Chapter 5.2.1

SUPPORTING RURAL PROCEDURAL PRACTICE

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Introduction

Rural people need services as close to their community as possible. Many have argued, especially in developed countries, that centralised services and transport are an alternative. This is doable and necessary with advanced specialised surgery but for more common conditions of less complexity and higher frequency, the need for local delivery of services increases.

In striving for elusive perfection, all service can be lost from all but 'centres of excellence'. When a mother is about to deliver a baby in a rural area, the presence of an obstetric service 300km away is not much comfort. What is required is a local well-trained generalist service.

A number of studies have shown the efficacy of rural procedural practice. Many factors influence the availability of rural procedural services, however, including infrastructure; workforce; funding; and skills (training and maintenance).

This chapter will touch on skills maintenance and the funding aspects of this.

What's the evidence? Do we really need procedural practice?

In the hospital sector, a Norwegian study reviewed the effectiveness of hospitals staffed by GPs (1). They examined the admissions to 15 of these hospitals and compared them to alternative care, based on municipality and hospital accounts and standard charges for patient transport. Their study concluded that GP care in hospitals incurs the lowest costs to society.

A number of studies have reviewed obstetric services in generalist staffed hospitals. Nesbitt (2) studied 33 rural hospital service areas in Washington State, in the United States, and categorised them by the extent to which patients left their obstetric services. Women with fewer obstetric providers in proportion to the number of births

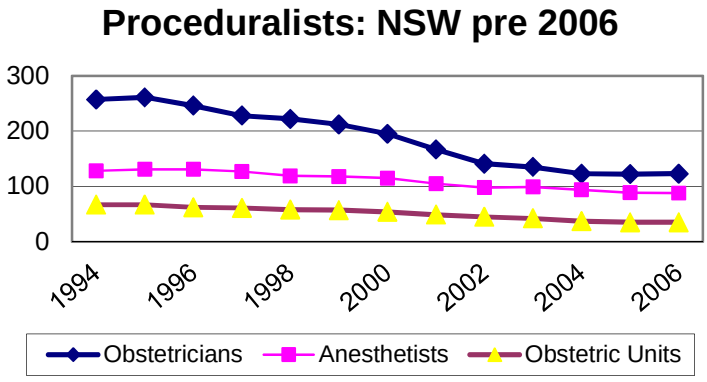
were less likely to deliver in their local communities. Women from these high outflow communities 'had a greater proportion of complicated deliveries, higher rates of prematurity and higher costs of neonatal care than women from communities where most patients delivered in the local hospital'. One would have to conclude that, with better outcomes and the lowered travel costs, this would, *ipso facto*, lead to cost savings for the patients and communities.

Similarly in Australia, Tracey et al (3) in a population based study using the National Perinatal Data collection, showed that for low risk primiparous and multiparous women in hospitals with less than 100 births per annum, there were lower rates of induction of labour, intrathecal analgesia/anaesthesia, instrumental birth, caesarean section after labour and admission to a neonatal unit.

In a study of maternity policy in Iowa, USA, Hein concluded that, while arguments were put forward for consolidation of existing obstetric facilities to reduce medical care cost via economies of scale, 'available evidence is to the contrary, since small hospitals offer obstetric and newborn care that are less expensive than larger communities' (4).

Recent reviews of rural generalist models of practice have been very positive (5, 6). In Australia recent positive evaluations (7) of training programmes for this model of care, have resulted in a Health Workforce Australia review with a view to implementation of a national framework.

Figure 1:
An illustrative anecdote - What are the barriers?



Source NSW RDA 2006

Decline in procedural practice

In the early 1990s, it was clearly identified that especially the procedural areas of obstetrics, anaesthetic and surgery were in decline. By 2002, Australia was at the height of an indemnity crisis and the proceduralists were in steeper decline. Steps were taken to address this.

In response to this, a study into the barriers to procedural practice was undertaken by the Australian College of Rural and Remote Medicine (ACRRM) in collaboration with a number of other organisations. (8). The other factors that might be responsible for the decline in procedural practice were explored and solutions proposed.

Of the 87 doctors polled, including procedural doctors, 65% responded – and were interviewed in focus groups. Among the barriers to the maintenance of procedural skills, the top two barriers at the time were, predictably, insurance costs and litigation. The next six were

1. maintenance of multiple standards, benchmarks and qualifications;
2. costs of upskilling vs income recovery;
3. general undervaluing of the procedural GP;
4. pressures of maintaining a broad range of skills;
5. ability to take leave for training opportunities - time constraints, professional limitations; and
6. access to appropriate skills programmes - type locality and cost.

Turning the decline around: the Rural Procedural Grants Programme

With these data, a concerted campaign was launched to overcome these issues and in the budget of 2003, two measures were introduced: one a financial incentive for rural procedural practice and the other a training incentive. The latter will be discussed in more detail.

Following the budget announcement, ACRRM met with the bureaucracy to ensure that the budget announcement was able to achieve the government's aims. From these discussions the key elements of the scheme were developed:

1. Ensure minimal red tape.
2. Provide an incentive, not reimbursement to help achieve this.
3. Have a high entry standard of credentialied practice with on-call commitment to ensure that doctors were providing the needed service.
4. Ensure key areas of need - including obstetrics, anaesthetics and surgery - were targeted.
5. Promote peer assessment of appropriateness of professional development activities.
6. Provide funding directly to the doctors.

The initial payment was $1 500 per day for a max of 10 days. This was subsequently increased to $2 000 per day. The original payments were for obstetrics, major surgery and general anaesthesia. An emergency medicine component of three days was subsequently added.

The now titled Rural Procedural Grants Programme (RPGP) is administered by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners. This collaboration comprises a representative from each discipline - obstetrics, anaesthetics, surgery and emergency medicine for each college.

Uptake

The RPGP does regular surveys of those utilising the programme. In the last survey, the majority of respondents (57%) were registered in the procedural medicine component, with most practising obstetrics (26%), followed closely by anaesthetics (24%). Surgery is the least subscribed discipline, practised by only 7% of respondents. A little less than half of the respondents are registered under the emergency medicine component.

Most respondents are multi-credentialed to practice both obstetrics and emergency medicine (40%), with an almost equal number of respondents engaged in both anaesthetics and emergency medicine (39%).

The programme was popular for a number of reasons most of which addressed the original findings of the ACRRM research (Table 1).

Table 1:
Top rated reasons for participation

Financial incentive/compensation allows time away from usual practice	55%
Update/increase skills and knowledge	47%
Relieve cost of accessing training activities	34%
Meet professional responsibility for ongoing education	29%
Increase knowledge and skills in a specific area	23%
Relieve cost of travel & accommodation	22%
Maintain skills/knowledge	20%
CPD[1] points & vocational registration purposes	18%
To remain a rural GP proceduralist	15%
To meet challenges of rural practice	9%
Relieve cost of locums	8%

Participants regarded the strengths of the programme as, not unexpectedly, the financial support, the ability to upskill and the simple low red tape process. Significantly the programme, by putting the money in the hands of the doctors, has encouraged a marketplace of courses with increasing number and quality of these (Table 2).

Table 2:
Strengths of the RPGP

Financial support to undertake CPD	62%
Encourages rural proceduralists to up-skill	33%
Lack of 'red tape'	20%
Variety of accredited courses	18%
Flexible, self-directed programme	17%
Competent administration	15%
Incentive to remain in rural procedural practice	12%
Recognition of rural procedural GPs	10%
Increases confidence to perform procedural medicine	9%
Improves health outcomes of rural communities	5%
Fosters collegial support	4%

1 CPD = continuing professional development

Sixty-nine percent of respondents, registered only in the procedural medicine (obstetrics, anaesthetist and surgery) component, reported that their participation in the programme had positively influenced their intent to remain in rural and remote practice - while 30% of respondents reported no impact on their intention to remain in rural practice. The programme now has the most comprehensive database of doctors practicing in rural and remote practice due to the rigorous criteria (9) and the high participation due to the financial incentive.

The RPGP both popular and effective as evidenced by the suggestions for improvement (Tables 3 & 4).

Table 3:
Suggestions for improvement

Increase emergency medicine grant	27%
No changes required	21%
Increase number of funded training days	12%
Wider range of courses	11%
More courses in rural areas	11%
Assistance in finding/paying locums	10%
Increase grant remuneration with CPI[2]	9%
Offer grants for other disciplines (e.g. palliative care and mental health)	8%
Travel time to be grant funded	8%
More grant funding for multi-credentialed proceduralists	8%
Scaled grant funding according to remoteness	6%
Electronic registration/payments process	6%
Give grants for GPs to up-skill in procedural medicine	6%
Grant funding offered over triennium rather than financial year	3%
Easy access to records (i.e. how many days used; how many days remaining)	3%
Grant funding for team training	2%

2 CPI = consumer price index

Table 4:
Additional comments

Excellent programme	43%
Keep the programme going	36%
Excellent support for rural proceduralists	30%
Keeps me in rural procedural practice	11%
Makes ongoing training affordable	7%
Encourages ongoing training	6%
Excellent administration	6%
More emergency medicine days needed	5%
User-friendly programme	5%
Financial support should increase	4%
Allows me to meet MOPS[3] requirements	4%
Would cease to perform procedural practice without RPGP	3%
Programme increases confidence to perform procedural medicine	1%
Programme should permit GPs to up-skill in procedural medicine	1%
More locum relief is needed	1%
End of year statement would be good	1%

The programme has also been effective at increasing the number of proceduralists, although the number of multiple proceduralists continues to slowly decline (Table 5).

[3] MOPS = Maintenance of Professional Standards

Table 5:
RPGP registration by discipline component

	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
Anaesthetics	116	127	134	141	140
Surgery	20	19	18	20	19
Emergency	1 252	1 425	1 529	1 813	1 855
Obstetrics	11	126	124	126	129
Anaesthetics & Emergency	184	195	222	250	262
Anaesthetics & Obstetrics	42	41	36	33	33
Anaesthetics & Surgery	4	4	2	2	2
Obstetrics & Emergency	230	240	257	284	287
Surgery & Emergency	36	42	45	46	48
Obstetrics & Surgery	15	16	13	12	12
Anaesthetics & Emergency & Obstetrics	196	228	237	245	243
Anaesthetics & Surgery & Emergency	17	18	22	25	22
Anaesthetics & Surgery & Obstetrics	18	19	18	17	18
Emergency & Obstetrics & Surgery	76	83	87	87	87
Anaesthetics & Emergency & Obstetrics & Surgery	105	111	110	105	103
Total	**2,427**	**2,694**	**2,937**	**3206**	**3260**

The programme has meant the re-entry of older proceduralists to practice, the entry of younger proceduralists and a proportionately larger recruitment of female doctors although form a smaller base (Table 6).

Table 6:
RPGP registration by age and gender

	2008-09	2009-10	2010-11	2011-12	2012-13
Gender: Female					
<30	16	26	21	28	31
30-39	163	172	188	189	198
40-49	218	254	275	309	315
50-59	149	168	204	231	232
60-69	29	42	48	69	68
70-79	1	1	1	1	1
Total	**578**	**665**	**737**	**827**	**845**
Gender: Male					
<30	19	20	19	19	21
30-39	281	287	297	301	317
40-49	642	669	682	721	730
50-59	618	701	767	813	822
60-	229	281	353	420	421
70-79	39	47	57	77	76
Total	**1,849**	**2,029**	**2175**	**2351**	**2387**
Age (female and male)					
<30	35	46	40	47	52
30-39	444	459	485	490	515
40-49	860	923	958	1031	1046
50-59	767	869	971	1044	1054
60-69	258	323	401	490	490
70-79	40	48	58	78	77
Total	**2,427**	**2,694**	**2,913**	**3180**	**3234**

***The small number who whose status was undetermined have been omitted for this table.

Broader applicability

In Australia, as in many countries, the infrastructure to support procedural practice has continued to decline and the procedural training programmes are only just beginning. The procedural education incentive programme is just one of the strategies for ensuring the promotion and development of rural procedural practice. Despite the hostile environment, this programme seems to have stemmed the decline in rural proceduralists – and the positive response from the participants suggests that its simple format has been well accepted.

The cost of the programme in comparison to other funding programmes in this area has been reasonably modest and the benefit to rural communities significant. It would seem feasible for other countries to provide proportional support for their procedural doctors and assist in training and retaining their rural procedural workforce.

Practice pearls

What to do

- Concentrate incentives on the skills that are needed.
- Use entry criteria to select for the skills that are needed.
- Allow participants the freedom to choose the appropriate education for them.
- Keep paperwork low, but maintain rigour.
- Concentrate on education needs.
- Provide funding to the doctors.
- Allow this to develop a marketplace.

What not to do

- Don’t create perverse incentives.
- Don’t reimburse; it wastes money on administration. Incentivise instead.
- Don’t fund the providers directly; let the doctors decide.

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