'*The Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas'*

Dr Ian Dumbrell: GP VMO at Deniliquin Hospital NSW; practising GP in Rural Areas of Australia since 1998.

31/01/2012

Submission to Senate Committee Hearing on '*The Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas'*

Firsthand experience of rural workforce shortage: I have worked as a GP in small inland country towns, in the RFDS, in remote Aboriginal communities, in a small coastal town, and finally again in a small inland country town over a period of 12 years. During this time, I also worked as locum GP in small inland country towns in southern NSW for a period of 15 months. I have experienced rural medical workforce shortage firsthand, and have been in a position to assess the success or failure of various programs to address rural medical workforce shortage over these years.

Synopsis of the problem: The balance of disincentives and incentives in medical workforce initiatives is in favour of city GP practice. Financial incentives to promote country GP practice will never be enough to change this balance. Doctor singleness, and doctor's partners with city jobs, are the greatest barriers to overcome in trying to promote country GP practice. An extra $10,000 per year in a rural incentive grant will not be enough to motivate city GPs to move to the country.

Failure of current financial incentives, and voluntary programs; versus the success of compulsion: There already exist a number of programs to boost country GPs incomes, relative to city GPs incomes. These are of course welcome, but they do not seem to have worked over the years I have been in the country, during which time there has been a steady decline in overall country GP numbers and more particularly in the numbers of Australian Medical Graduates (AMGs) working in the country.

The marginal utility of increasing country GPs incomes has a ceiling effect, where eventually if the income is high enough, country GPs will actually decrease their hours of work. On the other hand, decreasing city GPs incomes may make some city GPs sufficiently financially uncomfortable to motivate them to uproot themselves from their support network of social and family ties in the city and move to work in the country. This is a harsh solution, but eventually public outcry about rural medical workforce shortage might make this politically expedient.

Over the years, I personally have hosted many medical students in rural placement programs, and I have not seen or heard of any of them returning to the country to work as GPs. The more the remote the country town from the young Australian Medical Graduates' (AMGs) support network of friends and family in the city, the less the likelihood of attracting young AMGs to those towns. I believe that the rural medical school campus years, and the country medical scholarships are good ideas, but they have no ultimate compulsion, and finally are voluntary programs relying on a sense of goodwill on the part of the AMGs, which goodwill is not strong enough motivation to cause young AMGs to leave the city in the face of social network factors compelling these AMGs to stay in the city.

Most of the older country GPs I have met or worked for, are men, who married nurses or teachers, when these male GPs where in their mid to late 20's. This situation allowed these male doctors to go to the country to practice. Now, most AMGs entering General Practice are female, and they have

partners who have an established career in the city. If not, the young single AMGs, male and female, will still be reluctant to move to the country because of a perceived lack of suitable partners for them in small country towns.

The only program to quantitatively successfully address the rural medical workforce shortage has been compulsion: the moratorium on city practice imposed on IMGs. It is unusual now in small country towns to have AMGs in greater numbers than IMGs. IMGs have become the backbone of the rural medical workforce, and I personally am very grateful to them for their support, and I have found them to be very committed colleagues to work with.

Summary: Financial incentives to country GPs, and voluntary programs with Australian medical students have been failing to make much impact over the last 12 years in terms of numbers of AMGs working as country GPs. On the other hand, programs involving compulsion can claim to have worked.

The balance of disincentives for doctors to stay in the city and of incentives for doctors to move to the country has to be repositioned in favour of real motivation for city doctors to make the difficult decision to leave a supportive network of friends and family and interests and move to the country. These incentives and disincentives should also be brought to bear on medical specialist programs, to divert doctors from the specialities into rural general practice and into rural speciality practice.

Some sort of compulsory program of rural medical work for all Australian Medical Graduates (given appropriate training and support for this work) seems like the only program and the conceptually simplest program that will work in the short to intermediate term, and needs to be seriously considered.

The newly adopted rural classification systems fails to address the perceived social disadvantages of living in isolated small country towns with adequate financial incentives, but as argued above, I believe that financial incentives ultimately have a ceiling effect, and do not seem to have worked in their current form.

Dr Ian Dumbrell

Deniliquin Central Clinic, Deniliquin NSW