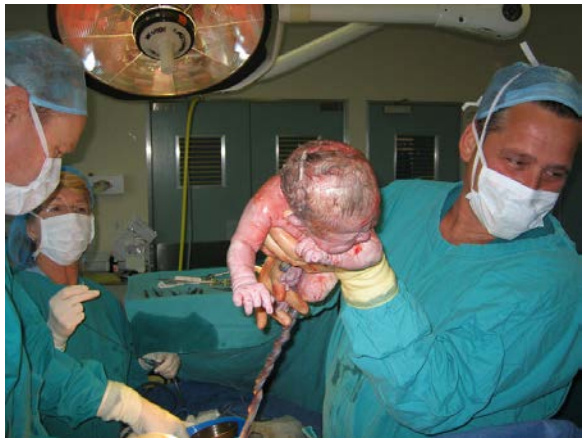
The supply and distribution of GP proceduralists: Implications for rural workforce policy



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Background

- Problem: timely & local access to specialist services in places in rural and remote Australia which:
  - Are too small to support resident specialists
  - Are big enough but have unmet need/demand
  - Have sufficient infrastructure/staff base
- Two main solutions:
  1. Specialist outreach
  2. Procedural GPs

1. Specialist Outreach

- ~20% of specialists provide outreach
  ~3% of specialists provide remote outreach[1]
- Well targeted
  - 42% of outreach services are to ASGC-RA 3-5[2]
- Frequently subsidised
  - 46% of outreach specialists receive subsidies[3]
  - Almost half of the subsidies are from Rural Health Outreach Fund (RHOF) [3]
  - Comprehensive subsidies[4]

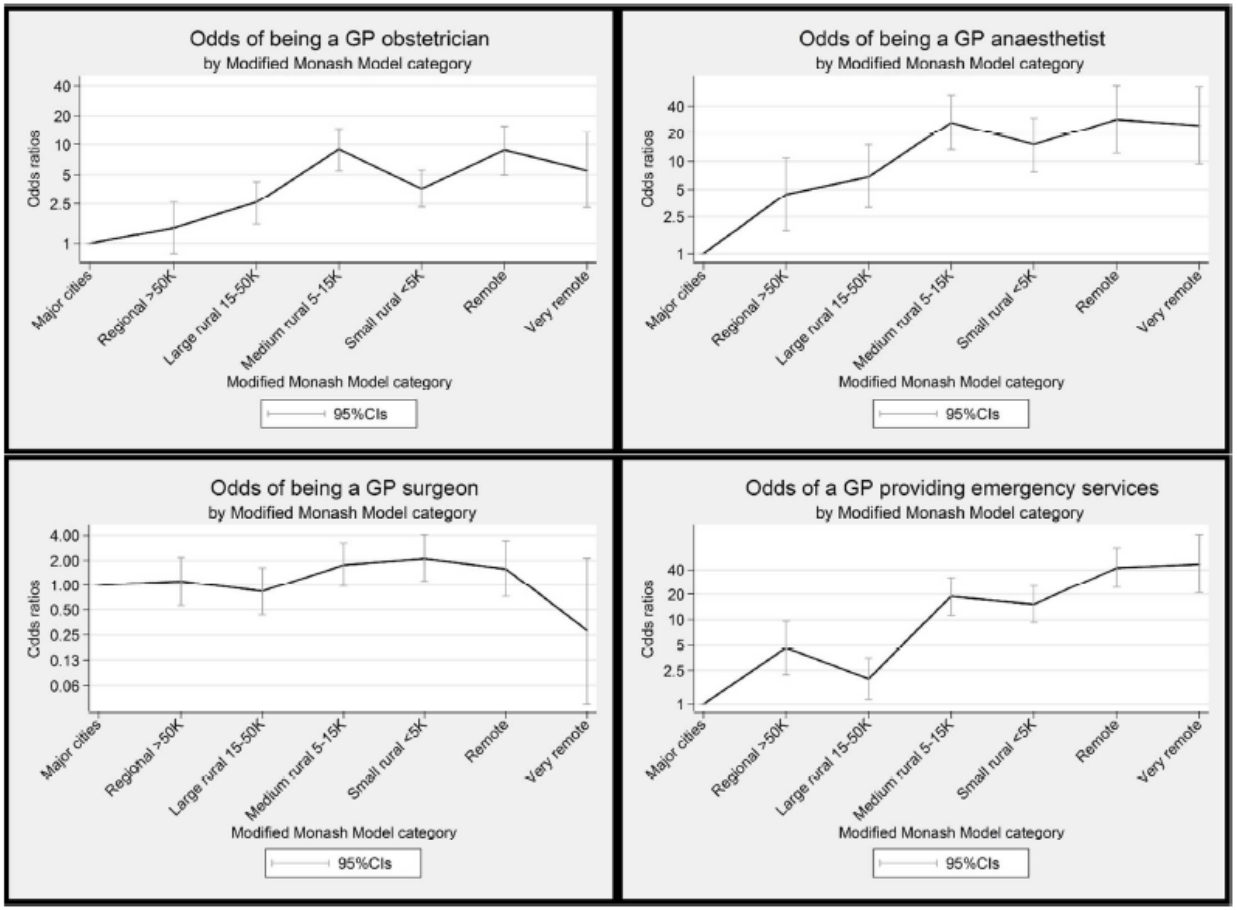
Specialist Outreach (2)

- Complex drivers: multiple factors influence supply and retention in different ways[1]
- ~Half services are sustained 3+ years[5]
- Outreach to smaller towns more stable[5]
- RHOF associated with:
  - priority services in more remote locations[3]
- Outreach by obstetrician/anaesthetists/ED uncommon

2. Procedural GPs

- GPs with advanced skills
  - Anaesthetics, obstetrics, surgical, emergency
- Live locally → more timely care
- Provide continuity of care (better retention)[6,7]
- Save lives & reduce morbidity
- Over last 20 years ↓numbers, ↓proportion of GP workforce & ↓procedural services provided

Distribution of Procedural GPs



- Located in medium-sized or smaller rural and remote communities[8]

Hours worked by setting

- Procedural GPs work longer[8]
  - Total hours ~10 hours more
  - Similar hours in private rooms, ↑hospital hours

	Anaesthetics		Obstetrics		Surgery		Emergency	
	No	Yes	No	Yes	No	Yes	No	Yes
Private consultation rooms	31.4	27.5	31.3	31.3	31.1	34.4	31.4	30.2
Public hospital	1.3	13.4	1.3	7.4	1.6	3.0	0.7	9.0
Private hospital	0.6	2.6	0.6	0.6	0.5	3.4	0.6	0.8
All other settings	4.8	5.8	4.8	5.3	5.0	3.1	4.6	6.8
TOTAL HOURS WORKED	38.1	48.5	38.0	44.6	38.1	43.5	37.3	46.5

Hours worked 2011-2013

- Consistently more hours hospital and total
  - multiple regression models adjusting for confounders[8]

(a) Hours worked in a hospital setting				
	Anaesthetics	Obstetrics	Surgery	Emergency
	Effect†	Effect	Effect	Effect
Wave 4	2.09**	1.28**	1.36*	1.67**
Wave 5	2.11**	1.14	1.39**	1.93**
Wave 6	1.77**	1.21	1.33*	1.71**
(b) Total hours worked each week				
	Anaesthetics	Obstetrics	Surgery	Emergency
	Effect	Effect	Effect	Effect
Wave 4	1.09*	1.14**	1.08**	1.18**
Wave 5	1.10**	1.09**	1.07*	1.17**
Wave 6	1.03	1.09**	1.08*	1.10**

†Effect values are % increase in hours worked (eg. 1.28 represents a 28% increase in hours worked compared to the reference group)

Providing on-call services

- Significantly more likely to provide on-call
  - multiple logistic regression models adjusting for confounders[8]

	Anaesthetics	Obstetrics	Surgery	Emergency
	Odds Ratio	Odds Ratio	Odds Ratio	Odds Ratio
Wave 4	2.6**	2.6**	1.3	3.5**
Wave 5	2.9**	1.9**	1.1	2.4**
Wave 6	3.9**	2.4**	1.2	3.1**

* p<0.05

** p<0.01

Policy implications (1)

- Procedural GPs are providing core specialist AND GP services where most needed

  →rural workforce maldistribution

- Longer hours/on-call, wider scope of practice, ability to manage patients locally & continuity of care

  → excellent value for money

- Policy responses to date have included:
  - Rural Generalist Training Programs (GP Registrars)
  - GP Procedural Training Support Program (VR GPs)
  - Rural Procedural Grants Program (CPD)

Policy implications (2)

- Recent graduates interested in procedural work but not in long hours and on-call

  →investigate alternative models of service delivery
  →change funding/financial incentives

- Next steps to ↑uptake of GP proceduralism may include:
  - Ensure seamless pathways into procedural practice
  - ↑Professional recognition
  - Streamline IMG pathways to procedural practice

References

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