Retention before recruitment

– creating the contexts of sustainable rural health services

Martin London MBChB Dip Obst FRNZCGP

Martin London is a Senior Lecturer in Rural Health in the Department of Public Health and General Practice at the Christchurch School of Medicine, University of Otago.

He was a rural practitioner in Akaroa on the Banks Peninsula for 11 years. In 1994 he moved to suburban practice and, with Jean Ross, opened the Centre for Rural Health in Christchurch. In 2001, on behalf of the Rural Health Directors of Aotearoa, he was contracted by the Ministry of Health to write the first draft of the Implementation of the Primary Health Care Strategy in Rural New Zealand.

Abstract

A change in language away from the widespread references to *recruitment and retention* in relation to health workforce towards putting *retention* before *recruitment* is a welcome development for improving the contexts of rural health care delivery. The conceptual change and its possibilities are explored.

Key words

Retention, recruitment, rural health

Recruitment and retention of the medical workforce continues to be a problem for which the very expression *recruitment and retention* may, in part, be to blame. It is therefore good to see a first linguistic step in the right direction starting to appear when we read about *Retention and Recruitment* in official documents.[1] The distinction is more than semantic – it is conceptual, and represents a different way of thinking for those responsible for workforce planning.

The underlying motive associated with 'recruitment' is to persuade people to come and work where you need them. It is an exercise in advertising and as such will aim to paint a rosy picture of fascinating work with friendly cohesive teams in idyllic locations. It is up to the recruited practitioners to then find out for themselves, after a honeymoon period, what their new job really entails. If there has been previous difficulty retaining staff this may be no more than an exercise in seduction followed by escape leading on to further recruitment problems.

An example of this can be the experience of Westport following an exodus of rural GPs in 1998. The need for several new doctors was acute and a crisis meeting drew up a list of requirements to attract them. Minimum salaries, acceptable on-call rosters and free membership of the golf club were among the carrots. There were a substantial number of applicants and rapid appointments, but the subsequent turnover of staff saw over 20 practitioners pass through the four positions over the next three years.[2]

It must be said that there appears to be a more stable workforce now in Westport. Is this because the environment has further evolved to be more practitioner-friendly or could it be the 'hitch-hiking' phenomenon? When setting out on the road with

pack and thumb and a distant destination, how the journey goes depends on how soon you get *the long lift* in the right direction. Sometimes you may spend much of the day with a frustrating series of short lifts before eventually, with a bit of luck, striking gold – 'Invercargill? Sure mate, hop in!' On another occasion the long lift presents itself very quickly and you're there by lunchtime. Do some locations struggle to retain staff because there is something fundamentally unacceptable or because they have not yet found the horse for their course?

Putting *retention* as the first priority approaches workforce provision from a different angle and is not only more ethical, but has clear advantages. Retention looks at working on the job circumstances alongside those already familiar with the setting, aiming for an environment which is professionally fulfilling and socially sustainable. This is a more genuinely creative process treating the practitioners as valued participants rather than tradeable commodities.

As has often been the case in changes in health services, the rural sector is leading the way.[3] It has recognised fundamental reasons whereby retention must be considered before recruitment:

- ***The more we can keep primary health care workers socially and professionally fulfilled in their rural locations the fewer new staff need to be sought.*** This is a simple matter of numbers – less vacancies to be filled.
- ***If the rural practitioners are seen to be content with their lot, it sends a message to others that the work there is desirable.*** A former Minister of Health berated a deputation of rural GPs for projecting a negative image of rural practice. 'It doesn't help the cause.' Maybe not, but it reflected their reality. Dealing with that reality as a priority is not only humane but also very practical, sending its own message of 'Come on in, the water's fine.'
- ***A frequent change of rural practitioners does not enable continuity of care and the development of the strong therapeutic relationships that are the essence of holistic family and community health care.*** Clearly retention and continuity has much to offer, both in quality of care and probably its cost effectiveness.
- ***High turnover of the workforce makes the development of effective, cohesive primary health care teams more difficult.*** The team approach to primary care is already a strong feature of most rural health practices. However it is enhanced by strong relationships between the members who become increasingly familiar with, and can adapt to, each other's strengths and weaknesses.
- ***As clinical education in rural areas is recognised as supporting the recruitment of future practitioners, having staff who stay for longer periods enables their accreditation as rural teachers.*** The increasing movement of core medical curriculum into the rural context offers solutions to a variety of issues, including offering an excellent context for clinical education, overcoming professional isolation for the rural practitioners and developing a career pathway for them.
- ***Clinical teaching in rural localities exposes students and trainees to a career model. What they see must be attractive.*** An enthusiastic rural registrar changed his mind about his intended rural practice when he saw the stress on his rural GP teacher.[4] This was a disaster of failed recruitment. How often does this happen, even before registrar level?
- ***Recruitment of rural practitioners is an expensive exercise, both financially and emotionally. It is a poor investment if the recruited practitioner stays for only a short time and the exercise needs to be repeated.*** During three years it cost Buller Medical Services (Westport) $10 000–$20 000 plus 2/10 of an administrator to keep the facility staffed.[2]

Evidently, resolving the problem of retention significantly eases the problem of recruitment. Conversely, neglecting retention multiplies the challenges of recruitment.

If the rural practitioners are seen to be content with their lot, it sends a message to others that the work there is desirable

Putting retention as the first priority…is a more genuinely creative process treating the practitioners as valued participants rather than tradeable commodities

It was this utterly simple formulation that has underpinned the integrated action plan, currently with the Ministry of Health, for restoring the vitality of New Zealand rural health services.[1]

The past decade saw the anguished cries of struggling rural practitioners largely ignored as based on self-interest and lack of fortitude. The concern of health planners and funders was not to respond to the demands of doctors *but to meet the health needs of rural communities*. This was characterised by numerous health-needs assessments and community consultations, which often came up with the communities' fundamental needs being their *sense of security* associated with a stable workforce.

This 'greedy doctors' versus 'needy communities' dichotomy has for years bedevilled cohesive collaboration between the rural sector (i.e. communities and their primary health workforce) and the government. However, it has latterly been

reformulated to recognise the validity of both concepts. High quality primary health services for rural communities cannot exist in a vacuum. They need a workforce to deliver them and one that is vibrant, well resourced and retained over a period of time. To achieve this requires *a sustainable context of service delivery* and it is at this level that collaborative efforts can be made to retain and sustain the workforce.

The Annual Rural Workforce Survey 2000[5] took into consideration rural on-call rosters and practitioner-patient ratios and indicated that the rural workforce of about 500 practitioners is approximately 100 short of the ideal. While this seems a very large number to recruit, there may not be cause for undue despondency. At present there are indeed too few practitioners, leaving many of those who remain stressed and offering poor images to attract others. If some of these also throw in the towel things will go from bad to worse. However, if the numbers can be built up past a null point to where there are enough to share the workloads and rosters, the reality of rural practice then becomes visibly more favourable. Others may then be tempted to join in the delights of rural practice, relieved of the overwhelming challenges of former years. With genuine attention to the contexts of rural health care delivery finding solutions tailored to each locality, New Zealand could be moving towards a time when young graduates will be saying 'Where is my rural practice opportunity?'

> High quality primary health services for rural communities ...need a workforce ...that is vibrant, well resourced and retained over a period of time

The shifts towards greater community and local government participation and the movement of substantial undergraduate and postgraduate education into the rural setting are major recent developments that may contribute to creating those contexts. Rural practices may soon become part of wider networks within their regions with stronger academic and secondary care contacts, supporting a career pathway entailing the concept of seniority for increasing experience. There are many ways in which the community can participate in this, such as contributing to accommodation for students, trainees and locums, socially supporting these visitors and loyal use of the local services, accepting students as a constant feature of the practice.

There is also a new acceptance that 1:4 rosters should be the minimum (allowing for compensated exceptional circumstances), that workloads in small or deprived communities should be manageable and that income support may be required to achieve these.[1]

A government prepared to adopt and fund this focus on retention may now be offering hope to the needy rural sector and could well see its investment result in huge savings in crisis management and recruitment costs, finally quelling the anguished cries.

Returning to the impact of language on our thought processes, let us now appeal for systematically putting *retention before recruitment* in our conversation and publications. What goes for rural health services may prove to be as valid for all areas of workforce development.

References

1. Ministry of Health. Implementing the primary health care strategy in rural New Zealand. Draft document circulated for discussion March 2002.
2. Rae C (Practice manager, Westport) Personal Communication, June 2001.
3. Sjönell G. 'Rural Health – the cradle of general practice.' Opening address to First International Conference on Rural Medicine, Shanghai; 1995.
4. Kirkpatrick D. Personal communication, May 2001.
5. London M. Annual Rural Workforce Survey 2000. Report to Ministry of Health, National Centre for Rural Health, October 2001.