



## Addressing GP Recruitment and Retention Issues in Rural Victoria

*"If you think things can stay the way they've always been, you're whistling Dixie.."*

Report on Community Consultations, February 2006

## **Addressing GP Recruitment and Retention Issues in Rural Victoria – Report on Community Consultations, February, 2006**

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Addressing GP Recruitment and Retention Issues in Rural Victoria –  
Report on Community Consultations, February, 2006

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## 1. Background

The core business of the Rural Workforce Agency Victoria (RWAV) is the recruitment and ongoing support of rural doctors in Victoria. RWAV programs are supported by medical education and training, and they take their direction from continuing workforce monitoring and trends analysis.

RWAV is a not for profit company funded primarily by the Australian and State Governments and is governed by a Board which includes representatives from key medical and rural stakeholders.

During February 2006, RWAV conducted a series of community consultations throughout rural Victoria to identify the critical medical workforce issues of concern to rural communities. Consultations were held across Victoria in:

- Glenormiston
- Horsham
- Shepparton
- Traralgon
- Robinvale
- Melbourne

## 2. Process

The consultation forums were two hour meetings, chaired and facilitated by the Mayor of the relevant local government area in which the forum was held. In the case of Melbourne, facilitation was provided by the CEO of RWAV. The forums included:

- a presentation on the current situation of GP shortages in rural Victoria
- an overview of the current vacancy levels and challenges pertinent to the area in which each forum was held, and
- a series of structured questions related to local doctor recruitment and retention issues.

The questions posed included:

1. What issues do communities face in recruiting doctors to their areas?
2. What challenges do communities face in relation to retaining doctors?
3. How could these issues be tackled from a community perspective?
4. What can agencies like RWAV and General Practice Divisions do to help communities recruit and retain doctors?
5. What key issues/ messages did participants want to see considered in RWAV's strategic planning processes?

A wide range of stakeholders were invited to attend the forums including:

- General Practitioners
- Medical/ Health Services with no GPs
- Hospitals
- Divisions of General Practice
- Local Government
- Community Service Groups eg Lions, Rotary, Probus, CWA
- Pharmacists
- Local MPs
- Aboriginal Community Controlled Health Services
- Members of Rural Medical Family Network
- Ambulance services
- Community members

In all, approximately 150 participants attended the forums<sup>1</sup>.

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<sup>1</sup> Note: Some participants didn't officially register/ fill in an attendance sheet so actual numbers are likely to be higher than reported here.

### 3. Snapshot of workforce issues

GP workforce shortages throughout Australia, and particularly in rural Australia are well documented. According to the Australian Medical Workforce Advisory Committee (AMWAC, 2005), Australia faced a shortage of some 800 -1300 GPs in 2002 and this is expected to continue. In Victoria, the shortage was 250 GPs with a requirement of 270 new GPs per year until the year 2013 to bring about a balance of supply and demand.<sup>2</sup> With the current entrants into the Victorian GP workforce (including both medical graduates and Overseas Trained Doctors) it is estimated that this State will continue to experience shortages in the vicinity of 115 GPs per year.

Current advertised vacancies in rural Victoria alone are almost 100 and this figure has been gradually increasing since 2003. It is taking, on average, 8 months to fill a vacancy with over half of all vacancies taking longer than 6 months to fill. A significant proportion (25%) of vacancies are in regional centres – Bendigo, Ballarat, Shepparton and Wodonga.

The shortages in the GP workforce are leading to an increased pressure on existing GPs to work longer hours and take less leave in order to maintain a service to their patients. RWAV statistics indicate that approximately a third of all rural Doctors take no annual leave, and half take less than 3 weeks.

Recruitment challenges are expected to increase as the profile and preferences of the GP workforce change. Some of the key drivers include:

- an ageing GP workforce with a significant proportion of existing GPs expected to retire by 2010
- an increase in the number and proportion of female GPs who want a better balance between work and family life and prefer shorter hours and part-time positions
- fewer medical trainees choosing general practice and even fewer choosing rural general practice
- younger doctors showing an increasing tendency to favour flexible working arrangements that are not always available in rural practice.

Rural communities are facing increasing competition for both Australian and overseas trained doctors particularly from other States where recruitment and relocation packages are far more attractive than what is offered by the Victorian government.

Local governments, while not historically involved in recruitment efforts, recognise the importance of good medical services to the health and well-being of communities. While attracting a range of professionals to rural locations is challenging, GPs often have a pivotal role in ensuring that other services are also available to the community such as aged care, allied health services, hospitals and pharmacies. In the worsening situation of GP shortages in rural locations local government will need to play a more active role in facilitating and contributing to community efforts to recruit and retain doctors.

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<sup>2</sup> This is based on GP to population ratio only, and does not necessarily reflect actual need as defined by a range of other factors such as access, community well-being etc.

## 4. Key findings/ Feedback

### 4.1 The current picture of rural General Practice in Victoria

*"The published GP vacancy numbers do not reveal the true level of need in rural Victoria it only reflects advertised vacancies. In Mildura we have facilities that are fully utilised. Even though we need more doctors there is nowhere for them to go to unless they build their own practice. So the actual vacancies are probably double – no- probably triple what the government says they are."*

### 4.2 Recruitment Issues

- Not enough Australian Doctors being trained
- Not enough Doctors being trained who choose General Practice
- Increasing competition for few Doctors (both Australian and Overseas trained) is leading to a need for increased incentives to attract Doctors to rural practice
- Length of internship in rural hospitals is too short to develop an interest in rural lifestyle
- Rural living is not attractive to many doctors and their families
- Recruitment process is cumbersome, confusing and lengthy for both recruiting practices and for candidates
- Lack of procedural GPs particularly GPs providing obstetrics and anaesthetics services to their local hospitals
- Australian Medical Council examination system viewed negatively
- Doctors want choices and mobility and don't want to commit to rural practice "for life"
- Doctors seeking work-life balance and not interested in long hours
- New graduates increasingly interested in working in hospital settings (set hours, variety of work, well remunerated)
- Financial disadvantages associated with living in rural areas if long term goals include moving back into a metropolitan setting

### 4.3 Retention and support Issues

- Education choices for children (especially in smaller towns)
- GPs are working longer hours than they want to
- "On-Call" expectations are too great
- Remuneration of "on-call" is inadequate
- Inflexibility of practice models
- Inability to get locum support for sick leave, study leave and holidays
- Locum services too expensive
- Few opportunities for older GPs to easily transition to lesser hours/locum work/teaching

- Arrangements with local hospital for procedural work and training/supervision are needed but not always available
- Supervision of registrars not sufficiently recompensed
- Cost of physically expanding practices too onerous
- Spouses experiencing difficulties in finding suitable employment
- Overseas trained Doctors and families often experience “cultural disconnect”
- Remuneration (alternative career choices more lucrative)

#### **4.4 What is helping now?**

- Incentive packages
- Rural medical schools for rural students
- Internships in rural hospitals
- Family support
- Community capacity to meet cultural needs
- Inter-town/ practice on call arrangements
- Multi GP practices
- GP arrangements with hospitals
- Strengthening Medicare and other recruitment programs
- Recent changes to Medicare such as practice nurse initiatives have helped

#### **4.5 What else could help?**

- Greater co-operation and collaboration by key agencies and local government in recruitment and retention efforts
- Community wide awareness – the loss of a doctor can have significant flow-on effects to a wide range of services in a town eg pharmacist, aged care facilities, etc
- Communities need to have the right “package” to attract and retain GPs
- Community owned assets that can be leased by GPs including houses, practices and equipment
- Co-ordination of effort re establishment and operation of rural medical schools
- Lowering of entrance scores to medical courses to increase opportunities for rural students
- Reserving places in medical courses for rural students
- “Bonded” scholarships and other local scholarships
- Financial support to expand existing practices to take on supervision of student, eg to add consulting rooms
- Financial recompense for supervision equivalent to income earned if consulting
- Increased opportunities for placement/supervision of students in practices
- Different models of practice, eg larger practices, more part-time positions, more salaried positions
- Tax incentives for rural GPs, eg housing, HECs

- Higher level of Medicare rebates for GPs in rural areas
- Different models of locum support, eg one recruitment agency, models like UK
- Succession planning
- A national / consistent process of assessing Overseas Trained Doctors
- Support for placements in cultural/religious hubs to improve capacity for cultural connection by Overseas Trained Doctors and their families
- Marketing and promotion of rural areas and rural lifestyle
- Changes to Australian Government's District of Workforce Shortage scheme that determines where overseas trained doctors are placed

## 5. The Solutions

### 5.1 "Grow Your Own"

#### *Increase the number of medical training places*

While it was acknowledged that recruiting overseas trained doctors was filling a much-needed gap, participants felt this was short-term solution to an ever-increasing problem.

*"We are just doing stop gap strategies... we need to combine these short-term strategies with a long-term strategy of getting more trainees through the system."*

The recent announcement relating to the increase in the numbers of medical trainee places, whilst welcomed, was seen as a solution that "might help in ten years time" but did little to alleviate current shortages. Many participants were frustrated at the lack of government action in this regard and felt that the current crisis was a result of poor and short-term thinking at a political level.

*"It's an absolute indictment on our medical - political system that we can't get local graduates."*

Participants want to see bi-partisan political support for increasing the number of rural medical student places over the next 10 years so there is a long-term solution in place as well as short-term strategies.

#### *Make rural General Practice a preferred choice for students*

There was a consistent message from participants that increasing the intakes of medical students alone would not be enough to address the GP crisis in rural Victoria. An increase in numbers is a necessary first step but strategies are also needed to ensure an increasing proportion of students choose General Practice as a career path and **then** make a choice to practice in a rural location. General Practice was not seen as the "career of choice" when speciality areas could offer a doctor a future that is better remunerated, defined more narrowly and where hours of work can be better managed.

The general view was that during their early years of training students were actively being discouraged from pursuing general practice, once they were captured by the hospital system and convinced to undertake speciality training.

A number of participants were keen to see rural General Practice recognised as a specialty in its own right. As a formal stream of medicine this would both ensure trainees receive appropriate training in the range of skills and practice related to rural practice including obstetrics, anaesthetics, accident and emergency, Aboriginal health, women's health, etc, as well as ensure that remuneration is commensurate with the range of services rural GPs provide.

## *Train more rural students in General Practice*

Even with an increase in numbers of GPs, communities were faced with the fact that a significant proportion of the population are not interested in working and living in a rural location. Fewer and less choice of facilities and services were seen as major barriers to attracting professionals in short supply including doctors and other health professionals.

Participants were generally passionate advocates for country lifestyles but acknowledged the difficulty in “selling” the benefits of working and living in a rural location to those that had never experienced rural life.

There is, however, increasing evidence that living and working in rural locations is a much more attractive option to people who have been born in or have had extensive periods of time living in the country.

It was noted that some medical schools and rural schools are beginning to track the career and location choices of graduates and that the findings were encouraging with significant percentages electing to choose rural practice. In the case of the Gippsland Rural Clinical School around 70% of students were returning for additional training. Some of these students were not necessarily from that area but were coming from a range of locations. It was thought this was because of the increasing recognition that the clinical training provided in rural communities is better than that provided in metropolitan hospitals, offering students a much more “hands-on” experience with greater variety. Students appreciated the level of training provided in rural areas.

Participants were keen to see a number of strategies to increase the number of young people choosing medicine and taking up rural General Practice. These included:

- establishing rural medical schools in rural Victoria
- quarantining a proportion of places for students from rural backgrounds
- reviewing the selection criteria/entrance requirements for medical courses in all universities. It was felt that the cut-off mark for entry was in itself not an adequate predictor of whether some-one would make a good doctor. Academic scores while important, were considered arbitrarily high, based on demand for places not on capability, and disadvantaged country based students
- additional bonded scholarships for rural students, to support them to complete their degrees in return for a commitment to practice in a rural location

*“We have an abundance of smart kids in this area. They can’t get into medical school at the moment even if they make the grade. We need to challenge the entrenched entrance hurdles to medical schools – ENTER scores or money in the bank shouldn’t be the key to selection.”*

Forum participants were able to provide a number of examples of where “bonded scholarships” had worked in their communities. In one town, the community provided the incentives by way of rental assistance for a physiotherapy student needing to go to Melbourne to complete her studies. At the end of her course she made a commitment to practice in the town for a minimum of two years. Another example was given of a Pharmacist offering work experience for students in years 11 and 12 and sponsoring them to go on and study with the expectation that they would return to the town and business after the successful completion of their course.

## ***GP training/placements***

Communities saw that the current length of internship in rural hospitals as too short for doctors to engage in rural lifestyle. There was general support for extending the length of compulsory internship in a rural hospital setting to 12 months to enable young doctors to make a reasonable connection with rural life including friendships, memberships of clubs, service groups, etc.

Opportunities for trainee placements in GP practices are also limited by both a lack of physical infrastructure in many practices and reluctance on the part of some GPs to undertake supervision. (The majority of participants considered that supervision of students was not adequately recompensed).

Formal residents programs in communities were seen as an important way of exposing young doctors to a rural setting.

Rural GP training through Regional Training Providers was seen as another important strategy, however, participants were generally not yet convinced that registrars coming out of these training providers were electing to stay on in rural locations. It was acknowledged it was still "early days" and more time was needed to see if training in these settings was going to have an impact on the number of Doctors who decide to stay in rural general practice.

## **5.2 Recruitment**

### ***Incentive and relocation packages***

Increasing competition for fewer doctors (both Australian and Overseas trained) is leading to a need for increased incentives to attract doctors to rural practice. Some participants resented the fact that they had to find a range of incentives to attract doctors. However, the majority of participants acknowledged that in a global market all communities are competing for skilled professionals and if they want particular services they need to offer suitable packages. There was concern that as the crisis worsens the capacity of communities to remain as viable players in the market would be compromised.

Examples were provided of other States offering considerable relocation packages, local governments providing support with housing and transport for a period of time while the GP and their family settles into a community, practices providing a guaranteed income for the first six months as patient loads build up, local businesses providing gym/club membership and discounts, and of community members getting together to "welcome" families and help them familiarise with community facilities and services.

It was noted that overseas trained doctors could also be attracted by packages that included financial coverage of assessment fees, exam fees, and where appropriate set-up fees.

*"There is an \$80,000 cost to bring a GP from overseas and get them to stay for 12 months. That's a cost to the medical practice. We need to provide a car, premises, relocation, etc and this is before we even think about salary."*

It was suggested communities would benefit from a centralised person to co-ordinate packages that include a range of components provided by local government, GP practices, businesses and clubs.

### ***Collaborative planning and support***

There was general recognition that communities needed to be proactive in recruiting and retaining a range of professionals, however GPs, in particular were recognised as an important community asset given the interdependencies with a range of other professional services.

*"This is a community problem. Maybe in 10 years we won't have a doctor and this will mean we will lose our pharmacy and our aged care facility. The whole community needs to acknowledge that it is pivotal to have a doctor here."*

Participants agreed there needed to be greater collaboration of effort between government, local government, and communities.

Getting local government more actively involved in recruitment and retention strategies was seen as critical. Many local governments have not been actively involved to date leaving these issues to the likes of RWAV, GP Divisions, medical practices and local community members. However, participants, including local government representatives, were quick to agree that it was timely for greater local government involvement.

Opportunities for greater collaboration of effort included:

- Workforce and infrastructure planning (examples were provided of local governments planning for significant housing developments, and while consideration is given to community health services and aged care facilities, this does not often include consideration of the GP needs of expanded communities)
- Provision of housing for a period of time while the GP family settles into the community
- Facilitating the establishment and operation of a stakeholder representative group to develop "solutions" to meet the individual needs of GPs and their families
- Greater co-operation between the Skilled Migration Program (which works across local governments and has 11 officers based in rural locations) and key agencies such as RWAV, GP Divisions and the Rural Medical Family Network to provide support (including spouse employment) to OTDs taking up rural practice

### ***Community marketing and promotional activities***

Forum participants acknowledged that communities need to take responsibility for marketing and promoting their locations to potential rural Doctors including overseas trained doctors. Marketing needs to capture the "essence" of rural life, availability of services and facilities as well as "good news" stories. For example Mildura, Wangaratta, and Shepparton have all had success in recruiting overseas doctors and nurses. One participant suggested that a promotional video of the experiences of overseas trained doctors and nurses in the Mildura Base Hospital would be a useful tool for marketing the area to other overseas trained health professionals.

There is also a clear responsibility for agencies such as RWAV to increase overseas recruitment efforts to ensure potential recruits are identified and have easy access to marketing and promotional materials from regional Victoria.

In addition, there was a strong sense that rural communities had been “protected” from the GP workforce crisis because existing rural GPs were working longer hours to cover the gaps. Many communities were not yet aware of the full extent of medical workforce shortages.

There was general agreement that an awareness campaign focused on the pivotal role that GPs play in ensuring the existence and viability of other community services and facilities e.g. local hospital services, pharmacy, aged care and allied health. The loss of GP services to a town can have a devastating effect on other services and therefore severely impact on the economic viability of rural towns.

### ***Change the definition of GP need***

Participants were generally not happy with how the need for GPs is defined and supported by Governments in filling vacancies.

*“A ridiculous problem we face is this game of “area of needs” stats!”*

Three issues in particular were raised:

- GP/population ratio as a measure of need for towns which experience an influx of tourists in school holidays and weekends, when the population doubles and even triples, is inappropriate.
- Some towns which service a wide catchment area from outside of their own local government area (sometimes upwards of 30% or more of patients can live outside of the town’s boundaries) are often not considered an area of need.
- The District of Workforce Shortage that enables priority recruitment of OTDs is a “moveable feast” and once a vacancy is filled the town is no longer considered as being in need and must reapply for this status if they then lose another GP.

Solutions suggested in the forum included:

- Group practices be given flexible provider numbers so that during quiet periods “inland” doctors can move to coastal areas and service holiday populations. This could reduce dependency on locum services in some areas such as Philip Island, Lorne, Apollo Bay, etc.
- District of Workforce Shortage status being valid for a reasonable length of time or even permanently for some towns to assist practices to remain viable in times of GP turnover.
- A review of how towns are classified to take into account catchment areas as well as the provision of specialist services such as obstetrics and Aboriginal health.

## *Streamline the recruitment process for Overseas Trained Doctors*

The issue of the recruitment process as it applies to overseas trained doctors provoked heated discussion amongst participants at the forums.

The main concerns raised were:

- The OTD recruitment process is considered onerous, confusing and lengthy, taking up to 2 years to complete
- Assessment processes are inconsistent across States leading to some of the more informed OTDs to “shop around” for the easiest and least expensive option
- The Australian Medical Council (AMC) examination system was viewed as “cruel” and disrespectful of experienced OTDs

Participants were tired of having to deal with the current system and process and are desperate for change that will make things more efficient for candidates, practices and recruiting agencies.

*“I don't want to spend my time recruiting, I want to be a GP. I don't want to do this. I don't have the energy and it's not my expertise. I want someone to do this for me”.*

*“The paperwork and the hurdles we need to get through are unbelievable. Even though we are in an area of need we can't get the paperwork done fast enough. Dr XXX has been in general practice for 15 years but still has to go through such a lengthy process. This needs to be addressed – especially when we are experiencing chronic shortages.”*

*“The exam system is quite intolerable ...it's a nightmare for [OTDs]. These are experienced people and think differently to new young graduates. There must be some other way to test their skills.”*

It was suggested that what was needed was:

- A nationally consistent system for recruitment including assessment
- Greater recognition of prior learning and qualifications from other countries
- Alternative ways of “examining” OTDs including working under supervision in hospital and health service settings
- Fast-tracking of “qualifying periods” in approved settings for experienced GPs who need familiarisation with the system

## 5.3 Retention Strategies

### *Family support*

*"You have to understand that when you are recruiting a GP, you are, in most cases, recruiting a family whose members all need support to settle into their new location."*

It was agreed that when a GP takes up practice in a rural location support to their family was critical to their retention. An unhappy family means an unhappy GP who is more at risk of leaving than a GP whose family needs are being met. The major needs identified were:

- Education choices
- Spouse employment opportunities
- Child care (for dual career families)
- Access to facilities and services such as sports, arts, recreation
- Community connections
- Cultural fit

Community members were well aware of the importance of GP and family support issues and that some of these were easier to address than others.

Perceptions that country education was somehow inferior to education in metropolitan Melbourne was certainly something rural communities had to continually combat. While it was generally thought that education standards are high the range of choices is often limited in smaller towns.

Spouse employment can be difficult particularly if both the GP and his/her spouse are professional people and jobs in the spouse's profession are hard to come by.

Similarly, the availability of child care options is often limited particularly if the need is for out of hours care because of work demands on the GP and his/her spouse, school holidays or the need to care for sick children.

The capacity to make connections in the community and be accepted as members of the community is important for all new families, but especially for families from overseas. As one OTD said:

*"Some families helped me in my endeavours in my everyday life. If I had not met these friends I would not be here today. You need some personal attachment to the community – personal tutoring and friendship is very, very important."*

Cultural connection is also very important. Settling into communities is often easier for families in locations where families of a similar cultural background are already established. The ability to attend an appropriate church, purchase familiar foods and participate in cultural activities can ease the settling in process. For example, OTDs from Muslim backgrounds were thought to have a relatively easy time settling into a town like Shepparton where there is a strong Muslim community.

Participants offered many suggestions in regard to supporting families. They included:

- Linking GP families moving to a rural location into the Skilled Migration Program, Regional Migration Incentive Fund, Settlement Officers who offer a range of support services including resource kits on local services, advice on local issues, and identification of spouse employment opportunities
- Local government working with local businesses to provide advice and support on spouse employment opportunities
- Cross professional advertising targeted at dual career couples
- Setting up GP peer support and mentoring programs
- Placing OTDs in towns where there are clinical schools, and or GP Registrar training so they are part of a learning culture
- Establishing local support groups to “buddy” families and assist them to make community connections in their first 6 to 12 months in a rural location
- Finding opportunities to place OTDs in towns where communities from a similar cultural background are already established
- Providing child care in or close to hospitals/practices

### *Incentives*

All forums identified that taking up rural practice came at a cost to GPs because of the disadvantages they experienced in terms of remuneration and relatively poor returns on investments when they purchase a practice or home in a rural location.

The level of Medicare rebates for doctors in rural practice was raised in several forums with most GPs supportive of higher rebates relative to those applicable to metropolitan based doctors whose earning capacity can be significantly higher. Most believed this would attract more GPs to rural practice.

Tax incentives/breaks were also a popular suggestion in many of the forums. These included:

- Reduced mortgage rates on residential homes purchased in a rural location
- Elimination or discount of Higher Education Contribution Scheme (HECS) payments for graduates choosing rural practice
- A reduction on capital gains tax for investments in practices.

Another suggestion made was the awarding of bonuses for long-term stayers. This could be from businesses in the community, local government, or corporations such as pharmaceutical companies.

## 5.4 Locum Recruitment and Management

### *Improve access*

Accessing locum support when it was needed was a significant problem mentioned in most of the forums. In some areas, it has become necessary to book a locum 12 months in advance for the purpose of planning holidays and it has become virtually impossible to secure any sort of support when a GP is sick. In these cases, the GP continues to work to support his/her patient needs - putting both the GP's health and the health of their patients at risk - or simply closes the door.

The cost of Locums was also seen as prohibitive for some practices, particularly small practices. The financial support offered under the Locum subsidy scheme was considered inadequate, providing barely enough to cover half a week's wages for the locum.

*"Being a solo practitioner I just can't get a locum so I can take a holiday. I can only get \$2000 from RWAV which is half a week's wage. It costs me a lot to go on holiday. The only choice I have is to close the door so I can have a break."*

Some retiring Doctors mentioned they would be willing to take on locum work as a way of transitioning out of full-time practice. However, ongoing professional indemnity insurance liabilities were leading many older GPs to quit practice altogether.

Some suggestions made by participants to address these issues included:

- Increasing the financial support to GPs who needed to employ locums, particularly those working as solo practitioners or in small practices.
- Establishing/appointing a central agency to manage locum vacancies across all of rural Victoria.
- RWAV becoming an employer of full-time, salaried locums who could be allocated as needed to rural practices.

## 5.5 Sustainable Models

### *Alternative on-call and after hours services*

In general, GPs attending the forums expressed frustration at the increased expectations on them in terms of the hours they had to work.

The capacity to manage "on-call" and locum requirements appears to be related to location and size of practice as well as the degree to which practices within and across towns are able to establish collaborative arrangements. Where practices are small and/or where it is not possible to work with other practices to establish shared "on-call" services, doctors are struggling.

One GP mentioned he worked all week and only had one weekend off in three.

*"The best view I have from my practice is the view in the rear vision mirror as I head off to Melbourne on my weekend off"*

Another GP commented that doctors were not obligated to provide “on-call” services and there was an increasing trend amongst GPs in his area electing not to do so. This was putting increasing pressure on other GPs as well as the local hospital.

Not surprisingly, many doctors attending the forums complained of over-work and constantly being tired.

Despite the frustrations there were many examples of different ways of managing these issues that have already been established.

For example, Shepparton, has recently opened an after-hours clinic where patients of a range of different GPs are able to access medical services outside of normal business hours.

“Inter-town on-call” arrangements were mentioned in several communities. In one case (Camperdown and Cobden) 8 Doctors have established an “out of hours” joint roster which has been a huge improvement from the previous 1 in 3 that it used to be. Similar practices have been established in Mt Beauty and Bright.

In the Mallee, Doctors also work across towns, which now means they only have to work one in four weekends.

While it was acknowledged that these arrangements were not universally popular amongst patients, they were providing necessary breaks to doctors and patients were adjusting to the new type of service.

Participants were sceptical as to the impact of national or state call centres on local after hours services and how these call centres could support and understand local rural arrangements.

### ***“Easy Entry, Easy Exit”***

Participants in all focus groups mentioned the increasing preference of GPs coming to rural locations not to purchase a practice and associated infrastructure. The traditional scenario of a GP buying a practice “in town” and settling down in a single location for the rest of his/her career is no longer a reality for the majority of doctors. Many GPs want both flexibility and mobility and are no longer prepared to tie up capital in bricks and mortar only to find their return on investment after many years of service is very low. Even those doctors who have purchased a practice are finding it difficult to sell their practice and realise the value of their financial investments.

It was noted that some towns in rural Victoria are supportive of investing in community owned practices providing GPs with an “easy entry, easy exist” practice option. In general, people thought that smaller rural communities were more likely to make this long-term investment in order to attract and retain GPs, but that this was not something that larger towns and regional centres had shown a great deal of interest in. In many cases the “community owned practice” was purchased through collaborative efforts of service clubs, businesses and local governments. A few cases were cited where the Commonwealth Government had provided some financial support.

## ***Salaried GPs***

Participants in a few of the forums mentioned that they had seen an increase in the preference of younger GPs for salaried positions in hospital-based settings. This was a popular option for those GPs wanting predictable incomes and hours as well as opportunities for training and practice in a range of procedural areas such as accident and emergency, obstetrics and anaesthetics. While normally contracted positions, GPs opting for these types of positions had the advantage of mobility in their careers, variety of work, and a greater capacity to achieve work life balance.

It was also suggested that the idea of shifts might work outside of a hospital setting in, perhaps, larger practices or health centres.

*"The old concept of "on-call" one in three or whatever needs to go. We need to develop the idea of shifts in rural areas. This requires some funding support from Government so that if you work on a night shift you are guaranteed a salary regardless of patient load. Young doctors are just not interested in on-call".*

## ***Part-time work***

It was acknowledged that an increasing proportion of the GP workforce is made up of women and that those with families were demanding much greater flexibility in the way they worked. Shorter hours, sessional work and part-time work were required to enable them to spend time with their spouses and children. While a lot of male GPs were also looking for, and expressed interest in, working less hours, it was felt that the increasing number of women in the profession was more likely to make this a non-negotiable option in the future.

Some GPs also expressed the desire to work less hours so they could further develop their practice and services they provide to their communities.

*"I love the community and will work hard to get more services – eg air ambulance, the technology to screen for skin cancer, etc – but I don't have time to go and do this. I want to work 4 to 5 hours a day and then spend time on these other things which will add value to the community."*

## ***Working with local hospitals***

The capacity to work with local hospitals was seen as critical to ensuring the viability, range and quality of GP services. Mildura Base Hospital was mentioned as an example of where the collaboration between the hospital and local GPs was working particularly well and providing much needed training for GP Registrars. However, there were other rural locations where arrangements were not in place or not working well and this was impacting the capacity of GPs to provide the range of services their patients needed.

It was thought this type of arrangement could also work well in locations such as Shepparton, Gippsland, Ballarat and Bendigo. They are particularly useful for OTDs working under the 10 year moratorium who are not able to work in a metropolitan setting for some time. Through access to hospital training they are getting solid GP training in a rural setting and once completed are ready to move into rural general practice.

## ***Managing the shortfall of GP Proceduralists and Medical Specialists***

The availability of GP proceduralists was an increasing challenge in many towns. Obstetrics were no longer being offered in some towns with patients having to travel long distances for these services. Access to Medical Specialists was also a problem with GPs having to increasingly make patient referrals to regional centres or in some cases to metropolitan Melbourne.

*" We have a huge oncology services problems in Gippsland – there isn't even one physician in oncology and no palliative care physicians. We will not be able to open our oncology centre because we can't get a doctor".*

## ***Managing GP transition and turnover***

It was widely acknowledged that the nature of general practice in rural locations was changing and that it was unrealistic to expect GPs to stay in the one location for the duration of their careers. The current evidence about OTDs is that they will change location five times in their careers as GPs in Victoria. As one community member said:

*"We shouldn't expect [the Doctor] to stay here long-term. If he does the best he can while he is here that is all we should ask for."*

Nevertheless, concern was expressed, about how to manage the turnover of GPs more effectively, and in particular how to assist older GPs planning to retire to transition out of the workforce over a period of time. This was an important step for ensuring the community doesn't suddenly lose the benefit of their skills, knowledge and experience.

It was suggested that financial support for ongoing indemnity fees for retiring GPs who want to continue practice for limited hours or take on locum work would be a great help.

It was also suggested that there need to be processes that help GPs transition out of practice through reduction of hours, perhaps through sharing positions with younger doctors, particularly women who might want part-time work while they are caring for children. Help with developing succession planning for GPs as well as models that support shared positions were seen as within the scope of RWAV's responsibilities.

## ***Health Teams***

Doctors attending the forums recognised that the demands on them from patients were changing as the demographics, needs and expectations of rural communities were changing. The ageing population is experiencing more complex and chronic conditions requiring support from a range of medical services including GPs as well as other allied health professional and specialist support.

Many GPs attending the forums mentioned the value of Practice Nurses. There were mixed views on the potential of Nurse Practitioners to fill the current gaps. In either case, the current shortage of nurses with the necessary skills may mean it will be just as hard to fill these types of positions, as it is to fill GP vacancies, at least in the short-term.

## 6. Where to from here?

The community forums were held as part of RWAV's strategic planning for the next 3 years. In early March, RWAV held a workshop to consider the future directions and priorities of the organisation. Feedback from the consultations provided significant input to the discussions and thinking of Board members and senior staff.

A major outcome is that RWAV will work closely with and form partnerships with relevant stakeholders to develop a submission to the State and Australian Governments to ensure greater effort and financial commitment is provided to the GP recruitment and retention efforts of RWAV, GP Divisions, GP practices and communities.

The community consultations also provided a clear message that greater collaboration between all local stakeholders could help address the myriad of strategic and practical challenges faced around GP recruitment and retention.

A commitment and willingness on behalf of many local governments attending the forums to work with RWAV on issues to tackle the GP crisis is viewed as a critical and positive step forward.

RWAV will continue to work with local communities to support local efforts with recruitment and retention of their doctors.

## Appendix 1 - Community Consultation Forums – List of Attendees

Dr Malcolm Anderson	GP, Nhill Medical Clinic, Nhill
Mr Belby Bailey	Community Member
Dr Ferdoushy Begum	General Practitioner, Desaily Medical Centre
Mr Andrew Blair	Clinical Educator, Rural Ambulance Victoria
Ms Patricia Blane	GP Recruitment Officer, GPAG
Ms Eileen Bleakly	Program Co-ordinator, Department of Health and Ageing
Mr Shane Boyer	Medical Workforce Manager, Mt Beauty GP Division
Mr Peter Brown	Chairperson, Wimmera Primary Care Partnership, Horsham
Mr Robert Bulmer	CEO, East Wimmera Health, St Arnaud
Mr Bernie Byrne	Community Member
Dr Peter Carter	Practice Principle, Stawell Medical Centre, Stawell
Dr Alfred Chehade	General Practitioner, Cobram
Ms Vivien Clark	Consultant, Clark Phillips
Ms Pat Coles	Principle, Gippsland Relocation Service
Mrs Kate Connellan	Vice Chair, Rural Medical Family Network
Dr Michael Connellan	GP, Ararat Medical Centre, Ararat
Ms Debra Cottrell	CEO, Goulburn Valley GP Division
Dr Jeannine Creely	Chief Executive Officer, Cobden District Health Service
Mrs Mary Cunan	Community Member
Dr Andrew Cunningham	GP, Stawell Medical Centre, Stawell
Mrs Sue Cunningham	Practice Manager, Stawell Medical Centre, Stawell
Cr Keith den Houting	Councillor, Ganawarra Shire Council, Kerang
Mrs Patricia Dignan	Treasurer, CWA Mortlake
Ms Sharon Dodd	Office Manager, Saint Lukes Medical Centre, Traralgon
Ms Jo Dukes	Community Member
Mr Ron Eason	Lions Club of Tatura
Mrs Jenny Eason	Lions Club of Tatura
Dr Fred Edwards	Medical Director, Hazelwood Health Group, Churchill

Mrs Judith Edwards	GP Spouse, Churchill
Mrs Jean Edwards	Secretary, CWA Mortlake
Mrs Judy Egan	Community Member
Mr Ken Ellis	Environmental Scientist, Goulburn Valley Water
Dr Roger Fitzgerald	General Practitioner, Breed Street Clinic, Traralgon
Dr Chris Foord	GP, Lister House Clinic, Horsham
Mr Jack Forbes	President, Robinvale RSL
John and Mary Fox	Community Members
Ms Donna Gardner	Co-ordinator Skilled Migration Strategy, City of Greater Bendigo
Cr Kevin Gibbins	Councillor, City of Greater Bendigo
Dr Alan Gostelow	CEO, South Gippsland Division of General Practice
Mr Stuart Hall	Pharmacist, Healthwise Pharmacy, Horsham
Mr Matt Hastings	Senior Operations Officer, Rural Ambulance Victoria
Ms Narelle Hibberd	Acting Executive Officer, Ballarat Migration Project
Ms Jacqui Hickey	Regional Trauma Co-ordinator, DHS Gippsland
Mr Barry Holt	Retired Health Worker, C/O Moe Lions Club Inc
Cr Jenni Houlihan	Mayor, City of Greater Shepparton
Ms Louise Howlett	Project Officer, Department of Health and Ageing
Ms Kathy Huett	CEO, Edenhope and District Memorial Hospital, Edenhope
Ms Vicki Hunt	Recruitment Officer, Otways Division of General Practice
Dr Licenia Ihuraraqui	GP Edenhope Medical Centre, Edenhope
Mr Robert Indrigo	Skilled Migration Co-ordinator, City of Greater Bendigo, Skilled Migration
Mr Rod Jackson	CEO, Gunditjmara Aboriginal Co-operative, Warrnambool
Mr Robert Jarman	CEO, Kerang District Health, Kerang
Ms Shell Johnson	Practice Manager, Latje Road, Robinvale
Mr Jim Jones	Paramedic, C/O Moe Lions Club Inc
Mrs Deborah Jones	RFMN Chair, Heywood Family Services, Heywood
Dr Graham Jones	School of Rural Health, Melbourne University, Shepparton
Cr Bruce Jones	Mayor, Swan Hill Rural City Council
Ms Freule Jones	Community Member

Mrs Clare Jury	Community Member
Mr John Katis	Councillor, Swan Hill Rural City Council
Ms Sue Kearney	Manager Health Development, Latrobe Regional Hospital
Mr Graham Kelly	CEO, Robinvale District Health Service, Robinvale
Mr Alan Kennedy	Area Manager, Rural Ambulance Victoria
Dr Peter Keppel	General Practitioner, Yarrawonga Denis Medical Group, Yarrawonga
Dr Samer Khalil	General Practitioner, Robinvale
Mrs Joy King	Secretary, Minyip Lions Club
Ms Linda Kruger	Program Manager, GetGP, Churchill
Ms Marion Leslie	Robinvale Sentinel
Dr David Leembruggen	GP, Listerhouse Clinic, Horsham
Mr Kevin Linton	Secretary, Rotary Club, Tatura
Dr Luigi Lucca	General Practitioner, Latje Road, Robinvale
Mrs Alison Lucca	Administration Officer, GP Spouse, Latje Road, Robinvale
Dr AJ Mahmood	Consultant Surgeon
Mr Frank Martin	Board Member, Cobden District Health Service
Mr Peter Martin	Chairperson, Stawell Regional Health, Stawell
Ms Ann Maynard	C/- Robinvale Hostel
Mr Mal McArthur	Carer's Representative, South Mallee MH Carers
Mr Paul McKenzie	Manager Aged and Disability Services, Shire of Campaspe
Mr Bruce McLeod	Lions Club of Tatura
Mrs Glenda McLeod	Lions Club of Tatura
Dr Boris Mezhov	Practice Principle, Hollie Drive Medical Centre, Morwell
Dr Wadie Michael	Overseas Trained Doctor
Cr Roslyn MacInnes	Mayor, Horsham Rural City Council
Mr Craig Midgley	Co-ordinator, Great South Coast Region, Warrnambool
Mrs Helen Modoo	President, Catholic Women's League, Robinvale
Mrs Amber Moynihan	President, Rural Medical Family Network, Ararat
Mr Bob Mutton	Executive Officer, Mallee Division of General Practice
Ms Bernadette Norris	Community Member

Dr Peter O'Brien	Director of Medical Services, South West Health
Ms Teresa O'Brien	Program Services Officer, Mallee Division of General Practice
Dr Michael O'Sullivan	GP, Lister House Clinic, Horsham
Mrs Lyn Pauline	Personal Assistant, Doctor Staff, Forest Hill
Mr Norman Pauline	Manager, Doctor Staff, Forest Hill
Dr Daryl Peddler	Director, Gippsland Regional Clinical School, Monash University
Dr Chitra Perera	General Practitioner, Buckey Street Family Practice, Morwell
Dr Ranjith Perera	General Practitioner, Buckey Street Family Practice, Morwell
Ms Megan Phelan	Regional Skilled Migration Co-ordinator, Regional Migration Incentive Fund
Ms Annette Pickering	Practice Manager, Dimboola Medical Centre, Dimboola
Dr John Pickering	GP, Dimboola Medical Centre, Dimboola
Mr Chris Pickett	Portfolio Manager Workforce, Goulburn Valley GP Division
Dr David Pierce	Senior Lecturer, School of Rural Health, Melbourne University, Ballarat
Dr Brendan Pitts	VR GP, Murray Valley Aboriginal Co-op, Robinvale
Ms Tricia Pollard	CDO Drought Social Recovery, Swan Hill Rural City Council
Mr Alan Porter	Owner/ Pharmacist, Cobden Pharmacy, Cobden
Mrs Jeanette Powell	Member for Shepparton, Victorian Parliament
Mr H Pragt	Community Member
Cr Lisa Price	Mayor, Latrobe City Council
Cr David Quayle	RWAV Board Member, RWAV/ Councillor Swan Hill Rural City Council
Mr Peter Quinn	Clinic Manager, Orbost Regional Hospital, Orbost
Ms Deborah Quinn	RMIT Co-ordinator, Swan Hill Rural City Council
Ms Helen Panozza	Workforce Support Officer, Western Victorian Division of General Practice
Cr Alan Pignataro	Councillor, Horsham Rural City Council
Mr Ted Reedy	Community Member
Mr Dale Richards	Senior Operations Officer, Rural Ambulance Victoria
Ms Jennie Ritchie	Manager, HealthCare, The Slade Group, Melbourne
Dr Clyde Ronan	Principle, Yarrawonga Medical Centre, Yarrawonga
Ms Marion Rowe	Board Member, Robinvale District Health Service, Robinvale
Ms Teresa Ryan	Community Member

Cr Ian Sedgman	Councillor, Horsham Rural City Council
Dr Philip Sabien	Executive Director, Wimmera Development Association
Ms Anjana Sasi	Skilled Migration Co-ordinator, Wodonga Skilled Migration
Ms Samantha Scott	National Rural Faculty of RACGP, RACGP College House
Mr Kerry Shade	CEO Horsham Rural City Council
Ms Marilyn Shultz	Practice Manager, Yarrawonga Medical Centre
Ms Louise Simm	Acting Team Manager, Public Health and Innovation, DHS, Bendigo DHS
Cr Geoff Smith	Mayor, Corangamite Council
Mrs Betty Smith	Community Member
Dr. Peter Starick	CEO, Heywood Rural Health, Heywood
Ms Dianne Taylor	Practice Manager, Goulburn Valley Community Health Centre, Shepparton
Mrs Lorraine Telford	Community Member
Mr Brian Trotter	Education Programs, Greater Green Triangle GP Education & Training Inc
Mr Catrynes van der Vlugt	President, Board, Orbost Regional Hospital
Dr Janet Van Leerdam	GP and Board Member, Cobden District Health Service, Cobden
Cr Jan Vonarx	Mayor, Alpine Shire, Bright
Ms Sandra Walker	CEO, Goulburn Valley Community Health Centre, Shepparton
Mrs Molly Walsh	Community Member
Dr Philip Webster	GP, Ontario Medical Clinic, Mildura
Dr Geoff Westwood	Director of Medical Services, Echuca Regional Health, Echuca
Dr Barbara Westwood	Echuca Regional Health, Echuca
Mrs Amanda Wilson	Nurse, GP Spouse, Horsham
Dr Philip Wimbury	GP, Edenhope Medical Centre, Edenhope
Cr Jean Wise	Councillor, Yarrambiack Shire Council, Warracknabeal
Mr Kim Wood	CEO, Central West Gippsland Division of General Practice
Mr John Worters	PASA, DHS Gippsland