Recruitment and retention of rural GPs: The role of skill substitution and home and work balance

Abstract

For sometime it has been recognised that there is a maldistribution of GPs, favouring metropolitan areas and disadvantaging country areas. This problem also exists in a number of other developed countries. There has been extensive research carried out in Australia as well as the US, UK, and Canada on how to attract and retain GPs in country areas. This research has focussed on aspects such as financial incentives to offer to GPs and on how to create career incentives through rural practice. This paper focuses on two themes emerging from the literature that have currency for addressing the lack of GPs in Australia. The first is that GPs can reduce their workload in rural areas by delegating some of their tasks to other health professionals such as nursing practitioners, a practice common in the US and Canada. The second is that increased emphasis needs to be given to creating a work and homelife balance for GPs and their spouses in order to create an attractive lifestyle in country areas for GPs. If these two factors are given greater emphasis in rural health policy, they may increase recruitment and retention rates for GPs by creating less workload and a more supported work and home environment.
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Background

More than 30 years ago, a report on ‘Rural Health in Australia’ to the Commonwealth Parliament by the then Hospitals and Health Services Commission (1976) did not mention the shortage of doctors. Yet a ‘crisis’ in the rural doctor workforce has since been identified and there has been a significant amount of research undertaken on the maldistribution of medical services in rural and remote areas.

The Rural Doctors’ Association of Australia (2007) reports that at least 1000 extra doctors are urgently in rural and remote Australia to provide basic healthcare. An acceptable ratio of doctor to patients, they argue is 1:900. In some rural towns the ratio is now 1 doctor to 4000 patients. Also, some Australians in the bush are waiting more than six weeks for a basic consultation. Many of the dedicated doctors working in rural and remote areas are also approaching retirement.

Against this backdrop of a lack of county health services there have been a number of social changes. There has been a substantial growth in the proportion of women in the medical workforce and women have been argued to rate home and family needs highly (note McMurray et al., 2002, Ozolins et al., 2004, Roach, 2002, and Wainer, 2004); the health workforce has been growing proportionately older; in addition young people are leaving rural areas and a mainly older population is left (Larson, 2006); A newer phenomenon of seachange and treechange has also been occurring with many retirees moving to country areas (Costello, 2007).

This paper aims to outline a number of factors found to be important in explaining
recruitment and retention of GPs in rural areas. However, there are two factors which have been presented in the literature that the authors expand on. One that has been evident for a relatively long period of time, particularly in Canada, the UK and the US is role substitution of GP services by nurse practitioners. In Australia, there has been resistance by groups such as the Australian Medical Association (AMA) to role substitution, therefore hindering a potent way of providing additional medical services to rural and remote regions. The other factor has become more important recently for most types of work. That is the extent to which rural and remote GPs can experience a work and family/homelife balance, based on a demanding job in areas where there are fewer social and community resources. A small number of studies on work/family balance and its importance in attracting and retaining country GPs are reviewed in the paper. Based on findings from these studies this area is presented as one warranting further research.

Factors to affect recruitment and retention

There have been hundreds of research papers over the past two decades on how to recruit and retain GPs voluntarily in country areas. Policy responses have been largely doctor centric (Chan et al., 2005, Han and Humphreys, 2006, Hays et al., 2003, Humphreys, et al., 2001, Jones et al., 2004a, Veitch et al., 2006, and Wilkinson et al., 2003).

Some common themes in recruitment and retention include: whether the GP or spouse has a rural background (e.g. Chan et al., 2005, Laven and Wilkinson, 2003, and Wilkinson et al 2003); the impact of GPs being trained in a rural areas and its effect
on their return to practice in rural areas (e.g. Veitch et al., 2006); the role of overseas trained doctors (Kearns et al., 2006); and, technological advances, such as e-health (telemedicine and telehealth) are being used to support a number of aspects of GP’s work (Lim et al., 2000). Advanced technologies have been used for some time in areas such as psychiatry with videoconferencing, dermatology with teledermatology services, remote physiotherapy services and teleradiologyes (Scheinfeld, 2005).

Expressed drawback to country practice by GPs include the lack of professional support, including limited opportunity for continuing medical education, and dealing with high risk and medico-legal issues (Eley et al., 2007). This general level of a lack of support both professionally and in private life has been the subject of many studies on retention of non metropolitan GPs.

Four main aspects of recruitment and retention in non metropolitan areas identified in studies include

- practice factors such as working hours and on call availability (Hays et al., 2003, Szafran, et al 2001, Humphreys et al., 2002)
- relationship factors such as adjustment of spouses including work availability and community support (note Veitch and Crossland, 2005).
- community factors such as recreational options and schooling opportunities for children (note Szafran et al., 2001, Veitch and Crossland, 2005, Hays et al., 2003);
- economic factors such as financial and other incentives including free accommodation, travel, etc (note Jones et al., 2004b);

We need to understand these factors and the impact they have if we are going to be
able to understand their effect on the lifestyle of GPs and their spouses/families, and consequently on recruitment and retention.

Recent initiatives in rural and remote Australia

The Australian government (see Rural Doctors’ Association [http://www.rdaa.com.au/]) has used a number of practices to encourage doctors to work in the country. For example, in the past it has used financial incentives to encourage health workers, especially GPs to voluntarily move to rural and remote areas. It has also encouraged overseas trained doctors to work in country areas where there are shortages and to access the Medicare Benefits Schedule, and non-vocationally registered GPs to obtain the full Medicare Benefits rebates by practicing in areas where there are shortages.

Some GPs are attracted to non metropolitan practice because of perceived professional freedom. State and local governments in the past have provided financial assistance to patients to travel for specialist consultations; there has been housing assistance, scholarships and similar supports for GPs; and childcare payment grants to aid female GPs. New teaching programs for undergraduate courses have been established in regional locations, as well as courses with a rural focus. Local community initiatives include council provided homes, as well as surgeries and other work related supports (Rural Workforce Agency Victoria, 2006).
**Substitution of other medical providers for GPs**

In Canada and the US nurse practitioners or physicians’ assistants are trained to perform a number of procedures carried out by GPs and are delegated immunization, diagnosis, and other tasks (Ballweg at al, 2003). Kenny and Duckett (2004) and Ellis et al, (2006) report that more GPs need not be the whole answer, and that GPs need to take on skill substitution or delegation of tasks to address the problems of workforce shortages.

The emphasis on GPs is not as strong in some countries such as Canada and the US where physician assistants and nurse practitioners play an important role and perform some of the physicians’ more routine tasks (Ballweg at al: 2003) The Productivity Commission (2005) suggests blurring professional boundaries (meaning creating a more flexible workforce). Despite a substantial literature over at least two decades, the problems related to adequate medical coverage in rural and remote areas has not been solved. Nor is Australia alone in this. Some of the studies reviewed below have very positive findings on using nurse practitioners to substitute some of the skills of GPs, but others point to problems in collaboration and question the argument that nurse practitioners are the most cost effective option for providing rural and remote services.

Laurant et al (2005) report that there have been extensive shortages of rural GPs in developed countries. They argue the perception of observers is that high costs associated with providing doctors in rural areas can be contained by using nurse practitioners. Laurant and co-workers carried out a study to evaluate how doctor/nurse
practitioner substitution impacted on outcomes of care, resource utilisation and patient care. They found there is evidence that trained nurses can provide equivalent care to doctors and that patient outcomes can be similar. They suggested further that reducing the doctor’s workload was possible, but depended on the context of care.

Banham and Connelly (2002) however, draw on data from the UK and raise some questions about the fragmented evidence related to skill substitution of doctors’ work. They argue that policy makers should look at skill mix between nurses and doctors only when they are clear about the evidence base, purpose, accountability and acceptable risk. They also maintain that there is evidence to show that skill substitution is not necessarily cost effective, nor a gain to the nursing profession nor for improved quality of care. However, Vlastos, Mpatistakis and Gkouskou (2005) undertook a study on the cost effectiveness of replacing interns in rural areas with nurses in Greece. They found that two-thirds of doctor visits were for things a nurse could do, and concluded that properly trained nurses could be a cost effective replacement for junior doctors.

In the UK GPs were fairly positive about the roles of nurse practitioners (Carr et al., 2002). Using nurse practitioners gave GPs a reduced workload and patients some choice over which practitioner to see. However, some GPs were reluctant about the role of nurse practitioner due to the cost of training them, and some GPs disagreed over the tasks that should be assigned to them.

Wilson et al (2006) studied nurse practitioners’ collaborative experiences in New South Wales, Australia and found that collaboration was often difficult to achieve.
The study was qualitative and undertaken in rural and remote hospitals and clinics. Despite the small sample of nurse practitioners there were similar patterns in their experiences. Nurses generally found that working in ineffective collaborations with medical and allied health staff was quite dissatisfying. There were few instances of total collaboration taking place, yet nurse practitioners were determined to collaborate in effective ways.

Consequently while there is support for the role of nurse practitioners and positive outcomes including patient benefits and reduced workload for doctors, there is some conflicting evidence on cost effectiveness. However the benefits of service quality, patient outcomes and reduced workload for doctors are enough to consider nursing practitioners as a viable alternative to support doctors’ roles. Substitution also provides patients with a greater range and choice of practitioners to see. Delegation of some tasks from GPs to other health professionals and GPs and nurse practitioners working in collaborative and cooperative arrangements are important as a means of reducing their workload and increase lifestyle satisfaction. There appears to be a general acceptance overseas and a growing acceptance “in principle” only in Australia of the nurse practitioners, given the opposition of groups such as the AMA.

**The role of work and life balance in recruitment and retention**

Doctors are the backbone of rural health. But with a growing older country population and increasing proportion of female GPs it is apt to consider the effects of work and related lifestyle balance for doctors. As outlined earlier, there have been social and demographic changes in rural and remote areas and these have influenced the authors
to examine the lifestyle opportunities and their effects on GP recruitment and retention. In sociological studies of work the issue of work/family and life balance has emerged as important in contemporary society as the nature of work changes and female labor force participation increases (particularly during child rearing years) (note Hill et al. 2001 and Tausig and Fenwick, 2001).

As previously outlined, there are four well researched areas where improvements can be made to attracting and retaining GPs to non metropolitan areas. These are practice characteristics such as time on call and workload, relationships and the needs of the spouse and family, support from the community for the GP, spouse and family, and the role of economic incentives that makes remaining a positive option. If these factors are positive a beneficial lifestyle can develop which includes a balanced work and family life.

Some of the studies cited below demonstrate there are gender differences also that need to be accounted for amongst GPs in country areas. For example, males may favour practice factors as more important, while females rate relationship and community factors as dominant. Given there is a growth in female GPs in non metropolitan areas these differences are important.

The following studies show the importance of positive lifestyle to recruitment and retention of GPs in non metropolitan areas. Veitch and Crossland (2005) maintain that family issues make a major contribution in retention in rural practice. Family and spouse factors are some of the most common reasons for exiting rural practice. Their own previous research had shown that professional and personal support and
workload were key issues. The study focused on investigating the support needs of rural GP families, identifying the support strategies available for families. They used in-depth semi-structured interview method with families of rural GPs, and key informant information from support organisations. Sixteen Queensland based families were randomly selected. The most common difficulty for spouses when moving to a new rural area was loss of identity, that is being seen as the doctor’s spouse. Schooling and childcare were also seen as difficulties. While some support agencies had formal GP spouse strategies, most spouses reported that they needed to find their own answers to problems relating to support. Consequently the role of the spouse and of family friendly factors in the community has an important impact on GP recruitment and selection. For example other studies such as Chenay and co-workers (2003) have shown that a lack of physical resources, privacy and facilities for young families have also been argued to influence recruitment and retention.

In an earlier study Hays, et al., (2003) investigated the factors involved for GPs in staying and leaving rural general practice. In the longitudinal interview based study 18 GPs were re-interviewed 10 years after their first interview. The following factors were reported as strong in maintaining them in rural practice: attachment to the community they lived in, work allowing time off for holidays, and time off-call were major factors. However several GPs were stressed and thinking of leaving. Stressors consisted of factors such as overwork and their children’s education. Consequently factors related to reducing GP workload and increasing family recreation were seen as important to GPs.

Kimball and Crouse (2007) conducted a study using unstructured interviews of ten
female physicians practicing in rural Wisconsin to understand their perspective on practicing in rural areas. Interviews were conducted between 30-60 minutes and a thematic analysis was carried out. They found that most of the women had rural backgrounds which influenced their choice of rural practice. Other important factors keeping them in rural areas were: having a good environment to raise a family; professional satisfaction; to engage with the community and to serve it. However they found there were also drawbacks, including too much on call, insufficient providers and a lack of family and professional life balance.

Szafran, et al (2001) undertook a study of factors influencing choice of practice location in Canada. They found the major factors in attracting doctors to their current location were type of practice; influence of the spouse; and being close to extended family. In choosing rural practice the following factors were important. Female doctors said that spouse influence was the most important factor, while for men type of practice was most important. In addition female doctors more than males ranked being familiar with the medical community, hours of work and the availability of support as influencing their decisions on where to practice.

Other studies have also supported the finding on the importance of lifestyle for recruitment and retention. Tolhurst et al (2000) and Boles and Yuterzenka (2000). for example, report on a qualitative study of work, family and lifestyle issues particularly for female GPs.

There is an expressed need for rural communities to offer incentives and attractive life options for families and also specifically with females in mind. The studies reviewed
show that decreasing GP workload and increasing time for families to spend in recreation and supportive activities were important for GPs. Some of the studies also demonstrated that female GPs were more family conscious than male GPs and required effective, family oriented activities and supports in their rural communities. An increase of balance between work and home (including community based activities and recreation) was a need reported both by GPs and their spouses.

Consequently policy needs to be informed of these lifestyle factors in programs of recruitment and retention of GPs to rural and remote areas. Not only should the expressed needs of GPs be considered, some studies have demonstrated that the spouse may even be a stronger determinant of whether GPs moving into rural practice and whether they staff. This focus may also lead to a more stable country GP population.

**Conclusion**

Given that there are a number of factors that have been shown in research to affect the recruitment and retention of GPs in rural and remote areas, two major factors are timely to focus on. Firstly, the delegation of tasks to other healthcare professionals, particularly to nurse practitioners has been shown in other developed countries to lessen the workload of GPs and enable them to engage in other more creative aspects of their jobs. The delegation would be likely to reduce their workload and give them more time to spend with their families. The second factor, a focus on work and family balance would enable GPs and their spouses to develop more family friendly lifestyles, and reduce some of the pressure that lead GPs to leave country areas. In
view of the increasing feminisation of the GP workforce, and that female GPs in particular have responded very positively to changes that create work and home balance, the profession needs to seek out opportunities to work with country communities to create more balance in the lives of country GPs.

It is timely for policy makers to address both of these issues, delegation of tasks to other health professionals and creating more work and family balance in order to reduce overwork of country GPs. These changes are likely to create a more appealing, balanced lifestyle for GPs and their spouses and lead to greater retention in rural and remote areas.

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References


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