Background

General Practice Victoria (GPV) is the peak body for Victoria’s 29 divisions, associations and local networks of general practice. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities.

This paper provides input to The Victorian State Government Inquiry into Liveability Options in Outer Suburban Melbourne. ToR (d) concerns general practice:

Identify the provision of medical/health and support services in outer suburban areas.

GPV has drawn upon recent comment and data received from divisions in response to this Inquiry, and an extensive in-depth research project completed in 2009:


11 of the 14 metropolitan divisions of general practice in Victoria contain some component of outer metropolitan classification according to the Commonwealth classification of outer metropolitan. Several rural divisions also have outer metropolitan areas.

The DoHA map of outer metropolitan areas is at the following link:
Map of outer metro areas for Melbourne

Access to general practice in outer metropolitan areas

Evidence from general practices right across outer metropolitan Melbourne – from Werribee to Lang Lang to Rosebud – illustrates the difficulty of meeting the demand for services. The Appendix to the Metropolitan Health Plan illustrates the variability in GP supply across the metropolitan area, by comparing the percentage of metropolitan GP services with the percentage of metropolitan population within each planning area. South East, Peninsula, North East, Outer East, Outer North West and Outer West (i.e. six of the ten planning areas) all have a reduced percentage of GP services compared to their population levels. The largest gap between population percentage and percentage of GP services is found in the Outer West area which covers Brimbank, Melton, Moorabool & Wyndham. This area has 11.2% of the metropolitan population but only 7.7% of metropolitan GP services. Outer East covering Knox, Maroondah, Murrindindi and Yarra Ranges has 10.4% of the metro population and 7.5% of metro GP services

The evidence of workforce statistics is borne about by local experience of general practitioners.

1 Metropolitan Health Plan, Technical Paper, May 2011
Outer metropolitan areas have struggled since the mid-90s to meet demand but accelerated population growth now threatens the capacity to provide accessible primary care. Two examples from opposite sides of the city illustrate the problem:

- The overall GP-to-population ratio in the catchment of the Dandenong Casey General Practice Association is estimated to be 1 GP (FTE) to over 1,700 people. This rate is already substantially above the national average of 1:1400. The City of Casey adjoins the Greater City of Dandenong and the population is increasing at a rapid rate requiring 1 FTE GP to establish in the area every 6-8 weeks to maintain the current ratio.

- The most recent Australian Bureau of Statistics data for Wyndham showed that the city’s population for the period 2009-2010 grew by 12,600 people, a growth rate of 8.8%. To meet the population demand for general practice on the basis of the Commonwealth benchmark of 1:1400, there would be a need for a new GP every 5.7 weeks.

Furthermore, the annual survey of GPs conducted by the Dandenong Casey Division of General Practice found that 62% (60) of its practices report that they do not have an adequate number of GPs to meet demand. Some of the key indicators of access problems are closed books, long waiting times, high admission for Ambulatory Care Sensitive Conditions and high numbers of applications for District of Workforce Shortage status.

### Increased waiting time for appointments and closed books

In [GPV and RWAV’s research](#) of 2009, evidence of closed books was widely reported. Even areas of Melbourne East and Bayside (places that would not in the recent past have been associated with the idea of workforce shortage) had a number of practices with closed books. In general, divisions did not have the data on this but Bayside reported that 12% of practices had closed books at the time. The division anticipated that a follow-up survey would show an increase. An interviewee from another metropolitan division said:

> “We did a survey. No one will say they’ve closed their books and no one will say whether they bulk bill. There are some things they just won’t say. We think probably half of them have closed their books.”

A small survey conducted in the Outer East of Melbourne for this submission found that three out of 10 practices had closed books.

The Division in the Outer North West area commented that there have been calls from community centres and other organisations trying to get GP appointments for patients in need:

> “Often I will need to ring 3 or 4 practices before I can find a practice willing to take a new patient. A recent newspaper article in the Moonee Valley leader did a similar short survey and found a number of inner metro practices had closed their books. This in turn puts pressure on surrounding practices including outer metro practices already facing workforce shortages.” (Moonee Valley Leader, April 11 2011)

Evidence of long waiting times to get an appointment is more anecdotal and the system lacks a consistent method for gaining evidence. Some areas, in particular the outer west, report very long waiting times. Others assert that corporate practices offer a walk-in solution that threatens continuity of care:

> “Waiting times vary. A few of the corporate practices now ask you to see the next doctor available and if you are lucky it may be your normal GP. This is not good for continuity of care but has been adopted as a method of dealing with patient demand.”
**Ambulatory Care Sensitive Conditions**

DH collects very detailed data on the level of admission to hospital for conditions that are ideally controlled and managed in primary care. Evidence suggests that this category of hospital admission is strongly correlated with problems of access to general practice and other primary care. Outer metropolitan areas are disproportionally represented in higher than average statistics for ACSCs with very high levels of admissions for diabetes complications and COPD among others in areas from the outer west to the outer east.

**The need for change to the District of Workforce Shortage (DWS) measure for GPs**

GPV and RWAV’s research identified that the basis for the determination for Commonwealth District of Workforce Shortage status is flawed and restricts the capacity of practices to recruit when necessary.

A repeated message from divisions was that using the average GP:population ratio as a basis for determining workforce shortage was a flawed approach. As the workforce shortages grow, the average goes up, so the shortages are masked. This particularly affects outer-metro areas that have very rapid growth because the DoHA measure does not keep pace with the real population component of this equation.

Even though this issue is a Commonwealth matter, it requires a united Victorian view about the need for change. It is important for the state government to understand the nature of this particular problem and use their avenues for advocacy.

All outer metro divisions have reported a low success rate in applications by local practices for district of workforce shortage. For example, in the Dandenong/Casey area the division was aware of sixteen (16) practices that applied for DWS status during 2010. Only three (3) of these were successful.

Division representatives are particularly concerned about the failure of governments to recognise and remove the policy and administrative impediments to solving local workforce problems. In particular, DWS is based on outdated population data that fails to take into account the rapidly changing population status of most outer metro areas. The failure to use up-to-date data in the review of an application means that workforce crises are needlessly intensified.

“My main criticism is the rigidity of the DWS areas which have not been revised for a decade or more. Outer Bayswater is more a DWS area than Rowville or Lilydale. There is a need to have some flexibility in marginal areas - we are less than 1km from DWS but cannot recruit doctors.”

“The DWS measure definitely needs to be changed. The calculated shortages are definitely inaccurate due to the very rapid population growth in the City of Casey.”

Another problem associated with DWS is the lack of flexibility in the boundaries between inner and outer metropolitan:

“Another issue arises for Dandenong which is now considered ‘inner metropolitan’. GP shortage is critical with well established practices on the verge of closure due to the inability to recruit GPs. The population in and around Dandenong is extremely diverse and it is recognised as being one of the most disadvantaged suburbs in Australia.

In recruitment of GPs for Dandenong the problem of being located at the gateway to an outer metro area is highlighted. GPs are more likely to choose a practice just a few
kilometres down the road if they qualify for the More Doctors for Outer Metropolitan Areas Relocation Incentive Grant.”

**Greater workforce needs due to socio-economic status**

Outer metropolitan areas are characterised by high levels of need. Northern, south eastern and western areas all have very high migrant and refugee levels. For example, Northern Melbourne has a substantial ageing population and a large proportion of the new residents (in the existing zones at Epping, Lalor, Broadmeadows etc) are refugees, Aboriginal or recent arrivals from non-English speaking backgrounds. A large number of these people are Muslim which brings special demands for culturally specific services, especially for women. It is also largely low income. Similarly, the very high migrant population in the south east and western area leads to special needs for culturally appropriate health services which are difficult to offer in times of workforce shortage.

**Infrastructure development to support access to primary care**

**The placement of Super Clinics under the Commonwealth GP Super Clinics Program**

There is a Super Clinic being built in Berwick and allocations have been made for Superclinics in South Morang and in Wallan. Invitations to apply have been called for:

- Western Melbourne with the eligible Local Government Areas being Melton, Hobsons Bay, Maribyrnong, Brimbank, and Wyndham
- the Local Government Area of Hume City

Divisions have argued that there needs to be a more thorough consideration before deciding on the location of Super Clinics. For instance:

The location of the Super Clinic in Berwick was controversial as it sits within a health precinct surrounded by quite a number of general practices. It is accepted that these practices are over-worked because of the rapid growth of the population, however, if they were given more support and assistance in recruiting GPs they would be more able to cope. The Super Clinic is not viewed as a competitor for patients but more a competitor in recruitment of GPs. (Dandenong & Casey GP Association)

We do not have adequate public clinical space for State services e.g. CAHMs or private and public allied health that is so important to provide for high need communities and for the support of local GPs. We would prefer the GP Super Clinic money be provided to the community health services or hospital to provide primary care outposts to support smaller GP providers…rather than attempt to compete with private GPs in the market. Frankly we can’t find GPs willing to staff them anyway. (Northern Melbourne Division of General Practice).

These divisions, and others, have expressed reservations about Super Clinics being the best response in many areas.

**Infrastructure Grants**

On 25 November 2010 the Government announced the allocation of $64.5 million in primary care infrastructure grants to over 240 clinics across Australia.

There are three types of primary care infrastructure grants, with grants of up to $150,000 each; up to $300,000 and up to $500,000.

68 of the 240 grants were offered to Victorian practices or other primary care facilities. Of these, 20 (29%) are for outer metropolitan practices.
GPV has been advised by divisions that they are aware of outer metro practices that applied for an infrastructure grant but were unsuccessful. Figures provided by three divisions have indicated between 1 and 5 practices in their catchments in this situation. Even given that this will be an under-estimate of the practices that applied (or considered applying), there are many outer metro practices with an un-met need for infrastructure development support.

ACT is one jurisdiction that has invested substantially in the development of general practice to meet local need. Consideration of this by Victoria would be most welcome.

**Access to other health services**

It is a substantial task to identify:

- the extent and nature of service gaps to primary and secondary care, and
- the support needs (e.g. travel, additional allied health) that must be in place to enable appropriate access

Medicare Locals will be well-placed to undertake this role if they have adequate capacity to do so. GPV is hopeful that the Victorian Department of Health will work closely with the Department of Health & Ageing to support these new organisations to achieve the best results possible for the people of Victoria. There is an urgent need to support a consistent approach to workforce data collection at small area and larger regional areas to support health workforce analysis and planning.

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Submitted on behalf of GPV

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