The career intentions of solo doctors in rural Victoria

December 2008

Rural Workforce Agency Victoria 2008

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Abbreviations and Symbols

Abbreviations

CME	Continuing Medical Education
ERP	Estimated Resident Population
GP	General Practitioner
IMG	International Medical Graduate
RRMA	The Rural, Remote and Metropolitan Areas Classification system
VMO	Visiting Medical Officer

Symbols in tables

. .	Not applicable
–	Nil or rounded to zero

Executive Summary

This report presents the findings of research conducted by Rural Workforce Agency Victoria (RWAV) on the career intentions of solo GPs in rural practice in Victoria.

Solo rural GPs face significant challenges in maintaining the viability of their practices, particularly those with no other, or only one or two other GPs operating. The loss of just one GP can have a substantial impact on the delivery of primary care and hospital services across a whole region. It can mean loss of choice and procedural skills in a local community, and reduce the availability of after-hours activity and flexibility in the way services are delivered.

A number of issues were of concern to RWAV in undertaking this project, including determining the career intentions of solo rural GPs, and understanding how GP services in small towns with a limited number of alternative GP services can remain viable.

Main findings

RWAV data as at November 2007 indicate that of the 317 general practices in rural Victoria, 103 (33%) operate as solo practices. There are 1,080 GPs working across rural Victoria, with 112 (10%) working in solo practice.[1] Of those working in solo practice, 43 GPs worked in towns with five or fewer doctors, while 21 worked in solo doctor towns.

Workforce intentions

While none of the 18 GPs that participated in this study planned to retire within the next five years, a significant number indicated they planned to reduce hours and/or would consider changing the type of work they did, including becoming a locum. Work and family balance were important reasons to consider changing workforce arrangements as were choices around children's education, workload and health. Being solo GPs, changes such as these are likely to impact practice viability.

Satisfaction with solo rural practice

The GPs interviewed for this study identified a range of benefits and positive experiences in rural solo practice. The majority chose this form of practice because it provides a high level of autonomy, independence and the opportunity to "be my own

[1] The number of GPs working in solo practice (112) is higher than the total number of solo practices in rural Victoria (103) because some practices operate with job sharing arrangements.

boss". The majority of solo GPs enjoyed the connectedness to the communities in which they live, the rural lifestyle and the convenience of living in a rural community. Practising in a rural location enabled GPs to work closely with their patients, with nearly two thirds indicating that this was important to them.

The autonomy of solo rural practice, however, has some less favourable aspects. The lack of locums and limited opportunities to take leave, the administrative/management burden, the high cost structure of solo practice, and the lack of professional support and back-up were reported to be significant challenges. Many respondents also felt there was limited professional support and access to medical facilities.

This sample of solo GPs reported high workloads, including both on-call and after hours work, with half indicating they disliked this aspect of their practice. In comparison to other practice structures, solo GP practices also face the challenge of sustaining a level of revenue sufficient to support total practice overheads.

Support and assistance needed

The shortage of GPs continues to be a pressing issue for rural communities, health service providers and GPs themselves. As long as the supply of GPs to rural communities remains below demand, slowing the rate of GP exits by providing the support and assistance needed by rural GPs will, in the short to medium term, be an important point of policy leverage.

For solo GPs, support and assistance must be targeted at maintaining the viability of their practices. In particular, the majority of respondents in this study indicated that a Statewide locum service would be highly valued. Improved access to locums would alleviate some of the pressures of always being in demand, enabling solo GPs to take holidays, spend time with their families and to take study leave. Assistance with recruitment may also enable solo rural GPs to stay in or better manage their practices.

Other types of support that may assist solo GPs with practice viability include advice on how to work more collaboratively with other practices (while maintaining their independence); and the provision of professional support and back-up to ensure long- term sustainability.

The provision of these types of business advisory services, in addition to formal retirement planning support, are critical in rural Victoria, particularly in those towns that rely on the services provided by solo GP practices and where GPs are approaching retirement age.

1 Introduction

The Rural Workforce Agency Victoria (RWAV) assists rural Victorian communities gain accessible, equitable and sustainable medical and supporting health services to improve their health status. RWAV's key programs focus on the attraction, recruitment and retention of doctors to rural Victoria. As a state-wide organisation, it also conducts medical workforce research and planning.

Recent reports have demonstrated that the Australian rural workforce is characterised by an increasing demand for GP services, a decrease in the number of hours worked by GPs, an ageing medical workforce, and an inadequate number of Australian and overseas trained doctors to meet the demand for health services in rural areas (AMWAC 2005; APC 2005). These factors are impacting on health service delivery for people living in rural areas, and the loss of just one GP can have a substantial impact on the delivery of primary care and hospital services across a whole rural region.

Solo GPs face greater challenges with practice viability than GPs in other practice structures. Solo GPs in small towns with no other, or only one or two other GPs practising are the most vulnerable. RWAV's database of GPs and practices, as at November 2007, indicated that:

- 112 of 1080 GPs (10%) worked in solo practice in rural Victoria (RRMA 3-7; see Table A1.1 in the Appendix for more information on the RRMA classification)
- 43 solo doctors were working in towns with five or fewer doctors, and 21 worked in solo doctor towns
- 103 of 317 (33%) practices in RRMA 3-7 classified locations were solo practices.

There has been some research conducted on solo practice, the most notable as part of the Rural Doctors Association of Australia National Viable Practice Study conducted by Monash University for the Rural Doctors Association of Australia (RDAA 2003). However, there has been no research conducted that examines the workforce intentions and experience of solo general practitioners in small communities in rural Victoria.

This report presents the findings of research conducted by RWAV regarding the career intentions of the 10% of rural GPs working in solo practice in Victoria.

1.1 Report overview

The career intentions of solo doctors in rural Victoria research project involved:

- a literature review
- an analysis of data from RWAV's GP workforce database
- semi-structured interviews with a sample of solo GPs.

Section 2 summarises key issues and trends in the rural GP workforce environment. Section 3 presents an analysis of data from the GP workforce database and the results of the interviews with the GP sample. A discussion of the research findings is provided in Section 4, and conclusions are presented in Section 5. The research methodology is outlined in the Appendix.

1.2 Research Objectives

With a significant number of Victoria's rural GP workforce operating as solo doctors in towns with a limited supply of alternative GP services, coupled with the fact that 4 in 5 of these GPs are approaching retirement age, a number of issues were of concern to RWAV in undertaking this project. In particular, the research on solo GPs explored:

- their satisfaction with solo rural general practice
- their intentions in relation to retirement or other changes to participation in the workforce
- their intentions in relation to their practice including their views on the future of service delivery in their town and what they would like to see happen
- decision drivers and barriers
- replacement issues including what will be needed to maintain services to their communities
- retirement, financial or succession planning considered or undertaken
- forms of assistance that may extend their satisfaction with solo practice or extend their participation in the workforce.

2 The rural GP workforce environment

To provide context for this study of the career intentions of solo GPs in rural Victoria, this section provides a summary of some of the prevailing issues and trends in the rural GP workforce, the most critical being the insufficient supply of GPs.

Solo GPs face greater challenges with practice viability than GPs in other practice structures, and solo GPs in small towns with no other, or only one or two other GPs operating are the most vulnerable. The loss of just one GP can have a substantial impact on the delivery of primary care and hospital services across a whole region. It can mean loss of choice and procedural skills in a local community, and reduce the availability of after-hours activity and flexibility in the way services are delivered.

Health service need

It is well documented that on a range of measures, Australians living in rural areas experience poorer health than those living in capital cities and have less access to health services (AIHW 2005). Access to GPs, in particular, has been shown to be related to the rate of avoidable mortality, that is, those causes of death that are potentially avoidable at the present time, given available knowledge about social and economic policy impacts, health behaviours and health care (Page et al 2006). Similarly, there is evidence of a relationship between continuity of care with a GP or family physician and a reduction in hospitalisation rates. For example, a Canadian study of older adults found that those with high continuity of care had reduced odds of being hospitalised for ambulatory care-sensitive conditions relative to those with a low continuity of care profile (Menec et al 2006).

The growing and ageing population

Australia's estimated resident population (ERP) passed the 21 million mark in 2007. Over two-thirds (68.5%) reside in the major cities and 31.5% live in regional, rural and remote locations. Victoria's population now exceeds 5.2 million with an estimated 73% (3.8 million) living in Melbourne and surrounds and 27% (1.4 million) living in regional and rural Victoria (ABS 2007).

As well as growing, Australia's population is also ageing. Population projections based on current trends in fertility, mortality and net overseas migration show that the ageing of the population will continue. This is the inevitable result of fertility remaining at low levels over a long period and increasing life expectancy. As growth slows, the population is

projected to age progressively with the median age of 35 years in 2000 increasing to about 40 in 2021 and to above 45 years in 2051. By 2051, approximately 1 in 4 Australians will be aged 65 years and over, with coastal and inland areas having significantly older populations than urban and regional centres (ABS 2005). Coastal regions are estimated to experience growth of 210% in the number of seniors between now and 2045. For inland regions, the rate is estimated to be 180% (DoHA 2008).

As the population ages so of course does the workforce. Since the mid 1970s the workforce (especially the full-time workforce) has been ageing at a rate faster than the general population. The average age of the workforce increased from 35.8 years to 38.6 years (an increase of 2.8 years) between 1984 and 2004, while the average age of the general population rose by 2.2 years (from 36.6 years to 38.8years). This is partly due to an increase in the number of older women who have entered the job market, with the average age of women in the workforce increasing by 5.6 years (from 34.9 years to 38.5 years) (Parliament of Australia 2005).

The average age of the workforce differs across industry with workers in education and health among the oldest workers. In comparison to the average age of the total workforce in 2004 (38.6 years) the average age of workers in the education sector was 43.4 years, while the average age of workers in the health and community sectors was 41.7 years. In these two sectors the average age has risen by 5.2 and 5.5 years respectively in the twenty year period in question.

According to Schofield and Beard (2005) the ageing of the "baby boomer" generation (those born between 1946 and 1964) and population growth will place an unprecedented demand on health services, and there is a shrinking pool of employed younger people to meet this demand.

An ageing GP workforce

The rural GP workforce is ageing faster than the urban GP workforce. Schofield et al (2006) analysed the age distribution of rural and urban GPs between 1986 and 2001. They found that during this time both the rural and urban GPs aged, with rural GPs being significantly older by 2001. The percentage of rural GPs aged over 40 years rose from 40% to 60% during this period compared to 43% to 57% for urban GPs. In 2001, baby boomers (those GPs born between 1946 and 1964) made up 52% of the city GPs compared to 59% of the rural workforce.

GP working hours

The average number of hours worked by rural GPs is influenced by age and gender. In 2007, over half of Australian rural female GPs (56%) worked part-time (less than 35 hours per week) while this was the case for only 27% of male GPs (HWQ and NSWRDN 2008). With women now making up 32% of all rural GPs and 53% of rural GPs under the age of 35, the decreased average number of hours worked is likely to continue. The proportion of women in Australian medical schools is now approaching 60%, and 63% of GP registrars are women (Medical Training Review Panel 2007). According to Brooks et al (2003), female doctors have a working life that approximates to 60% of that of male doctors due to family demands, and a desire to work sensible (and regular) hours on their return to the workforce. The desire for greater work-life balance is also evident in younger male and female doctors.

Older GPs tend to work longer hours than younger GPs. There is increasing evidence that younger GPs regardless of gender are working (and wanting to work) fewer hours than their older counterparts. For example, Tolhurst and Stewart's 2004 study of medical students showed that most wanted to achieve a balance between work and family and indicated they would seek out locations, disciplines and organisational arrangements where it was possible to achieve this.

Policy drivers

In addition to changes in the workforce demographics and workforce participation patterns of rural GPs, the supply of GPs has been significantly impacted by policy decisions that control the number of medical student intakes. The medical workforce was considered to be in surplus throughout the 1980s and into the 1990s, and medical school intakes remained static. In the late 1990s, opinion began to swing back to a view of medical workforce shortage, and after a 20-year period of no change, intakes to medical schools were once again rigorously augmented.

The number of domestic graduates from Australian medical schools is set to increase by 81% in seven years, from 1,348 in 2005 to 2,442 by 2012. Including international students, medical school graduates will total almost 3000 by 2012 (Joyce et al 2007). While this change in policy has been widely welcomed, the impact is not likely to be felt for several years because of the long duration of medical courses, some of which involve 12 years of study. Furthermore, domestic medical graduates have demonstrated great reluctance to pursue careers in rural general practice, and an increase in the overall number of medical graduates does not necessarily mean that there will be more GPs for rural areas (RHWA 2008).

The Commonwealth government has used a series of incentives to attract young graduates into rural and remote areas such as scholarships and greatly enhanced rural registrar payments, but there is still a critical shortage of GPs in rural and remote areas. One policy measure that has improved the number of GPs in rural areas is the recruitment of International Medical Graduates (IMGs) (RHWA 2008). However, with increased competition nationally and internationally for these graduates, new initiatives must be developed to meet the challenges of attracting and retaining GPs to rural areas (RWAV 2006).

Insufficient supply of GPs

A combination of the above factors has resulted in GPs being in short supply in Australia. The growth of the overall GP workforce in the past 10 years has not kept pace with the rate of population growth. Over the decade from 1996-97 to 2006-07, the number of full-time equivalent GPs increased by 11% while the population increased by around 13%, representing an overall decrease in supply (DoHA 2008). In 2005, Australia ranked 20th out of 31 OECD countries in terms of the number of medical practitioners per 1,000 population. Although Australia had a greater number of medical practitioners per 1,000 population (2.7 per 1,000 population) than the United Kingdom (2.4 per 1,000 population), the United States of America (2.4 per 1,000 population) and New Zealand (2.2 per 1,000 population), all of these countries are reporting health workforce shortages (DoHA 2008).

Table 2.1 below shows that GP access declines on a population percentage basis with geographical remoteness. Not surprisingly, overall workforce shortages bite particularly hard in rural and regional towns.

Table 2.1: Medical workers: Ratios per 100,000 population by state and territory and Remoteness Area, 2006

State	Major cities	Inner regional	Outer Regional	Remote	Very Remote
Victoria	370	149	88	–	. .
NSW	395	147	110	103	–
Qld	415	147	230	46	42
WA	661	111	77	69	44
SA	444	150	121	73	48
Tas	. .	312	115	102	92
ACT	378	281	. .	. .	. .
NT	. .	. .	363	224	30
Australia	**417**	**155**	**170**	**96**	**39**

Source: ABS 2006 Census of Population and Housing

Note: ABS data provides an estimate of head count rather than an estimate of equivalent full-time positions

Research by the Australian Productivity Commission (2005) and the Australian Medical Workforce Advisory Committees (AMWAC 2005), demonstrated major trends in the rural workforce including:

- an increase in demand for GP services
- a decrease in the hours worked by the GP workforce
- an ageing medical workforce
- an inadequate number of Australian and overseas trained doctors taking up rural general practice

In a recent audit of the health workforce in rural and regional Australia by the Department of Health and Ageing (2008), these findings still held true. Broad ranging stakeholder consultations in this study reported that work pressures continue to increase for GPs and that:

- existing incentives do not encourage older doctors to remain in the workforce
- problems still exist in attracting and retaining GPs
- many younger doctors will leave a rural community disenchanted with rural practice due to a lack of infrastructure, resources and supervision
- more training places for GPs are needed.

AMWAC (2005) also found that Victoria was short 250 GPs in 2002 and would need to recruit 270 per year until 2013 to balance supply. On average, between 2002 and 2006, Victoria's supply was estimated to be 169 GPs, well short of the number of doctors required to meet demand. While the exact shortfall may be the subject of debate, there is general agreement that Australia, and particularly rural and remote Australia, needs more doctors.

The expected fall in the number of full-time equivalent GPs (through retirement and the reduction of hours) is not likely to be off-set by new entrants to the medical workforce by Australian trained or international medical graduates. With a potential net loss of GPs the generally poorer health outcomes for rural Australians may be exacerbated. The loss of just one GP can have a substantial impact on the delivery of primary care and hospital services across a whole region. It can mean loss of choice and procedural skills in a local community, and reduce the availability of after-hours activity and flexibility in the way services are delivered (Jones et al 2004). It may also mean that people living in rural and remote Australia will be increasingly more likely than their urban counterparts to be hospitalised for certain conditions, such as complications associated with diabetes. GPs in these locations may therefore see an increasingly greater proportion of patients with chronic diseases than their urban counterparts.

Solo GPs in the rural GP workforce

GPs operate in a range of practice structures including solo arrangements which have, historically, made up a significant proportion of GP services across Australia. However, this proportion is declining. The Australian Institute of Health and Welfare (AIHW 2004) reported that in 1990-91 more than 25% of the country's 23,000 GPs practised in solo arrangements, while this had fallen to 14% by 2002-03. Over the same period the proportion of GPs working in practices of four doctors or more increased significantly from 34% to 60% (Phelan 2007). The results from the combined rural health workforce agencies national minimum dataset has confirmed this trend is continuing in rural Australia (RRMA 4-7): in 2005 the percentage of solo GP practices was 15% but fell to 13% in 2007 (HWQ and NSWRDN 2008).

3. Characteristics of rural solo GPs in Victoria

To provide context for this study on rural GP career intentions, the characteristics of solo GPs and GPs working in group practice arrangements were compared to highlight some key differences between the two groups. The data were obtained primarily from RWAV's 2007 annual survey of the rural GP workforce (see the Appendix).

Semi-structured interviews with a sample of rural solo GPs were also conducted for this study. Eighteen (16%) of the 112 rural solo GPs volunteered to participate.

3.1 GP characteristics

As at November 2007, there were 1080 permanent GPs practicing in rural Victoria, in 317 practices. Of the permanent GP workforce, 112 (10%) GPs were working in solo practice with the remainder working in group arrangements. Of the 317 practices, 103 (32%) were solo practices (RWAV 2007).

The demographic profile of solo GPs differs slightly from that of GPs in other practices. Males make up a greater proportion of solo GPs compared to GPs in other types of practice: 80% of solo GPs are male, compared with 69% for other types of practice (Table 3.1).

The average age of solo GPs was significantly greater at 54.4 years, compared to 49.0 years for GPs in other types of practices (RWAV 2007). Solo GPs were less likely to have gained their qualification in Australia (59%) than other GPs (67%).

Given the high proportion of missing data for country of birth and citizenship (50% and 48% respectively), it is difficult to make valid comparisons of solo GPs and GPs in other practice arrangements for these characteristics.

The vast majority of both solo GPs and GPs in other practice arrangements had VMO rights (81% and 88%, respectively).

Table 3.1: Rural GP population: selected characteristics of solo GPs and other GPs; and career intentions survey sample of solo GPs, Victoria, 2007

		Total rural GP population[a]						Career intentions interview sample (solo GPs)	
		Solo GPs		Other GPs		Total			
Characteristic		**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Gender	Male	90	*80.4*	670	*69.2*	760	*70.4*	14	*77.8*
	Female	22	*19.6*	298	*30.8*	320	*29.6*	4	*22.2*
	Total	**112**	***100.0***	**968**	***100.0***	**1080**	***100.0***	**18**	***100.0***
Country of qualification	Australia	66	*58.9*	648	*66.9*	714	*66.1*	10	*55.6*
	Overseas	46	*41.1*	320	*33.1*	366	*33.9*	8	*44.4*
	Total	**112**	***100.0***	**968**	***100.0***	**1080**	***100.0***	**18**	***100.0***
Country of birth	Australia	28	*49.1*	296	*61.4*	324	*60.1*	7	*38.9*
	Overseas	29	*50.9*	186	*38.6*	215	*39.9*	11	*61.1*
	Total	**57**	***100.0***	**482**	***100.0***	**539**	***100.0***	**18**	***100.0***
Citizenship	Australia/NZ	53	*89.8*	437	*87.1*	490	*87.3*	17	*94.4*
	Permanent	3	*5.1*	44	*8.8*	47	*8.4*	1	*5.6*
	Temporary	3	*5.1*	21	*4.2*	24	*4.3*	. .	. .
	Total	**59**	***100.0***	**502**	***100.0***	**561**	***100.0***	**18**	***100.0***
VMO Status*	VMO Rights	43	*81.1*	386	*87.5*	429	*86.8*	14	*77.8*
	No VMO Rights	10	*18.9*	55	*12.5*	65	*13.2*	4	*22.2*
	Total	**53**	***100.0***	**441**	***100.0***	**494**	***100.0***	**18**	***100.0***
RRMA	3	24	*21.4*	209	*21.6*	233	*21.6*	. .	. .
	4	28	*25.0*	280	*28.9*	308	*28.5*	6	*33.3*
	5 & 7	60	*53.6*	479	*49.5*	539	*49.9*	12	*66.7*
	Total	**112**	***100.0***	**968**	***100.0***	**1080**	***100.0***	**18**	***100.0***

(a) Based on those GPs who participated in RWAV's annual survey in 2007.
(b) See Table A1.1 in the Appendix for more detail on the RRMA classification.
Source: RWAV 2007 GP database (unpublished).
Note: All figures based on valid cases only

GP characteristics in the career intentions study

The characteristics of the 18 rural Victorian GPs who participated in the career intentions study generally reflected the total population of solo GPs (Table 3.1).

- Over three quarters (14 or 78%) of the respondents in the career intentions of solo GPs were male and 4 (22%) were female. This is similar to the gender composition of all solo GPs across rural Victoria (80% male and 20% female).

- The average age of respondents was 52 years (compared to 54.4 years for all solo GPs), with a range of 36 to 62 years. Seven (38%) were aged over 55.
- Over a third of the GPs were born in Australia, 4 were born in the United Kingdom, with the remaining 7 respondents born in 6 other (predominantly non-English speaking) countries.
- 10 of the respondents had obtained their basic medical qualification in Australia, 3 trained in the United Kingdom and the remaining 5 respondents trained in 5 other (predominantly non-English speaking) countries.
- All except one GP were Australian citizens, with the remaining GP having permanent residency status.
- Two thirds of respondents worked in RRMA 5 classified towns. On average, responding GPs had worked in their current geographic location for 14.5 years.
- 16 of the 18 respondents were vocationally registered.

3.2 Working Patterns

Hours worked

RWAV's 2007 survey showed that rural GPs often engage in a wide variety of medical activities—the major ones being clinical GP work, routine hospital work and on-call work.

There are differences in the working patterns of rural solo GPs and those in other forms of practice (Table 3.2). Rural solo GPs report working significantly longer total hours, on average, than other rural GPs—48.5 hours per week compared with 43.9 hours per week. Solo GPs work longer clinical GP hours than GPs in other forms of practice, however GPs in other forms of practice report working longer hospital hours. Rural solo GPs tend to work longer on call hours than other GPs.

Table 3.2: Rural GP population: self reported average weekly hours worked by solo GPs and other GPs, Victoria, 2007

Activity	Solo GPs	Other GPs
Clinical GP work	42.3	35.9
Routine hospital work	5.5	7.2
On call hours (worked)	17.8	10.2
Total [(a)]	**48.5**	**43.9**

(a) Includes clinical GP work, routine hospital work, teaching and supervising, GP representative work, travelling between practices, and any other medical roles and activities, but does not include on call work.

Source: RWAV 2007 GP database (unpublished)

Note: All figures based on valid cases only

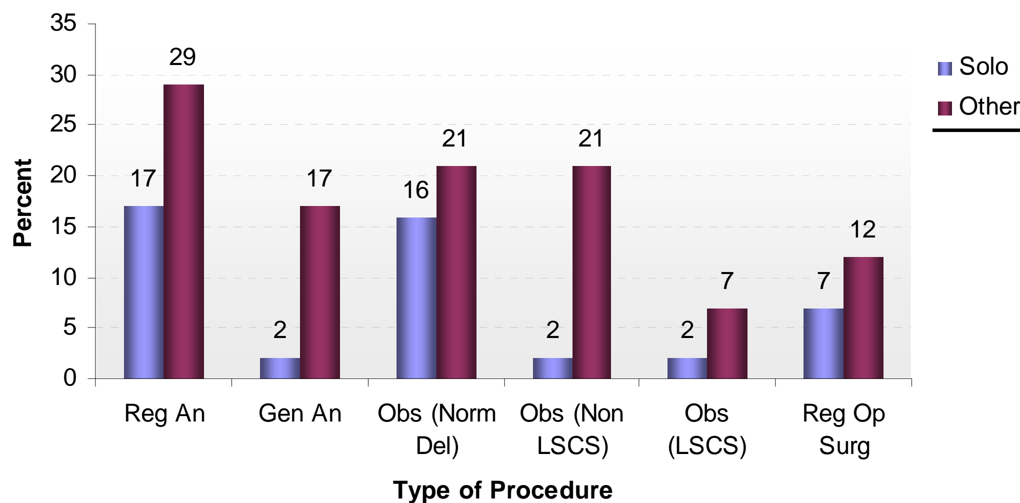
In the career intentions interview sample, the average number of hours worked per week was 42.1 hours, significantly lower than the average number of hours reported by the solo GP population overall.

Fifteen of the 18 respondents indicated they worked after hours, while only three indicated they provided any type of locum service. On average the GPs interviewed saw 137 patients per week, which equates to around four patients per hour (assuming a 3.5 hour session and 10 sessions per week).

Procedural Work

Figure 3.1 shows a comparison of procedures, as self reported by rural GPs. Significantly lower proportions of GPs regularly practise, compared to other GPs, regional anaesthetics (17% compared to 29), general anaesthetics (2% compared to 17%), and obstetrics (non-LSCS; 2% compared to 21%).

Figure 3.1: Rural GP population: proportion of GP proceduralists, Victoria, 2007



Training practices

Solo GPs were less involved in the supervision of GP registrars and medical students than other GPs (RWAV 2007). Significantly fewer (13%) of solo GPs indicated that they were involved in supervising GP registrars, compared to just over half (52%) of other GPs. Significantly fewer (45%) were involved in supervising medical students, compared with over two-thirds (69%) of other GPs.

3.3 Practice characteristics

The respondents in the career intentions study were asked about the staffing and management profile and physical infrastructure of their practices to determine if these aspects have any impact on their workforce intentions.

Staffing and management

The practices that GPs worked in were generally well established, with the average length of time since commencement being 19 years. Twelve of the 18 GPs indicated they worked in a practice with a practice manager, while 15 indicated their practice employed a receptionist, and 13 employed a practice nurse. On average the total number of staff employed in each practice (other than the GP) was 2.8. Only five of the GPs indicated that their practice had visiting specialists.

Apart from one GP who didn't respond to this question, all of the GPs interviewed indicated they were owners of the practice, and 13 of the practices were accredited.

Almost half (44%) of the GPs indicated their practice provided supervision for medical students, while only four (22%) provided placements for GP registrars.

Physical infrastructure

When asked to rate the general condition of their building[2], 10 of the 18 GPs said their building was in "good" condition, while six said their building was in "fair" condition. None of the GPs interviewed indicated their building was in "excellent" or "poor" condition. Each practice had, on average, 2.4 rooms. Just over a quarter (28%) of the GPs indicated their practice had room to expand.

3.4 Satisfaction

Participants were asked what they liked and disliked about:

- living in their community
- working in rural general practice
- working in solo practice.

The results are presented in Tables 3.3 and 3.4 respectively.

[2] Missing data on 2 GPs for this question

Table 3.3: Respondent "likes" about being a GP in a rural location

	Number	Percent
Aspects of the community		
Close community/friendships/connectedness	14	78
Lifestyle	(13)	(72)
• Family general	5	28
• Children	4	22
• Interests/activities	10	56
Convenience	(9)	(50)
• To work	5	28
• To services/facilities/family	7	39
• Ease of driving	4	22
Rural features of town/setting	5	28
Professional position in the community	3	17
Aspects of rural practice		
Continuity of Care/Relationships with Patients	11	61
Variety	7	39
Access to and relationships with other professionals/ specialists/services/hospitals	7	39
Autonomy	2	11
Hours of work	2	11
Income	2	11
Aspects of solo practice		
Business ownership/"own boss"/control/independence/ autonomy	16	89
Flexibility	2	11
Income	1	6

Note: figures in brackets indicate number of respondents

The majority of respondents (14 out of 18, or 78%) liked the connectedness of the communities in which they lived, the rural lifestyle (72%) and 50% enjoyed the convenience.

Practising in a rural location enabled GPs to work closely with their patients with 11 respondents indicating that this was important to them. Seven respondents also valued the variety of work associated with rural practice.

Being part of a solo practice also provided a high sense of autonomy, independence and the opportunity to be one's "own boss" for 89% of the respondents. Comments provided by the GPs interviewed included that they enjoyed being able to run their practices in their own way, and there were no disputes over practice issues and decisions.

Table 3.4: Respondent "dislikes" about being a GP in a rural location

	Number	Percent
Aspects of the community		
Lack of privacy/anonymity/always in demand	9	50
Choice and quality of schools	7	39
No dislikes	4	22
Lack of employment opportunities for family members	3	17
Limited access to cultural and other events/activities of interest	3	17
Little capital gains on property	1	6
Aspects of rural practice		
Workload (on-call, after hours)	8	44
Limited professional support/access to medical facilities	6	33
Limited access to training/Continuing Medical Education	3	17
Difficult/demanding patients	3	
Cost of living	1	6
Nothing	1	6
Aspects of solo practice		
Lack of locums/unable to take leave	11	61
Administrative/management burden	8	44
High cost structure (high overheads, less income)	7	39
Professional isolation/lack of support/back-up	7	39
Relationship with hospitals (& other practices)	5	28
Poor/lack of medical facilities	1	6

Overall, there were few consistent dislikes about living in a rural town or centre within this particular sample of GPs. The most common (50%) was the lack of anonymity and always being in demand.

In terms of working as a GP in rural practice, the most commonly reported dislike was the workload (44%) followed by limited professional support and access to medical facilities (33%).

The lack of locums and limitations on their ability to take leave was of concern for nearly two thirds of respondents (61%), followed by administrative/management burden (44%), the high cost structure of solo practice (39%) and professional isolation/lack of support and back-up (39%). GPs spoke of difficulties with regards to not being able to get away from their practices (feeling "tied" to the practice and patients even when away), the long hours with lack of support, and the scarcity of locums.

3.5 Workforce intentions

In RWAV's 2007 survey, 51% (26) of rural solo GPs indicated they intended to change their workforce participation during the five year period 2007 to 2012, compared to 47% (202) of other GPs. The most common change intended for both types of GPs was to reduce hours (46% for solo GPs and 53% for other GPs).

Participants in the career intentions study were asked about their workforce intentions over the next five years. The results are presented in Table 3.5 below.

Table 3.5: Respondent workforce intentions over the next 5 years

Intention	Number	Percent
No plans to change	6	33
Reduce hours	6	33
Change type of work (including locum, retirement transition)	6	33
Recruit additional GPs/expand Practice	4	22
Relocate	3	17

About a third had no intentions to change their workforce participation, a third wanted to reduce hours and a third indicated they were considering changing the type of work they were involved in. No-one in this sample indicated they had plans to retire.

Reasons for change

Participants were asked what were the key factors influencing their decisions around potential changes to the nature of their workforce participation. Responses are presented in Table 3.6 below.

Table 3.6: Key factors influencing decisions around workforce intentions

Key factor	Number	Percent
Work family balance	5	28
Children's education	4	22
Workload	4	22
Own health or spouse health	4	22
Relationship with hospital (negative)	2	11

Again, there was no indication of an overall or common theme behind the reasons GPs wanted to change their workforce participation. Work/family balance was mentioned by just over a quarter (28%) of respondents, while 22% mentioned their children's education, workload and health issues. One doctor, who indicated he planned to relocate and work in a hospital, commented that he wanted time away from work to be with his family, that he had "no holidays", "no quality of life with family" and was "sick of the hours demanded".

Implications for practice

Participants were asked what the implications would be for their community if they made the changes they had planned. Responses are presented in Table 3.7 below.

Table 3.7: Implications for practices if GPs make the changes they have planned

Implications	Number	Percent
Need to recruit (but difficult to do so)	4	22
If can't recruit	(6)	(33)
- loss of hospital service	1	6
- patients seek GP elsewhere (other towns)	3	17
- level of service reduced	2	11
Possible closure	3	17
No implications – other GPs can cover or in event he/she leaves, situation covered by other services in town	2	11

Note: figures in brackets indicate number of respondents

Clearly, if GPs leave solo practice recruitment of a replacement GP or the ability to sell the practice is essential to maintain the viability of the business. Where towns have few GP services, the closure of a solo practice will lead to a reduction in services.

Implications for the community

Participants were asked about the implications for their community if they made the changes they planned. Responses are presented in Table 3.8 below. Overall, it was felt that changes would result in a reduction in GP services.

Table 3.8: Implications for communities if GPs make the changes they have planned

Implications	Number	Percent
Loss/reduction in hospital/aged care services	4	22
Reduce access to GP services (including procedural/ after hours)	6	33
Other GPs/practices to pick up patients	4	22

Succession or retirement planning

Participants were asked whether they had a formal succession or retirement plan in place. The overwhelming majority (88%) did not have formal succession or retirement plans. Of the GPs interviewed only one GP had made formal plans for his retirement and only three (16%) mentioned that they had contemplated possible options.

Future of the practice

Participants were asked if they had particular concerns about their practice should they leave. Responses are presented in Table 3.9.

Table 3.9: Concerns for practice should GP decide to leave

Concerns	Number	Percent
Probably close	10	56
Recruit replacement	6	33
Amalgamate with larger practice or sell	4	22
Unsure	3	17

In the event that GPs did leave their practice, the majority of respondents felt their practices would close. A third of respondents thought their practice could be sustained if they were able to recruit a replacement and some also believed that the future lay in selling or amalgamating with a larger practice.

3.6 Support and assistance for GPs

Participants were asked questions to ascertain what support and assistance could be provided to ensure continuity of services to rural communities when GPs retire or otherwise change their workforce participation. Responses are presented in Table 3.10.

Table 3.10: Support and assistance needed to assist GPs

Type of support/assistance	Number	Percent
Locums (reduce hours, take leave)	11	61
Assistance with recruitment	7	39
Supportive hospital	4	22
Additional GPs	4	22
Education/training/upskilling	4	22
Capital/ facilities improvement	3	17
Assistance with succession/retirement planning	2	11
Capacity to maintain a GP registrar	2	11
Business/practice model advice	2	11
Change to bulk billing rate/increase income	1	6
Nothing	1	6

Locums (61%) followed by assistance with recruitment (39%) are key services that may enable solo GPs to stay in or better manage their practices.

Services for GPs

RWAV used the interview process to canvas the views of GPs on the services they use and what programs/services could be provided to assist GPs and their practices in the future. Responses are presented in Table 3.11.

Table 3.11: Support and assistance needed to assist GPs

Service	Does the GP currently use this type of service?		Would the GP like to use this type of service?	
	Number	Percent	Number	Percent (of those not currently using)
Advice on collaborative activities with other practices	4	22	9	69
Advice on succession planning	1	5	9	56
Human resources advice	3	17	6	43
Support to review model of practice	2	11	6	40
General business advice	6	33	5	45
Legal advice	7	39	4	40
Financial planning advice	7	39	3	30
Advice on alternative forms of practice management	3	17	3	33
Accounting advice	10	56	2	29

Of those respondents not currently using specific services, over two thirds (69%) indicated advice on collaborative activities with other practices would be useful. Over half (56%) indicated advice on succession planning would be useful and a significant proportion of others indicated advice on general business (45%) human resources issues (43%), reviewing current models of practice (40%) and legal issues (40%) would be valuable.

GPs interviewed were also asked whether they would find a Statewide locum program useful. Fourteen GPs indicated that such a service would be very valuable, enabling them to take holidays, spend time with family and take study leave.

4 Discussion

The GPs participating in this research identified a range of benefits and positive experiences in rural solo practice. The overwhelming majority chose this form of practice because it provides a high level of autonomy, independence and the opportunity to “be my own boss”. The majority of solo GPs enjoyed the connectedness to the communities in which they lived, the rural lifestyle and the convenience of living in a rural community. Practising in a rural location enabled GPs to work closely with their patients, with nearly two thirds indicating that this was important to them. Approximately one third also valued the variety of work associated with rural practice and the access they had to other professionals and services including hospitals.

The positive experiences of rural solo GPs identified through this research support the findings of other similar research. A 2007 AMA survey of rural GPs across Australia identified the rewards of rural practice as:

- autonomy
- less administrative obstacles
- holistic care
- personal interaction with patients and staff
- close and rewarding professional relationships
- satisfaction of serving a rural population
- esprit de corps in small hospitals and practices
- greater responsibility (AMA 2007).

Similarly, Hays et al (1997) in a survey of Queensland doctors who had left rural practice, found that positive factors included professional autonomy and support, community relationships, work variety, family lifestyle and continuity of care.

Overall, there were few dislikes about living in a rural town or centre within the sample of GPs selected for this research. The most common dislike was the lack of anonymity and privacy followed by the choice and quality of schools available. However, the drawback to “being my own boss” is the lack of locums and limited opportunities to take leave. Nearly two thirds of the respondents cited these factors as being negative aspects of practising as a solo doctor. Administrative/management burden, the high cost structure of solo practice, and the lack of professional support and back-up are also challenging.

As is the case for many rural GPs a third of respondents also felt there was limited professional support and access to medical facilities.

This sample of solo rural GPs reported high workloads, including on-call and after-hours work, with half indicating they disliked this aspect of their practice. Nevertheless this was seen as a necessary part of solo practice. As one GP in this research noted, solo practice has “less economic viability” than group practice. Group practices have lower costs per GP because fixed costs are shared, and “to be equivalent a solo doctor has to work more hours”.

On-call arrangements and professional support have been consistently found in studies of rural doctors to be important factors in determining retention in rural and remote areas. In a study of rural and remote community based GPs, Humphreys et al (2002) found that of three broad categories (professional issues; social issues; and external factors relating to communities and geographical location) known to affect GP retention in rural areas, professional issues overwhelmingly influenced length of stay in rural practice. The inability to get time away for recreation leave and family commitments, lack of emergency relief and relief to complete Continuing Medical Education (CME) programs all contributed to reducing a GPs length of stay in rural practice. Humphreys notes that

> *in the absence of good on-call arrangements and professional support, the unrelenting nature of after-hours care imposes an excessive workload, with negative effects both on GPs’ (and their families’) health and well-being, and on their opportunities to enjoy their rural location.*

These issues are likely to be exacerbated for solo rural GPs who must also address the substantial challenges associated with practice financial and administrative viability. The Rural Doctors Association Australia (2003) has defined a viable practice as

> *one which meets the particular medical needs of the community by providing appropriate services in a way that takes account of the financial and personal costs to both the practitioner and the community at large.*

The RDAA found that the core components of viability are:

- professional—the ability to recruit appropriately skilled doctors, manageable workloads, acceptable levels of responsibility, adequate access to relief
- economic—the capacity to develop sources of income other than Medicare such as hospital or other packages
- practice organisation and structure—the capacity for strategic planning not just practice coordination, affordable premises and infrastructure.

While none of the GPs in this study planned to retire within the next five years, a significant number indicated they planned to reduce hours and/or would consider changing the type of work they did, including becoming a locum. Work and family balance were important reasons to consider changing workforce arrangements as were choices around children's education, workload and health. Being solo GPs, changes such as these are likely to impact practice viability and approximately 50% of respondents indicated that if they left their practice, it would most likely close down.

Improved access to locums and assistance with recruitment may enable solo rural GPs to stay in or better manage their practices. The majority of respondents indicated that a statewide Locum service would be helpful to enable them to take holidays, spend time with family and take study leave.

Half of the GPs interviewed also indicated they would find advice on succession planning and advice on collaborative activities with other practices helpful. Approximately one in three GPs interviewed indicated they would find human resources advice and support to review their models of practice helpful.

5 Conclusions

Over the last ten years a range of strategies and policies have been implemented to address the shortage of GPs in rural Victoria and Australia, including: bonded medical places; recruiting overseas trained doctors; funding regional medical schools and University Departments of Rural Health; provision of incentive payments; and, more recently an increase in the number of medical student places. Nevertheless, shortages continue to be a pressing issue for communities, health service providers and GPs themselves. As long as the supply of GPs to rural communities remains below demand, retaining the existing workforce will be critical. Slowing the rate of GP exits by providing the support and assistance needed by rural GPs will, in the short to medium term, be an important point of policy leverage.

Rural solo practice is a clear preference for some GPs who particularly value autonomy and independence. This benefit does, however, come at a price as solo GPs face a number of challenges in terms of managing workloads, lack of professional support and isolation, a greater administrative burden and higher cost structures. Evidence indicates that for solo rural GPs, support and assistance must be targeted at building the viability of their practices. Vasilos (2006) has suggested that solo GPs in particular need to have at least a five year plan to transition to retirement, particularly if a GP is interested in on-selling their practice as a viable practice/business.

Programs and services that would be most valued by GPs who work in this type of structure include: more locums (at an affordable rate); advice on how to work more collaboratively with other practices (while maintaining their independence); and the provision of professional support and back-up to ensure long term sustainability.

The provision of these types of business advisory services are critical in rural Victoria, particularly in those towns which rely on the services provided by solo GP practices and where GPs are approaching retirement age.

Appendix: Research methodology

This project involved:

- a literature review
- an analysis of data from RWAV's GP workforce database
- semi-structured interviews with a sample of solo GPs.

Literature review

The literature review involved an internet search of articles and reports on the GP workforce in Australia, relevant policies, strategies and drivers that have influenced GP supply and demand particularly in rural settings, and national and international research on GP workforce patterns and satisfaction (both in rural and urban settings).

Analysis of RWAV data

RWAV maintains a database of GPs working in rural Victoria. Data are collected primarily through an annual telephone and mail-based survey program. The database also includes information received about doctors entering or exiting rural practice, or as they participate in RWAV programs. RWAV uses the Medical Practitioners Board of Victoria online register of medical practitioners to validate data where relevant. Core data items on the database include gender, date of birth, country of undergraduate qualification and length of stay in current practice.

A telephone survey of all rural practices is conducted in May each year to confirm practice details and the names of GPs working at that practice. A mail-based survey of GPs and practices is conducted annually in September. Data on primary income source, models of service provision, hours of work, procedural skills and types of practice are reported through the survey process. Other information collected through the survey includes, for example, professional interests, leave and locum support and spouse information.

For this report, an analysis of relevant data items from the RWAV database was undertaken following completion of the annual survey in November 2007. Where relevant, comparisons were made to information collected in the previous two years.

Semi-structured interviews: participant recruitment

GPs working in a solo practice in a rural or remote location in Victoria, in a postcode with five or fewer GPs, were identified through RWAV's GP workforce database.

For the purposes of this research, a solo practice was defined as any practice with fewer than two resident doctors operating at any one time. This included practices:

- that had GP registrars or students from time to time; or
- where one or more doctors job-shared a position.

All 49 GPs who met the criteria were invited to participate in this study. A letter outlining the research was mailed to potential participants and was followed up by phone and, in cases where further written information was requested, by fax.

Eighteen GPs participated in this study. Participation was voluntary and the participants were compensated for their involvement.

Interview data collection

The semi-structured interviews were undertaken between mid-March and mid-August 2007. Interviews were conducted face-to-face at the GPs medical practice and lasted between 55 and 75 minutes.

The interviews consisted of closed and open-ended questions to obtain information on demographics, workplace (medical practice) characteristics, background and current work situation, satisfaction with work and location, future workforce intentions and views on support and assistance for rural GPs.

The 18 interviews were shared across six interviewers. Prior to data collection the interviewers participated in two training sessions to ensure interviewer consistency.

Interview data coding and analysis

Interview data were recorded by the interviewers using written notes. The written records were typed into Microsoft Word and imported into NVivo software.

A coding system was set up using NVivo software. Interview data were coded and thematically categorised in accordance with the four main topic areas covered in the interviews:

1. GP background
2. satisfaction
3. workforce intentions
4. support and assistance.

Coding was carried out independently by two researchers. To ensure consensus of themes, inter-coder reliability was checked by one joint coding session and two meetings.

Quantitative data including demographics, medical practice characteristics, current workforce participation and responses regarding specific support and assistance programs, were entered into Microsoft Excel for analysis.

Rurality indicator

The Rural Remote and Metropolitan Area (RRMA) classification system was used as the indicator of rurality (see Table A1.1).

Table A1.1: RRMA classifications and associated population sizes for rural and remote towns

RRMA Classification	Population Size
RRMA 3, large rural centres	25,000 – 99,999
RRMA 4, small rural centres	10,000 – 24,999
RRMA 5, other rural centres	<10,000
RRMA 6, remote centres	>5,000 < 9,999
RRMA 7, other remote centres	< 5,000

Source: Department of Primary Industries and Energy and Department of Human Services and Health, Rural and Remote and Metropolitan Areas Classification 1991 Census Edition. 1994
Note: There are no towns classified RRMA 6 in Victoria.

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