Defining and Targeting Areas of Primary Care Need
A Five-Country Comparison
Acknowledgements

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- Department of Health and Ageing
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- Country expert informants

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Outline

- The travelling fellowship
- The Robert Graham Centre
- Taste of the Research
  - Very brief outline
  - Key points of relevance to Australian policy making context
APHCRI/ RGC Fellowship

- 6 week immersion at Robert Graham Centre in Washington D.C in the USA
- Involvement in daily work/projects of RGC
- Attendance at the North American Primary Care Research Group annual conference
- Attendance at stakeholder meetings and local events/meetings/clinics
- Rich picture of US primary health care & research
Robert Graham Center

- Primary Health Care Policy Research Centre
  - Conducts own research vs APHCRI commissions
- Independent functioning
- Blended funding arrangement
- Collaborations with stakeholder and research groups (national and international)
- Emphasis on geographical policy analysis
- Access and expertise with large datasets
Robert Graham Center cont. . .

- Small multi-disciplinary team
  - 2 x Family Physicians - 1 x Geographer
  - 1 x Health Economist - 1 x Statistician
  - Administrative assistance x 2
  - Variable research assistants and students

- Month ‘internships’ for Family Physician residents – ongoing relationships

- Year fellowship for new FP fellow

- Large research output and presence
DEFINING AND TARGETING AREAS OF PRIMARY HEALTH CARE NEED
A FIVE COUNTRY COMPARISON

• Australia
• Canada
• New Zealand
• United Kingdom
• United States of America
Motivation for Research

“Virtually all OECD countries suffer from a geographical maldistribution of their health workforce between rural, remote or poor areas and urban, central and rich localities”.

OECD Health Policy Studies, 2008. The Looming Crisis in the Health Workforce: How Can OECD Countries Respond?
Research Questions

- How do different countries define areas of workforce shortage?
- How do they use these definitions in workforce and training policy?
- What strategies do different countries use to attract medical graduates into General Practice or Family Medicine?
- What strategies do the countries use along the provider production pathway to redistribute these doctors to areas of shortage?
Methodology

- Descriptive comparison
- Published literature (pubmed), Grey literature
- International workforce websites
- Country-specific data and websites
- Snowballing from identified references
- Country expert informant interviews
- Cobbled data and sources – care with interpretation
## Australia Workforce Definitions

<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
<th>Trainees</th>
<th>GPs</th>
<th>IMGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRMA</td>
<td>- Population - Straight line distance to bigger town</td>
<td>- Required rotation - Pathway restriction - Debt repayment</td>
<td>Locum &amp; Education Support</td>
<td>License &amp; pay Restriction</td>
</tr>
<tr>
<td>GPARIA+</td>
<td>- Population - Road distance to medical services</td>
<td>Rural incentive payments</td>
<td>Rural Retention payments</td>
<td>(Trainees eligible for incentives)</td>
</tr>
<tr>
<td>Outer Metro</td>
<td>Census - 200pop/km2 but fringe</td>
<td>- Required rotation - Small incentive</td>
<td>Relocation incentive</td>
<td>Limited license facilitation</td>
</tr>
<tr>
<td>DWS</td>
<td>Medicare claims &amp; population data</td>
<td>Bonded Students</td>
<td>N/A</td>
<td>License facilitation</td>
</tr>
<tr>
<td>AON</td>
<td>“Hard to recruit” State defined</td>
<td>N/A</td>
<td>N/A</td>
<td>License facilitation</td>
</tr>
</tbody>
</table>
Melbourne - poverty, population: GP ratio and ‘shortage’

Low Income Households
Households with gross weekly income of less than 500 dollars
As a percentage of all households
Based on Place of Usual Residence, 2006
Melbourne (Statistical Division) by Statistical Local Area

4 Number of residents per GP
General Practice divisions, Melbourne, 2003
Australia – notable features

- Loose definitions of shortage – geographically determined.
- No publicly available workforce data for outer metropolitan areas.
- Only country to embed workforce policy explicitly within training policy:
  - 42% of places for ‘rural’ training pathway
  - ‘general pathway’ required to work 6 month rural, 6 month outer metro
Canada

- Provincial approach to workforce and health
- Generally no formal definitions of shortage areas
- Primarily geographical approach
- British Columbia – Rural Subsidy Agreements
  - Blended payment options for rural/remote
    - Base salary for areas with small list-size
    - Supplemented with fee for service
- Potential in Australian remote areas?
United Kingdom and New Zealand

- No formal definition of shortage areas
- Capitation payments – workforce priorities embedded within overall payment system
  - Rurality payments
  - Deprivation index payments
- Potential for Australia?
  - ABS does calculate deprivation indices
  - Difficult with fee-for-service payments
  - Would introduce socioeconomic element
UK direct policies

- **Primary Care Development Scheme (For PCTs)**
  - GPs/100,000 adjusted
  - Difficult to recruit (based on annual survey)
  - Proportion of GPs over 55
  - Local discretion

- **100 Practices (new practice creation)**
  - 38 areas in 25% most ‘underdoctored’ locations
  - Similarity to superclinics?

- **Local Improvement Finance Trusts (practice refurbishment and building)**
  - ‘deprived inner city areas’
**United States of America**

*MUA is primarily used to define areas eligible for federally qualified health centers. HPSAs can be geographic, population or facility. MUAs can be geographic or population.*

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<th>FP</th>
<th>IMG</th>
</tr>
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<tbody>
<tr>
<td>Health Professional Shortage Area (HPSA)</td>
<td>- Pop:PC physician 3,500:1 OR 3,000:1 with high needs - Surrounding poor access</td>
<td>Scholarships with required service</td>
<td>- Debt repayment -10% bonus Medicare $</td>
</tr>
<tr>
<td>Medically Underserved Area (MUA)*</td>
<td>4 weighted variables to create index; • Pop: physician • Infant mortality • % poverty • % &gt;65 years</td>
<td></td>
<td>(higher Medicare payments in health centres)</td>
</tr>
<tr>
<td>Physician Scarcity Areas (PSA) - Historic</td>
<td>(20% lowest physician: Medicare patient ratios)</td>
<td></td>
<td>(5% bonus Medicare payment)</td>
</tr>
</tbody>
</table>
USA – notable features

- Direct simple, elegant measures of workforce shortage and demand
- No automatic designation except Native service areas (demanding application)
- Small scale incentives compared to Australia
Income disparity - UK example

- Poor recruitment and retention of GPs
- New contract to increase flexibility and pay
- Average GP pay increase of 35% real terms between 2003 and 2007. (Compared to 15% for specialists)
- 69.6% increase in GP registrars ‘97-2006
- 9,000 applicants for 3,862 training posts in 2007
Income as ratio of per capita GDP

- OECD 2005 data
- Australia improved with extended primary care item numbers

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<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Canada</th>
<th>NZ</th>
<th>UK</th>
<th>USA*</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP or FP</td>
<td>2.1</td>
<td>3.3</td>
<td>4.0</td>
<td>3.8</td>
<td>4.4</td>
</tr>
<tr>
<td>Specialist</td>
<td>5.2</td>
<td>4.9</td>
<td>3.7</td>
<td>4.8</td>
<td>6.5</td>
</tr>
<tr>
<td>GP income as % of specialist</td>
<td><strong>39.6</strong></td>
<td>67.3</td>
<td>108</td>
<td>79.2</td>
<td>67.7</td>
</tr>
</tbody>
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Discussion Points

- Variable definitions approaches
  - Geography
  - Ratios
  - Key factors to capture ‘need’ (Index or simple)

- Australia embeds workforce policy within training
  - Opportunity to make real difference to access
  - Responsibility to get it ‘right’

- Incentives within overall pay structure or separate ‘add-on’ policies
Discussion and Questions
Methodology – Search terms

- “workforce” OR “human resources”
- AND “health”, “primary care”, “general practi*” OR “family physician”
- AND “definition”, “area of need”, “shortage”, “redistribution” OR “disadvantage”. “Index of deprivation”, “Deprivation Index” OR “socioeconomic” were also used for sub-searches.
Methodology – Inclusion/Exclusion

**Inclusion criteria - broad**
- Workforce, planning or policy focus
- Addressing distribution, shortage, socioeconomic factors, training, incentives or regulatory requirements
- Pertained to at least 1 of the 5 study countries

**Exclusion criteria**
- Not available in English
- Clinical focus
- Did not pertain to one of the 5 countries
Methodology - sources

- Commonwealth Fund
- Organisation for Economic Development
- World Health Organization
- Health Policy Monitor
- McMaster University Centre for Health Economics and Policy Analysis
- European Observatory on Health Systems and Policies
Methodology – sources cont

- Human Resources for Health Global Resource Centre database
- International Medical Workforce Collaborative conference records
- Country specific sites