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EDITORIAL

Always one doctor away from a crisis!

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Why do we continue to have rural and remote workforce crises? Are we - governments, communities, universities, colleges, professionals - just not trying hard enough? Or perhaps a foundational assumption is flawed.

My colleagues and I in rural practice often muse on what we could do if all the seats on the workforce bus were full. No longer overwhelmed by the urgent, we could invest in the areas, such as pre-emptive population approaches to health and community education or teaching undergraduate students, that we all know will bring great returns, but are put on the back burner when the next major trauma arrives, or because we are too tired after too many nights on call. The Holy Grail of an appropriate workforce appears worthy of the quest.

This issue of the Journal contains a number of articles dealing with solutions to the rural health professional workforce[1-6]. A common theme among these articles is the creation of an efficient health service. Could it be that in achieving efficiency we are perpetuating workforce crises?

Let us take medicine as an example. Rural communities are often classified as 'a two-doctor town' or 'a five-doctor town' according to the number of doctors required to provide the acute services for that region. An additional factor in some countries is the number of doctors able to be supported on a fee-for-service basis. This classification is then seen as the target for recruitment and retention efforts. What is the result of successfully recruiting three doctors to a three-doctor town? The answer is two-fold.

First, if one doctor leaves, there is another crisis. More than that, if one doctor is ill, or wishes to take leave for study, or dare it be said, a holiday, then there is a crisis for the two remaining, especially for after-hours calls. This crisis may even be precipitated by a doctor's partner no longer being able to provide child care after hours, as child care costs are never factored in to after hours payments. Or, alternatively, one or more doctors wishing to practise part-time can create resentment and chaos.

Second, because population health and education activities are not factored into either the funding or doctor number equations, either they don't get done, or they are undertaken on the road to burnout.

The result is a system under constant strain, open to manipulation and blackmail. This scenario is probably even more common for specialist doctors in rural practice, who would rarely be in a practice with two other similarly qualified colleagues. Business structures independent of the doctor can ease the financial implications to the doctor of leaving, but they do not alter the crisis recruitment plan that must regularly be put into effect, or the cost of expensive and, compared to care by the resident doctor, inefficient locum services. This often results in the recruitment of whoever is available to fill the gap, without the luxury of waiting for a doctor with the right mix of skills. This reality, that doctors do leave rural communities, often without much warning, needs to be factored into our workforce planning so that each time it occurs it does not precipitate a further crisis.

How can it be avoided? Is it too obvious to suggest that a one-doctor town should always recruit two doctors; that a town requiring three GP obstetricians should always recruit four, and so on? Is it too obvious to realise that such a policy would enable those doctors to undertake the important non-urgent aspects of practice and professional life, to 'have a life' while practising the medicine they love, and to search patiently and confidently for a replacement when a doctor leaves.

Ah, you say, but no system can afford such staffing, and we do not have the doctors to fill such expectations. This is where courage and long-term vision are required of policy makers and those in the professions and rural communities who advise them. First, the cost of perpetuating systems in developed nations where the important, but non-urgent, are not attended to, will come home to haunt future generations. Second, developed nations, in particular, have for too long underestimated the number of health professionals they need to train, probably by at least 50%, relying on foreign-trained graduates to fill in the gaps. The resulting intellectual pillage inflicted on developing nations, and the illness burden created for our own children are causes for shame, not opportunities for boasting about efficiency in health and education funding or sophisticated recruitment strategies.

While we persist in setting the workforce bar at the efficient management of acute conditions, we are creating a system that is bound for continued crisis. The health professionals in the system are suffering, their patients and communities are suffering, and paradoxically, the policy makers, administrators and funders are also suffering.

Is it time for us to radically reset the bar in workforce planning so that we aim to never be one doctor away from a crisis in any community? This may require decisions about who delivers services, where they are delivered, and how they are funded. But, in the end, it may not actually cost that much more. The current foundational assumptions are perpetuating crises. Workforce crises are extremely expensive! Systems and individuals under stress are unsafe. Medical errors are extremely expensive! Relegating primary healthcare tasks to a rainy day option leads to epidemics of preventable diseases. Epidemics are extremely expensive! Perhaps our emphasis on cost-effectiveness, as measured in an annual funding cycle, is a false economy leading to a false sense of security.

Creating an evidence base that informs a sustainable high quality rural and remote health system is core business of this journal. I hope you are challenged by engaging with our authors as we all work towards this goal.

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