Access all areas:
New solutions to GP shortages in rural Australia

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There are serious access problems – especially in rural and remote areas

People reporting access barriers due to cost in the last year, by remoteness, 2010

Source: Commonwealth Fund
There is huge variation in GP services per person across Australia – we focus on areas of extreme shortage.

Fulltime Work Equivalent GPs per 100,000 population, Medicare Local areas, 2011-12

GP FWEs per 100,000

Current service level

Melbourne & Sydney average: 103

Source: Grattan Institute
There is huge variation in GP services per person across Australia – we focus on areas of extreme shortage

Fulltime Work Equivalent GPs per 100,000 population, Medicare Local areas, 2011-12

GP FWEs per 100,000

Current service level

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Proposed increase

Kimberley – Pilbara
the Northern Territory
Central and North West Queensland
Goldfields – Midwest
New England
Southern New South Wales
South West Western Australia

Source: Grattan Institute
Fulltime Work Equivalent GPs per 100,000 population, Medicare Local areas, 2011-12
Low access consequences 1: Health and hospital cost outcomes

Costliness of care
Adjusted cost per separation (relative to Australian average, 2008-9 to 2010-11)*

Adjustments include controls for:
- DRG mix
- Admission mode
- Separation mode
- Age
- Indigenous status
- Patient remoteness
- Hours of mechanical ventilation
- A weighted charlson score
- SLA measures of public health (e.g. smoking rates)
- Hospital network scale
- Hospital network scope
- Whether a hospital is a specialist women’s/children’s

Source: Grattan analysis of NHCDC data
Low access consequences 2: High financial costs for patients who need care the most

Bulk billing by GP access, 2011

Average proportion of services that are **not** bulk billed

Source: Grattan Institute (from DoHA data)
New solutions are needed – progress is too slow where the problem is worst

GP FWEs per capita, 2006-07, 2011-12 (left) and annual growth rates (right)

Years to reach major city (2011-12) level on current trends, by remoteness

Source: GP Workforce Statistics, 2013
GPs could get more support from a team of professionals who can focus on less complex visits

### GP visits by complexity and remoteness, 2011-12

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>New problem</td>
<td>10%</td>
</tr>
<tr>
<td>Existing problem</td>
<td>9%</td>
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<tr>
<td>‘More complex’ visits</td>
<td>81%</td>
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</tbody>
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**‘Less complex’ GP visits**
- Only one problem managed
- 1-2 medications prescribed
- No pathology or imaging
- No procedures (excluding immunisations)
- No referrals
- No other clinical treatments (excl. advice/education)

*Source: Grattan Institute analysis of BEACH data*
Proportion of ‘less complex’ visits with relatively straightforward problems

- Oral contraceptives
- Allergic dermatitis
- Sinusitis
- Ear infections
- Bronchitis
- Immunisations
- Colds

Proportion of ‘less complex’ visits by remoteness

Source: Grattan Institute analysis of BEACH data
GP agreement that “I often undertake tasks that could be done by someone less qualified than me” (left) and relationship with job satisfaction (right)

Source: MABEL, w4
Pharmacists are trusted professionals, located throughout Australia, who could provide a wider range of services

- Pharmacists play broader roles in primary care in many other countries
- There is good evidence that this is convenient for patients, improves quality of care, and contains costs
- Pharmacists should:
  - give vaccinations – independently
  - give repeat prescriptions – with GP referral
  - advise on chronic care – with GP referral

**Some broader pharmacist roles around the world**

**Pharmacist vaccinators**
US, Canada, Portugal, Ireland and the UK. Successful trials in New Zealand

**Reissuing prescriptions for long-term conditions**
UK and some Canadian provinces

**Pharmacists in a chronic care team**
Canada, the UK, New Zealand and the US
Retail pharmacist FTEs/100k relative to national average (100%)

Source: Grattan Institute analysis of ABS Census data
Physician assistants are a new workforce group that could increase flexibility and access, while containing costs

- Physician assistants practice medicine *under the direct supervision of a doctor*

- Their role is agreed with the supervising doctor, and can develop over time along with trust, experience and training

- They do a two to three-year degree, much of which overlaps with medical training

- Around 13 countries have experimented with physician assistants, but they are most widespread in the US, where there is around one for every 10 doctors. Many work in primary care, and in rural and remote areas.

- Two trials in Australia (QLD and SA) have been very encouraging
Health worker views on how well physician assistants would integrate into a rural/remote context, Queensland, 2010

Patient views on physician assistants, Qld pilot, 2010

Wait time compared with last visit

<table>
<thead>
<tr>
<th>Wait time</th>
<th>Before</th>
<th>After</th>
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</thead>
<tbody>
<tr>
<td>Much shorter</td>
<td></td>
<td></td>
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<tr>
<td>A bit shorter</td>
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<td></td>
</tr>
<tr>
<td>About same</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A bit longer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much longer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure</td>
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Willingness to see physician assistant next visit

<table>
<thead>
<tr>
<th>Willingness</th>
<th>Before</th>
<th>After</th>
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<tbody>
<tr>
<td>Definitely</td>
<td></td>
<td></td>
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<tr>
<td>Probably</td>
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Source: Urbis
Using these suggestions, filling access gaps in the worst-served rural and remote areas would cost less than $43 million

Based on conservative assumptions, in the seven worst-served rural Medicare Local areas:

- Pharmacists could fill almost one quarter of the gap (24%) – for $5 million
- Physician assistants could do the rest – for $37 million
- Physician assistants would only be able to claim on the PBS and MBS if they work in an under-served area and would be required to bulk bill
- Estimated patient savings of over $7.5 million
- GP clinics would generate a surplus from employing physician assistants (Medicare Local area averages range from $18,000 to $56,000 a year per physician assistant)

All pharmacists and physician assistant care is delegated by GPs (except vaccinations)

Nationally, less than 1% of all GP visits would shift to a new provider

This doesn’t replace or rule out other solutions: nurses, paramedics, flying doctors, etc.
Hospital CEOs and their direct reports saw big opportunities to shift workload between workforce groups

For each of the following groups respondents were asked to estimate the percentage of workload that could be done by a lower-cost group, without reducing quality of care.
There was very strong agreement with a wide range of substitution options.

Respondents were asked to what extent they agreed that the following shifts of workload would reduce the cost without reducing quality and safety.

- Interns to ENs
- ENs to cleaners
- Residents to clerical workers
- ENs to clerical workers
- RNs to personal care assistants
- Specialists to RNs
- RNs to clerical workers
- Specialists to physician assistants
- Residents to physician assistants
- ENs to personal care assistants
- Occupational therapists to allied health assistants
- Physiotherapists to physiotherapy assistants
- Interns to nurse practitioners
- ENs to nurse practitioners
- RNs to ENs
- Interns to clerical workers
- Residents to clerical workers
- RNs to personal care assistants
- ENs to clerical workers
- Residents to clerical workers
- Interns to ENs
Professional culture and industrial relations were seen as the biggest barriers to substitution across all fields …

Proportion of respondents identifying barriers that prevent the shifting of workload

- Implementation or transition costs
- Management Capacity
- Not Specified
- Other
- Substitute workforce availability
- Registration Restrictions
- Substitute workforce capacity/quality
- Tradition
- Industrial Relations
- Professional Culture