to Aboriginal communities.

Primary health care provided by ACCHSs incorporates a 'comprehensive' approach which includes clinical care – emergency care, treatment of acute illness and management of chronic conditions; population health programs – including immunisation, screening and health promotion programs; facilitation of access to secondary and tertiary care; and client/community advocacy (Shannon and Longbottom, 2004) (Queensland Aboriginal and Islander Health Council, 2009).

In ACCHSs medical practitioners are part of a multidisciplinary team with governance arrangements whereby the doctor is not the dominant player. This differs from mainstream general practice where the GP generally controls how the service is operated (Gilles et al, 2008, p655). One of the great strengths of ACCHSs is that their roots are in the community and as a result of local knowledge they are in a position, not only to provide good individual care (knowing the patient well), but are also able to undertake community development and address some of the social

1 The Australian Medical Association has reported evidence of ongoing inherent discrimination in the Australian health system. It found that Aboriginal and Torres Strait Islanders do not benefit from mainstream health services to the same extent as other Australians because they either are located out of the reach of Aboriginal communities or the medical attention they receive is culturally intolerant and unwelcoming (Australian Medical Association, 2007).



determinants of health. The services they provide are limited only by their resources.

Information on the proportion of Aboriginal people using ACCHS GPs compared with those using mainstream general practice services for medical care is lacking. Data from the Australian Bureau of Statistics suggested in 2008 that 70 percent of Aboriginal and Torres Strait Islander people used mainstream health services and 30 percent used ACCHSs. This figure was subsequently found to be based on one poorly worded question in the Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Health Survey 2004/05 and has been contested (Couzos and Delaney Thiele, 2009 p 541). It has been established more recently that ACCHSs provide potentially between 50 and 60 percent of all care received by Aboriginal and Torres Strait Islander people (A Healthier Future for All Australians, 2009, p87). ACCHSs also have more clients with complex diseases than do mainstream GPs. The Larkins, Geia and Panaretto study, for example, compared consultations at Townsville Aboriginal and Islander Health Service with those of both Indigenous and non Indigenous patients in mainstream general practice. They found that “the greater number of problems managed per consultation in ACCHS, compared with Indigenous patients in mainstream general practice, supports the assertion that ACCHS fill an important role in the health system by providing care for their largely Indigenous patients with complex care needs” (Larkins, Geia and Panaretto, 2006, p2).

The National Health and Hospitals Reform Commission, which presented its Final Report to the Australian Government in June 2009, recommended strengthening and expanding the organisational capacity and sustainability of ACCHSs to provide and broker comprehensive primary health care services (Recommendation 60, A Healthier Future for All Australians, 2009, p24).

There are many examples in Australia and overseas where community controlled health care has led to demonstrably better health outcomes. Studies recently published in the *Medical Journal of Australia* reported that patients attending Aboriginal Medical Services were more likely than patients attending mainstream general practices to get necessary treatments for risk factors such as high blood pressure, diabetes or cholesterol (Peiris at al, 2009) (Webster et al, 2009). Researchers evaluating the impact of an integrated model of antenatal shared care delivered from the community controlled Townsville Aboriginal and Islander Health Service found the community based model resulted in increased access to antenatal care and was associated with fewer preterm births (Panaretto et al 2005).

Findings overseas also report that transferring health care to community control is yielding results. Research in Canada, for example, published in November in the *Canadian Medical Association Journal* has revealed striking evidence “that First Nations control of health care leads to better health” (Canadian Medical Association Journal, 2009, pE249).

1.3 General Practitioner Workforce Issues

GP workforce problems are common among ACCHSs across Australia and include difficulties recruiting and retaining GPs, high GP vacancy and turnover rates and problems with getting the right "match" between the GP and the community[2]. In Victoria the shortfall of GPs working in ACCHSs predicted for 2011 is estimated to be between 29 and 51 GPs (VACCHO, 2008, p16). In Western Australia the GP under supply in the Kimberley region in 2006 (where the majority of GPs are employed in ACCHSs) was 30; 9.4 of which were current vacancies and 20.6 of which were estimated to be the number of additional positions required to provide an adequate service (Roach et al, October 2006, pp12 & 15).

GP workforce shortages are not confined to ACCHSs. Indeed medical workforce shortages are experienced in most countries of the world. While the current under supply in Australia is the result of many factors, it is in part due to the perception in the 1980s and early 1990s of a doctor over supply, particularly in metropolitan areas, and concerns about the growing Medicare expenditure, which is linked to the number of providers (Gavel et al, 2000, p8).

Additional factors compound the under supply of general practitioners. These include the ageing of the GP workforce; a reluctance of younger GPs to work the long hours sustained by older doctors; fewer medical graduates choosing to work in general practice; and an increasing number of women in the GP workforce. Women tend to work fewer hours than their male counterparts and are less likely than men to practice rurally. GP shortages are particularly pronounced in regional, rural and remote Australia with the GP to population ratio decreasing significantly with the greater remoteness. In Australia the lowest GP supply is in the very remote areas, particularly in New South Wales and Western Australia (Department of Health and Ageing, 2008).

2 In 2004 Access Economics estimated a national shortfall of at least 250 primary health care medical practitioners providing services to Indigenous Australians through community controlled and mainstream services (Access Economics, July 2004, p1).

2 GPs – Deal or No Deal? General Practitioners in Aboriginal Community Controlled Health Services in NSW

2.1 Introduction

The project *GPs – Deal or No Deal?* was initiated by the Board of the Aboriginal Health & Medical Research Council of NSW (AH&MRC) and Member Aboriginal Community Controlled Health Services (ACCHSs) in response to difficulties experienced by ACCHSs in recruiting and retaining general practitioners. There was also concern that salary packages and conditions offered to ACCHS GPs vary considerably across NSW with some being more beneficial than others. This leaves some ACCHSs in an uncompetitive position when attempting to recruit GPs. ACCHS CEOs are concerned that some GPs are picking and choosing between services and creating bidding wars. No baseline data is available to assist ACCHSs to decide what might constitute an "appropriate" or "reasonable" salary package.

2.2 Project Objectives

The objectives of the project *GPs – Deal or No Deal?* were to:

- examine GP salary packages and conditions in NSW Aboriginal Community Controlled Health Services
- obtain baseline data to assist ACCHSs to decide what might constitute an appropriate or reasonable remuneration package
- develop strategies to improve recruitment and retention rates of ACCHS GPs

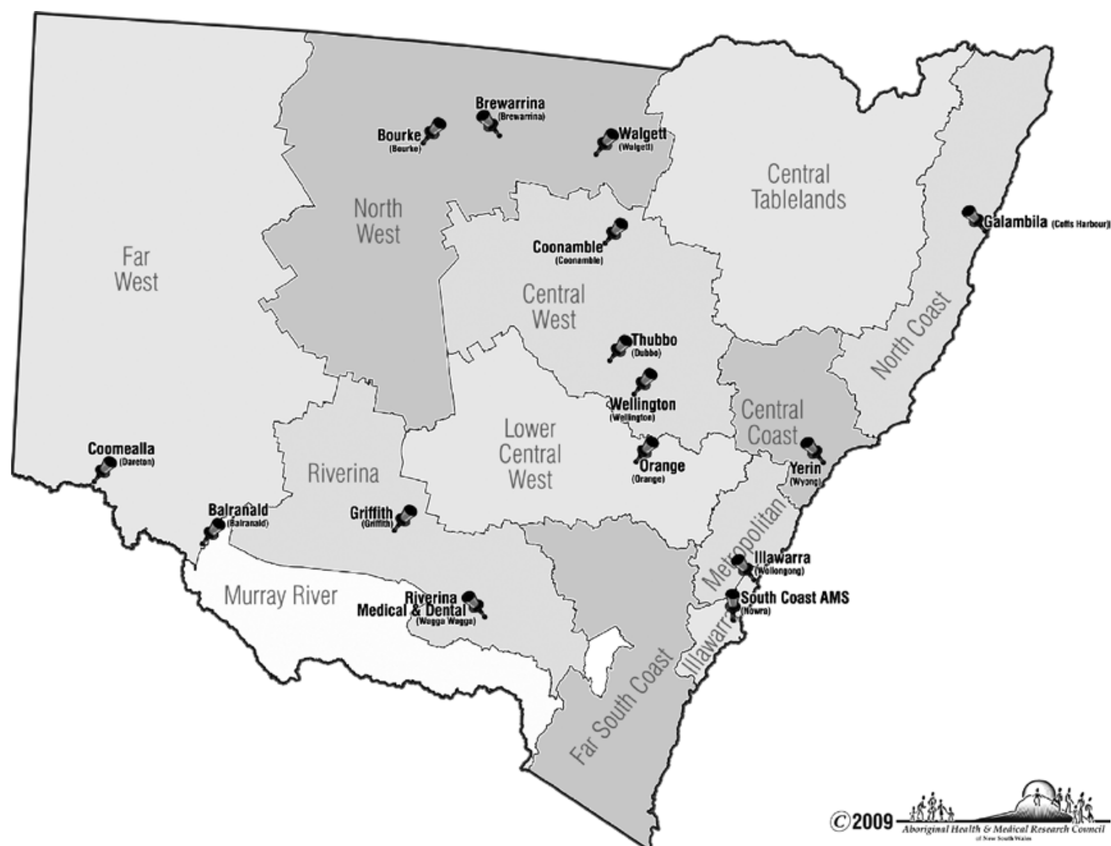
2.3 Project Methodology

Ms Kirsty McEwin was contracted by the AH&MRC to undertake the project and worked part time on it from May to December 2009. During this time she consulted with and surveyed a sample of ACCHSs and also sought information from other relevant individuals and organisations. The published and unpublished literature was interrogated. The views of ACCHSs on the best ways to address the recruitment and retention issues were sought.

Project consultations were held with 15 of the ACCHSs with resident or visiting GPs (listed in Appendix A). There are more than 45 ACCHSs in NSW, all but five of which are in rural and remote areas. Thirty five have resident or visiting GPs. The sample surveyed represent 43 percent of ACCHSs with GPs. The participating ACCHSs came from across the State with all four ASGC – RA[3] localities represented (see Map 1).

3 ASGC–RA: Australian Statistical Geographic Area – Remote Areas – a classification system used by the Commonwealth Government that replaces the Rural, Remote and Metropolitan Areas (RRMA) classification system.

Map 1: Location of ACCHSs consulted in the *GPs – Deal or No Deal?* Project



The methodology used in the consultations with ACCHSs was based around a survey tool that was developed to gather quantitative and qualitative information focusing on three main areas:

- details of the general practice services provided by the ACCHSs
- the salaries and conditions of the GPs, GP registrars and locums working in the ACCHSs
- the problems that ACCHSs encounter particularly in relation to recruitment and retention of GPs

The survey sought information on the number of GPs, GP registrars and locums; details of the sessions worked per week; information about the recruitment processes; salary packaging arrangements; details of GP vacancies; and other GP recruitment and retention issues. There were opportunities for additional comments and/or observations and often the discussions were far reaching.

Consultations held with individuals and organisations outside the ACCHSs primarily focused on obtaining baseline data on mainstream and locum GP earnings and conditions; examining models of innovative and sustainable general practice; and

exploring potential sources of funding for the strategies developed and presented in this Report. A list of individuals consulted is attached at Appendix B.

The selected ACCHSs were invited to participate and site visits were arranged to the ACCHSs. Where a visit could not be arranged (in the case of one ACCHS) the survey was administered in the form of a telephone interview. In most cases the respondent was the CEO with or without the practice manager. In a few cases a GP and/or the office manager was interviewed without the CEO.

The respondents were asked to complete a Disclosure Consent Form to indicate the degree to which the information could be shared among other NSW ACCHSs.

2.4 Survey Findings

At the time of the interviews thirty six GPs were working in the fifteen ACCHSs that were surveyed. The characteristics of the GPs are described in Table 1. The numbers of sessions worked per week by the GPs are described in Table 2. One session is 3.5 hours. A very high percentage (64%) of the GPs worked fewer than eight sessions/week.

Table 1: Characteristics of the GPs by ASGC – RA Classification of Surveyed ACCHSs

ASGC–RA	Male			Female			Total GPs
	Aust'n/ NZ Grads	OTDs	Total Male GPs	Aust'n/ NZ Grads	OTDs	Total Female GPs	
RA 1	5	0	5	2	0	2	7
RA 2	2	1	3	8	1	9	12
RA 3	1	2	3	1	2	3	6
RA 4	1	6	7	1	3	4	11
Total	9	9	**18**	12	6	**18**	**36**

Table 2: No of GP Sessions/week by ASGC – RA Classification of Surveyed ACCHSs

ASGC–RA	Male		Female		Total GPs	
	Working less than 8 sessions/ week	Working 8 or more sessions/ week	Working less than 8 sessions/ week	Working 8 or more sessions/ week	Working less than 8 sessions/ week	Working 8 or more sessions/ week
RA 1	4	1	2	0	6	1
RA 2	1	2	5	4	6	6
RA 3	0	3	3	0	3	3
RA 4	5	2	3	1	8	3
Total	10	8	13	5	**23 (64%)**	**13 (36%)**

Note: 1 session is 3.5 hours

The tables show that there were:

- An equal number of male and female GPs (**18** male; **18** female)
- More Australian and New Zealand graduates than overseas trained doctors (OTDs) – **21** (58%) compared with **15** (42%) for the State overall. **But** looking only at the rural and remote ACCHSs (those in RA 2, 3 and 4 localities) there were more OTDs than Australian and NZ graduates – **15** compared with **14** Australian and New Zealand graduates – ie of the GPs in ACCHSs in rural and remote NSW just over 50% were OTDs
- More male OTDs (**9** males compared with **6** females)
- More GPs working fewer than 8 sessions/ week compared with the number working 8 sessions or more/week – **23** (64%) compared with **13** (36%). (Ten sessions equals five days/week)
- More males working 8 sessions or more/ week – **8** males compared with **5** females

Other findings:

- The 36 GPs worked a total of 178 sessions/week across the 15 ACCHSs. As 1 FTE = 10 sessions/week, the GP full time equivalent (FTE) was 18. The average GP in the surveyed ACCHSs thus worked 0.5 FTE
- The GPs working 8 to 10 sessions/week were equally Australian/NZ graduates and OTDs
- The GPs had worked between 1 month and 11–12 years in the ACCHSs (with an even range in between)
- The GPs were equally spread across the age groups of 30s, 40s and 50s with one in the 20s

In summary the 36 GPs working in the 15 ACCHSs were more likely to be working three days/week or less than to be working full time; were equally male and female; and were evenly spread across the age groups 30s, 40s and 50s. They were a mix of Australian/NZ graduates and OTDs. State wide there were 58% Australian and New Zealand graduates compared with 42% OTDs, but significantly when looking only at the ACCHSs in rural and remote NSW, a little over 50% were OTDs. This finding has implications for recruitment and retention strategies. The 36 GPs were recruited through a variety of means as shown in Table 3.

Table 3: How GPs were recruited to the Surveyed ACCHSs

Recruitment Method	Number
The GP is a mainstream GP in the town and provides a part time service to the ACCHS	9
The GP is provided as a long term locum through a commercial recruitment and/ or locum agency(1)	6
The GP approached the ACCHS for work	4
The GP was recruited by the senior GP in the ACCHS	3
The GP was a registrar in the ACCHS and returned to the service(2)	3
The GP was recruited from the RDN Vacancy Website with help from RDN	3
The GP was recruited from a GP Regional Training Provider by the ACCHS CEO	1
The GP was recruited by the Division of General Practice	1
The GP was recruited through the Area Health Service	1
Not known	5
TOTAL	36

Notes:

(1) The ACCHSs in the remote Bila Muuji area often need to rely on commercial recruitment and locum agencies to supply GPs in the absence of their own sustainable resident GP workforce.

(2) Significantly three of the five ACCHSs with GP registrars had registrars return to work with the services after the registrars had gained their RACGP fellowships. GP registrars are a good source of future GP recruitment.

The variety of recruitment methods highlights the importance of strategic partnerships (eg with the town GPs, the NSW Rural Doctors Network, the Divisions of General Practice and the Area Health Services).

GPs are described variously as “employees”, “contractors” and “locums”. Fifty percent (18) of the 36 GPs were either “employees” or on contracts of between 1 – 3 years. The remaining 50 percent were on sessional or locum contracts. The remuneration rates are negotiated directly between the GP and the ACCHS and vary across NSW. The more remote the setting the more likely the GP was described as a “contractor” or “locum” rather than an “employee”.

Other findings:

The remuneration packages provided to the GPs in the surveyed ACCHSs varied considerably. While there were outliers (both above and below the average), overall the remuneration packages were reasonable considering the market shortage of GPs. Rates of pay generally reflected the degree of difficulty in attracting GPs. The more difficult, the more generous the package (including furnished accommodation etc). The more remote the ACCHS the higher the cost to the ACCHS of providing a GP service. (The range and average of GP Salaries by ASGC – RA Classification for Surveyed ACCHSs is available but has been withheld from this abridged version of the report for reasons of confidentiality). Payments received by GPs were not always the same as costs incurred by the ACCHSs to run a GP service as locum agencies charged between 12 percent and 17.5 percent agency fees with even higher hourly charge out rates.

Twenty one GPs (a little over 50 percent) received no benefits (salary sacrifice, leave entitlements etc) besides their pay although accommodation was provided in a few cases. Salaries were not based on any particular award rate.

The remaining 15 GPs were on packages that were calculated from an hourly, sessional or annual rate of pay but which included benefits – salary sacrifice, 4-6 weeks annual leave, 10-12 days sick leave, 3-5 days compassionate or bereavement leave, maternity leave. Some also received study and/or conference leave. Vehicles were generally not included in the package except in the very remote towns. Relocation subsidies were generally not available although were negotiable in some ACCHS packages. Mobile phones were often included in the package. Flights (and/or travel home) were also negotiable in the remote centres (although commercial airlines no longer fly to many of these towns).

The differing remuneration rates reflect history and context (including location, degree of remoteness, size of community etc). The ACCHSs west of the Blue Mountains had greater difficulty recruiting GPs compared with their coastal counterparts and those in the remote North West and South West of the State experienced the greatest difficulties. The smaller and more remote inland towns suffered the worst GP shortages. The coastal ACCHSs were more likely to be able to call upon mainstream GPs to provide one or maybe two sessions a week and to provide OTD and/or GP registrar supervision.

Only one of the 36 GPs in the survey was receiving a percentage of MBS revenue as the majority of CEOs were reluctant to offer a percentage of Medicare income to their GPs. They believed that it could encourage GPs to push their patients through and detract from quality practice. On the other hand it can act as an incentive to ensure that all MBS entitlements are claimed by the GPs. The CEOs interviewed believed that it is a decision best made by the CEO who is able to consider the particular circumstances of the GP and the ACCHS clients.

Eight (or more than half) of the ACCHSs had 11 GP vacancies between them, representing an overall GP vacancy rate of 25 percent. In some cases these vacancies were "plugged" by locums while other ACCHSs were operating despite (or with) the vacancies. The vacancies were spread across the four ASGC – RA localities. The 25 percent vacancy rate is the same as it was for all ACCHSs in March 2009 (AH&MRC MSOAP Specialist Needs Assessment Survey March 2009) suggesting that these are long term vacancies. It is twice the vacancy rate for all of rural and remote NSW which was 11.7% in June 2009 (RDN Database and GP Vacancy Database June 2009). The GP metropolitan vacancy rate is not available. While "vacancy rate" is a blunt instrument as a measure of workforce shortage and more sophisticated workforce planning methodology is preferred (see McEwin, 2003, Chapter 5), in the absence of any other tool, the "vacancy rate" is a useful indicator.

Only 5 of the 15 ACCHSs had GP registrars, comprising a total of 6 GP registrars, equivalent to 4.3 FTE. Four of the registrars were located in RA 2 (Inner Regional) towns and one in an RA 1 service (Major City). There were no registrars in Outer Regional (RA 3) or Remote (RA 4) areas, which are the most difficult towns to recruit GPs to ACCHSs. As registrars are a good source of future GP recruitment for ACCHSs, it is obvious that the barriers for not having registrars should be addressed.

Table 4: Reasons Given by ACCHSs for not having GP Registrars

Reason	Number
Difficulties with providing GP supervisors	5
Don't have the space	4
Don't have the need	1

Anecdotally one of the issues raised prior to the commencement of the *GPs – Deal or No Deal?* Project was that as GPET reimburses the salaries of the GP registrars, some registrars are demanding and receiving higher hourly rates of pay than their GP supervisors in the ACCHSs. This was not the case among the surveyed ACCHSs.

2.5 Mainstream GP Earnings

There is a reluctance to put a dollar figure on GP earnings in mainstream general practice, partly because there is considerable variation in style and scope of practice and many different factors influencing earnings (eg whether or not a doctor bulk bills, time spent with each patient, hours worked and so on). Nonetheless it is possible to estimate ballpark nett earnings (ie after practice costs) and these are provided in Table 5. Practice costs have been estimated to be 40 percent of total earnings.

Table 5: Ballpark GP Nett Earnings(1) in Mainstream General Practice by ASGC – RA

GP Earnings(2)	RA 1 Major City	RA 2 Inner Regional	RA 3 Outer Regional(3)	RA 4 Remote(3)
Lower level	$130,000/year ($2,500/week)	$156,000/year ($3,000/week)	$260,000/year ($5,000/week)	$300,000/year ($5,770/week)
Upper Level	$250,000/year ($4,800/week)	$250,000/year ($4,800/week)	$350,000/year ($6,731/week)	$500,000/year ($9,615/week)
Sources:	Personal conversations with GPs, GP practice managers and Divisions of General Practice; GP vacancy advertisements from Divisions of GP, Australian Doctor, eAMA, RACGP Classifieds on line and Medical Journal of Australia accessed June & Oct 2009; Australian Doctor, (1st June 2009); RDN Information Sheet: What Can a GP in Rural NSW Expect to Bill? (Jan 2009)			

Notes:

(1) Nett earnings = 60% of total earnings; ie practice costs = 40%

(2) Assumes that the standard consultation is 15 minutes

(3) Estimated earnings in RA 3 and RA 4 towns include hospital VMO earnings. (GPs working in rural and remote practice with hospital VMO rights would expect to earn an additional $1,000+ per 24 hour VMO shift over and above the earnings from their rooms. How much they earn per week will therefore depend on their on call roster). The number of hours worked/week is expected to be higher for GPs with VMO hospital work than for those without VMO rights

3 Discussion and Recommendations

3.1 GP Salaries and Conditions

The CEOs and staff of the ACCHSs surveyed were concerned that it is difficult to access information on GP salaries and conditions in other ACCHSs as well as in mainstream practices. The CEOs indicated that they are willing to share the details of their GP salary arrangements with each other. They want information on mainstream GP earnings to be able to offer their GPs appropriate or reasonable salary packages in a competitive market.

The mainstream ballpark GP earnings have been provided in Table 5. These are possibly conservative estimates because of the reluctance to disclose earnings in private practice. It is fair to say, however, that with a few notable exceptions, the survey has revealed that GPs in ACCHSs do not, on the whole, earn less than their mainstream counterparts[4]. There are of course exceptions to the rule and the author is aware of examples in RA 1 areas (Major Cities) where GPs in ACCHSs that were not included in the survey earn less than mainstream GPs.

The findings revealed that only one of the 36 GPs in the survey was receiving a percentage of MBS revenue. Most CEOs were reluctant to offer this as they worried that it could be detrimental to quality practice. The MBS issue is also complicated as the revenue can be the result of a team effort even if it is claimed in the doctor's name. Offering a percentage of the MBS revenue is a matter for local judgment.

4 As mentioned in Section 2 of the report the range and mean of GP Salaries by ASGC – RA Classification for Surveyed ACCHSs is available but has been withheld from this abridged version of the report for reasons of confidentiality.

Recommendation 1:

***It is recommended* that ACCHSs offer GPs remuneration packages that are on a par with mainstream general practice earnings and that ACCHSs in NSW establish a consistent approach to terms and conditions of employment for their GPs. A schedule of annual GP salaries by ASGC-RA locality is available separately as a guide for ACCHSs and is based on current ACCHS GP earnings and ballpark mainstream earnings.**

OATSIH allocated funding for a GP is nominally between $120,000 and $220,000 per annum depending on location, size and a range of historical factors (verbal advice provided by OATSIH on 26th May 2009). GP earnings, particularly in rural and remote areas, have risen over the last few years and the OATSIH "nominal" GP allocation does not cover the full cost of employing a GP. ACCHSs are therefore spending Medicare revenue or other core and/or program funds to support GP services. As mainstream GP earnings have been increasing, so too has the amount of money ACCHSs have had to spend to maintain general practice services. The ACCHS CEOs interviewed for the *GPs – Deal or No Deal?* Project were concerned about managing their money appropriately to ensure that expenditure is directed to the "right service mix". They were aware of the evidence of the return on investment in primary care and agreed that GPs are vital members of the team.

Recommendation 2:

***It is recommended* that AH&MRC (in partnership with other State and Territory Affiliates) consider sustainable financial models of general practice within ACCHSs**

including the proportion of an ACCHS budget that would ideally be spent on GP services.

3.2 GP Recruitment Strategies

CEOs and other staff interviewed as part of the AH&MRC *GPs – Deal or No Deal?* Project were very concerned about the problems associated with GP recruitment and anticipated that the situation will become more difficult in the future. The CEOs stated that they should present a united front and resist paying the high rates sought by recruitment agencies and some general practitioners. They supported the introduction of shared recruitment strategies (for example, marketing ACCHSs to GPs and GP registrars) and also welcomed additional support from the AH&MRC. They felt that they did not necessarily have the skills and expertise required, for example, to recruit overseas trained doctors and suggested that the AH&MRC should have a dedicated GP recruitment officer to assist ACCHSs. There would be economies of scale and shared information and possibly better "matching" of GPs with ACCHSs.

Recommendation 3:

It is recommended **that an officer within the Member Service Support Unit of AH&MRC assumes responsibility for assisting ACCHSs with GP recruitment initiatives.**

The officer would work with the NSW Rural Doctors Network (RDN) and ideally would also involve the relevant Divisions of General Practice. The NSW Rural Doctors Network is a non government and not for profit organisation that aims to provide quality health care to rural and remote communities in NSW, through the support of a continuing and high quality medical workforce. RDN has expertise and experience in recruiting and retaining doctors in rural and remote NSW and also provides assistance as required to ACCHSs in metropolitan areas**.** AH&MRC signed a Memorandum of Understanding with RDN on 27th November 2009.

ACCHS CEOs and practice managers were keen for AH&MRC to work with them to develop a marketing strategy to promote ACCHSs to GPs and GP registrars.

Recommendation 4:

It is recommended **that AH&MRC develops a marketing strategy to attract GPs to work in ACCHSs in NSW. The marketing project would be developed in association with ACCHSs and would build upon materials already available.**

In September 2009 the AH&MRC and RDN jointly funded a workshop on GP recruitment and retention issues for ACCHS CEOs and practice managers. The workshop received favourable evaluations and the participants requested that it become an annual event.

Recommendation 5:

It is recommended **that a second AH&MRC/RDN GP Issues Workshop be held in 2010 to develop and show case strategies aimed at improving the recruitment and retention of GPs to ACCHSs.**

In recruiting GPs to ACCHSs it can be an advantage to encourage the GPs to consider applying to the Area Health Service for Visiting Medical Officer (VMO) accreditation. Being a VMO links the GP with other medical practitioners and health care providers, it

provides continuity of care opportunities and can significantly increase earnings. GP VMOs are required to care for all patients not just those from ACCHSs and are required to be on call and undertake emergency work.

While some ACCHS GPs do not want hospital work (as they find the regular nine to five, Monday to Friday, hours with no after-hours and no on-call work attractive), it is helpful to consider the issue when recruiting GPs.

Recommendation 6:

It is recommended **that GPs in ACCHSs be encouraged and supported if they wish to apply for Visiting Medical Officer accreditation with the Area Health Services and that this option be promoted (if appropriate) when ACCHSs are recruiting GPs.**

Local government contributes significantly to the recruitment and retention of mainstream GPs in many towns in rural and remote NSW. The Shire Councils support local GPs by providing housing and vehicles and often subsidise surgery rentals. Some Shires fund practice infrastructure – computers and medical equipment and so on. The findings indicate, however, that only one Shire Council (Coonamble) supports the ACCHSs that were surveyed.

Recommendation 7:

It is recommended **that the dedicated GP Workforce Officer in AH&MRC (see Recommendation 3) approach the NSW Local Government and Shires Association of NSW to present at the 2010 Shires Association NSW Annual Conference (to be held from 31st May to 2nd June). The aim would be to forge a closer relationship with local councils to encourage them to offer incentives to GPs in ACCHSs, similar to those offered in mainstream general practice.**

Regional groupings of ACCHs have been established in NSW to encourage ACCHSs to co-operate rather than compete over limited resources and to take a regional view of what resourcing is required and where resources should be directed. The ACCHSs are autonomous in their individual practices but work together to share resources and professional support. The first to be established was Bila Muuji (River Friends), a network of twelve ACCHSs in North Western NSW that grew out of an informal meeting of CEOs in 1995. The Many Rivers Aboriginal Medical Alliance on the North Coast of NSW brings together five ACCHSs and was established in 2006. It meets every six weeks. The South Coast CEO Forum, formed in 2009, brings together five services, and the Riverina/Murray CEO Forum, also formed in 2009, comprises five ACCHSs. These two southern groups meet bi-monthly to discuss initiatives, developments and issues across the regions and have been working collaboratively to incorporate workable and functional regional models.

Recommendation 8:

To promote shared GP recruitment initiatives across a regional network *it is recommended* that a pilot GP recruitment project be funded and established in the BIla Muuji area. This would build upon and further develop the shared efforts of ACCHSs within this region. The pilot project would run for 12 months and be evaluated at the end of that period. The pilot would be managed as a vertically integrated model with short and long term GP recruitment strategies

introduced. These would involve medical student placements, support for pre vocational doctors through the Pre-vocational General Practice Placements Program (PGPPP), increased GP registrar placements and additional support for overseas trained doctors in the Bila Muuji ACCHSs. Marketing and locum programs would be introduced, Councils and other organisations would be approached to offer support to ACCHSs (housing etc) and partnerships between ACCHSs and other stakeholders (Divisions of General Practice, Regional Training Providers etc) could be strengthened.

3.3 GP Locums

GP locums provided by commercial locum agencies are becoming increasingly costly. They can cost more than $10,000 per week plus travel and accommodation.

In October 2009 Bila Muuji ACCHSs were offered a locum by Wavelength International for $2,000 a day ($10,000 per week) plus travel and accommodation and also two locums from Charterhouse Medical for $1,300 and $1,400 per day ($6,500 and $7,000 per week respectively). One ACCHS manager calculated the real cost of the Charterhouse locums as follows:

> Adding the cost of travel and accommodation to these locums brings the total to in excess of $7,500 and $8,000 per week. If ACCHSs are nominally receiving $4,000 per week ($200,000 per annum) from OATSIH per GP they then need to make $3,500 to $4,000 per week from Medicare just to break even. The ACCHSs are then spending all the Medicare revenue on supporting GP locum services. “The bottom line is that ACCHSs are not sustainable if they use all the Medicare revenue to fund the doctors. On the other hand there is not much point having a medical clinic with no doctor”.

The NSW Rural Doctors Network provides subsidised locums to NSW rural and remote GPs. The locums are engaged/employed by RDN. The cost of a locum is $4,500 plus GST for 10 sessions/week with accommodation and a vehicle provided by the practice. RDN gives priority to practices in ASGC RA 3 (Outer Regional) and RA 4 (Remote) areas and/or towns with three or fewer GPs. The RDN Locum Service is designed to support incumbent GPs on recreational, personal and study/professional development leave and locums are available for up to four weeks. ACCHS can apply for these locums (see http://*www.nswrdn.com.au/site/index.cfm?display=61480*). The demand for RDN short term locums is, however, greater than its capacity to provide them.

The RDN Locum Service does not provide a locum where there is a “GP vacancy” ie to cover a workforce shortage rather than to provide relief to an existing GP. The RDN Locum Officer advised that this relates to the locum’s “duty of care” to the patients and that continuity of care is required in a shared-care arrangement – for pathology test results, referral to specialists etc (email dated 13th October 2009). Where there is no incumbent GP returning to the practice shared-care is not implied, and the responsibility of duty of care would then lie with the locum (being the doctor who has ordered the tests, referred to the specialist etc). The RDN officer further advised that if there is an avenue for ensuring handover of patients and therefore continuity of patient care, then RDN would consider

extending the locum service. Any arrangement would be clearly documented in a contract for service.

Recommendation 9:

***It is recommended* that AH&MRC and the NSW Rural Doctors Network work together to consider if the RDN GP Locum Service could be extended to provide GP locums to ACCHSs for short periods where there is no incumbent GP.**

A number of ACCHS CEOs have suggested that AH&MRC establish a GP locum service employing or contracting at least one FTE GP to provide subsidised locum cover to support ACCHSs in NSW. Locum placements would be flexible to suit the special needs of ACCHSs. This would, however, require considerable resources from AH&MRC – not just for the costs of providing the subsidised locums but also for the administrative support required to run a good service. If a locum were to be available to an ACCHS at a subsidized rate of say, $4,500 per week (with the ACCHS providing the travel and accommodation) the full cost (ie actual cost) to AH&MRC would be closer to $6,500 per week per locum. In addition the AH&MRC would also need to supply a vehicle and possibly a mobile phone to the locum. (Costings are based on advice from NSW Rural Doctors Network, December 2009).

There are also other models of locum provision. Locum programs have, for example, been established whereby urban GPs provide locum services to remote Aboriginal communities in the Northern Territory. GPs in a Leichhardt group practice in Sydney's inner west provide eight months locum cover a year to the remote Borroloola Health Centre in the NT by spending a month at a time there on a rotational basis. One of the Walgett locum GPs is involved in a similar program. This is organised through a practice in Noosa in Queensland and provides locum support to Elcho Island.

There is scope to introduce a similar model in NSW with the Bila Muuji ACCHSs promoted as opportunities to practice remotely ("why for example go to the Northern Territory? Go to Walgett" etc). Cultural training could be offered and an attractive package developed for GPs "to try it out". The program could be extended to include ACCHS GPs in metropolitan (RA 1) ACCHSs providing locums to rural ACCHSs and back filling GPs in the metropolitan service; or the model could have a regional flavour with ACCHSs in RA 2 regional towns providing locums to more remote ACCHSs and back filling. Federal funding to support the program could also be sought.

The Medical Specialist Outreach Assistance Program (MSOAP) Indigenous Chronic Disease Expansion has opportunities for ACCHSs to benefit from fly-in fly-out GPs. Funding has been allocated to the program to introduce multidisciplinary teams, comprising medical specialists, general practitioners and allied health professionals to better manage complex and chronic health conditions in rural and remote Aboriginal communities. This provides an opportunity for ACCHSs to 'top up" GP services in eligible communities. The draft guidelines for the program have been released (26 October 2009) and planning is underway in NSW.

A Federally funded GP Locum Program, announced on 21st December 2009 by the Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery, The Hon Warren Snowdon MP, will also be available to rural ACCHSs. The Rural GP Locum Program will provide locum services and subsidies to rural GPs to allow them to undertake professional development activities, take leave and attend to personal emergencies. The program will be managed by Rural Health Workforce Australia in association with the NSW Rural Doctors Network in NSW. ACCHSs in ASGC-RA areas 2 to 5 will be eligible to register for the program. For details of the program and information about registering visit the RWHA website at ***http://www.rhwa.org.au/client_images/876389.pdf*** or phone the RDN Locum Manager on 02 4924 8065.

The locum subsidy will be provided only to replace a GP who will be away from his/her practice and is not available for vacancies or to provide additional workforce.

Recommendation 10:

***It is recommended* that AH&MRC explores the options of increasing the access of ACCHSs to reasonably priced GP locums and that these options include an examination of different models such as an AH&MRC locum service, an urban – rural partnership, and fly in – fly out GP locum service models.**

3.4 Overseas Trained Doctors

The *GPs – Deal or No Deal?* Project showed a high percentage of overseas trained doctors working in rural and remote ACCHSs – more than 50 percent in the surveyed ACCHSs. OTDs comprise about 31% of the overall Australian Medical Workforce (Gilles, Wakerman and Durey, 2008, p655). The more remote the ACCHS, the more likely that the GP is an OTD.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) found that the shortage of GPs in ACCHSs in that State was related to the cultural difficulties many GPs experience when working with Aboriginal communities (VACCHO 2007). This is consistent with anecdotal evidence in NSW. Gilles et al conducted research in Queensland, the Northern Territory and Western Australia and found that orientation to the Australian health care system (Medicare, the Pharmaceutical benefits Scheme and referral pathways), cross cultural matters and information technology was generally found wanting. Many OTDs felt inadequately prepared for practice in Aboriginal health settings where social and historical issues differed from their previous experiences (Gilles, Wakerman and Durey, 2008, p658). “Health care is delivered through a social framework as well as an economic framework. In the social framework, the delivery of care in a culturally sensitive manner is (one) of the keys to effectiveness” (Access Economics, 2004, p3).

Medicare has become increasingly complex over time; OTDs have to adjust to different names for medications – even OTDS from English speaking countries take time to adjust to these clinical differences; OTDs are increasingly drawn from countries where English is not the first language – these doctors therefore face both language and cultural differences. In addition OTDs who stay in Australia long term are more likely to come from countries where English is not their first language. Those from the UK, Ireland, Canada

or the USA are likely to work in Australia for only short periods of time. OTD GPs therefore need to be supported to sustain the ACCHS medical workforce. While systematic cultural, historical and political orientation is best conducted at the local level, a State wide workshop on the Australian health care system and Aboriginal health issues for OTDs interested in ACCHS practice would be of value. GP registrars and OTDs already working in ACCHSs could also be invited.

Recommendation 11:

It is recommended **that AH&MRC and the NSW Rural Doctors Network conduct a one-day workshop introducing the Australian health care system and cultural awareness of Aboriginal health issues to overseas trained doctors interested in ACCHS practice.**

In general, overseas trained doctors are limited to where they can work by Medicare Provider Number restrictions for a period of ten years unless they have RACGP Fellowship or are on a training program. Section 19AB of the Health Insurance Act 1973 restricts access to Medicare provider numbers and requires overseas trained doctors to work in a district of workforce shortage for a minimum period of ten years, in order to access the Medicare benefits arrangements. This is referred to as the *Ten Year Moratorium.*

In January 2010 the Australian Medical Association (AMA) wrote to the Federal Health Minister urging the Government to abandon the Moratorium which the AMA claims "effectively forces many IMGs (International Medical Graduates – ie OTDs) to work exclusively in rural and remote areas for 10 years or more" (AMA Media Release, 18th January 2010). Without the OTD workforce many ACCHSs would be without GPs at least until sufficient numbers of new medical graduates are appropriately trained in Australia. "The recent expansion of medical schools and undergraduate places in Australia is intended to make Australia more self-reliant but it will be at least several years until these graduates move into the workforce." (Rural Health Workforce Australia CEO, Dr Kim Webber, Media Release, 20th January 2010)

Overseas trained doctors can apply for a Section 19AB exemption to the full Ten Year Moratorium if they agree to meet certain requirements[5]. For the more rural and remote places this ten years may be reduced to 3.5 to 5 years. This provides incentives for OTDs to work in some of Australia's smaller rural and remote communities by reducing the length of time that provider number restrictions apply. The Federal Government announced further changes to the reduction in the Ten Year Moratorium in its May 2009 Budget. It is still uncertain what will happen but it is likely that a sliding scale scaled according to ASGC – RA will be introduced.

Recommendation 12:

As the GP vacancy rate in ACCHSs in NSW is twice that of rural NSW as a whole, *it is recommended* that AH&MRC lobbies the Department of Health and Ageing to provide additional incentives for overseas trained doctors to work in ACCHSs by reducing the length of time that provider number restrictions apply if a doctor works in a NSW ACCHS and meets other eligibility criteria.

5 To be eligible for this program, applicants must be willing and able to gain Fellowship of either the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM) within two years and where applicable, gain permanent residency during that same two year period.

3.5 GP Registrars

The survey identified that only five of the 15 ACCHSs had GP registrars. Their salaries and on costs are reimbursed by GPET. In three of the five services registrars had stayed on or returned to work after gaining RACGP Fellowship. Registrars are potential ACCHS GPs of the future and should be valued as such.

Potentially 11 of the 15 services surveyed could have GP registrars although barriers exist including lack of space; insufficient GP supervisors; the lack of active promotion of the benefits of working in ACCHSs; the reluctance of registrars to work in remote areas; and an insufficient number of GP registrars to meet the total (ie including mainstream) number of available placements.

The benefits of working in an ACCHS include challenging and rewarding clinical work in a well supported environment, flexibility and teamwork, being able to spend a longer time with patients than in mainstream practice, adequate time available for study (as there is no after hours work) and, of course, experience in Aboriginal health. One registrar interviewed for the project (on 12th November 2009) said that she thought the work would be very rewarding but that she was also pleasantly surprised at how well supported she was.

Anecdotally registrars choose their placements based largely on the experiences of other registrars. "Once the word gets around registrars go to a practice (or ACCHS) because the previous registrars say it was good" (GP Registrar comment, 12th November 2009). Rates of pay are also important, particularly as many of the registrars are older with families and financial commitments. It is therefore important that salaries are appropriate and above the baseline. Difficulties associated with supervision can be addressed by encouraging more mainstream GPs to provide supervision, particularly for subsequent or advanced term registrars. Registrars could be shared with mainstream practices.

A successful GP training program in ACCHSs does, however, depend on a sustainable general practitioner workforce in NSW ACCHSs. The GP shortage and the high number of OTDs who are ineligible to become supervisors preclude many ACCHSs from offering registrar supervision. To overcome this, an innovative GP Supervisor model could be developed as follows: a mainstream or academic GP could be available (or appointed) to provide supervision to registrars in a number of ACCHSs. The model could, for example, have a GP located in a regional centre, say Dubbo, Wagga Wagga, Orange or Lismore, attached to a Rural Clinical School, who is able to provide supervision to GP registrars as well as supervision for overseas trained doctors working in ACCHSs. A Rural Clinical School GP provides teaching to medical undergraduates and hence the model becomes a vertically integrated program supporting medical students, pre vocational doctors, GP registrars and Area of Need (AON) and Rural Locum Relief Program (RLRP) GPs in ACCHSs.

Recommendation 13:

***It is recommended* that AH&MRC seeks funding to develop a "Regional and Roaming GP Supervisor Scheme" whereby GPs in regional centres provide supervision to GP registrars in ACCHSs in the region.**

3.6 Why do GPs work in ACCHSs?

Numerous studies have examined the factors that impede or facilitate the recruitment of medical practitioners into rural practice. This research has shown that students from a rural origin and those with early exposure to rural and remote practice are more likely to take up rural practice (Humphreys et al, 2007, p9). In the absence of definitive research on the reasons why GPs choose to work in ACCHSs and given that the majority of ACCHSs are in rural and remote areas, the initiatives to attract GPs to ACCHSs are often based on the successes of programs to recruit and retain rural doctors.

Recommendation 14:

***It is recommended* that research is conducted examining the reasons why GPs choose, or choose not to, work in Aboriginal Community Controlled Health Services. The findings will inform recruitment strategies aimed at attracting GPs to practice in ACCHSs.**

3.7 ACCHSs are not cottage industries and need to think strategically[6]

ACCHSs need to be smart about business planning in a rapidly changing landscape. Research has confirmed that core funding to ACCHSs is insufficient to meet the costs of comprehensive primary health care. There is now greater reliance on the Medicare Medical Benefits Schedule but even so this is insufficient to meet the costs of the medical workforce (Couzos and Murray 2008). In addition, new Federal Government initiatives are encouraging mainstream general practice to provide more targeted services for Aboriginal patients. The most sustainable ACCHSs will be those with business acumen.

A range of Commonwealth Government initiatives have been introduced over the years to improve access to MBS for GPs and services providing care to Aboriginal people. These include the:

- Exemption under Subsection 19 (2) of the *Health Insurance Act 1973*. This enables ACCHSs to claim Medicare rebates for services provided
- Appointment of Medicare Liaison Officers for Indigenous access within Medicare Australia
- Creation of certain Enhanced Primary Care items intended to meet specific Aboriginal and Torres Strait islander health needs, such as health assessments for Aboriginal and Torres Strait Islander adults and children
- Additional payments for bulk billing concessional patients and children aged under 16 years

ACCHSs vary in their capacity to capture all the Medicare income to which they are entitled. The 2006 Urbis, Keys, Young study into Aboriginal and Torres Strait Islander Access to Major Health Programs found that the reasons for under claiming include:

> "Varying GP familiarity with Medicare and varying degrees of motivation to claim; limited Medicare knowledge among other ATSIHS staff; the complexity of some aspects of Medicare; the limitations of administrative systems, patient records and IT systems; variations in the ways in which services are structured and

6 Comment from an ACCHS CEO interviewed during the consultations

the relationships between management and GPs; and the competing pressures that may reduce staff time available for investment in Medicare" (Urbis, Keys, Young 2006 p44).

While no ACCHS wants to compromise quality medical care by being driven by the dollar, ongoing information and training about Medicare for ACCHS GPs and staff is clearly important. As one ACCHS CEO said "open the flower a little to get the pollen". It is also important to remember that when the GPs sign over their MBS revenue to ACCHSs under Subsection 19 (2) of the Health Insurance Act they are doing so for the ACCHS to have additional funds for a range of services and not just to be able to pay their GPs more. Linking MBS revenue directly with GP salaries is therefore problematic, nonetheless in the current funding model for ACCHSs it is wise to maximise Medicare MBS revenue entitlements.

Recommendation 15:

***It is recommended* that a Medicare Enhancement Officer be appointed in AH&MRC to provide information to ACCHSs on all Medicare related issues. The primary focus of the position initially would be to conduct Medicare audits with ACCHSs to streamline Medicare practices and operations.**

The Council of Australian Governments (COAG) initiatives are also providing opportunities for ACCHSs to become involved in new and expanded programs that will bring revenue to the services, for example the expanded Practice Incentive Program (PIP), which is available to ACCHSs and non Aboriginal Community Controlled organisations, such as Divisions of General Practice and private-for-profit medical practices. The new PIP Indigenous Health Incentive is designed "to encourage better care, particularly from mainstream general practices of Aboriginal people with chronic disease to help 'close the gap' by reducing Aboriginal health disparity" (Couzos and Delaney Thiele, 2009). The new PIP, due to commence in May 2010, will not be available to ACCHSs without accreditation (or those not aiming to gain accreditation within 12 months) against the RACGP standards.

Good practice management underpins the future sustainability of ACCHSs. While GPs tend to come and go in many ACCHSs, anecdotally the turn over among practice managers is generally low. Practice managers have a crucial role in ACCHSs to ensure that the services are well informed about Government programs including Medicare, PIP and so on. Additionally there is a raft of recruitment and retention incentives available for rural and remote GPs. The incentives are, however, funded from a variety of government programs (Federal and State) and often change. Practice managers should be supported to ensure that eligible GPs are applying for available incentives. Support for practice managers could be managed through State wide and regional Practice Managers Forums.

Recommendation 16:

***It is recommended* that AH&MRC establishes a network of ACCHS Practice Managers.**

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APPENDICES

APPENDIX A
List of ACCHSs consulted in the *GPs – Deal or No Deal?* Project

Balranald Aboriginal Health Service
Bourke Aboriginal Health Service
Brewarrina Aboriginal Health Service
Coomealla Aboriginal Health Corporation
Coonamble Aboriginal Health Service
Galambila Aboriginal Health Service
Griffith Aboriginal Medical Service
Illawarra Aboriginal Medical Service Aboriginal Corporation
Orange Aboriginal Health Service
Riverina Medical and Dental Aboriginal Corporation
South Coast Medical Service Aboriginal Corporation
Thubbo Aboriginal Medical Co-op
Walgett Aboriginal Medical Service
Wellington Aboriginal Corporation Health Service
Yerin Aboriginal Health Services

APPENDIX B
List of People Consulted in the *GPs – Deal or No Deal?* Project

In the ACCHSs

Mr Darren Ah See
Ms Julie Bailey
Mr Darren Barton
Dr Jennifer Bell
Ms Julie Booker
Dr Jane Brabin
Ms Glynis Byers
Ms Jen Cook
Ms Christine Corby
Mr Phillip Dowse
Ms Skye Duncan
Ms Rose Gordon
Mr Lyndon Gray
Ms Anne Greenaway
Mr Tim Horan
Ms Judy Johnson
Mr Danny Kelly
Mr David Kernick
Ms Hellen Mannix
Ms Stacey Meredith
Ms Fran Mooy
Ms Jo Naughton
Mr Jamie Newman
Ms Lisa O'Hara
Dr Helen Palmer
Mr John Pickles
Ms Sharon Silversides
Ms Karnie Walford

In AH&MRC

Ms Melinda Bell
Mr Stello Doussis
Ms Sally Dunn
Ms Victoria Elwood-Jones
Mr Warren Frost
Dr Jenny Hunt
Ms Sofia Lema
Ms Kerri Lucas
Mr Ben Thomson
Mr Rodger Williams

Others

Ms Karen Argall, RWAV
Ms Wendy Bachaus, OATSIH
Ms Deborah Bardon, Central West DGP
Dr Liz Barrett, RDN
Dr Jenny Beange, Dubbo Plains DGP
Dr Ian Cameron, RDN
Professor Stan Capp, Cappela Consulting
Ms Sandra Christensen, Central West DGP
Dr Paul Collett, RDN & Outback DGP
Ms Shirley Crowley, GP Logic
Dr Heather Dalgety, GP Bourke
Dr Grahame Deane, GP Gunnedah
Dr Myra Dunn, GP Logic
Dr Rose Ellis, RDN
Mr Tony Ellul, OATSIH
Mr Peter Faulkner, Bendigo Health Service
Ms Sharon Flynn, CCC Training
Mr Stuart Gordon, Outback DGP
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Dr Jane Marr, GP Walgett
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Mr Marc Prospero, GP Logic
Ms Suzanne Riley, RDN
Ms Sian Rudge, NSW Health
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