



From the Ground Up - Successful Models of Community Capacity Building to Address Recruitment and Retention of GPs in Rural South Australia



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INTRODUCTION/OVERVIEW

Health care services in rural Australia

There are a number of issues that have contributed to workforce shortages in rural Australia including the growth in patient demand for medical services being greater than population growth¹. The health workforce in rural, regional and remote Australia needs to maintain and build on its skills to respond to the challenges of current and future health care needs².

Retaining sufficient health professional staff is a constant struggle. Recruiting, training and retaining adequate numbers of staff is a particular issue for rural, regional and remote communities. The advantages of the lifestyle such as open spaces, small communities, independent working conditions and the need for self reliance can sometime turn to disadvantages for health professionals. General Practitioners in rural and remote Australia lead complex and busy professional lives. They are the key part of the primary health care teams, initially handling most the medical emergencies and treat patients in local hospitals. Many of them have multiple qualifications and skills in obstetrics, anaesthetics, surgery and trauma medicine. Small or solo practices and long hours of duty can take a toll on their own health and family life and recruiting and retaining GPs in rural, regional and remote areas is difficult³.

Current and emerging medical workforce issues

There is a well-recognised chronic, geographical maldistribution of doctors in Australia with a shortage of adequately trained rural and remote general practitioners and specialists⁴ which is consistent with international literature that indicates that medical workforce maldistribution is a common problem around the world⁵.

Attempts to address this problem in Australia have focused on providing appropriate education and training for rural and remote practice and encouraging recruitment of general practitioners through relocation assistance, training packages and retention grants⁶. In South Australia a study revealed that reduced opportunities for children's education is the overall most significant factor that lead to doctors leaving rural practice⁷, and spouse satisfaction is consistently identified as one of the important factors affecting both the recruitment and retention of doctors in rural settings⁸. Other issues identified as contributing to doctors leaving rural areas include lack of locum

relief, professional isolation, high levels of responsibility, long working hours, increased costs associated with running rural practices, and a concern about inadequate training opportunities⁹.

Based on current trends, medical graduates are less willing to work the hours that current rural GPs are, preferring more part-time positions, are female¹⁰ and less likely to become a practice partner. For this reason, there is a clear need for policy and programs to more adequately consider the future nature of the rural and remote medical workforce. By concentrating on maintaining existing models of practice, and by designing programs, which might appeal mainly to the types of practitioners who are currently in rural and remote practices, there is a real risk that the total possible pool of rural and remote practitioners will continue to shrink and under-servicing of rural and remote populations will not only continue, but will become a more acute problem in health service provision in Australia¹¹.

Capacity building in rural communities to address medical workforce issues

Rural general practices are inherently unstable because the size of the practices are unable by themselves to support adequate local professional support, continuing education and recreation leave, and in small practices only minor changes in workforce structure can have large and compounding adverse effects on supply of medical services. The size of the practice is also a reflection of the size of local communities. The challenges faced in providing medical services to these communities is a symptom of the problems facing small rural and remote communities. In many circumstances a decline in health services is perceived as a contributing factor in their social and economic decline. Many of these smaller towns have had stable medical facilities for a number of years but erosion of the population, improved transportation systems and mobility, downgrading of community health services and facilities and changing expectations of medical graduates means that this stability cannot be expected to continue¹².

As a result of involvement by the community, the general practices can be more attractive to doctors. Better standards of practice, moving towards virtual amalgamation and more consistent on call arrangements enhance doctor's satisfaction. Doctors visibly supported by the community are more committed and express a desire to stay for extended periods of time in these areas. Community involvement is proving a very positive factor in planning and encouraging retention of rural doctors in isolated areas¹³.

So what factors contribute to community involvement in supporting the recruitment and retention of rural GPs? The concept of capacity building within rural communities has been suggested as an appropriate process to both ensure community ownership and involvement in addressing rural workforce issues, and to also ensure their long-term viability and sustainability.

Capacity building has been defined as being (at least) three activities¹⁴.

Building infrastructure to deliver specific programs

In rural Australia, the building of infrastructure such as rural Divisions of General Practice has contributed to supporting the local communities through the provision of expertise and resources that will assist in developing solutions to local rural medical workforce issues in a strategic way.

In addition to this, where the community owns and provides some or all of the infrastructure for GP services, the financial burden is reduced for a doctor trying to maintain a financially marginal rural/remote practice, thus improving sustainability. Community ownership also provides a sense of “corporate memory” for GP services which transcend an individual GP’s own career or personal sustainability¹⁵.

Building partnerships and organisational environments so that programs and their associated gains are sustained

The primary unifying feature of sustainable communities, even where diverse economic and service bases exist, is an active community. In places where communities demonstrate substantial interest in their future, including the future of general practice services, these communities have a vested interest in their own sustainability, and are proactive in ensuring that their economic, service and population bases continue to support them¹⁶.

The development of local workforce committees and/or forums in rural and regional areas of Australia provides the ‘environment’ for the implementation of workforce programs. In addition to this, the development of a Sustainable Practice Models Discussion Paper in 1998¹⁷ has provided a useful model for communities to address medical workforce issues in a planned and strategic way ensuring that the solutions developed, are sustainable.

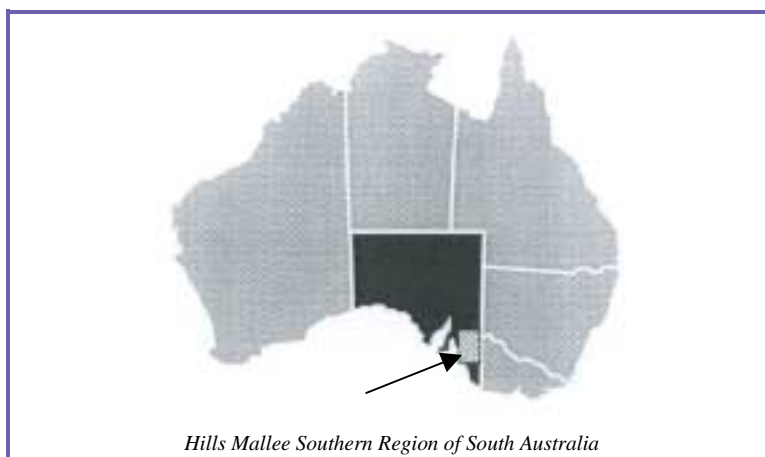
Building problem-solving capacity

Sustainable services involve co-operation between GPs within and between communities. General Practice services involve corporate memory, which includes aspects of the history of the service, the needs of the population, and particular service experiences. This memory must be maintained within the community, even when specific service providers change¹⁸.

Through ongoing local community workforce committees and/or forums that include a wide range of community representatives, local and corporate knowledge can be developed. This knowledge can then be adapted to a variety of other issues in other community settings.

The rest of this presentation will focus on how the communities of the Murray Mallee and Limestone Coast regions of South Australia, have worked at the local level to address rural medical workforce issues, and what their achievements have been. The real strength of both of the approaches is that the solutions developed not only address specific and current workforce needs, but also that they were developed and owned locally, which makes sustainability more likely.

HILLS MALLEE SOUTHERN REGION RURAL MEDICAL WORKFORCE FORUM



Where?

The Hills Mallee Southern Health Regional Health Service of South Australia includes the Adelaide Hills, Murray Mallee, Southern Fleurieu Peninsula and Kangaroo Island. It covers more than 30 000 square kilometres and has a population in excess of 100 000 people. There are 13 hospitals and 5 community health centres, which are part of the public health system, and approximately 110 GPs in 21 practices. Four Divisions of General Practice operate within the boundaries.

The area is predominantly rural with three large regional centres and numerous small towns with populations from 100–3000 people. The communities have a strong sense of ownership of their hospitals and health services, with many families having supported fundraising efforts to build and maintain their hospitals over 3 or 4 generations. The hospitals are managed by Boards, with members elected from within the community. The hospitals are significant employers in the local community, and the presence of a general practitioner is critical to their survival and to the health and well-being of the communities.

Rural Medical Workforce Forum — Why?

The sustainability of rural general practice is under threat. Rural medical workforce recruitment and retention issues are recognised not only locally, but also at the state, national and international level.

The reality of this issue was brought home to the Murray Mallee Division of General Practice in 1997, when solo general practitioners in two of our outlying towns moved on, one after 43 years in the town. The communities and their hospitals were at a loss to know how to go about finding replacements and sought assistance from the Division. The Division was also relatively new to the process. Together we bumbled through, learning as we went.

Out of these experiences, the concept of a Rural Medical Workforce Forum was conceived, not only to assist communities with recruiting general practitioners but also to provide support with other issues related to medical workforce when they arise.

We recognised from our early experience, that those with the greatest investment in addressing medical workforce issues were those with most to lose, rural communities. We determined that it was important to engage the community in the process, as it is the local level response that is central to developing sustainable responses to medical workforce issues. It was obvious that as individual groups of people, we were unable to address workforce issues comprehensively, and that a multi-system response was needed for the best chance of success. We hoped that any activity undertaken would build the capacity of the community to respond effectively to future workforce challenges.

Who?

The Medical Workforce Forum brings together two groups of people.

- ◆ Core stakeholders of the group include representatives from Health Consumers of Rural and Remote Australia, general practitioners, practice staff, Divisions of General Practice, Regional Health Units, local government, Regional Health Service Executive staff and the South Australian Rural and Remote Medical Workforce Agency (SARRMSA). This group of representatives has between them a body of knowledge about systems and resources able to be accessed by rural communities.
- ◆ Community stakeholders are those who have identified a medical workforce issue in their community. This may include medical practice GPs or staff, hospital board, local government and any other organisation, group or individual, with an interest in addressing medical workforce issues.

By working in partnership, the two groups are able to:

- ◆ optimise the chance of finding a satisfactory solution to an identified issue;
- ◆ increase community awareness of the range of resources and support available; and
- ◆ increase the capacity of the community to respond to identified needs.

How?

Core stakeholder representatives were invited to an inaugural meeting in July 1999, to discuss the potential role of a Rural Medical Workforce Forum. Over time, three areas of activity were identified for the core group.

- ◆ To work collaboratively with community stakeholders to address medical workforce issues as they arise
- ◆ To work towards a process of planned intervention in medical workforce issues rather than crisis intervention
- ◆ To develop longer-term strategies for recruitment and retention of the medical workforce

What?

Hills Mallee Southern Rural Medical Workforce promotional brochure

The availability of the core stakeholders of the Workforce Forum to work with rural communities, was promoted by letters to practices and hospital boards, and to the general community through a press release to local newspapers. Follow-up articles have been written to promote the issues identified and activities of the Forum.

Community and practice profiles

A profile of the Murray Mallee Division has been prepared. The profile includes:

- ◆ an overview of the area served — towns, local government, district councils;
- ◆ demographics of region — economy, climate, population features and population projections;
- ◆ medical practices — GP demographics, staffing, services offered; and
- ◆ hospitals — separation data, services offered, community and allied health, emergency services, visiting specialists.

Although this is a snapshot in time, it provides a starting point for understanding the services that are currently available and to assist in identifying current and future workforce needs. The profile is a useful starting point for longer-term workforce planning.

Sustainable practice guidelines applied locally

The Commonwealth Government “Sustainable Practice Models Discussion Paper”²⁰ has been identified as a useful resource for considering the sustainability of local general practitioner services. A precis of sustainable practice issues has been developed from the paper. This identifies the range of issues that should be considered when general practice recruitment and retention plans are being developed.

Criteria are organised into seven categories:

- ◆ practitioner related issues;
- ◆ administration, funding and financial arrangements of the service;
- ◆ nature of the service;
- ◆ community characteristics and infrastructure;
- ◆ characteristics of the population;
- ◆ health service environment; and
- ◆ policy environment.

By applying these criteria to a local situation, it is possible to identify changes to be implemented by general practice and the community, to ensure the long-term viability of medical services in a particular rural community.

Recruitment case study

The Forum was funded by SARRMSA to document workforce planning processes. One of the first issues raised with the Forum was the need to recruit a general practitioner to a solo practice in a remote area. The Forum worked with the community to recruit a new GP and this process has been documented as a case study.

Outcomes

Commitment of key stakeholders to work together

A Medical Workforce Forum of core stakeholders has been established in the Hills Mallee Southern Region. The group meets quarterly to develop medium to long-term strategies to address medical workforce issues. The drivers behind the Forum are the Divisions of General Practice who have identified medical workforce issues as part of their core business. The Forum can be convened at any time to assist practices or communities who have identified a medical workforce issue.

The Workforce Forum understands that the role and functions of the Forum are long-term (recruitment and retention support is an ongoing need in rural areas) and that there needs to be sustainable long-term commitment from stakeholders. This was recognised by the Commonwealth Government in the last budget when resources were allocated to rural Divisions of General Practice specifically to address medical workforce issues.

The Forum meetings have contributed to the development of an informal medical workforce network in the region. Individuals involved with the Forum are developing a body of knowledge, which is being shared informally at the local and regional level.

Resources for community capacity building

- ◆ Community and practice profiles.
- ◆ Sustainable practice precis.
- ◆ Recruitment case study.

PENOLA AND DISTRICT MEDICAL SUPPORT GROUP



Background to the region

Let me paint the scene. If you are a person who enjoys excellent red wine, you would know where Coonawarra is. Penola and district within Wattle Range Council which

reaches from Coonawarra, Penola and Nangwarry to Kalangadoo. The population is approximately 3700 with industry being viticulture, forestry, timber, grazing, farming, potato processing and tourism.

It sounds a beautiful region — doesn't it ... and it is, and only 1 hour away from fantastic beaches too. Notwithstanding this, however, we still have medical workforce shortages.

How the support group started

During January 2000, a meeting was called by the Wattle Range Council, Penola Hospital and the Penola Medical Clinic, in response to growing community concerns about the future availability and accessibility of medical and allied health services for Penola and district residents.

Penola Medical Clinic had one full-time and another part-time general practitioner (GP) practicing at this time, however, there was mounting pressure to find a successor for a long serving retiring GP and despite the valiant efforts of an active hospital, the meeting considered the problem as too difficult to be resolved by any one entity. It was at this time therefore, that the Penola and District Medical Support Group (PDMSG) was formed.

Key stakeholders

Representatives from local industry, business associations, Wattle Range Council, service clubs, the Penola Memorial Hospital, the Penola Medical Clinic, Limestone Coast Division of General Practice and regional health bodies joined together to form the PDMSG, and were invited to work collaboratively towards finding a replacement GP for the Penola Medical Centre and addressing the future of the district's medical services.

With such a broad cross section of relevant stakeholders represented on PDMSG, there has been a clearer recognition and acceptance of the specific health service needs of local industry and the wider community, as well as a plan for any remedial action.

Determining the roles of group representatives

Clearly, time spent very early in the formation of the group in determining the roles of all representative stakeholders is crucial to ensuring the most efficient use of the members skills and spans of influence, and of course the ultimate effectiveness of the community group.

The role of the Division

Over the last 7 years Divisions of General Practice around Australia have shown that in their involvement with communities; whether it be injury prevention, health promotion or in this case, GP recruitment; they are excellent catalysts of change.

The Limestone Coast Division of General Practice is well placed to source information relevant to general practice, develop and maintain networks, in addition to providing a good skill base which can be applied in facilitation and planning processes.

In the case of the PDMSG, the enthusiasm and genuine commitment of its members to a clear succession plan for maintaining and strengthening their community's medical workforce, illustrated the importance of an holistic approach to the recruitment and retention of GPs and their families for the longer-term.

The Division's role is to assist with the planning process, sourcing of grants, evaluation and most importantly to provide the much-needed medical perspective.

The recruitment process is lengthy and at times confusing, with the roles of SARRMSA and the Division, encompassing the advertising, interviewing, access to relevant grants and immigration/medical board follow up. In addition, to accessing local medical information and practice support, and to working with the community in housing, schooling, access to family services and other social support.

The blue print

We often talk of risk management in relation to finances and occupational health and safety, but we sometimes forget that all communities need to take a risk management approach for their sustainable future.

With the facilitation of the Division, the PDMSG had a very productive strategic planning session. A SARRMSA grant allowed the plan to be developed and subsequently written up by a consultant. The process was not only rewarding as it reflected total committee involvement but also as this blue print's vision and goals, are shared by all.

Significant determinants of success

The most significant determinant of success is the community's 'fire in [its] belly'. The PDMSG's drive, despite some challenges and setbacks, has been constant. Led by an effective chairperson, committed GP and Division, and with the unyielding energy of all other stakeholder representatives, the district has now secured a new GP and her family.

Long-term success is difficult to measure; however, a succession plan is in place and reflects a vision of sustainability for the regions medical workforce. As the 'fire in the belly' becomes less intense, the effort and involvement, which created the blue print for the future, will be mirrored by a community, which not only understands but also has direct influence over future health services in its region.

You may ask if this model can be transferred to other communities? IT CAN!!!!

When community stakeholders are more directly involved in a strategic partnership with Divisions who understand issues facing the medical workforce, and given the continued support from SARRMSA and governments, then we can begin to be assured that the issues of sustainable and adequate health provision is being effectively addressed.



SUMMARY

Key principles for community capacity building — our ‘recipe’

The following is a summary of the main areas that we have identified from the two models presented today as ‘key ingredients’ to develop sustainable community owned solutions to address rural medical workforce issues.

Need for a ‘driver’

Any process to address medical workforce issues must have a ‘driver’ or ‘champion’ to provide an impetus for action and sustainability for the process. Ideally the responsibility will fall within someone’s job description but it can also be driven by the community. This may be less sustainable, as it is likely to be a short-term response to a particular situation rather than part of a longer-term strategy.

Community ownership

The process of addressing workforce issues must be owned by the community. This may involve community ownership of some or all of the general practice infrastructure — practice accommodation, family accommodation, vehicle etc. Community ownership can also provide a sense of ‘corporate memory’ for medical services, providing a sense of continuity despite GPs moving in and out of the practice.

Community awareness

To put in place structures and processes to retain general practitioners for an agreed period of time, requires that the community understands the GP’s need for a personal, family and social life and is able to accommodate this.

A ‘multi-system response’

No one organisation can provide or address the multitude of issues around medical workforce recruitment and retention. Involvement of all levels of the health system and community sectors, working in partnership, provides the potential for a more comprehensive response to identified needs.

Sharing the knowledge base — capacity building

Any process that involves collaboration across sectors, incorporates community stakeholders and the sharing of knowledge and resources, should build the capacity of the community to respond more effectively to medical workforce issues as and when they arise.

These principles have been drawn from two successful models of medical workforce development in South Australia and we believe that they can be applied to other rural settings.



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AUTHORS

Jenny Fleming is a Science graduate (Hons) from Flinders University and is currently completing her Graduate Diploma in Public Health. Jenny has worked in and with rural communities for the past 9 years. She has a deep concern and empathy for rural and regional Australia, and strongly supports efforts to ensure that it remains strong and viable. Most recently, Jenny has worked for the South Australian Rural and Remote Medical Support Agency and the Yorke Peninsula Division of General Practice where her passion and commitment to rural general practice has evolved and grown. In addition to this, Jenny has worked as a private consultant to a number of rural communities throughout South Australia in the past 2 years.

Susi Tegen has worked with the Lime Stone Coast Division of General Practice in planning and administration since it was formed in 1994. Her current role is Manager of Workforce and Planning. Susi has a real passion for rural communities, their achievements and their potential. She is on several local and State-wide committees related to the health, safety and service access for rural communities, and acts as a mentor for various groups.

She enjoys overseas travel with her family and gardening. Susi and her partner live on a farming property between Coonawarra and Robe (the beach) with their children Sebastian and Yasmin.

Christine McRae graduated from the South Australian Institute of Technology in 1979 with a Bachelor of Social Work. She has worked extensively in the health and welfare fields as a social worker, lecturer and administrator. She has held the position of Executive Officer of the Murray-Mallee Division of General Practice since 1995. Prior to this she was the Executive Officer of the Murray Mallee Health and Social Welfare Council. It was here that her interest in community participation, community development and community capacity building had its genesis. This interest has been incorporated into her work within the Divisions' programs.