



Position summary

The RACGP NRF **strongly opposes** the use of Geographic Provider Numbers as a solution to general practice workforce maldistribution. Restricting provider numbers as a means of forced redistribution of workforce poses significant risks for communities and their profession.

On safety aspects

- Exposes communities to harm by placing less experienced doctors in unsupported and clinically complex environments
- Further disadvantages the rural communities most in need by failing to provide the right GP skill mix to meet safely their community and hospital based healthcare needs
- Links inexperience, those just commencing their career, to regions with least capacity to educate and supervise.

Removing choice and individual rights

- Fails to nurture rural intention, removing choice and flexibility for GP Registrars, compromising longer-term supportive policy aims
- Inherently negative in approach, is a gross encroachment on civil liberties, and fails to address the policy issues and determinants to practice in the more disadvantaged locations.

In addressing maldistribution

- Becomes a motivator against both General Practice and working in disadvantaged regions, placing at further risk those already within the sector
- Flawed policy which has failed elsewhere working against retention aims making rural practice less viable and appealing.

The following Position Statement expands on these important areas and outlines a preferred policy approach utilising existing policy levers which allow for flexibility and choice.

Introduction

Virtually all countries have a geographic maldistribution of health workforce, with deficits in rural and remote and urban fringe regions relating to a complex matrix of factors. These policy influences, both historical and cultural, comprise a range of choice of lifestyle factors including part-time and on-call arrangements, family and social ties, spouse employment opportunities, access to secondary and tertiary education services for children, overall income and professional ambitions. To improve the geographic distribution of doctors, governments typically have considered combinations of compulsory service and incentives.¹ In that context it appears logical to allocate provider numbers to regions according to population demographic with weightings for low economic status.

However, the notion of allocating Provider Numbers to specific towns is inherently faulty. Important policy requirements such as the clinical and health needs profile and capacity to provide social and collegiate support to the trainee are overlooked. Similarly, policy context, the financial and administrative aspects of practice sustainability, is also overlooked. These policy anomalies, set against an already ineffectual policy framework, underpinned by a flawed Australian Standard Geographical Classification (ASGC) system, predestine policy failure.

General practices operate in a predominantly private business model with a complex range of market forces including infrastructure, changing labour market supply and service construct and broader affordability markers. Population demographics dictate the GP skill mix to meet safely their community and hospital based health care needs. Practices located in regions of socio-economic disadvantage are often themselves disadvantaged. There is a strong reliance on rural GPs to balance a high clinical workload, in workforce shortage areas, with a training commitment as well as meet their own training needs.

Impacts on the profession

Medicine is a profession. It is a gross encroachment on civil liberties to be bonded to work in a particular geographic location. It is important to acknowledge that whilst GPs receive government funding indirectly through Medicare, its design as a social insurance scheme means it provides rebates to patients, not the doctor, to support a key policy aim of equitable access to primary medical services. General Practitioners are not public sector employees. The policy option to create salaried GP positions in any geographic location is available to state and territory governments, thereby diminishing the need for bonding. However salaried positions come at a significant public cost, requiring a lucrative salary and on-costs such as leave benefits and superannuation.

The Australian taxpayer invests heavily in medical education and logically seeks a return on its investment, but strategies to reduce urban-rural health disparities and improve the health of those living in rural and remote communities must consider the underlying capacity of general practice. A forced distributional policy applied to one sector of the workforce can only undermine general practice as a career of choice. A highly motivated future rural workforce is an invaluable resource unlikely to be obtained through coercive measures, as was demonstrated by the earlier 10 year (provider number) moratorium scheme for international medical graduates.

Geographic restrictions no solution for rural

Targeted workforce policy must be developed in line with the realities of rural practice, taking into consideration existing workforce shortages and service gaps. Responsive policy must address key barriers and ensure rural general practice remains a viable and attractive career within the wider field of medicine. Applying a forced distribution strategy not only erodes doctors' independence to choose workplace location, it also adds to bureaucracy through a centralised workforce planning mechanism. Letting the market organise the workforce is almost always more efficient together with incentivised supports and increased training positions for rural and remote practice.

Support structures that empower and flexibility that enables choice are needed along with targeted, yet accommodating, incentives in support of rural intention. On **safety aspects** alone, this approach has potential to place junior doctors at risk – without essential support structures in the more underserved communities, as has been seen with bonded places. Those least able to work safely and effectively in unsupported environments will be mandated to fill these positions, removing the pressure to adequately address the risks and workloads. This will work against rural and remote retention aims, more importantly it exposes communities to harm.

In **removing choice** and **individual rights**, provider number restrictions create more problems than they solve by replacing an altruistic motivation to work in disadvantaged regions with a sense of imposition. Without compensatory incentives and supports, this becomes a motivator against both General Practice and working in disadvantaged regions, placing at further risk those already within the sector. It will require complex mechanisms to allocate the workforce according to a yet to be determined scale of need, which will create anomalies as has been seen in geographic scales such as ASGC RA and Accessibility/Remoteness Index of Australia (ARIA).

Finally, in **addressing maldistribution**, restrictive approaches that place constraint on where doctors can live and work are fundamentally flawed, exposing government to potential litigation for restriction of trade. In Canada an attempt at such a policy resulted in doctors leaving the profession. Each time debate around using policy levers such as this intervention resurfaces in Australia, the sector unites and opposes it but each time it creates an environment of uncertainty that impacts on future recruitment. If the provider numbers become a saleable commodity the potential market to accelerate financial benefit to metropolitan regions is considerable. It allows for politicisation of particular regions or even states.

For more information on supportive recruitment and retention policy that works: NRF Position Statement 'Supporting the next generation (June 2015)

www.racgp.org.au/download/Documents/Policies/Health%20systems/NRF_positionstatement_nextgeneration.pdf

1 Zurn et al, 2004. *Imbalance in the health workforce*. Human Resources for Health, 2:13 doi:10.1186/1478-4491-2-13 BioMed Central Ltd.

2 <http://forums.whirlpool.net.au/archive/1353473> Joe112

3 Leveratt M, 2009. *Will increased undergraduate places result in more health professionals for the bush? Lessons from the medical workforce*. Rural Health Workforce Australia paper to the 10th National Rural Health Conference [online] available from: <http://10thnrhc.ruralhealth.org.au/program/?IntCatId=4>