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COMMENTARY

Evidence-based rural workforce policy: an enduring challenge

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ABSTRACT

David Wilkinson is Professor of Health Sciences, Pro Vice-Chancellor and Vice-President, Division of Health Sciences, University of South Australia, Australia. He was Foundation Chair in Rural health at University of Adelaide and University of South Australia between 1999 and 2002, and is an Editorial Board Member of *Rural and Remote Health*.

In their article *Rural origin and rural medical exposure: their impact on the rural and remote medical workforce in Australia* Dunbabin and Levitt provide a useful narrative overview of the literature on this important topic[1]. The authors seek – in their own words – 'to explore the relationship between rural origin and rural exposure during undergraduate and postgraduate training and choice of practice location'. They acknowledge that theirs is a narrative, rather than a systematic review, that their literature review is limited to the years 1977-2003, and that they do not seek to draw quantitative conclusions of associations between exposures (rural background and rural medicine experience at under- and postgraduate levels), and the outcome (medical practice location). The authors summarise several of the major reports from the USA, 'other countries' and Australia. They go on to very usefully list the major Australian Commonwealth government initiatives in this field in recent years, and then to explore medical-school level initiatives in Australia (including rural selection, and undergraduate rural-practice exposure) and rural postgraduate opportunities. In the section on evaluation, the authors summarise the few studies that have attempted to quantify the impact of these initiatives on the workforce. In short, have we got more rural doctors as a result? – the answer is not clear. And, in their conclusion, the authors note that the number of rural origin medical students has

increased, but that more time will be needed before we know the impact of the other policy initiatives on the workforce.

The problem of providing an appropriate rural medical workforce is common throughout the world. The need to increase the number of doctors working in rural and remote Australia is clear. Indeed it is an enduring policy challenge, and the current Commonwealth Government has ploughed millions of dollars into a wide range of initiatives aimed at addressing this challenge. Some of the initiatives – such as establishing the rural academic network of university departments of rural health and rural clinical schools - are truly visionary and are long term efforts. Others, such as recruitment and retention grants, are much more immediate. Do they work? Are they likely to work?

Policy is rarely evidence-based, or at least is rarely entirely evidence-based. Policy is about politics and that is about lobbying – there is plenty of self-interest around in most policy. Taking a less cynical view, policy development is much like public health medicine: often policy makers do not have all the evidence that they would like so all they can do is gather the best available information, seek a range of expert views and make some decisions. How can the required evidence be gathered?

Efforts are needed at several levels. First, all initiatives must be evaluated. That evaluation should be explicit, quantitative as well as qualitative, and is best designed *a priori* with a view to providing an independent and rigorous determination of whether the desired impact is occurring. Sadly this rarely happens. Typically, the Commonwealth Government seeks external evaluations from academic and/or commercial groups that nominate their own methodologies, and the outcomes are unpredictable. Surely we can devise a better way? It is heartening that for the rural clinical schools, strict quantitative outcome measures were part of the initial contracts. Independent, high quality research is also important. Substantial investment has gone into developing the capacity of rural researchers in recent years and this must continue. There is good quality, quantitative and qualitative work from the USA that can demonstrate the workforce impacts that result from these sorts of policies, and these are summarised by Dunbabin and Levitt. There is less evidence from Australia, but it is reasonable to assume that the US experience is broadly applicable here.

Our own research in South Australia provided reliable quantitative information on the impact of a number of rural exposures on choice of practice location[2]. Doctors with a rural background, a rural partner, and with rural exposure during training were more likely to be working in the country. This work has now been extended through a rigorously designed postal survey with a high response rate to a large national sample of general practitioners. The first papers from this research are in press in *Medical Education* and the *Medical Journal of Australia*[3,4]. In brief, we confirm that rural background and rural under- and postgraduate medical education increase the probability that doctors will work in rural practice, and the odds ratios of the associations are in the order of 2 to 3.5. As part of this work we have completed a large and systematic literature review seeking to summarise the quantitative research done throughout the world on this topic. This review has been submitted for publication in the *Australian Journal of Rural Health*, and will usefully complement the review by Dunbabin and Levitt.

All in all, it is now clear in Australia that rural background and rural exposure during medical training do increase the likelihood of doctors working in the country. This is but one component of effective policy, though. We need efforts at all points in the entire continuum, ranging from the number of students with a rural background entering medical school, to high quality and sustained undergraduate rural experiences, through to rural intern and postgraduate training opportunities. The contextual issues are critical too, of course. Remuneration must be appropriate, doctors must be able to access locum relief and continuing professional development support, and the critical roles of rural doctors' families and their needs must not be ignored.

Many of the building blocks are in place and several are starting to deliver now. The challenge is to ensure the

motivation and commitment to make them all work continues. Finally, serious consideration must be given to the need for, and needs of, nurses, pharmacists and allied health workers in the country. The focus has – rightly – been on doctors to date, but we risk losing sight of the big picture that is the entire health system. So, a major effort at integration of all levels – policy, workforce and education - is needed. That is perhaps the next big challenge.

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