Solving the shortage of general practitioners in remote and rural Australia: a Sisyphean task?

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Despite all our efforts, the boulder is barely halfway up the mountain

> *When I set up in practice at Kununoppin [Western Australia] in 1958, the hospital was administered by a teenage girl working 3 days per week, the bed average was 20 and if I had a problem, the Medical Department would solve it.*
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> *Today, the bed average is 14.5, a number that includes 10 residents in the permanent care facility, the hospital administration requires 3.6 full-time employees and if ever I have a problem, the Medical Department has almost certainly caused it.* — Dr John Radunovich, addressing the Country Medical Foundation in 1993, when country medicine was in danger of being "rationalised" by the government.

Perhaps the problem of rural medical workforce in Australia is best represented by the Greek story of Sisyphos, King of Corinth. He was a mortal, an individualist and, like many rural doctors, disinclined to do the gods' bidding. For interrupting one of Zeus' amorous pursuits, Sisyphos was sent to the bottom of Hades as punishment, condemned to forever push a boulder towards the top of a mountain, only to have it roll down as he neared his goal, so he had to start again.

For more than 70 years, Australia has been trying to solve the problem of a paucity of rural and remote doctors. We have not been helped by the vagaries of workforce planning, which most developed countries, including Australia, got wrong. Now there is a worldwide shortage of general practitioners, general physicians and surgeons (and nurses) and, as always, the rural areas bear the major brunt.

In the past 20 years, a mass of descriptive research has been published, inquiries and conferences held, and programs put in place. A plethora of rural medicine organisations and institutions have been formed to implement them. But our boulder continues to roll back down the mountain, and we have to continually push it up.

Fly-in/fly-out specialist services to rural towns have been in place for many decades, and are now supported nationally through the Medical Specialist Outreach Assistance Program. The Rural and Remote General Practice Program recognises the need for extra support for rural medicine, with programs for the recruitment of rural GPs and students, and programs for retention and succession planning. We have tried a variety of incentives with at least partial success. We have also reinvented many programs in a different form to be implemented by a new organisation. Truly, Sisyphos is an appropriate candidate for patron of Australian rural medicine.

So where do we find solutions — in the rock, in the mountain, in Sisyphos, or in appeals to the gods to ease his eternal labour?

The rock

We need to make Sisyphos' rock smaller and smoother. The nature of general practice has changed. Many rural GPs are unwilling to take on the worries of business ownership. They prefer to go into a service environment that supports and rewards them, and allows them to use their skills and find their own balance between work, social and other priorities.

The 1930s saw the rise of "collectivisation" in agriculture. In rural general practice, this is having its expression as integrated primary care, which combines individual and population health, with combined Commonwealth, state and local government funding sources. The New South Wales Government Integrated Primary Health and Community Care Services program is an example that shows promise of fulfilling the dual aims of providing a locally managed but state-supported base for GPs with a single integrated base for primary health care. GPs have the opportunity to retain their own practice, with clinical and professional freedom, while working directly with community-oriented nursing and allied health professionals. Crucial to the success of the project is a third governance structure, locally developed, which maintains the separation of the general practice from the state health department, but builds workforce and clinical care integration.[1]

Doctors who wish to continue in a traditional practice management structure have also been asking for assistance in management. The South Australian Government has, as part of its "Recognising the past — rewriting the future" program, funded the Rural Doctors Workforce Agency in SA to facilitate the availability of management and legal advice to rural practices.[2]

The mountain

We need to make the mountain smaller and the path easier. Government policies recognise the resource needs of rural practice and support programs that attract, recruit and retain rural doctors. These programs are spread across myriad administering agencies, from undergraduate programs such as rural clinical schools to relocation support and retention payments. All have had some success and need to be continued. However, on their own, incentives recognise the need without affecting the cause. Incentive programs need to take into account the work initiated by the Rural Doctors Association of Australia in defining the conditions necessary to run and sustain a viable rural medical practice.[3] They also need to be matched with programs that reflect the environment of today's doctors — a work environment that is attractive to the increasing number of women in medicine and general practice, that encourages a healthy lifestyle for doctors, and that educates communities to be more aware of doctors' needs, as we educate doctors to be aware of patients' needs.

Overseas-trained doctors make up 35% of GPs in rural and remote Australia. Many have temporary registration in areas of medical need and have never had their medical skills assessed. Rural communities and medical regulatory bodies display ambivalent attitudes towards these doctors. But it is clear that medical services in rural Australia would collapse without them.[4] The

Australian Rural and Remote Workforce Agencies Group points the way forward: overseas-trained doctors "need to be viewed as colleagues and community members contributing to solutions — not outsiders contributing to problems".[5]

Sisyphos

Rural medicine is inextricably tied to generalism, but it is under extreme threat, as instanced by the following.

- Between 2000 and 2005, generalist doctors decreased by 1%, while specialists increased by 47%.[6]
- Of Monash University medical graduates from 1980 and 1985, 50% were working in general practice 8 years after graduation. Of graduates from 1995, 33% were working in general practice 8 years after graduation.[7]
- Only 4.9% of University of Queensland medical graduates from 1990 to 2004 are currently working in rural and remote Queensland.[8]

These figures support findings from NSW evaluation and exit interviews, which increasingly show cadets staying in rural areas but taking up specialties other than general practice.[9]

This march to specialisation is compounded by poor resource support for health sectors dependent on generalists. The states need to acknowledge that their rural hospitals are largely reliant on GPs providing services to the public health system. Primary medical care needs to be able to compete with the specialties on a more level playing field in terms of facilities, conditions of service, career structure and financial reward. The latter is increasingly important as more and more medical students graduate with large debts.

At the macro level, there is a need to attract doctors into generalist careers. Beyond seeing rural general practice as a specialty requiring its own fellowship recognition is a need for young doctors to see advantage in general and rural practice. Undergraduate programs have had some success in achieving this aim. However, much of this is lost in the early postgraduate years, as new graduates are captured by hospitals and find exciting and rewarding alternatives. Eighty per cent of new doctors have not decided on their career choice before their PGY 1 year.[10] There is a need to have challenging GP and rural GP terms incorporated into their early postgraduate training.

The gods

In Greek mythology, the affairs of state were influenced by competing deities, exemplified today by government departments. However, their lack of coordination results in contradictory actions, such as Commonwealth programs to re-skill procedural GPs, while state health departments close down obstetric units and dismantle anaesthetic machines in those doctors' hospitals. And even before the rural clinical school initiatives come to fruition, we dilute their possible effect by introducing similar programs for outer metropolitan regions.

In Australia, there is federal government funding for mental health, diabetes, obesity and other chronic disease programs. These programs are laudable, but in rural areas there also needs to be a pool of primary medical care funding to effect prioritisation and provision of local health needs. Country doctors are intolerant of excessive centralisation and managerialism by state health departments. Increased respect from bureaucrats towards those working at the coalface will go a long way towards keeping them there. Many formerly involved country people feel alienated by state health departments which cannot provide them with GPs, let alone locally grown ones, but which at the same time reduce their opportunities to have a real say in the organisation of their health care.

The shortage of doctors in rural and remote Australia has been and will probably always be a Sisyphean problem. We do not need any more questionnaire-based surveys of rural intention or one-off reviews that only add to the weight of Sisyphos' rock. We do need a method to enable us to take a continuing and holistic overview of what is actually happening at the grass roots level in providing rural and remote communities with appropriate and safe health care. One possible process could be an independent Office of the Inspector of Rural Health Care. A comparable example is the state-based Office of the Inspector of Custodial Services, which is supported by legislation that enables direct reporting to parliament. The rural health inspector would monitor workforce, problems of coordination and red tape, and propose policy and mediation for getting individuals, government-funded organisations and sectional groups to see further than their own self-interest.

Ultimately, we must ask the gods to move beyond our fragmented programs of the past 20 years and towards coordinated programs that address the major impediments to having a viable rural medical workforce.

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