

The Senate

Community Affairs
References Committee

The factors affecting the supply of health
services and medical professionals in rural
areas

August 2012

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43rd Parliament

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Abbreviations

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ACCRM	Australian College of Rural and Remote Medicine
ADA	Australian Dental Association
AGPN	Australian General Practice Network
AHP	allied health professions
AHW	Aboriginal Health Workers
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMWAC	Australian Medical Workforce Advisory Committee
APA	Australian Physiotherapy Association
APS	Australian Psychological Society
ARIA	Accessibility/Remoteness Index of Australia
ASGC-RA	Australian Standard Geographical Classification-Remoteness Area
ASGS	Australian Statistical Geographical Standard
BMP	Bonded Medical Placements
CD, CCD	Census Collection District
COAG	Council of Australian Governments
Congress	Central Australian Aboriginal Congress
COSA	Clinical Oncological Society of Australia
CRERRPHC	Centre of Research Excellence in Rural and Remote Primary Health Care
CSU	Charles Sturt University
DH&AC	Department of Health and Aged Care
DWS	District of workforce shortage
FGAMS	foreign graduates of an accredited medical school
FTE	Full-time equivalent
FWE	Full-time work equivalent
GISCA	National Centre for Social Applications of Geographic Information Science
GP	General practitioner

GPALS	GP Anaesthetist Locum Scheme
GPRIP	General Practice Rural Incentives Program
GPV	General Practice Victoria
HECS	Higher Education Contribution Scheme
HWE	Health Workforce Australia
HWQ	Health Workforce Queensland
IMG	International medical graduates
JCU	James Cook University
MABEL	Medicine in Australia: Balancing Employment and Life
MBS	Medicare Benefit Schedule
MJA	Medical Journal of Australia
MRBS	Medical Rural Bonded Scholarship
MSOAP	Medical Specialty Outreach Access Program
NAHRLS	Nursing and Allied Health Rural Locum Scheme
NAHSSS	Nursing and Allied Health Scholarship and Support Scheme
NRAS	National Registration and Accreditation Scheme
NRF	National Rural Faculty (of RACGP)
NRHA	National Rural Health Alliance
NTGPE	Northern Territory General Practice Education
OTD	Overseas Trained Doctors
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentive Program
QAMH	Queensland Alliance for Mental Health
RA	Remoteness Area
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australian College of Physicians
RAMUS	Rural Australia Medical Undergraduate Scholarship
RCNA	Royal College of Nursing Australia
RCS	Rural Clinical Schools
RCTS	Rural Clinical Training and Support
RDAA	Rural Doctors Association of Australia
RGPLP	Rural GP Locum Program
RHWA	Rural Health Workforce Australia

RHWS	Rural Health Workforce Strategy
RPGP	Rural Procedural Grants Program
RRIG	Rural Relocation Incentive Grant
RRMA	Rural, Remote and Metropolitan Areas
RUSC	Rural Undergraduate Support and Coordination
SARRAH	Services for Australian Rural and Remote Allied Health
UQ	University of Queensland
VAST	Viewer Access Satellite Television

Executive summary

Chapter 2: The distribution of medical, nursing and allied health professionals across Australia

The committee considered the distribution of medical, nursing and allied health professionals across the country. Over the last two decades there have been efforts to quantify the adequacy of the health workforce in Australia in order to ensure that policy is evidence-based and accurately reflects community requirements. The task of measuring the adequacy of the medical workforce is complex, requiring more than a national headcount.

The figures available present a picture of contrasts across the health workforce. Although statistics show that GPs and nurses are spread evenly across regions of differing remoteness on a per capita basis, we know access to this workforce is inconsistent. Medical specialist numbers plummet outside the major cities, to levels as low as one-sixth of those in the large capitals. Accessibility, particularly in remote areas, is an issue. Health care needs amongst populations may also vary, and the committee is aware of data showing higher disease burdens and poorer health outcomes in regional and remote areas for some conditions.

The committee accepts the Australian Institute of Health and Welfare's view that the new national registration scheme is producing higher quality data for the numbers and types of medical and health practitioners. However the committee has heard repeatedly that there are data issues limiting the ability to analyse the factors affecting health service delivery in rural areas. The committee thinks that this is a key area of responsibility for the Department of Health and Ageing's Rural and Regional Health Australia.

Recommendation 1

The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, prioritise the collection of robust and meaningful data on rural health as part of the forthcoming review of rural health programs.

Recommendation 2

The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, review the current literature from key stakeholders and universities and develop a strategy to address the gaps in research and knowledge affecting rural health service delivery.

Health professionals can face both professional and personal barriers to entering and staying in rural locations. These barriers relate to factors including professional development, income, accommodation, and opportunities for spouses and children. Allied health professionals face additional challenges in delivering services to non-metropolitan populations. This is attributable to current Medicare and other funding arrangements, social barriers, access to appropriate, affordable and secure

accommodation, and is exacerbated by lower remuneration than doctors. More effort needs to be expended in ensuring that appropriate policies are in place to promote the development and retention of multidisciplinary health teams in non-metropolitan areas.

Chapter 3: The nature of the medical profession in rural areas

The committee explored the nature of the health workforce in rural areas, specifically breaking down the types of medical practitioners working in those areas. It then examined the policy proposals of some of the specialist colleges that submitted to the inquiry.

The committee noted a growing trend towards medical specialisms and sub-specialisms. This is having a disproportionate impact on the supply of doctors in rural and regional areas. This is principally due to specialisation causing a reduction in generalist training pathways which has been cited as the area of medical practice most required in rural and regional areas.

The committee concluded that there needs to be a significant increase in rural generalist GPs. The committee is strongly supportive of the efforts of various stakeholders to increase the numbers of rural generalists in the rural medical workforce through the development of rural generalist training pathways.

The committee is strongly supportive of the Queensland Health initiative to develop a program based on local needs. The evidence the committee has received has also endorsed the program as being successful in delivering increased access to healthcare in rural areas. The committee accepts that this program may not be suited to all areas of the country, as each jurisdiction faces distinctive challenges in terms of its dispersal of population and workforce arrangements. Each state and territory Government may wish to explore different pathways to provide increased access to health care tailored to local need.

The model adopted by the Central Australian Aboriginal Congress displays innovation necessitated by need. The emphasis on multidisciplinary teams allows professional development across the health specialties and appears to be successful in combating professional isolation. The collaboration between different education providers to provide health workers and training opportunities has also led to a steady flow of GPs, nurses and Allied Health Workers that appears to be sustainable, and the committee was impressed with the systems put in place by Congress to provide a blueprint for centrally managed healthcare in remote areas.

Recommendation 3

The committee recommends that the Commonwealth place on the agenda of the Council of Australian Governments' Standing Council on Health an item involving consideration of the expansion of rural generalist programs. It further recommends that, as part of that agenda item, the Council consider an evaluation of the Queensland Health Generalist Program and whether it should be rolled out in other jurisdictions.

Recommendation 4

The committee recommends that the Commonwealth government work with education providers and the medical profession to address the issue of the inadequate supply of rural placements for medical interns in their pre-vocational and vocational years.

Chapter 4: Attempts to address the rural medical skills deficit

The committee considered attempts that have been made over recent years to alleviate workforce pressures in rural areas. It looked at the many factors involved in the decision to work in a rural area, and how effective the various government and non-government measures have been in addressing these issues.

The committee is supportive of the efforts of the Commonwealth Government under the Rural Clinical Training and Support scheme. However, the committee does not believe that four weeks structured rural practice training is sufficient time to expose the student to the full gamut of experience available in rural Australia. The committee also heard of a number of instances where the local community had actively welcomed students and ensured that they had a positive feeling of engagement and connectedness with the area. The committee does not think that four weeks is long enough to foster that level of input from the community.

Evidence received by the committee shows a large disparity between the support provided for allied health professionals and that provided for doctors to work in non-metropolitan areas. The committee considers that this situation neither promotes access to quality healthcare in rural areas, nor does it take into account the requirements of team-based patient care.

Most of the existing support mechanisms available for medical specialists should also be available to allied health professionals and nurses. In particular the committee strongly supports the introduction of a HECS reimbursement scheme for nurses and allied health professionals for reasons of equity and incentive.

Recommendation 5

The committee recommends that the HECS Reimbursement Scheme available for doctors be extended to nurses and allied health professionals relocating to rural and remote areas as soon as possible.

Given the extensive range of government programs and measures to address different aspects of rural health, it would be beneficial if there was an office located within DoHA, similar to the Chief Nurse and Midwife, that would provide a strong voice within government on all issues relating to Australia's rural health workforce.

Recommendation 6

The committee recommends that the post of Rural and Regional Allied Health Adviser be established within Rural and Regional Health Australia to coordinate and advise on allied health service provision in rural and regional Australia.

The committee considers the expansion of eHealth and telemedicine to be an opportunity to supplement health care delivery across Australia, with particular

relevance to rural and remote areas. It should not be considered as a replacement for personally delivered primary health. It has the potential to improve training, access to specialist advice and professional development and will be key in future health care delivery. However it will need to be coordinated with current management systems and agencies such as Medicare to ensure that remuneration as appropriate is delivered, and its potential is realised.

In some cases communities lack the population and infrastructure to support specialised practices, and the existing workforce in non-metropolitan areas is frequently overworked. One way to try and overcome this is by broadening the scope of skills and competencies of the existing workforce, particularly through the nurse practitioner model. The committee recognises that any reallocation of professional responsibilities will be contentious, and may encounter strong opposition from some groups. However, the committee did not receive any evidence against equipping the existing workforce to as high a level as possible. Furthermore, it is aware of evaluations showing that professionals and patients have been supportive of such initiatives.

The government is spending a significant amount of money to try and ensure adequate health services in regional Australia. The evidence provided to the committee during the course of this inquiry has highlighted deficiencies in the development and evaluation of these programs. There is an urgent and fundamental need to better understand what programs have been effective and therefore where energy and resources need to be applied.

New programs should include an evaluation strategy that will allow both assessment of the programs' impact and the creation of information needed to compare cost effectiveness with other initiatives. The government should be prepared to redirect funds from less cost effective programs to the more effective ones, but at present it appears difficult to establish which initiatives offer the best value for money for meeting the needs of regional healthcare patients.

The committee acknowledges the excellent work of the House of Representatives Standing Committee on Health and Ageing, in its report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, tabled in March 2012. This committee endorses the recommendations made as part of that inquiry. This committee draws particular attention to the House committee chair's comments that:

it is clear that whilst [International Medical Graduates] IMGs generally have very strong community support, they do not always receive the same level of support from the institutions and agencies that accredit and register them...

[There were] a significant proportion of witnesses describing a system lacking in efficiency and accountability, and importantly, one in which IMGs themselves often had little confidence. Many IMGs also felt that they had been the subject of discrimination, and anti-competitive practices and that this had in some cases adversely affected their success in registering for medical practice in their chosen speciality.

This committee wishes to put on the record its recognition of the work that overseas trained doctors are performing, particularly in regional Australia.

Recommendation 7

This committee endorses the House of Representatives Standing Committee on Health and Ageing's report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors* and recommends that the Commonwealth Government accept and implement the recommendations contained therein.

Chapter 5: Australian Standard Geographical Classification for Remoteness Areas

The Department of Health and Ageing provides incentive payments to doctors based on the geographic area they work in. The greater the relative remoteness of that area, the greater incentive payment they will receive. The committee considered how incentive payments are determined and paid to doctors working outside metropolitan areas. The current scheme (which is presently under revision) is known as the ASGC-RA.

There will never be a perfect model that does not result in some anomalies as a result of the methodology used. However, evidence provided to the committee during its inquiry did not support the use of the ASGC-RA scheme in its current form as the sole determinant of classifying areas for workforce incentive purposes. Even the evidence in general support of the scheme was heavily conditional on it being augmented with further datasets to provide a more accurate representation of workforce conditions across the country. The committee was impressed with the comprehensive nature of the model developed by Professor Humphreys and his colleagues, and the merging of geographical, population and professional and non-professional indicators certainly seems to provide a more accurate picture of the rural workforce.

The committee is supportive of the methodology and data utilised by Professor Humphreys and his colleagues and would like to see this incorporated into a new scheme.

Recommendation 8

The committee recommends that the classification systems currently used for workforce incentives purposes be replaced with a scheme that takes account of regularly updated geographical, population, workforce, professional and social data to classify areas where recruitment and retention incentives are required.

Recommendation 9

The committee recommends that the revised workforce incentive scheme include a comprehensive, public evaluation process.

Chapter 6: The role of universities and medical schools

The committee considered the role of the universities and medical schools in providing educational pathways for the rural health workforce. It discussed the current issues facing the sector and some possible remedies.

The number of medical students in Australia has risen significantly in recent years with domestic student numbers at Australian universities rising to 12 946 in 2010 from 8768 in 2006. It is not possible to say how many students will go on to become doctors in rural areas. However there has been a gradual increase in the number of rural clinical schools across the country and the majority of these are in receipt of government funding through the 'Rural Clinical School' (RCS) program. There is also a scheme, under the Rural Undergraduate Support and Coordination Program, that specifies a target of 25 per cent of Commonwealth Supported medical students who must be from a rural background.

Evidence suggests that while the rural intake target should be met and enforced, it is only one element of a complex problem, and by itself holds no promise of an increase in the rate of graduates practicing in rural areas. However the committee heard evidence that suggests that regional universities are more likely to meet the target and consequently provide more graduates that will practise in rural areas. The committee supports meaningful sanctions for those institutions that do not meet the current target, and although it understands that this is now a mandatory target with funding conditions attached, it would like those sanctions to be in the public arena, and would also like evidence of those sanctions being applied where appropriate. The committee also considers that the definition of a rural student for the purposes of a quota needs to be reviewed.

Recommendation 10

The committee recommends the publication of those cases where universities do not meet the target of 25 per cent of medical students from a rural background, and subsequent publication of information about the sanctions that are applied in those cases.

Recommendation 11

The committee recommends that the commonwealth government explore options to provide incentives to encourage medical students to study at regional universities offering an undergraduate medical course.

Recommendation 12

The committee recommends that the definition of a rural student for the purposes of a quota be reviewed, and that the review should consider strengthening the definition to only include students who have spent four out of six years at secondary school in a rural area; four out of the last six years with their home address in a rural area; or city students showing 'ruralmindedness', defined as an orientation to work in rural and regional areas, and demonstrated by a willingness to be bonded.

The committee was impressed by the success of James Cook University and the model proposed by Charles Sturt University for a new rural medical school. The provision of a full scale medical school based in regional Australia would have a significant impact on the numbers of doctors, nurses, allied health and other essential health professionals that would come from rural areas and would therefore be likely to

remain in those areas after they complete their training. However the committee is also mindful that the current pressing issue is not the student numbers but the capacity in the system to adequately train those students all the way along a pathway from student to health professional who will work in rural areas.

The committee received evidence about affirmative action programs being administered by Queensland Health, James Cook University and Queensland University, which the committee strongly support. The introduction of options for underprivileged young people to enter a career in health and the provision of appropriate support throughout their training is highly commendable. The committee urges other regional and rural institutions and appropriate education providers to examine ways that can increase the opportunities of young people in the health field, with the added benefit of increasing the likelihood of retaining a health workforce if they are sourced locally.

Effective translation of medical students into rural and regional practice requires appropriate support at all stages in the training and placement process. There do not appear to be adequate systems that will support the internships, rotations, or mentoring of the expanding number of medical students. The situation will need to be improved in regional areas if the current drive to expand the number of students is going to translate into actual health professionals working on the ground.

The committee is looking forward to the department's forthcoming review of rural health and would like to see a full exploration of ways in which blockages in the system such as the shortage of rural clinical placements can be addressed.

Recommendation 13

The committee recommends that the Commonwealth, state and territory governments review their incentives for rural GPs with the aim of ensuring that rural GPs who provide training to pre-vocational and vocational students are not financially disadvantaged.

Recommendation 14

The committee recommends the Commonwealth government consider the establishment of a sub-program within the National Rural Locum Program that would provide support for rural GPs to employ locums specifically to enable the GP to deliver training to pre-vocational and vocational medical students in rural areas.

The committee considered the accommodation issues associated with placement programs, rotations and training. It acknowledges that a placement program can only work effectively if students have somewhere to live while undertaking it. The committee notes that existing programs and stakeholders are seeking to address this issue. It is imperative that adequate policies and programs are established to manage the increasing demand.

The specific issue of housing for Aboriginal Health Workers needs to be addressed. The committee is aware of the difficulties this causes in Aboriginal communities, both for staff working in remote communities and for attracting staff to those communities.

The committee urges the Commonwealth government and the state and territory governments to work together to address this need.

Recommendation 15

The committee recommends that a coordinated accommodation strategy for be developed for rural health workers, including Aboriginal Health Workers, in the government's forthcoming review of rural health programs.

Chapter 7: Medicare Locals

The committee examined evidence about the transition to Medicare Locals. Like the majority of submitters to this inquiry, the committee is of the view that the newness of the Medicare Local program makes it impossible to adequately assess its effectiveness at this time.

To be successful the program will require careful and intensive management to ensure that all the key stakeholders are adequately considered and consulted. Greater effort needs to be expended to ensure that the necessary information is available for interested stakeholders. However the committee shares the cautious optimism of the potential for Medicare Locals to fill the gaps between local hospital networks, and GP community care provision.

In the committee's view the needs assessment element of the Medicare Local program is the singularly most important aspect of their work as it will provide the strategic overview that has been missing to date. The timely dissemination of the results of the needs assessments can ensure the constructive input of many of the key stakeholders. The uncertainty over the provision of after-hours service provision is an area that requires evidence based decision making as quickly as possible to dispel the fear and anxiety that has been expressed over the status of existing services. In the medium to long term the regular dissemination of the monitoring and evaluation of the programs nationwide will also ensure that best practice is shared and replicated across the country.

Recommendation 16

The committee recommends that Medicare Locals Needs Assessment Reports are made public and a process of engagement and consultation is undertaken.

Recommendation 17

The committee recommends that where existing after hours services are operating effectively there should be no disruption to their administration or funding.

A range of evidence was put before the committee identifying potential gaps or overlaps between current policies and programs. These can include a mismatch that sometimes occurs between Commonwealth and state or territory health policy and resourcing. The committee is of the view that this particular barrier should be addressed at a national level rather than locally. The Needs Assessment Reports prepared by Medicare Locals will be a valuable resource from which to identify potential inter-jurisdictional issues.

Recommendation 18

The committee recommends that the Department of Health and Ageing prepare a brief for COAG's Standing Council on Health on existing or emerging gaps affecting the delivery of health services to rural and remote communities caused by mis-alignment between Commonwealth and state policy, including options for measures to remediate such gaps. The brief is to be based on engagement with relevant stakeholders, including state and territory governments, Medicare Locals, representatives of peak bodies such as RDAA, SARRAH and NRHA at both national and state level, and to be provided on at least a bi-annual basis.

LIST OF RECOMMENDATIONS

Recommendation 1

2.53 The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, prioritise the collection of robust and meaningful data on rural health as part of the forthcoming review of rural health programs.

Recommendation 2

2.54 The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, review the current literature from key stakeholders and universities and develop a strategy to address the gaps in research and knowledge affecting rural health service delivery.

Recommendation 3

3.52 The committee recommends that the Commonwealth place on the agenda of the Council of Australian Governments' Standing Council on Health an item involving consideration of the expansion of rural generalist programs. It further recommends that, as part of that agenda item, the Council consider an evaluation of the Queensland Health Generalist Program and whether it should be rolled out in other jurisdictions.

Recommendation 4

3.53 The committee recommends that the Commonwealth government work with education providers and the medical profession to address the issue of the inadequate supply of rural placements for medical interns in their pre-vocational and vocational years.

Recommendation 5

4.52 The committee recommends that the HECS Reimbursement Scheme available for doctors be extended to nurses and allied health professionals relocating to rural and remote areas.

Recommendation 6

4.53 The committee recommends that the post of Rural and Regional Allied Health Adviser be established within Rural and Regional Health Australia to coordinate and advise on allied health service provision in rural and regional Australia.

Recommendation 7

4.94 The committee endorses the House of Representatives Standing Committee on Health and Ageing's report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors* and recommends that the Commonwealth Government accept and implement the recommendations contained therein.

Recommendation 8

5.67 The committee recommends that the classification systems currently used for workforce incentives purposes be replaced with a scheme that takes account of regularly updated geographical, population, workforce, professional and social data to classify areas where recruitment and retention incentives are required.

Recommendation 9

5.68 The committee recommends that the revised workforce incentive scheme include a comprehensive, public evaluation process.

Recommendation 10

6.23 The committee recommends the publication of those cases where universities do not meet the target of 25 per cent of medical students from a rural background, and subsequent publication of information about the sanctions that are applied in those cases.

Recommendation 11

6.24 The committee recommends that the commonwealth government explore options to provide incentives to encourage medical students to study at regional universities offering an undergraduate medical course.

Recommendation 12

6.25 The committee recommends that the definition of a rural student for the purposes of a quota be reviewed, and that the review should consider strengthening the definition to only include students who have spent four out of six years at secondary school in a rural area; four out of the last six years with their home address in a rural area; or city students showing 'ruralmindedness', defined as an orientation to work in rural and regional areas, and demonstrated by a willingness to be bonded.

Recommendation 13

6.62 The committee recommends that the Commonwealth, state and territory governments review their incentives for rural GPs with the aim of ensuring that rural GPs who provide training to pre-vocational and vocational students are not financially disadvantaged.

Recommendation 14

6.63 The committee recommends the Commonwealth government consider the establishment of a sub-program within the National Rural Locum Program that would provide support for rural GPs to employ locums specifically to enable the GP to deliver training to pre-vocational and vocational medical students in rural areas.

Recommendation 15

6.76 The committee recommends that a coordinated accommodation strategy for be developed for rural health workers, including Aboriginal Health Workers, in the government's forthcoming review of rural health programs.

Recommendation 16

7.41 The committee recommends that where existing after hours services are operating effectively there should be no disruption to their administration or funding.

Recommendation 17

7.43 The committee recommends that Medicare Locals Needs Assessment Reports are made public and a process of engagement and consultation is undertaken.

Recommendation 18

7.46 The committee recommends that the Department of Health and Ageing prepare a brief for COAG's Standing Council on Health on existing or emerging gaps affecting the delivery of health services to rural and remote communities caused by mis-alignment between Commonwealth and state policy, including options for measures to remediate such gaps. The brief is to be based on engagement with relevant stakeholders, including state and territory governments, Medicare Locals, representatives of peak bodies such as RDAA, SARRAH and NRHA at both national and state level, and to be provided on at least a bi-annual basis.

Chapter 1

The factors affecting the supply of health services and medical professionals in rural areas

Terms of Reference

1.1 On 13 October 2011 the Senate referred the following matter to the Senate Community Affairs Committees for inquiry and report by 30 April 2012:

The factors affecting the supply and distribution of health services and medical professionals in rural areas, with particular reference to:

(a) the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres;

(b) the effect of the introduction of Medicare Locals on the provision of medical services in rural areas;

(c) current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:

(i) their role, structure and effectiveness,

(ii) the appropriateness of the delivery model, and

(iii) whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes; and

(d) any other related matters.

1.2 The reporting date for the inquiry was originally set as 30 April 2012; this date was subsequently extended to 15 August, and then again to 22 August 2012.

Conduct of the inquiry

1.3 The inquiry was advertised in *The Australian*, and through the internet. The committee invited submissions from the Commonwealth Government and interested organisations. The committee received submissions from 132 organisations and individuals (listed at Appendix 1).

1.4 The committee held six public hearings over the course of the inquiry. The hearings were held in:

- Alice Springs – 20 February 2012
- Darwin – 24 February 2012
- Townsville – 23 April 2012
- Canberra – 11 May 2012
- Albury Wodonga – 5 June 2012

- Canberra – 10 July 2012

A list of witnesses who appeared before the committee is set out in Appendix 2.

1.5 Submissions, additional information, the Hansard transcript of evidence and responses to questions on notice can be accessed through the committee's website at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/rur_hlth/index.htm

1.6 References in this report are to individual submissions as received by the committee, not to a bound volume.

1.7 The committee sincerely thanks all submitters and witnesses for their contribution and participation in the inquiry process.

Structure of the report

1.8 This report is comprised of 7 Chapters.

- Chapter 2 provides an analysis of the distribution of medical, nursing and allied health professionals across the country. It then discusses the impact on health outcomes of that distribution.
- Chapter 3 explores the nature of the health workforce in rural areas, specifically breaking down the types of medical practitioners working in those areas. It then examines the policy positions and proposals of some of the specialist colleges that submitted to the inquiry. The chapter concludes with a précis of the evidence received in central Australia that described how the workforce has developed there and the issues that are still faced.
- Chapter 4 outlines the attempts that have been made over recent years to alleviate workforce pressures in rural areas. The chapter then analyses the many factors involved in the decision to work in a rural area, and how effective the various government and non-government measures have been in addressing these issues.
- Chapter 5 discusses the system used to classify different areas of the country for workforce purposes. This classification dictates how incentives are managed.
- Chapter 6 outlines the role of the universities and medical schools in providing educational pathways for the rural health workforce. It then discusses the current issues facing the sector and some possible remedies.
- Chapter 7 examines the evidence the committee received about the transition to Medicare Locals. Submitters and witnesses discussed potential roles and priorities for Medicare Locals but due to their relatively recent introduction there was limited evidence of their impact on the rural health workforce.

Chapter 2

The distribution of medical, nursing and allied health professionals across Australia

2.1 This chapter provides information on the current geographic distribution of health professionals across Australia. It then considers issues arising from how the workforce is distributed across the country and how government policies that have impacted on this distribution.

Attempts to measure the adequacy of the rural health workforce

2.2 Over the last two decades there have been efforts to quantify the adequacy of the health workforce in Australia in order to ensure that policy was evidence based and accurately reflected community requirements. The task of measuring the adequacy of the medical workforce is complex; requiring more than a national headcount. Two similarly sized communities may have radically different workforce needs depending on the proximity to other centres, their respective age profiles, and various other factors. As the South Australian government noted, for example:

South Australia's geography and its dispersed population presents a particular challenge to the supply of health services, the recruitment and retention of health professionals and the management of demand in country South Australia.¹

2.3 Recent assessments of the health workforce and how it is distributed have varied in recent times. It was reported to the committee that in the 1990s the Commonwealth government was of the view that there was an oversupply of General Practitioners (GPs) and therefore would not increase medical school output and restricted GP training numbers.² This policy was reversed in the following decade when the number of doctors increased 20 per cent from 2005 to 2009.³ Recent research has suggested there is an oversupply of new graduate numbers that will severely stretch the ability of existing medical professionals to train them.⁴

2.4 Early empirical evidence of shortages in the regional workforce was provided by the Australian Medical Workforce Advisory Committee (AMWAC). In 1996 AMWAC reported that although non-metropolitan populations accounted for 27.7 per cent of the population, only 20.8 per cent of primary care practitioners and 11.8 per cent of specialists were located in rural and remote areas. The estimated shortfall in

1 South Australian Government, *Submission 111*, p. 2.

2 Rural Doctors Association of Victoria, *Submission 43*, p. 4.

3 Australian Institute of Health and Welfare, *Medical Workforce*, <http://www.aihw.gov.au/medical-workforce> (accessed on 14 August 2012).

4 Bob Birrell, *Australia's New Health Crisis – Too Many Doctors*, Melbourne, Centre for Population and Urban Research, 2011, p. iv.

non-metropolitan areas was 445 full time equivalent (FTE) for GPs, and 900 FTE for specialists.⁵

2.5 A decade later, the Productivity Commission released *Australia's Health Workforce*. The report noted:

A major theme in submissions to this study has been that access to health services in rural and remote Australia is inferior to that in the major population centres, and that these access difficulties are worsening. In a health workforce context, the primary concern is insufficient numbers of health workers – especially general practitioners, medical specialists and some allied professions.⁶

2.6 In 2008 the Department of Health and Ageing completed the *Audit of the Health Workforce in Rural and Regional Australia* (the Audit). The Audit found that although the number of FTE GPs had increased by 10.9 per cent during the decade from 1996–97 to 2006–07, there was a net decrease in the supply of medical practitioners as population grew by 13 per cent over the same time.⁷ The supply of dentists was similarly found to '[decrease] dramatically with remoteness', and the allied health workforce was found to be 'largely based within *major cities*'.⁸ The Audit noted that:

Determining where there are workforce shortages also relies upon determinations of what is adequate supply. There is not a body of work currently available for Australia that describes the population health care status and needs in terms of the numbers, proportions and mix of health professionals required to meet those needs.⁹

2.7 In March 2012 Health Workforce Australia (HWA) released the *Health Workforce 2025* report.¹⁰ The report provides a comprehensive analysis of the future supply of the Australian health workforce in a number of scenarios. It was

5 Australian Medical Workforce Advisory Committee, *The Medical Workforce in Rural and Remote Australia*, New South Wales, 1996, p. 5. Given the high proportion of casual and part-time practitioners accessing Medicare, 'head counts' of GPs generally overstate the workforce supply in Australia. Full-time Workload Equivalent (FWE) is a standardised measure used to estimate the workforce activity of GPs and adjusts for the partial contribution of casual and part-time doctors.

6 Productivity Commission, *Australia's Health Workforce*, Canberra, December 2005, p. 204.

7 Department of Health and Ageing, *Audit of the Health Workforce in Rural and Regional Australia*, Canberra, 2008, p. 27.

8 Department of Health and Ageing, *Audit of the Health Workforce in Rural and Regional Australia*, Canberra, 2008, pp 17–18.

9 Department of Health and Ageing, *Audit of the Health Workforce in Rural and Regional Australia*, Canberra, 2008, p. 21.

10 Health Workforce Australia is an initiative of the Council of Australian Governments (COAG). It was established to meet the future challenges of providing a health workforce that responds to the needs of the Australian community. Further information on HWA can be found here: www.hwa.gov.au.

demonstrated in the report that the current distribution of doctors, unlike that of midwives and nurses, remains inequitable between rural and city populations.¹¹ The report notes that poor distribution should not necessarily be confused with poor supply. As the report states: 'there is little purpose in having an adequate aggregate workforce supply unless it is distributed beyond metropolitan Australia.'¹²

2.8 Also in 2012, the Australian Institute of Health and Welfare (AIHW) released *Australia's Health 2012*, an overview of Australia's health and its medical and allied health workforce. The report noted strong growth in the health workforce: there was a 23 percent growth in health related employment between 2005 and 2010; comparing favourably with a 12 percent growth in total employment over the same period.¹³ Furthermore, the numbers of both social workers and psychologists are reported to have increased in excess of 50 percent over the period.¹⁴

2.9 Although the AIHW, HWA and the Productivity Commission have undertaken some evaluation of Australia's workforce, the AIHW noted that:

Detailed information for many health professions, particularly the smaller professions like the allied health practitioners and Aboriginal and Torres Strait Islander health workers, has not been available on a regular basis.¹⁵

2.10 In order to improve the nation's healthcare system, the Council of Australian Governments (COAG) decided at its meeting of 26 March 2010 to implement a National Registration and Accreditation Scheme (NRAS) for selected medical professions.¹⁶ This is intended to develop additional annual information on medical and allied health professionals:

The move to the national registration scheme and the agreed data flows between the three agencies will soon allow the release of annual data for [allied health professionals], a major improvement in the health workforce evidence base.¹⁷

2.11 The committee heard that far less research has been undertaken on the number and adequacy of allied health services in Australia compared to the amount of research looking at the supply of doctors. Whereas workforce data is regularly collected on the number of doctors and nurses, there is less information on allied professions.¹⁸ The Australian Psychological Society argued that:

11 AIHW, *Health Workforce 2025*, volume 1, Canberra, 2012, p. 154.

12 AIHW, *Health Workforce 2025*, volume 1, Canberra, 2012, p. 157.

13 AIHW, *Australia's Health 2012*, Canberra, 2012, p. 496.

14 AIHW, *Australia's Health 2012*, Canberra, 2012, p. 497.

15 AIHW, *Australia's Health 2012*, Canberra, 2012, p. 511.

16 Australia's Health Workforce Online, *National Registration and Accreditation Scheme*, available from: <http://www.ahwo.gov.au/natreg.asp>, accessed: 6 July 2012.

17 AIHW, *Submission 110*, p. [3].

18 AIHW, *Submission 110*, p. [3].

Collection of workforce data is currently inadequate and is a key limiting factor on the supply and distribution of health service and workforce in rural and regional Australia. In order to plan for sustainable provision of the range and intensity of all health services in an evidence based health system, collection of appropriate, detailed and comparable workforce data is required.¹⁹

2.12 Services for Australian Rural and Remote Allied Health (SARRAH) – the national peak body representing rural and remote allied health professionals working in both the public and private sector – argued that:

Difficulty also arises when grouping all health professions that are not medical or nursing under one umbrella and calling them 'allied health'. The assumption could be made that each of the difference professions known as 'allied health' has a similar profile in rural and remote communities.²⁰

2.13 The committee was provided an example by SARRAH highlighting the potential problems that can arise due to the shortage of available data on individual allied health professions:

...what has happened in pharmacy is that, because we have not had access to workforce data, we have not been able to forward plan and have instead reactively said, 'Oh dear, there are not enough pharmacists – they are very old; they are about to retire,' and opened a whole lot of new programs, and now we are looking at a surplus of pharmacists...So there is some real advantage to having ongoing discipline-specific workforce data.²¹

Current distribution of the medical workforce in Australia

2.14 It has long been acknowledged that assessing workforce imbalances is difficult.²² Data about health workforce distribution in Australia varies in quality and in the picture it presents. The committee was provided with statistics by several submitters, and from several publications, that gave at times contradictory impressions of the distribution of the health workforce. The committee accepts AIHW's point that the new national registration scheme is producing higher quality data, with more regular updates.

2.15 The 2008 *Audit of Health Workforce in Rural and Regional Australia* (the 2008 Audit) described the three main types of data available at that time. They were:

- Medicare data. This could provide a good 'indication of the relative geographic distribution of general practice services across Australia, and can be used as an indication of distribution of specialist medical services'. However, as it does not capture public sector healthcare, it cannot be used to

19 Australian Psychological Society, *Submission 87*, p. 12.

20 Services for Australian Rural and Remote Allied Health, *Submission 62*, p. 11.

21 Ms Sheila Keane, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 11 May 2012, p. 4.

22 Pascal Zurn, Mario Dal Poz, Barbara Stilwell & Orvill Adams, 'Imbalances in the health workforce', *WHO briefing paper*, World Health Organisation, 2002, p. 1.

estimate actual levels of service.²³ There is also a risk that, if the public-private case-mix in a state is different between the capital city and regional areas, the relativities in the Medicare data may also inaccurately reflect service use.

- AIHW surveys. The surveys represent the most detailed information available about the health workforce. They provide data on working hours, not just numbers of people providing services. However in most jurisdictions, completing the surveys was voluntary, and response rates have varied. The 2008 Audit's view was that 'this data should be treated as indicative rather than definitive'.²⁴
- ABS census data. Census data is valuable, but it does not capture hours worked, relies on individuals to decide how to report their occupation, and will underestimate the workforce size as in 2006, for example, the census 'did not collect information on an estimated 640 000 people'.²⁵

2.16 This picture is complicated slightly by the fact that some AIHW publications are based on its own survey data (for example, the Medical Labour Force Survey 2005), while other AIHW studies are based on ABS census data (for example, Health and Community Services Labour Force 2006).

2.17 Most importantly, the available data has been significantly improved by reforms in the health system, particularly the National Registration and Accreditation Scheme (NRAS) and the now nationally-administered workforce survey (which has seen greatly improved response rates).²⁶ The results of this work were not available when the current inquiry was first initiated, and were only released after the committee has received its submissions. As a result, submitters had to rely on earlier data, while this report has the benefit of the AIHW's latest research results.

Data and the different health professions

2.18 The most important distinction in medical workforce data is between different types of doctor. Data for "medical practitioners" generally includes general practitioners, specialists, specialists-in-training, and non-specialists who work in hospital settings or provide services not in private practice. As the figures below will demonstrate, there are marked differences between the distribution of general practitioners and specialists.

2.19 The data for other professions is less comprehensive however the committee examined the information available on the nursing and allied health workforces.

23 Department of Health and Ageing, *Report on the Audit of Health Workforce in Rural and Regional Australia*, Commonwealth of Australia, Canberra, 2008 (the 2008 Audit), p. 5.

24 2008 Audit, p. 5.

25 2008 Audit, p. 6.

26 AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, pp 1–2, 32–39.

2.20 Finally, the committee has focussed on the data published about numbers of professionals per 100 000 population, which is the most widely-used data. Raw numbers are of little use, as they do not give any indication of the number of people being serviced by the workforce.

Historical data on medical practitioners

2.21 Medicare data shows the number of 'full-time work equivalent' (FWE)²⁷ general practitioners accessing the Medicare system (Table 2.1) in 2006–07.

Table 2.1 General practitioners FWE per 100 000 population, 2006–07²⁸

	Major cities	Inner regional	Outer regional	Remote and very remote ²⁹	All Australia
GPs	97.0	83.1	74.2	58.1	91.3

2.22 As the 2008 Audit noted, Medicare data for the remotest areas should be treated with caution, as it does not include services provided by publicly funded healthcare services such as Royal Flying Doctor Service and the Aboriginal Medical Services.³⁰ The 2008 Audit provided long-term time series for data (dating back to 1984–85), which showed gradual improvement in the levels of service in regional and remote areas over the two decades, though remaining below that in major cities.³¹

2.23 The 2008 Audit reported the results from AIHW's 2005 survey of the workforce for *all* medical practitioners (not only GPs). These were calculated as FTE, which is slightly different to the measure used by Medicare. Their survey figures are shown in table 2.2.³²

Table 2.2 Medical practitioners FTE per 100 000 population, 2005³³

	Major cities	Inner regional	Outer regional	Remote and very remote	All Australia
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27 FWE 'is a measure of service provision that takes into account doctors' carrying workloads. It is generally considered to provide a good overall indicator of medical workforce supply. FWE is calculated by dividing each doctor's Medicare billing by the average billing of full time doctors for the reference period'. 2008 Audit, p. 47.

28 Department of Health and Ageing, *Report on the Audit of Health Workforce in Rural and Regional Australia*, Commonwealth of Australia, Canberra, 2008, p. 8.

29 This figure combines data for 'remote' and 'very remote' categories, presented separately in the 2008 Audit, p. 8.

30 2008 Audit, p. 12.

31 2008 Audit, pp 9–13.

32 The regional rates are underestimates, as 1809 respondents (around 3 per cent of all doctors) said they worked outside the major cities, but did not report the regional classification in which they worked. See 2008 Audit, p. 15.

33 2008 Audit, p. 15.

All doctors	335	181	153	148	287
Primary care (mostly GPs)	100	88	84	92	98

2.24 The Medicare data suggests that the number of GPs in the most remote areas is around 60 per cent of those in major cities, while the AIHW survey data shows very little drop-off. This appears to confirm that the Medicare data is not capturing as much of the care being provided in more remote areas, because that care is not funded through Medicare.

2.25 The Department of Health and Ageing and the National Health and Hospitals Network both drew on workforce data presented by AIHW and based on the 2006 Census of Population and Housing (the census). This data presents a different picture of the distribution of health professionals (table 2.3)

Table 2.3 Persons employed as medical practitioners per 100 000 population, 2006³⁴

	Major cities	Inner regional	Outer regional	Remote	Very remote	All Australia
All medical practitioners	324	184	148	136	70	275
Generalist medical practitioners	196	123	108	106	58	171

2.26 There is a range of possible reasons that the AIHW's analysis of census data on 'generalist medical practitioners' is so at odds with other sources. Noting that the number of generalist medical practitioners is far higher than in any other source, it seems likely that the ABS classified individuals as generalist medical practitioners who were not GPs, such as researchers and doctors who had not yet met the requirements for admission to specialisms. The census figures are a headcount, and therefore do not reflect different numbers of hours worked. This may have served to underestimate the service levels in regional and remote areas. The AIHW's analysis of the census data was based on place of residence. As such it would not reflect those cases where doctors were resident in major cities, but provided services in regional or remote areas. Finally, more recent figures³⁵ show that only around 85 per cent of registered medical practitioners are actually in clinical practice. If a large proportion of doctors who don't currently practice medicine are in the major cities, this could affect the census figures by showing more doctors in cities than are actively providing health care in those locations.

34 AIHW, *Health and community services labour force*, AIHW, Canberra, March 2009, p. 42.

35 AIHW, *Medical workforce 2010*, AIHW, Canberra, 2012, p. 6.

Current data on medical practitioners

2.27 All of the above data sources have limitations, and most of the data is over five years old. On 28 March 2012, the AIHW released *Medical workforce 2010*. This landmark study builds for the first time on data available through the NRAS and is the most comprehensive survey results in recent times. Although some of the figures exclude Queensland and Western Australia (because the registration period in those states closed after the deadline for the data collection), they nevertheless present the most up-to-date information on the health workforce. This most recent data gives the following results for medical practitioners.³⁶

Table 2.4 Employed medical practitioners per 100 000 population, 2010³⁷

	Major cities	Inner regional	Outer regional	Remote and very remote	All Australia
All doctors	375.7	213.7	174.5	242.0	345.0
GPs	105.2	105.6	103.1	124.0	109.6
Hospital non-specialist	41.1	18.7	18.3	50.3	38.7
Specialist ³⁸	219.5	85.5	47.6	59.3	188.1

2.28 The 2010 data shows very little variation in the age profile of doctors by region, though GPs in the major cities were slightly older than those outside cities.

2.29 This most recent information shows an even distribution of GPs across the population, a clustering of hospital-based non-specialists in the major cities and in remote areas, and a dramatic decline in the availability of specialists outside the capitals.

2.30 During the 2000s there was a significant increase in the numbers of all doctors per 100 000 people which includes specialists, hospital non-specialists and GPs. Table 2.5 illustrates the changes since 2002.

Table 2.5 All medical practitioners, FTE (40 hours per week), 2002–2009³⁹

	Major city	Inner regional	Outer regional	Remote/Very remote
2002	351	198	164	158

36 Data excludes Queensland and Western Australia. The committee understands these states will be included in subsequent reports.

37 AIHW, *Medical workforce 2010*, AIHW, Canberra, 2012, pp 23–29.

38 Includes specialists-in-training.

39 National Rural Health Alliance Inc., *Submission 95*, p. 6.

2006	374	207	173	215
2009	392	224	206	246

2.31 In 2011 research from Monash University suggested that Australia was not facing a shortage of doctors, but an oversupply.⁴⁰ Dr Birrell argued that:

Australia is awash with GPs. Signs of oversupply are showing up in competition for place in the GP registrar program, in the difficulties that [International Medical Graduates (IMGs)] are facing in finding hospital jobs, in regional communities where new clinics based on IMGs are sprouting and in the statistics which show a sharp improvement in the population-to-FWE-GP ratios through much of non-metropolitan Australia since 2003–4.⁴¹

2.32 Dr Birrell conceded that this view is not shared by most stakeholders:

This diagnosis is sharply at odds with the accepted wisdom in government, medical and media circles on the issue. Widely reported stories about continuing shortages of GPs in remote locations continue to feed the dominant paradigm, which is that there is a continuing shortage of doctors, including GPs.⁴²

2.33 Although Australia does have a higher number of doctors and other medical practitioners relative to population numbers when compared to some OECD countries including Canada, the United States of America, the United Kingdom and New Zealand,⁴³ Dr Birrell's findings were not supported by other submitters to the inquiry. The view expressed by the National Rural Health Alliance Inc. is representative of the majority opinion that argued that there is a shortage of medical professionals in regional areas, even if there are a sufficient number of professionals in Australia overall:

Rural and remote Australia is not awash with doctors, and there are as yet no certain signs that the shortage of GPs in the bush will be mitigated by the greater number of medical graduates in the pipeline.⁴⁴

Nurses and midwives

2.34 Nurses and midwives⁴⁵ represent by far the largest portion of Australia's health workforce comprising 62.7 per cent of all health workers.⁴⁶

40 Bob Birrell, *Australia's New Health Crisis – Too Many Doctors*, Melbourne, Centre for Population and Urban Research, 2011, p. iv.

41 Bob Birrell, *Australia's New Health Crisis – Too Many Doctors*, Melbourne, Centre for Population and Urban Research, 2011, p. 21.

42 Bob Birrell, *Australia's New Health Crisis – Too Many Doctors*, Melbourne, Centre for Population and Urban Research, 2011, p. 21.

43 AIHW, *Australia's Health 2012*, Canberra, 2012, p. 519.

44 National Rural Health Alliance Inc., *Submission 95*, p. 9.

2.35 The Royal College of Nursing Australia (RCNA) explained the role and importance of nurses in healthcare:

Nurses and midwives are the 'agents of connectivity' within our healthcare system. They have the unique role of providing essential linkages between the system's many users, health professionals and service arrangements...Nurses can play a pivotal role in reducing service gaps and in progressing the aims of a health system focussed on health promotion and disease prevention.⁴⁷

2.36 There are two main types of nurses in Australia: registered and enrolled. In 2009, registered nurses made up 81 per cent of the nursing labour force. Enrolled nurses typically work alongside registered nurses to provide basic nursing care, undertaking less complex tasks.⁴⁸ The Australian Institute of Health and Welfare recently reported that:

In 2009 there were 321 000 nurses registered or enrolled to practise, of whom 86 [per cent] were employed in nursing. The supply of employed nurses was highest in *Very Remote* areas (1,240 FTE nurses per 100,000 population) and lowest in *Major Cities* (997).⁴⁹

2.37 In 2008 the Audit reported that: 'The nursing workforce, considered as a ratio of nurses to area population, is relatively evenly available throughout rural and regional Australia.'⁵⁰ However, the report did go on to note:

[A]lthough the distribution of nurses is relatively even when considered at the national level, there are considerable variations across states and territories and across Remoteness Areas within most jurisdictions.⁵¹

Allied Health Professionals

2.38 The distribution problems of the health workforce are not confined to the doctors. It was reported to the committee that allied health professions (AHPs) also show strong signs of what has termed throughout the inquiry as maldistribution.

2.39 The health professions that are considered as part of the Australian allied health workforce, according to the Australian Health Workforce Advisory Committee, include:

[A]udiology; dietetics and nutrition; occupational therapy; orthoptics; orthotics and prosthetics; hospital pharmacy; physiotherapy; podiatry;

45 Hereafter the report will use the term 'nurses' to denote both nurses and midwives unless specification is required.

46 AIHW, *Australia's Health 2012*, 2012, p. 502.

47 Royal College of Nursing, Australia, *Submission 82*, pp 1, 3.

48 AIHW, *Australia's Health 2012*, 2012, p. 505.

49 AIHW, *Australia's Health 2012*, 2012, p. 498.

50 Department of Health and Ageing, *Report on the Audit of Health Workforce in Rural and Regional Australia*, Commonwealth of Australia, Canberra, 2008, p. 3.

51 2008 Audit, p. 16.

psychology; radiography; speech pathology; and social work. There also remain health professions that seem to fit most definitions of allied health but which are not usually included in listings of allied health professions, for example chiropractors and optometrists.⁵²

2.40 Allied Health Professionals form approximately 17 per cent of Australia's health workforce according to figures from the Australian Institute of Health and Welfare (AIHW).⁵³ DoHA stated that the majority of allied health workers practice in metropolitan locations,⁵⁴ and the Pharmaceutical Society of Australia reported: '[I]n common with other health professions, pharmacists are maldistributed across different parts of the country with 72 per cent located in the major cities.'⁵⁵

2.41 There is a similar trend among the allied health professions as there is for doctors. The availability of services decreases the further an area is from major metropolitan centres. It was reported to the committee that only 0.8 per cent of psychologists, for example, work in remote areas compared to the 79.5 per cent working in metropolitan and major regional centres.⁵⁶ Furthermore, of the few psychologists practicing in remote locations, most are comparatively professionally inexperienced.⁵⁷

2.42 Even in professions that have an adequate supply of qualified workers, such as pharmacy, there are often shortages in rural areas. The Australian Dental Association (ADA) noted that although there does not appear to be an undersupply of dentistry professionals in Australia, there is an issue of maldistribution of the current supply.⁵⁸ As noted by the ADA:

[T]here remains a considerable maldistribution of dental professionals whereby smaller regional and rural centres still lack adequate access to dental practitioners.⁵⁹

2.43 Following a similar distribution pattern as other medical professions, the number of dentists is in excess of three times higher for major cities compared to remote areas.⁶⁰

2.44 The committee heard from the Australian Physiotherapy Association (APA) that the present distribution of physiotherapists means that:

52 Australian Health Workforce Advisory Committee, *The Australian Allied Health Workforce: an overview of planning issues*, 2006, p. 14.

53 AIHW, *Australia's Health 2012*, 2012, p. 509.

54 Australian Government Department of Health and Ageing, *Submission 74*, p. 6.

55 Pharmaceutical Society of Australia, *Submission 83*, p. 3.

56 Australian Psychological Society, *Submission 87*, p. 5. Definitions of 'remote', 'metropolitan' and 'major regional' taken from the revised ARIA+ classification system.

57 Australian Psychological Society, *Submission 87*, p. 5.

58 Australian Dental Association, *Submission 73*, p. 2.

59 Australian Dental Association, *Submission 73*, p. 5.

60 AIHW, *Submission 110*, p. [3].

...a significant proportion of the Australian population is unable to access the physiotherapy services they require. Obviously, the most critical area of under servicing is in rural and remote Australia where there are significantly more potentially preventable hospitalisations for chronic conditions than in the metro areas.⁶¹

2.45 The committee was cautioned against regarding AHPs as optional extras that are secondary to providing sufficient numbers of doctors and nurses. The importance of AHPs to patient welfare was put to the committee by SARRAH:

There can be a perception that allied health services are 'discretionary' in nature. This may be true in some circumstances and not in others, not unlike the medical equivalent...Few would argue that the work of Optometrists is discretionary, or Exercise Physiologists conducting cardiac rehabilitation or Speech Pathologists treating life threatening swallowing disorders in acute hospitals. The diagnostic professions in radiography and medical technology provide doctors with information vital to medical treatment, and a person whose spinal cord was cut in a car accident would not consider rehabilitation services to be optional.⁶²

2.46 Similarly, several peak bodies representing the allied health professions argued that access to AHPs was important for community and patient health outcomes.⁶³ For example, the Pharmaceutical Society of Australia noted that:

[N]umerous studies which demonstrate and confirm that pharmacist interventions in all populations result in improved patient health outcomes, improved medication adherence, reduced hospitalizations and reduced healthcare costs.⁶⁴

Aboriginal Health Workers

2.47 One area where the numbers do not reduce with an increase in remoteness is Aboriginal Health Workers (AHW). According to 2006 census data analysed by AIHW, the number of Aboriginal and Torres Strait Islander health workers increases from 1 per 100 000 in the major cities, to 50 per 100 000 in remote areas and 190 per 100 000 in very remote areas of Australia.⁶⁵

2.48 Aboriginal Health Workers are unique in the services they deliver, and how they deliver them. They perform a typical health care role in that they deliver primary health care services including "clinical assessment, monitoring and intervention

61 Australian Physiotherapy Association, *Committee Hansard*, 5 June 2012, p. 52.

62 Services for Australian Rural and Remote Allied Health, *Submission 62*, p. 10.

63 Australian Physiotherapy Association, *Submission 71*, p. 4; Australian Psychological Society, *Submission 87*, p. 3; Australian Association of Social Workers, *Submission 96*, p. 1.

64 Pharmaceutical Society of Australia, *Submission 83*, p. 2.

65 AIHW, *Health and community services labour force 2006*, AIHW, Canberra, March 2009, p. 42.

activities; and...health promotion and illness prevention programs and chronic disease management"⁶⁶, however they also provide:

...culturally safe health care to Aboriginal and Torres Strait Islander people (such as advocating for Aboriginal and Torres Strait Islander clients to explain their cultural needs to other health professionals, and educating or advising other health professionals on the delivery of culturally safe health care.⁶⁷

2.49 Despite the predictable increase in numbers of AHWs as remoteness increases there is still an issue with supply in remote areas according to the Central Australian Aboriginal Congress (Congress). Congress suggested that supply problems are as a result of inconsistencies in the educational pathways to become an Aboriginal Health Worker. They explained that currently in the Northern Territory there are two types of AHW: registered and unregistered. The registered AHWs have obtained a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care and work mainly in clinical settings. The unregistered AHW have not necessarily obtained formal qualifications. This situation is changing with the rollout of the national curriculum for AHW that will require all AHWs to obtain a Certificate IV. However this mandatory requirement will be introduced over a 12-18 month period and in the meantime will result in a two-tier workforce.⁶⁸ The other issue discussed by Congress was that there is only one training provider in the Northern Territory and the number of students graduating is only one or two per year.⁶⁹

Committee view

2.50 The figures available present a picture of contrasts across the health workforce. Although statistics show that GPs and nurses are spread evenly across the remoteness categories on a per capita basis, access to this workforce is inconsistent. In the most remote areas, hospital-based non-specialists and Aboriginal Health Workers are present in significant numbers compared to both major cities and regional centres. However, medical specialist numbers plummet outside the major cities, to levels as low as one-sixth of those in the large capitals.⁷⁰ Other health professions, such as dentistry, also show large discrepancies in numbers according to location, and there is a general decline in the availability of AHPs with increasing remoteness. The committee believes that the issues around the registration of Aboriginal Health Workers is a result of a period of transition while the national curriculum is rolled out,

66 National Aboriginal and Torres Strait Islander Health Worker Association, *The Profession*, <http://www.natsihwa.org.au/the-profession> (accessed on 14 August 2012).

67 National Aboriginal and Torres Strait Islander Health Worker Association, *The Profession*, <http://www.natsihwa.org.au/the-profession> (accessed on 14 August 2012).

68 Ms Stephanie Bell, Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 20 February 2012, pp 10–11.

69 Ms Stephanie Bell, Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 20 February 2012, pp 10–11.

70 AIHW, *Submission 110*, p. 3.

however the committee would like the situation to be closely monitored to ensure that adverse outcomes do not result from the roll out.

2.51 The committee notes that providing equal numbers of health professionals per 100 000 people is not a solution in itself. It is a very important starting point, but other factors need to be considered. Accessibility, particularly in remote areas, is an issue. Health care needs amongst populations may also vary, and the committee is aware of data showing higher disease burdens and poorer health outcomes in regional and remote areas for some conditions (see below). Nevertheless, the data outlined above provides critical information for targeting effort where it is most needed.

2.52 The committee accepts AIHW's view that the new national registration scheme is producing higher quality data for the numbers and types of medical and health practitioners. However the committee has heard repeatedly that there are data issues limiting the ability to analyse the factors affecting health service delivery in rural areas. These issues include problems with determining the numbers of rural medical students. The committee thinks that this is a key area of responsibility for the Department of Health and Ageing's Rural and Regional Health Australia and should be prioritised in the forthcoming review into rural health. The committee is also aware of a need for better targeting and synthesis of research to support rural health service reform. Rural and Regional Health Australia should play a role in using research results to assess current gaps in knowledge. Rural and Regional Health Australia will need to build its capacity to ensure that up-to-date knowledge informs the key strategic decisions required in rural health service delivery.

Recommendation 1

2.53 The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, prioritise the collection of robust and meaningful data on rural health as part of the forthcoming review of rural health programs.

Recommendation 2

2.54 The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, review the current literature from key stakeholders and universities and develop a strategy to address the gaps in research and knowledge affecting rural health service delivery.

Impacts of the maldistribution of the medical workforce

2.55 The significant health impacts of the maldistribution of the medical and allied health workforce are evidenced by the poor health outcomes reported for people living in those areas. The committee heard from the Rural Doctors Association of Australia (RDAA) that:

Australians living in rural and remote areas have much poorer access to local health services, significantly worse health outcomes and a

significantly shorter life expectancy than Australians living in metropolitan areas.⁷¹

2.56 Although there may be similar numbers of GPs and nurses per head of population, access in rural areas is very different to the cities:

Many people living in rural and remote areas are unable to access even the most basic primary care medical services in their local communities, and have to travel significant distances just to see a GP for a basic consultation, or have to wait many weeks to be seen close to where they live.⁷²

2.57 The Royal Australian College of General Practitioners (RACGP) highlighted some of the health outcomes reported for non-metropolitan populations:

National health status and disease burden research data shows life expectancy is 1 to 2 years lower in regional areas and up to 7 years lower in remote areas compared with major cities. The prevalence of chronic disease data shows the incidence of cancer is about 4 per cent higher than those major cities with significantly higher incidence rates for preventable cancers. Lifestyle risk factors or health behaviours are attributed to the burden of disease in these communities with people in remote areas found to be engaging in more behaviours that carry risks.⁷³

2.58 Professor Koczwara from the Clinical Oncological Society of Australia (COSA) stated that there are different health outcomes for cancer depending on a person's location:

...we know that the outcomes for rural Australians when it comes to cancer are worse than for those in metropolitan areas...this is really a major problem in Australia.⁷⁴

2.59 Professor Koczwara also pointed that the situation is further complicated by the different treatment requirements for different cancers:

I would advise patients that bone marrow transplants will be given in large metropolitan areas forever because the complexity of care and the frequency of need is such that we are going to have much better outcomes if we do it in that area. It would just be too expensive to do it in small community areas. It is a little bit different for other cancer types and maybe not as clear-cut. But we are beginning to recognise that, if we really want to have the best outcomes and often the most cost-effective care delivery, we need to triage, so to speak, the work that we are doing. Some work will be done in highly specialised areas. Some cancer types might require one centre for the entire country. At the other end of the spectrum there will be

71 Rural Doctors Association of Australia, *Submission 67*, p. 5.

72 Rural Doctors Association of Australia, *Submission 67*, p. 5.

73 Royal Australian College of General Practitioners, *Submission 41*, p. 10.

74 Professor Bogda Koczwara, Clinical Oncological Society of Australia, *Committee Hansard*, 11 May 2012, p. 46.

a type of care that should be delivered close to home pretty much under most circumstances or all circumstances.⁷⁵

2.60 Statistics from the AIHW further highlight the health disparity between metropolitan and non-metropolitan Australians. When regional, rural and remote communities are compared with their city counterparts they tend to exhibit:

- 10 percent higher levels of mortality;
- 20 percent higher rates of injury and disability;
- 32 percent higher rates of risky alcohol consumption; and
- 10–70 percent higher rates of peri-natal death.⁷⁶

2.61 Furthermore, it was put to the committee by the Royal Australian College of Physicians that the maldistribution of the medical workforce carries significant, potentially unsustainable, fiscal costs for both individuals and the medical system:

Rural patients with complex illnesses may need to see multiple specialists, entailing multiple trips to distant urban facilities. The associated cost is tremendous and not sustainable. NSW Health Isolated Patient's Travel and Accommodation Assistance Scheme (IPTAAS), for example, reports the need for an additional \$28 million in supplementary funding, over four years. In 2011/12 forecast expenditure is \$18 million, a \$7 million increase on the previous year.⁷⁷

2.62 Due to the present maldistribution in the medical workforce, patients may also have to regularly travel significant distances for medical attention. For example, Ms Johnson from the Rural Doctors Association of Australia noted:

[P]eople are coming to the doctor and it is beyond the doctor's capacity or it is going to take too much time, so they are given a letter to go to casualty in the regional centre 100 kilometres away. To me, that is a major problem.⁷⁸

2.63 The committee also heard that workforce shortages present specific challenges for patients suffering from conditions that may carry a social stigma:

...some consumers in rural areas opt to travel...in order to avoid family/social contacts potentially finding out about their HIV status and any associated HIV-related stigma.⁷⁹

75 Professor Bogda Koczwara, Clinical Oncological Society of Australia, *Committee Hansard*, 11 May 2012, p. 48.

76 AIHW, *Health Workforce 2025*, volume 1, Canberra, 2012, pp 157–158.

77 Royal Australasian College of Physicians, *Submission 76*, p. 2.

78 Ms Jenny Johnson, Rural Doctors Association of Australia, *Committee Hansard*, 11 May 2012, p. 22.

79 Australian Federation of AIDS Organisations, *Submission 28*, p. 2.

Causal factors leading to workforce shortages in non-metropolitan areas

2.64 The causal factors that have contributed to medical workforce shortages in rural and regional areas are many and varied. Rural Health Workforce Australia's (RHWA) submission to the inquiry summarised some of the factors leading to workforce shortages:

...an ageing workforce, fewer health professionals following generalist pathways and inadequate number of GPs and health professionals choosing rural practice. Causes of GPs, as well as health professionals more generally, not taking up rural practice include inadequate remuneration and professional development opportunities, heavy workload and on-call hours, loss of anonymity, lack of opportunities for spouses and children and professional isolation.⁸⁰

2.65 Although RHWA was speaking specifically in relation to GPs, the bulk of their observations extend to the medical workforce at large. There are obvious parallels between the evidence received from RHWA and that received from the APA and the Australian Psychological Society (APS). The latter noted:

There are factors at each stage in the 'life cycle' of the psychological workforce which limit supply to small regional communities. Limited training opportunities, restricted career progression opportunities, poor recruitment and retention, challenges in accessing professional development, inflexible funding models and inadequate workforce data all contribute to limiting the supply and appropriate distribution of psychologists to small regional communities.⁸¹

2.66 While the former argued:

There are also well documented barriers to rural and remote recruitment and retention in the allied health professions...the lack of a career path, the lack of professional and peer support including networking, isolation, the lack of access and support to attend continuing professional development activities and postgraduate study, and a lack of remuneration and recognition, staff shortages and a lack of locum availability.⁸²

2.67 The committee received evidence about both personal and professional factors affecting career choices of those working in health professions.

Personal Factors

2.68 Personal preferences and barriers were cited as a key problem to be overcome in attracting sufficient numbers of medical and allied health professionals to non-metropolitan areas. The principal personal barriers that need to be addressed in order to attract the necessary medical workforce were succinctly summarised by

80 Rural Health Workforce Australia, *Submission 107*, p. 4.

81 Australian Psychological Society, *Submission 87*, p. 3.

82 Australian Physiotherapy Association, *Committee Hansard*, 5 June 2012, p. 52.

Professor Humphreys: 'every doctor requires an adequate housing structure, adequate schooling and adequate employment for spouse.'⁸³

2.69 The committee was informed that access to affordable, safe and comfortable housing was an importance consideration in attracting medical professionals. Dr Mourik reported to the committee at its hearing in Albury-Wodonga that '[w]hen doctors come to a country town, they do not want to be given a fleapit of an accommodation.'⁸⁴ Similarly, Rural Health Workforce Australia (RHWA) argued that the challenge of finding appropriate accommodation is more acute for allied health professionals:

Lack of appropriate housing is also an issue...The lack of housing can often be an even bigger issue in trying to place allied health professionals, nurses and GP registrars.⁸⁵

2.70 The availability of childcare was also cited as important consideration for attracting and retaining an adequate rural medical workforce. Dr Kirkpatrick related to the committee her experience as a rural obstetrician:

When I went bush I was a single parent with an 11-year-old child who I used to take out of town to get overnight care when I was on call. That was a one-in-two on call...It was also a problem if I had an unexpected delivery and was called out – but you are never off call in a rural community...⁸⁶

2.71 Despite the image of rural communities enjoying a relaxed lifestyle, available statistics indicate that non-metropolitan professionals work longer hours and have more demanding rosters than their metropolitan peers. Over time, the increased burden of long hours with limited professional support can become a disincentive to remain in rural practice. The President of the Rural Doctors Association of Australia reported a personal example for the committee:

I work with my wife and we are on call seven days a week, 24 hours a day, and that has been the case for many, many years and often for months at a time. We are just finishing a shift that has gone on for over 28 days straight. When you are called out to the hospital after hours, after 10 o'clock at night, for four nights a week, that starts to become a burden after 30 years in practice.⁸⁷

2.72 The committee heard that to address many of these issues solutions need to include:

83 Professor John Humphreys, Centre of Research Excellence in Rural and Remote Primary Health Care, *Committee Hansard*, 5 June 2012, p. 19.

84 Dr Pieter Mourik, private capacity, *Committee Hansard*, 5 June 2012, p. 57.

85 Rural Health Workforce Australia, *Submission 107*, p. 16.

86 Dr Kathryn Kirkpatrick, Royal Australian College of General Practitioners, *Committee Hansard*, 5 June 2012, p. 35.

87 Dr Paul Mara, Rural Doctors Association of Australia, *Committee Hansard*, 11 May 2012, pp 13-14.

...excellent relocation support to assist with employment for spouses and schooling for children and with finding appropriate housing, which is often a difficulty, as well as providing introductions to local communities.⁸⁸

Professional Factors

2.73 One of the reasons put forward to explain the maldistribution of the medical workforce in Australia is that, unlike the United Kingdom and some Scandinavian countries that use a salary-based model for GPs, General Practice in Australia is based on a model of private practice. Medical professionals are free to choose in which geographical location they would like work and as a result the government has significantly fewer policy levers available to distribute the workforce to areas of greatest need.⁸⁹

2.74 Many medical professionals, such as dentists, require high capital outlays to establish a practice. This is only viable, particularly for the non-government sector, in areas of consistently high demand. Many regional and remote communities do not have the 'critical mass' necessary to support resident medical specialists in terms of both population and infrastructure requirements.⁹⁰ In addition, the potentially higher incomes available in private practice in metropolitan areas act as a disincentive for specialists to consider rural practice.⁹¹

2.75 The committee also heard that a lack of access to professional development opportunities in non-metropolitan areas can act as a barrier in recruiting and retaining staff. The Royal College of Nursing noted that:

A significant barrier to addressing the nursing and midwifery workforce development challenges has been the difficulties for rural and regional nurses and midwives in maintaining continuing professional development activities as required by the National Registration and Accreditation Scheme.⁹²

2.76 SARRAH made the point that GPs in non-metropolitan areas are often required to undertake work that in a metropolitan setting would be carried out by other health professionals. This creates an additional burden on the GP that can have a significant impact:

[W]hen you are a rural practitioner you see everything. There is no social worker near you so you, as a physio, need to address their problems with Centrelink payment access or with carer support...What ends up happening then is that you operate outside of your normal scope of practice. That has

88 Dr Deborah Cole, Dental Health Services Victoria, *Committee Hansard*, 5 June 2012, p. 35.

89 Rural Health Workforce Australia, *Submission 107*, p. 8.

90 Productivity Commission, *Australia's Health Workforce*, Canberra, December 2005, p. 206.

91 Rural Doctors Association of Australia, *Submission 67*, p. 19.

92 Royal College of Nursing, *Submission 82*, p. 1.

been associated with job dissatisfaction, because people do not feel adequately prepared for that extended scope of practice.⁹³

2.77 Professional isolation was frequently listed as a barrier to practicing in non-metropolitan areas. As explained by the Executive Director of the National Rural Health Alliance:

GPs and other health professionals do not want to work alone in rural areas; they prefer to have peers with whom responsibilities can be shared and a range of other health professionals with whom they can work.⁹⁴

2.78 The potential lack of professional support was cited as a key impediment in attracting AHPs to non-metropolitan areas, stating that 'a lack of nursing and allied health staff within a community is likely to influence the decision of other professions whether to practise in that community.'⁹⁵ Similarly, the APS noted the importance of access to a variety of professionals arguing that: 'particularly in rural and regional communities, inter-professional or multidisciplinary practice is essential for efficient, effective and appropriate delivery of service to the community.'⁹⁶

2.79 Another key barrier in attracting health professionals was the absence of clear career paths in non-metropolitan areas. The committee heard from SARRAH that young professionals typically 'will stay one or two years and then leave for metropolitan areas because of the opportunities for specialist career advancement.'⁹⁷

2.80 In addition to the barriers discussed above that apply to the entire medical workforce, the committee heard that allied health professionals face additional barriers. Funding models, according to the Dietitians Association of Australia, do not support AHPs to work outside metropolitan areas:

Funding models do not support allied health to work outside the public health system anywhere [in Australia] but this is particularly problematic in rural areas. Most rural areas have a lower socioeconomic profile therefore direct payment for allied health services [are] limited.⁹⁸

2.81 Peak bodies representing allied health professions suggested the committee that lack of access to Medicare rebates for allied health services means that viable private practice in non-metropolitan areas is extraordinarily difficult stating that '[t]he very limited access to Medicare rebates for allied health services cannot support viable

93 Ms Sheila Keane, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 11 May 2012, p. 2.

94 Mr Gordon Gregory, National Rural Health Alliance, *Committee Hansard*, 11 May 2012, p. 23.

95 Rural Health Workforce Australia, *Submission 107*, p. 22.

96 Australian Psychological Society, *Submission 87*, p. 11.

97 Ms Sheila Keane, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 11 May 2012, p.3.

98 Dietitians Association of Australia, *Submission 86*, p. [2].

practice in rural areas.⁹⁹ It was pointed out by SARRAH that the issue of Medicare rebates become more important with increasing levels of isolation, noting that: 'It is more of an issue the further out you go into remote areas. For example, in Broken Hill there are literally no private allied health services.'¹⁰⁰

2.82 The Australian Association of Social Workers (AASW) argued that many programs established to improve rural health outcomes that include the use of social workers have short-term funding cycles. This creates significant uncertainty for the professionals filling those positions as ongoing employment is not guaranteed.¹⁰¹ The APA also reported difficulties caused by some current funding mechanisms, using the following example:

A single physiotherapist may work under a number of different funding streams for the same employer. They might be employed under a full time equivalent (FTE) 1.5 day position funded under a chronic disease funding stream and a FTE 3 day position under an aged outreach stream. In many instances, both of these funding streams would have separate and inconsistent reporting requirements.¹⁰²

2.83 The APA went on to comment that:

...complex funding arrangements are not transparent, and country health services suffer from onerous, multiple level reporting requirements. This means that the complexity and level of administration required takes time from clinical service delivery.¹⁰³

Committee view

2.84 Based on the evidence received it appears that AHPs do face additional challenges in delivering services to non-metropolitan populations. This is attributable to current Medicare and other funding arrangements, social barriers, access to appropriate, affordable and secure accommodation, and is exacerbated by lower remuneration than doctors. Further, more effort needs to be expended in ensuring that appropriate policies are in place to promote the development and retention of multidisciplinary health teams in non-metropolitan areas.

99 Dietitians Association of Australia, *Submission 86*, p. [2]; cf. Australian Psychological Society, *Submission 87*, p. 10; Pharmaceutical Society of Australia, *Submission 83*, p. 3; Australian Physiotherapy Association, *Submission 71*, p. 7.

100 Ms Sheila Keane, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 11 May 2012, p. 3.

101 Australian Association of Social Workers, *Submission 96*, p. 2.

102 Australian Physiotherapy Association, *Submission 71*, p. 5.

103 Australian Physiotherapy Association, *Submission 71*, p. 5.

Chapter 3

The nature of the medical profession in rural areas

Medical Specialisms

3.1 The committee has received evidence that the growing trend towards medical specialisms and sub-specialisms has a disproportionate impact on the supply of doctors in rural and regional areas. This is principally due to specialisation causing a reduction in generalist training pathways which has been cited¹ as the area of medical practice most required in rural and regional areas.

3.2 Professor Richard Murray, Dean of the Medical School at James Cook University, and President of the Australian College of Rural and Remote Medicine (ACRRM) described this trend:

I have watched the tide go out in the rural remote workforce. Once upon a time we would be able to look for a doctor with qualifications in public health and obstetrics et cetera to hold together services in the remote Kimberley, for instance, and I just watched all of that disappear over a period of a decade. So it felt like a shortage to me.

In fact, through that period and to now, we have continued to grow our medical workforce above population growth. We have more doctors than at any point in history...and we do very well compared to the other comparable countries. So, arguably, the greater problem is not so much absolute numbers; it is both geographic maldistribution and discipline maldistribution, in particular too many subspecialties—subspecialists in the cities—and too much of what we call multiple professional care.²

3.3 The reasons for the general increase of specialisation and subspecialisation are varied and range from the higher remuneration and greater career opportunities, to doctors "feeling comfortable within a domain of practice"³. The committee also heard from the Australian Medical Association (AMA) that the Medicare Benefit Schedule (MBS) contributes to the culture of rewarding specialisation over generalism:

...there is a consensus that the MBS generally speaking rewards subspecialty, [...] particularly in the procedural areas ... the thinking doctors, such as the generalist physicians, generally speaking are not looked after as well.⁴

1 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

2 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, James Cook University, *Committee Hansard*, 23 April 2012, p. 3.

3 Dr Paul Mara, Rural Doctors Association of Australia, *Committee Hansard*, 11 May 2012, p.17.

4 Mr Warwick Hough, Australian Medical Association, *Committee Hansard*, 11 May 2012, p. 63.

3.4 The AMA go on to suggest that this is achieved through higher rebates for particular MBS item numbers, and there are consequences for attracting new recruits into general medicine:

There certainly does need to be a review of those particular areas to try and restore some of the balance. So, ultimately, if you have got young graduates looking at careers in these areas they will see that if they want to go into generalism financially they will not suffer as a result compared to some of the other specialties.⁵

3.5 The MBS outlines the difference in rebates for initial services from a GP and a general physician. An initial attendance by a general physician for a single course of treatment commands a fee of \$148.10, while a typical attendance at consulting rooms for a GP commands a fee of \$35.60.⁶ While there are many other factors such as length of training, these basic figures illustrate the challenge of attracting students into general practice, even without bringing the rural and regional dimension into the equation. Comparisons between generalists and sub-specialists that would support the AMA's assertions are difficult on a purely fees basis because the MBS provides fees for specific activities rather than paying for who provides the service.

3.6 The numbers of GPs in Australia also support the suggestion that it is difficult to attract doctors into general practice. The most recent figures from the Australian Institute of Health and Welfare's (AIHW) Medical Workforce Survey in 2010 state that out of the 81 639 registered medical practitioners in Australia only 35.3 per cent of these were general practitioners compared to 36.1 per cent who were specialists.⁷

3.7 The figures in the Survey also provide valuable data about the distribution of the workforce. The number of full time equivalent⁸ medical practitioners across the country ranges from 400 per 100 000 population in Major Cities, to 185 per 100 000 in Outer Regional Areas, but if we look at general practitioners only then the variation is 105 to 103 respectively.⁹

3.8 These figures provide a picture of the workforce that shows the numbers of general practitioners across areas defined by the Australian Standard Geographical Classification-Remoteness Area (ASGC-RA) classification system are consistent, but

5 Mr Warwick Hough, Australian Medical Association, *Committee Hansard*, 11 May 2012, p. 63.

6 Medicare Benefits Schedule Book, 1 July 2012, pp 94, 98.

7 AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. vi.

8 Full time equivalent is defined as: the number of employed medical practitioners in a particular category multiplied by the average hours worked by employed medical practitioners in the category divided by the standard working week hours. In this report, 40 hours is assumed to be a standard working week and equivalent to one FTE. (AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. 48).

9 AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. vi.

proportionally they represent a much smaller percentage of medical practitioners in Major cities than they do across Inner Regional, Outer Regional and Remote areas.¹⁰

3.9 The figures point to a conclusion that the rural and regional populations are not served poorly in relation to GPs, rather it is that patients cannot access the services provided by specialists without travelling across significant distances at great cost to the patient and the health system. The submission from the Australian Institute of Health and Welfare supports this conclusion stating:

The number of clinical specialists decreased with increasing remoteness (142 FTE per 100,000 for *Major cities*; 24 FTE per 100,000 for *Remote/Very remote areas*).¹¹

Medical Specialist Colleges

3.10 In order to be registered as a Medical Specialist in Australia you have to be assessed by an Australian Medical Council accredited specialist college as being eligible for fellowship of that college, although actual fellowship is not a requirement.¹² This arrangement gives the specialist colleges a key role in shaping the nature of the medical workforce in Australia.

Royal Australian College of General Practitioners

3.11 General Practice itself is classified a specialism by the Australian Medical Council and the Royal Australian College of General Practitioners (RACGP) is the primary specialist college representing GPs. The RACGP also has a National Rural Faculty (NRF) with over 7600 members including more than 4,400 GPs living and working in regional, rural and remote Australia.¹³ The faculty's stated policy focus is to develop strategies that will produce rural GPs with procedural and advanced skills to meet the demands of rural medicine. They also emphasise the need for flexible policies and strategies to be developed through local needs-based assessments.¹⁴

3.12 Aside from the issue around procedural training discussed in the following section the RACGP's submission and evidence to the committee reflected the complex and localised nature of the problems that exist in the delivery of rural health. They propose the enhancement and expansion of current programs that have made an impact such as:

- expanded university placements and Medical Rural Bonded Scholarships;¹⁵

10 AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. 24.

11 Australian Institute of Health and Welfare, *Submission 110*, p. 3.

12 Medical Board of Australia, *Specialist Registration*, available at: <http://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx> (accessed 17 July 2012).

13 The Royal Australian College of General Practitioners, National Rural Faculty, *Submission 41*, p. 2.

14 *Submission 41*, p. 3.

15 *Submission 41*, p. 10.

- an emphasis on rurally orientated general practice at undergraduate as well as postgraduate level;¹⁶
- initiatives that increase training capacity by attracting new GP supervisors;¹⁷
- adequate remuneration for GPs for teaching roles;¹⁸
- an increase from 25% rural origin students for the Commonwealth Supported Places in medical schools to 33%;¹⁹ and
- decreasing student debt for those locked into rural pathways.²⁰

Royal Australian College of Physicians

3.13 The Royal Australian College of Physicians (RACP) is the college representing General Physicians. General Physicians or Consultant Physicians are often the first point of referral by a GP seeking expert medical advice.²¹ While having a different perspective than the RACGP, the RACP's position is consistent with the RACGP's focus on training that will address:

...the impediments for the supply of sustainable health care delivery in rural and remote communities: [that is] maldistribution of specialists in rural areas and chronic disease management.²²

3.14 The RACP contends that growth in the number of physicians, particularly those that are dual-trained in one or more specialisms, could lead to significant cost savings and other benefits in rural communities:

Facilitating the growth of accessible medical specialist services in small communities could lead to reduced hospital admissions, improved quality of life for patients through reduced interactions with the healthcare system and the development of system-wide savings over time. One of these savings could be the reduced cost of patient transfers and travel to metropolitan settings.²³

3.15 The RACP specifically propose a model of dual-trained physicians who will have "core training in general medicine and further training in an additional specialty."²⁴ This would result in physicians with:

16 *Submission 41*, p. 10.

17 *Submission 41*, p. 4.

18 *Submission 41*, p. 10.

19 *Submission 41*, p. 11.

20 *Submission 41*, p. 12.

21 Royal College of Physicians, *What is a Physician/Paediatrician?*, <http://www.racp.edu.au/index.cfm?objectid=D7FAA1D5-09B4-E1FD-5DE5E361F1A9C56E> (accessed 21 July 2012).

22 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

23 Royal Australian College of Physicians, *Committee Hansard*, 11 May 2012, p. 54.

24 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

...expertise in the diagnosis and management of acute, undifferentiated illnesses and complex, chronic and multisystem disorders in adult patients. Additional training in a specialty such as endocrinology, oncology or respiratory medicine, will increase the level of expertise of the general physician. For example, a general physician with an additional specialty in endocrinology would be able to manage complex acute complex diabetes cases in a population with a high rate of diabetes.²⁵

3.16 The current training program to become a physician takes upwards of six years, with the last three years involving advanced training in one (or more) of 30 possible specialities. The RACP proposal is that this three-year segment include the undertaking of two advanced training programs that would be assessed simultaneously.²⁶

3.17 According to the RACP the success of its proposal is contingent on a number of factors:

There is anecdotal evidence to suggest that trainees are interested and keen to participate in dual training with generalism as the core specialty, within a rural area. This is provided there is the capacity to train physicians within the rural facility and there is a clear career pathway and program to follow. Increasing the capacity of rural clinical schools and training facilities as centres of excellence and linked to universities will support this proposal.

There is also evidence that basing General Medicine physician training in rural areas, or longer-term rural placements, attracts the trainee to the area. They are more likely to stay in the areas as a physician, providing the community with a sustainable and secure workforce.²⁷

3.18 The 'dual-training' model proposed is similar to one that is has been running in New Zealand for over ten years. However the employment conditions for a physician in New Zealand are different, as the provision of services in local regional communities is included in their contract. This is unlike the Australian model where the physician decides if they want to provide services in a particular area or not.²⁸

3.19 The RACP used an example of a cancer patient with co-morbidities that require a coordinated approach to care as an illustration of the benefits that a general physician can provide:

We have a rural and regional oncology service in Albury-Wodonga. We have their specialist come down one day a week to Wangaratta. We have delivery of regional treatment in Wangaratta. I supervise the oncology on day to day. These patients have multisystem disease. They do not just have cancer; they have diabetes and heart disease. That is where I come in. The oncologist tells us what they are going to have and supervises that. But as

25 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

26 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 7.

27 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 8.

28 Royal College of Physicians, *Committee Hansard*, 11 May 2012, p. 55.

soon as they end up with pneumonia or their diabetes is out of control or their heart disease has been right, they end up being coordinated.²⁹

3.20 Professor Koczwara, President of the Clinical Oncology Society of Australia (COSA) also stated that cancer patients need access to a number of medical services, not just oncological:

...cancer care is multidisciplinary—very rarely do we deliver care by one professional. You often need surgery, chemotherapy, radiotherapy, allied health care staff, supportive care not to mention prevention and so on.³⁰

3.21 The representatives from the RACP expanded on the service they operate out of Wangaratta. They have six general physicians who have undertaken to visit up to 100 kilometres from Wangaratta at least one day a week. This service is carried out under the Medical Specialty Outreach Access Program (MSOAP).³¹ However as much as they endorse this model it is dependent on the specialists involved, and there is no coordinated approach to manage the integration of specialist services into ambulatory and primary care. According to the RACP this is in part because one setting, the local hospital networks, is with the states, while the Medicare Locals are the Commonwealth's coordinating tool for the delivery of services.³²

Australian College of Rural and Remote Medicine

3.22 The Australian College of Rural and Remote Medicine (ACRRM) is the specialist college specifically engaged with the issues contained in the committee's terms of reference. The College is an accredited medical college for the specialty of general practice,³³ however rural medicine itself is not a recognised medical speciality so the ACRRM is not the only college with a rural dimension. It has however played a key role in the development of Rural Generalist Pathways.

Rural Generalists pathways

3.23 There is a recognition that services once delivered by rural and regional GPs such as obstetrics or anaesthetics are now largely delivered by specialists in large regional towns or in major cities. Dr Mara from the Rural Doctors Association of Australia (RDAA) considered this trend to be unsustainable:

...we have lost the concept of generalism in medicine as being a vital thing...We simply cannot afford to have an ever-increasing superspecialisation, because it is going to cost the government and it is going to cost the taxpayer too much. At the end of the day, we have to start

29 Royal College of Physicians, *Committee Hansard*, 11 May 2012, p. 55.

30 Professor Bogda Koczwara, President, Clinical Oncological Society of Australia, *Committee Hansard*, 11 May 2012, p. 46.

31 Royal College of Physicians, *Committee Hansard*, 11 May 2012, p. 55.

32 Royal College of Physicians, *Committee Hansard*, 11 May 2012, p. 55.

33 Australian College of Rural and Remote Medicine, *Submission 125*, p. 2.

putting some investment into people who can do basic things very, very well in a comprehensive sense.³⁴

3.24 Professor Murray from James Cook University and the ACRRM agreed that the focus should be on producing more generalist practitioners to address the maldistribution of doctors across the country, and recent actions in the form of rural generalist pathways are already proving successful:

The big challenge for us in the regions now is to build the training pipeline into all of the medical specialties, with an emphasis on generalism. I will close perhaps on the rural generalist point. It is hard to explain how much of an impact this model has had locally. I have been around the rural and remote space for a long time. It was a very depressed space. Doctors' meetings would be full of woe and stories of gloom. I have watched that turn around, in particular in this area, as there is an obvious prospect of generational renewal and as people are coming through. What was once a shrinking healthcare facility now has a buzz and a life to it where people have taken on new and expanded roles within a teaching-intense healthcare service that in fact helps to underpin and secure their future. There has been a profound impact already.³⁵

3.25 Doctors Meagher and Douch, who practice in Young, suggested that there is a lack of "training in procedural skills"³⁶ for GPs working in rural areas and there are barriers for GPs wanting to access that training:

The first one might be a traditional barrier. A lot of the procedural training appears to have been an add-on to training GPs. If you take my own case, I was a little unusual in that I did my anaesthetics training before going out into rural GP practice, so I arrived skilled and trained to perform an anaesthetic. The usual routine in the past was to make that procedural training occurred at the end of your time. It meant that you were getting GP trainees moving out to the country who had no procedural skills. They were more or less committing to a line of work and a pathway of development, with family circumstances et cetera. To pick up and leave all that to go back and do procedural training was difficult.³⁷

3.26 They believed that barriers could be overcome in the long term through generalist pathways:

We see a light on the hill with the ideas being pushed about generalist pathway training—training people in a more fulsome sense for practice in the country. That would incorporate, I would expect, some form of procedural training rather than having it as an add-on. That may be a hope

34 Dr Paul Mara, Rural Doctors Association of Australia, *Committee Hansard*, 11 May 2012, p.17.

35 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, James Cook University, *Committee Hansard*, 23 April 2012, p. 4.

36 Dr Meagher, Young District Medical Centre, *Committee Hansard*, 11 May 2012, p. 33.

37 Dr Douch, Young District Medical Centre, *Committee Hansard*, 11 May 2012, p. 33.

for the future but, as Dr Meagher pointed out, that will be a long-term solution rather than a short-term solution.³⁸

3.27 The rural generalist pathway that Professor Murray referred to is the initiative taken by Queensland Health in 2002. Queensland Health explained the development of the pathway through a paper it delivered at the committee's hearing on 10 July:

The Rural Generalist Pathway concept was developed in 2002 through a consortium of Queensland Health, the Australian College of Rural and Remote Medicine (ACRRM), General Practice Education and Training, Remote Vocational Training Scheme and the Royal Australian College of General Practitioners (RACGP). The concept responded to the data analysis of rural medical officer attraction and retention, which indicated longitudinal decline of rural medical services with increasing dependency on international medical graduates.³⁹

3.28 Dr Denis Lennox, Executive Director of the Office of Rural and Remote Health at Queensland Health, described the pathway in detail:

We have developed a joined up, principle based pathway from secondary education at high school through medical training to postgraduate establishment in practice and registration, and then to vocational training in Australian general practice training, along with other elements that we require for the credentials in rural generalist medicine in Queensland, and that particularly relates to advanced specialised disciplines. We have eight approved advanced specialised disciplines covering areas of obstetrics, anaesthetics, emergency medicine, Indigenous health, adult internal medicine, paediatrics and mental health. These are all disciplines in which these doctors practice in rural settings that would otherwise be the prerogative of specialised practitioners in those disciplines.⁴⁰

3.29 The Queensland Health submission defined a Rural Generalist as:

...a rural medical practitioner who is credentialed to serve in hospital or community-based primary medical practice as well as hospital-based secondary medical practice in at least one specialised medical discipline (commonly, but not limited to obstetrics, anaesthetics and surgery) without supervision by a specialist medical practitioner in the relevant disciplines. The practitioner may also be credentialed to serve in hospital and community-based public health practice – particularly in remote and indigenous communities.⁴¹

3.30 The first rural trainees have now exited the program, and have been awarded fellowship of the ACCRM in 2012.⁴²

38 Dr Douch, Young District Medical Centre, *Committee Hansard*, 11 May 2012, p. 33.

39 Queensland Health, *Submission 126*, p. 1.

40 Dr Denis Lennox, Executive Director, Office of Rural and Remote Health at Queensland Health, *Committee Hansard*, 10 July 2012, p. 1.

41 Queensland Health, *Submission 126*, p. 1.

42 *Submission 126*, p. 1.

3.31 The committee found that there is significant support for the pathway from a number of submitters. Rural Health Workforce Australia reported that:

Our advice is that it works in Queensland and that it is being rolled out. What we need is pathways to rural practice. If that is one of the pathways then we would welcome it. We need to look at all the pathways that are available for domestic and overseas doctors.⁴³

3.32 The Royal Australian College of Nursing also endorsed the Queensland Health model suggesting that it could provide opportunities for advanced nursing practice in rural areas as well:

[The] whole idea of valuing being a generalist—we do not do that...Well, they do in Queensland now. And I think that the Rural Generalist Pathway that they have established in Queensland is actually a very good model. It probably could provide some sort of pathway for nursing to go down as well, but of course that would require external funding because it is outside of state government remit.⁴⁴

3.33 However the model has not attracted consistent support across the professions. Despite being one of the founding partners of the Queensland Health program the RACGP now say that:

State-based medical workforce initiatives (e.g. Queensland Health Rural Generalist Program) are working as deterrents to the recruitment and retention of rural general practitioners...with perceived success in Queensland due to lucrative salaries which cannot be matched by private practice. It should also be noted that the term 'rural generalist' represents a state jurisdictional term and is not a recognised specialty by the Australian Medical Council.⁴⁵

3.34 In their submission they state that their opposition to the measures taken in Queensland through the Rural Generalist Program are due to the lack of evaluation⁴⁶ and the emphasis on secondary or hospital based skills rather than the enhancement of the GP's skills in the community. The RACGP would rather see a broad suite of measures designed to "expand the availability and flexibility of procedural training"⁴⁷ and offer the NSW Rural Generalist Training Program as a good example.

3.35 When appearing at the committee's hearing in Albury the RACGP expanded on the comments made in their submission:

The feedback we have from some of our members in Queensland is that private general practice cannot compete with the amounts of money through the industrial award that Queensland health offers to attract private GPs. So

43 Ms Margie Mahon, Rural Health Workforce Australia, *Proof Committee Hansard*, 5 June 2012, p. 27.

44 Dr Mills, Royal Australian College of Nursing, *Committee Hansard*, 11 May 2012, p. 41.

45 Royal Australian College of General Practitioners, *Submission 41*, pp. 5, 8.

46 *Submission 41*, p. 5.

47 *Submission 41*, p. 9.

if as a fourth- or a fifth-year you can get \$300,000 working for Queensland health in a Queensland health facility, private general practice cannot compete with that.⁴⁸

3.36 Dr Kirkpatrick, the Chair of the National Rural Faculty of the RACGP provided the example of the situation in Dalby to illustrate the RACGP's point:

At Dalby we have a 20-bed hospital. There are four doctors employed by Queensland health at the hospital. They work purely in the hospital. We have three medical practices in town. I work in one of the major ones there. We have eight full-time-equivalent GPs. We work as VMOs to the hospital, but we are not employed by Queensland health. If the doctors are not at the hospital then the private GPs would be picking up the patients. The patients would get a Medicare rebate and then pay us, whereas the doctors at the hospital are paid by Queensland Health to see the patients that present at the hospital.⁴⁹

3.37 The committee is aware of the pressures involved in running a small medical practice in a rural or regional area. The doctors from the Young District Medical Centre described the margins they work on as a private practice:

We have a minimum of 55 per cent running costs before the individual doctors look at their own indemnity, their own running costs, equipment, superannuation and all of those things so it is only just a viable proposition. If we are not here working full time then it is not a viable proposition.⁵⁰

3.38 They then described a typical scenario which impacts heavily on their ability to staff the practice on a full time basis while also providing public hospital emergency services:

The demands of the hospital for the four of us doing that work is not only aligned to the time that we are on call for emergency or for obstetrics or for anaesthetics when we may get calls but also when we need to do rounds in the morning to follow-up patients. We can be up there for two to three hours in the morning. We receive numerous phone calls during the day about patients who are in-patients, which disrupts the services here, and then we receive emergency calls during the day to assist Caesareans or emergency airways or anything during that time.⁵¹

3.39 When asked about the views of the RACGP, the ACCRM defended the program on the results it has achieved to date:

I do not really want to comment on another college's approach or what they have said but I can only talk about what we have seen and the fact that the rural generalist program and generalist medicine is now very much on the

48 Dr Kirkpatrick, Royal Australian College of General Practitioners, *Committee Hansard*, 5 June 2012, p. 39.

49 Dr Kirkpatrick, Royal Australian College of General Practitioners, *Committee Hansard*, 5 June 2012, p. 39.

50 Dr Meagher, Young District Medical Centre, *Committee Hansard*, 11 May 2012, p. 32.

51 Dr Meagher, Young District Medical Centre, *Committee Hansard*, 11 May 2012, p. 32.

agenda within other states. We have a successful model now that addresses what the real workforce needs are within rural and remote communities. Hence, we would like to see that extended into general specialists within it. Those are the skills that are missing out of the area, too, so we have a challenge with that. The strength of it is that it is local training. As I said in my opening, it is about a totally different approach to workforce, wherein there is benefit to the community and the doctor providing the services out there.⁵²

3.40 Dr Lennox from Queensland Health also countered the perspective of the RACGP saying that it had "resulted in an increased number of medical graduates applying to be trained through Australian General Practice Training to general practice."⁵³ Dr Lennox also posed the question of whether the program, and its success in meeting its objectives, could be replicated nationally:

My response is overwhelmingly, yes, indeed it could. The need is common with variations upon the theme in each jurisdiction. The innovation we have embarked upon has been principle based; it is based upon evidence; it is based upon joining up policy and strategy, and existing operations. It is evidence based, it is systematic, it is principled and it can be extrapolated to other jurisdictions, and adjusted according to local need. Providing that happens, providing that it occurs in a principled way, I would argue very strongly that, yes, the transformation could be nationalised.⁵⁴

Indigenous Health

3.41 The issue of attracting health practitioners, GPs, and specialists to Indigenous communities was discussed in the committee's hearing in Alice Springs and Darwin. The nature of Indigenous health care in rural areas is often unique in its scope, the type of issues that health workers deal with, and the management and delivery of health services. The committee heard evidence from the Central Australian Aboriginal Congress who outlined their innovative approach to attract health practitioners:

We went from having three FTE GPs and about eight unfilled positions in 1995 to having 13 FTE GPs and no unfilled positions in the last, say, four years. The median length of stay is more than seven years and the average is more than nine years. What made the difference? Remuneration back in the mid-nineties was terrible, so we had to get more funding. That came both through greater grants, the Primary Health Care Access Program was very important, and access to the MBS, which happened in 2006. That meant we had more funding so we could offer more money. We also needed better working conditions. We had to get rid of the after-hours on

52 Ms Wyatt, Australian College of Rural and Remote Medicine, *Committee Hansard*, 5 June 2012, p. 11.

53 Dr Denis Lennox, Executive Director, Office of Rural and Remote Health at Queensland Health, *Committee Hansard*, 10 July 2012, p. 2.

54 Dr Denis Lennox, Executive Director, Office of Rural and Remote Health at Queensland Health, *Committee Hansard*, 10 July 2012, p. 1.

call service because we were the only ones offering that service. We hung onto that for a long time. We got rid of it in about 2005. That has further improved workforce retention.⁵⁵

3.42 Dr Boffa from Congress also emphasise the importance in having good governance and multidisciplinary teams to make the positions more sustainable:

We have effective multidisciplinary teams, so our doctors are working in an organisation that has good clinical governance processes. We have psychologists, social workers and alcohol treatment programs. Our doctors do not feel like they are on their own; they feel like they can refer to other services, they can make a difference and they can see how they are going in terms of outcomes. They get that feedback.

That has all helped, but I think Michael Wooldridge's 1999 overseas trained doctors scheme was critical. Without that we would not have a complete workforce. The GPs...from those countries have all now got their fellowships. They came under the five-year scheme and got their fellowships, but most stayed after that. We have only lost a couple at the five-year point. Most have stayed.⁵⁶

3.43 The importance of collaboration between key stakeholders is another theme that came out of the evidence in Alice Springs. Congress discussed the Northern Territory General Practice Education (NTGPE) which is a training provider of general medical education in the Northern Territory. NTGPE was established in 2002 by:

...a consortium of partners including Flinders University, Charles Darwin University, GP Divisions of the NT, Aboriginal Medical Services Alliance NT, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. It is funded by the Federal Government to provide postgraduate training in general practice, vocational placements for prevocational doctors and to provide specialised community based primary care placements to students from medical schools in all Australian states and also overseas.⁵⁷

Committee View

Queensland Health Rural Generalist Program

3.44 The committee is of the view that the purpose of a rural health workforce is to provide access to quality health care for communities in rural areas and that this goal is best advanced through a significant increase of rural generalist GPs. The committee is strongly supportive of the efforts of the ACCRM, the AMA and the other colleges to increase the numbers of rural generalists in the rural medical workforce through the

55 Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 20 February 2012, p. 2.

56 Dr John Boffa, *Committee Hansard*, 20 February 2012, p. 2.

57 Northern Territory General Practice, *About Us*, <http://ntgpe.org/index.php/about-us/>, (accessed 13 August 2012).

development of rural generalist training pathways. The Queensland Health Rural Generalist Program and the NSW Rural Generalist Program are two such pathways.

3.45 The NSW program endorsed by the RACGP has very similar objectives to the Queensland program, with an emphasis on providing practitioners in rural settings who provide:

...primary care to a rural community whilst being credentialed at the local health service to provide procedural / advanced skills on their chosen speciality (obstetrics and gynaecology and/or anaesthetics).⁵⁸

3.46 While the committee did not receive specific evidence on the NSW model, one of the differences between the two programs is that the NSW program is aimed at up-skilling GPs in private practice to provide the services required in a rural setting, for example, providing "care in a rural community and advanced procedural services at a rural hospital";⁵⁹ whereas the Queensland Health program provides salaried doctors to "serve in hospital or community-based primary medical practice as well as hospital-based secondary medical practice"⁶⁰.

3.47 On evidence received, both in written submissions and orally, the committee is not convinced by the argument from the RACGP that the Queensland program is a long term deterrent to the retention and recruitment of rural general practitioners. The program is now training an additional 50 new graduates per year and is committed and funded to do so over the next five years.

3.48 The committee is strongly supportive of the Queensland Health initiative to develop a program based on local needs. The evidence the committee has received has also endorsed the program as being successful in delivering increased access to healthcare in rural areas.

3.49 The committee accepts that this program may not be suited to all areas of the country, and each state and territory Government may wish to explore different pathways to provide increased access to health care tailored to local need. However it does not consider this to be sufficient grounds to reject innovative programs such as the Queensland model.

3.50 The model adopted by the Central Australian Aboriginal Congress displays innovation necessitated by need. The emphasis on multidisciplinary teams allows professional development across the health specialties and appears to be successful in combating professional isolation. The collaboration between different education

58 Health Education and Training Institute Rural Directorate, *NSW Rural Generalist Training Program factsheet*. P. 1 of 2, available at: http://www.ruralheti.health.nsw.gov.au/_documents/initiatives/rural-generalist-training-program/rural-generalist-information-fact-sheet.pdf (accessed 17 July 2012).

59 Health Education and Training Institute Rural Directorate, *NSW Rural Generalist Training Program factsheet*. P. 1 of 2, available at: http://www.ruralheti.health.nsw.gov.au/_documents/initiatives/rural-generalist-training-program/rural-generalist-information-fact-sheet.pdf (accessed 17 July 2012).

60 Queensland Health, *Submission 126*, p. 1.

providers to provide health workers and training opportunities has also led to a steady flow of GPs, nurses and allied health workers that appears to be sustainable. As discussed in Chapter Two there are difficulties in the supply of Aboriginal Health Workers that need to be managed, but the committee was impressed with the systems put in place by Congress to provide a blueprint for centrally managed healthcare in remote areas.

Increasing the number of Specialists in rural areas

3.51 The committee welcomed the evidence from the RACP and COSA as it illustrated the complex nature of health care delivery in rural areas. The changing pattern of chronic disease management requires more than GPs to provide care to rural and regional populations and the description of the Wangaratta model of physicians' outreach provided a template for the type of care the committee would like to see delivered across rural and regional Australia. The committee also took an interest in discussion about whether medical practitioners could be contracted to provide care in these areas.

Recommendation 3

3.52 The committee recommends that the Commonwealth place on the agenda of the Council of Australian Governments' Standing Council on Health an item involving consideration of the expansion of rural generalist programs. It further recommends that, as part of that agenda item, the Council consider an evaluation of the Queensland Health Generalist Program and whether it should be rolled out in other jurisdictions.

Recommendation 4

3.53 The committee recommends that the Commonwealth government work with education providers and the medical profession to address the issue of the inadequate supply of rural placements for medical interns in their pre-vocational and vocational years.

Chapter 4

Attempts to address the rural medical skills deficit

4.1 The Australian Government has put in place numerous measures designed to support, attract and retain an adequate medical workforce to meet the needs of Australia's non-metropolitan populations. This chapter considers the main policies and programs aimed at increasing the number of doctors and Allied Health Professionals (AHPs) servicing rural, regional and remote Australia.

Government-led actions and policies impacting on doctor numbers

4.2 There is a variety of programs aimed at increasing the numbers of doctors servicing non-metropolitan communities. It was reported to the committee that there are at least 50 different programs aimed at having an impact on one or more of the stages of this medical career path – from students through to experienced professionals.¹

4.3 Incentive programs aimed at increasing the number of non-metropolitan medical professionals broadly fall into three categories: attracting sufficient numbers of doctors to rural areas; retaining the existing workforce; and ensuring an adequate future supply of rural medical practitioners. The aims of specific initiatives are diverse, and include:

- Encouraging health workers to remain in regional areas;
- Encouraging entry to the regional health workforce;
- Boosting the number of students from regional areas that train to become health workers;
- Equipping practitioners with additional or different skills required to deliver services in rural and remote areas; and
- Reducing the risk of 'lock-in' for those practicing in rural areas.²

Skilled migration

4.4 An important plank in the policy of increasing doctor numbers in regional areas has been the use of Overseas Trained Doctors (OTD). The Department of Health and Ageing reported to the committee that:

The number of medical practitioners working in regional, rural and remote Australia has increased steadily during the past ten years. Much of this is attributed to the use of overseas trained doctors who have increased significantly since 2001–02.³

1 National Rural Health Alliance Inc., *Submission 95*, p. 3.

2 Productivity Commission, *Australia's Health Workforce*, Canberra, December 2005, p. 213.

3 Department of Health and Ageing, *Submission 74*, p. 7.

4.5 According to Australian Institute of Health and Welfare (AIHW) data (2009), approximately 25 per cent of the medical workforce in Australia are overseas trained. OTDs now comprise 46.2 per cent of GPs in non-metropolitan areas, up from 27.1 per cent in 2000–01.⁴ In 2009–10 30 per cent of OTDs were working outside of metropolitan areas.⁵ The growing importance of OTDs is underscored by the growth in services they provide to rural and regional communities. According to the Rural Doctors Association of Australia (RDAA):

The influx of OTDs is the only reason that medical workforce numbers in rural areas are not in complete free fall. Around 50 [per cent] of rural doctors are overseas trained and, in many areas, 100 [per cent] of services are being provided by OTDs.⁶

4.6 The importance of skilled migration was further emphasised by Professor Humphreys from the Centre of Research Excellence in Rural and Remote Primary Health Care who suggested that '[a]ny recent improvements largely reflect the increasing number of international medical graduates who, in effect, have limited choice in where to work.'⁷

4.7 In order to ensure that OTDs were meeting the needs of the Australian health system, the government in 1996 amended the *Health Insurance Act 1973*. The amendments introduced a clause with the effect that 'to gain access to Medicare benefits, OTDs must practise in a district of workforce shortage (DWS) for a period of ten years (commonly referred to as the ten year moratorium).⁸ This scheme is not unique internationally, the World Health Organisation report of 2010 alluded to 70 countries that have operated compulsory service schemes to ensure rural health services are available.⁹

4.8 The 10-year moratorium was cited by Rural Health Workforce Australia (RHWA) as a key reason that the number of rural doctors has been increasing and:

By effectively linking [Medicare] provider numbers to districts of workforce shortage and areas of need, governments have been able to focus the practice of [OTDs] to rural and remote areas. This has gone some way towards filling the gaps in the rural medical workforce supply and increasing absolute numbers. This is a demonstration of the effect that an

4 Australian Government Department of Health and Ageing, *Submission 74*, p. 9. (These figures are based on Full-time Workload Equivalent (FWE) which is a standardised measure used to estimate the workforce activity of GPs and adjusts for the partial contribution of casual and part-time doctors.)

5 Australian Government Department of Health and Ageing, *Submission 74*, p. 9.

6 Rural Doctors Association of Australia, *Submission 67*, p. 11.

7 Professor John Humphreys, Centre of Research Excellence in Rural and Remote Primary Health Care, *Committee Hansard*, 5 June 2012, p. 16.

8 Australian Government Department of Health and Ageing, *Submission 74*, p. 9.

9 Rural Health Workforce Australia, *Submission 107*, p. 29.

element of compulsion via Medicare can have in appropriately directing the GP workforce to where it is needed.¹⁰

4.9 Further incentivising practice in particularly disadvantaged areas, the 5-Year Overseas Trained Doctor Scheme (5-Year OTDS) reduces the number of years before an OTD gains access to Medicare benefits to five for those prepared to work in locations which experience the greatest difficulty in recruiting doctors. Although these are referred to as 5-Year OTDS, there are in fact three graded categories with differing time requirements. Category A, covering areas which experience exceptional difficulties attracting and retaining doctors, has only a three-year service requirement.¹¹ Categories under the 5-Year OTDS are set by individual states. For illustrative purposes, Category A locations in New South Wales include towns such as Bourke and Goodooga, Category B towns such as Hay and Moree, and Category C towns such as Gundagai and Broken Hill.¹²

4.10 The Central Australian Aboriginal Congress expanded on the concept of using Medicare provider numbers as a way of regulating the maldistribution of GPs:

It requires a legislative act to regulate the workforce. It is about regulating supply against need...[the ASGC-RA based incentive scheme is] not as effective as what we have argued for years, which is that we should have a system like geographic provider numbers, where you only allow a certain number of provider numbers per population in any part of the country.¹³

4.11 The 10-year moratorium has been criticised for a number of reasons. The RDAA argued that the current moratorium system may not be in the best interests of either patients or OTDs:

[OTDs] are often sent to areas where they are personally, professionally and culturally isolated. Many have limited access to the support, supervision and mentoring they need to orientate themselves to the Australian health care system and enable them to provide the highest quality of service that meets the needs of their communities.¹⁴

4.12 The committee also received evidence that indicates that many OTDs find rural practice rewarding. One sample found 73 per cent of OTDs in Western Australia who completed the 5-Year Overseas Trained Doctors Scheme still practicing rurally.¹⁵

10 Rural Health Workforce Australia, *Submission 107*, p. 11.

11 Rural and Regional Health Australia, *5 Year Overseas Trained Doctor Scheme*, available from: http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/5_Year_Overseas_Trained_Doctor_Scheme, (accessed 6 July 2012).

12 New South Wales Rural Doctors Network, *Five Year Rural Incentive Scheme for Overseas Trained Doctors: approved locations as at September 2008*, available from: http://nswrdn.com.au/client_images/665737.pdf, (accessed 23 July 2012).

13 Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 20 February 2012, p. 3.

14 Rural Doctors Association of Australia, *Submission 67*, p. 11.

15 Rural Health Workforce Australia, *Submission 107*, p. 29.

4.13 The committee also heard concerns regarding the ethics and ongoing viability of meeting domestic health requirements through the use of doctors from developing countries:

I am sure that you have heard that there is a very real backlash now, both inside Australia and in the international community, about developed countries stealing doctors from developing countries. The ethics has always worried us...The government of India has announced that it has plans for blocking the exit of doctors from India to other countries unless the countries guarantee to send them back. And many African countries are saying the same. So a policy that is relying on overseas-trained doctors for Australia could blow up in our face.¹⁶

4.14 Despite the increasing numbers of Australian trained doctors entering the workforce, the Deloitte Access Economics report *Review of the Rural Medical Workforce Distribution Programs and Practices* conducted on behalf of the Department of Health and Ageing suggested that: 'further diminution of [OTD] inflow would substantially reduce clinical service provision in regional Australia.'¹⁷

Incentives: education

4.15 A number of incentive programs have been developed and implemented to encourage specific demographics to study medicine, improve exposure to rural practice and prompt existing students to consider rural careers.

4.16 There are several initiatives that attempt to expose students to the challenges and opportunities available when practicing rural medicine. It was put to the committee that:

Positive rural experiences at the undergraduate, junior doctor and postgraduate level are important, as they increase the odds of medical students, junior doctors and registrars choosing to become a rural doctor.¹⁸

4.17 The Rural Australia Medical Undergraduate Scholarship (RAMUS) scheme assists selected students with a rural background to study medicine at university. Scholarship holders are selected based on their financial need and commitment to working in rural Australia in the future. Approximately 120 new scholarships are awarded annually. The scheme is administered by the National Rural Health Alliance on behalf of DoHA.¹⁹

4.18 To enable medical students to undertake extended blocks of their clinical training in regional areas, the Rural Clinical Schools (RCS) program was launched in

16 Professor John Dwyer, Charles Sturt University, *Committee Hansard*, 5 June 2012, p. 3.

17 Department of Health and Ageing (Deloitte Access Economics), *Review of the Rural Medical Workforce Distribution Programs and Policies*, 17 August 2011, p. 38.

18 Rural Doctors Association of Australia, *Submission 67*, p. 23.

19 Rural Australia Medical Undergraduate Scholarship Scheme, available from: <http://ramus.ruralhealth.org.au/>, (accessed 20 July 2012).

2000.²⁰ Rural clinical schools are charged with delivering significant components of the medical curriculum in a rural environment, with students undertaking a year or more of their medical training in a rural location. The 2008 report *Evaluation of the University Departments of Rural Health Program and the Rural Clinical Schools Program* found that:

The RCS Program complements other placement programs which provide students with short-term opportunities to experience rural medical practice, and in many instances students who have undertaken short-term placements have been inspired to apply to an RCS for part of their training. The development of the Rural Clinical Schools Program also allowed construction and furnishing of teaching and learning facilities and student accommodation in dozens of rural and regional locations across Australia.²¹

4.19 The Rural Clinical Training and Support (RCTS) Project was introduced in July 2011 and amalgamates the RCS and the Rural Undergraduate Support and Coordination (RUSC) programs.²² The RUSC program funded participating Australian medical schools to promote the selection of rural medical school applicants, develop support systems for medical students with an interest in rural practice, and provide short term-rural placements.²³

4.20 The stated objectives of the RCTS are principally the same as those previously part of the RUSC:

[T]o increase the rural medical workforce by enlisting medical schools to deliver rural medical training, to recruit rural medical students, promote and encourage rural medical careers and increase opportunities for Aboriginal and Torres Strait Islander students.²⁴

4.21 Additional measures under the RCTS include the requirement that:

- 25 per cent of domestic medical students must undertake a minimum one year placement in an ASGC-RA 2-5 [ie. regional or remote] location;

20 This overview of the RCS Program draws heavily from the 2008 report *Evaluation of the University Departments of Rural Health Program and the Rural Clinical Schools Program* prepared by Urbis on behalf of the Department of Health and Ageing. The full report is available here:

[http://www.health.gov.au/internet/main/publishing.nsf/Content/F113F29BD0A03FB8CA2575DE00227803/\\$File/udrheval.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F113F29BD0A03FB8CA2575DE00227803/$File/udrheval.pdf)

21 Urbis (on behalf of the Department of Health and Ageing), *Evaluation of the University Departments of Rural Health Program and the Rural Clinical Schools Program*, 2008, available from:

[http://www.health.gov.au/internet/main/publishing.nsf/Content/F113F29BD0A03FB8CA2575DE00227803/\\$File/udrheval.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F113F29BD0A03FB8CA2575DE00227803/$File/udrheval.pdf), (accessed 19 June 2012), p. 60.

22 Australian Government Department of Health and Ageing, *Submission 74*, p. 13.

23 Department of Health and Ageing, *Rural Undergraduate Support and Coordination Program*, available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/work-st-rusc>, (accessed 19 July 2012).

24 Australian Government Department of Health and Ageing, *Submission 74*, p. 13.

- 25 per cent of Commonwealth Supported medical students must be from a rural background; and
- All Commonwealth Supported medical students must undertake at least four weeks of structured rural placement.²⁵

4.22 The committee received evidence from Charles Sturt University that the measures under the RCTS Project will have limited impact on attracting doctors to return to rural areas to practise:

Typically, for some of them it will be a one-year rotation in a rural clinical school; for many of them, it is only four weeks. The mandatory four-week placement is really just a very brief exposure to rural and regional practice. It is good for the students, but it is not necessarily good in terms of delivering people who will want to come back and practise in the bush. Likewise, the one-year rotation out of a medical training career that is predominately metropolitan based is not enough to shift people away from relationships and social networks that they generate when living in metropolitan areas. They are unlikely to then want to come back to rural and regional areas to practise.²⁶

4.23 Another means used by the government to attract more medical students to regional areas has been through the use of bonded scholarships. The purpose and operation of the Medical Rural Bonded Scholarship (MRBS) Scheme is explained by the Department of Health and Ageing:

The Medical Rural Bonded Scholarship (MRBS) Scheme is an Australian Government initiative designed to address doctor shortage outside metropolitan areas across Australia. The MRBS scheme provides one hundred additional Commonwealth Supported Places (CSP) each year to first year Australian medical students at participating universities across the country. Students accepting the MRBS commit to working for six continuous years in a rural or remote area of Australia less any credit obtained through Scaling, after completing their medical training as a specialist.²⁷

4.24 RHWA supported the scheme as being 'very valuable in addressing long-term doctor shortages'.²⁸

4.25 The Central Australian Aboriginal Congress also strongly support the scheme and discussed how they have been lobbying to have bonded scholars and how successful they hope it will be in Indigenous areas:

25 Australian Government Department of Health and Ageing, *Submission 74*, p. 13. Chapter 5 of this report includes further information on the ASGC-RA system.

26 Professor Andrew Vann, Charles Sturt University, *Committee Hansard*, 5 June 2012, p. 2.

27 Department of Health and Ageing, *Medical Rural Bonded Scholarship Scheme*, available from: <http://www.health.gov.au/mrbscholarships>, (accessed 2 July 2012).

28 Rural Health Workforce Australia, *Submission 107*, p. 23.

We have become a rural clinical school so we are taking undergraduate medical students. We have bonded scholars coming through—none yet. I think next year will be the first year... We lobbied for years. We have been saying for years that as well as pull factors and the retention things we have talked about, we need sticks and carrots. We need some push factors and we lobbied for years for funded scholars, for funded scholarships, which means that students who get into medicine get in with all their fees paid on the understanding that they will deliver... When we first talked about that the AMA said the world would fall over if we did it, and they still do not like it. They predicted that most of them would get out of their bond. They are free to get out of their bond and, from what I hear, about 25 per cent will get out. Probably 75 per cent are going to work and implement their bond.²⁹

Committee view

4.26 While the committee is supportive of the efforts of the Government under the Rural Clinical Training and Support in particular, the committee does not believe that four weeks structured rural practice training is sufficient time to expose the student to the full gamut of experience available in rural Australia. The committee also heard of a number of instances³⁰ where the local community had actively welcomed students and ensured that they had a positive feeling of engagement and connectedness with the area. The committee does not think that four weeks is long enough to foster that level of input from the community.

Incentives: recruitment and retention

4.27 There have been significant efforts to encourage health professionals to relocate to non-metropolitan areas, as well as retain workers currently in those areas.

4.28 The committee heard that there are currently four rural-specific programs in operation offering financial incentives and support to rural doctors and rural practice:

- The General Practice Rural Incentives Program (GPRIP);
- The Rural Locum Education Assistance Program;
- The Rural Procedural Grants Program; and
- The Higher Education Contribution (HECS) Reimbursement Scheme.³¹

4.29 Since July 2010 the GPRIP has been the main structure for delivery of direct government incentives to rural GPs including relocation and retention assistance.³² The committee was informed that: '[GPRIP] is designed to provide a consistent set of

29 Dr John Boffa, Central Australia Aboriginal Congress, *Committee Hansard*, 20 February 2012, pp 2–3.

30 For example: Dr Deborah Cole, Dental Health Services Victoria, *Committee Hansard*, 5 June 2012, p. 46; Dr Mourik, *Committee Hansard*, 5 June 2012, p. 46; Mr Rod Hook, Tropical Medical Training, *Committee Hansard*, 23 April 2012, pp 12–13.

31 Rural Doctors Association of Australia, *Submission 67*, p. 14.

32 Rural Health Workforce Australia, *Submission 107*, p. 19.

incentive payments applied on equivalent basis for GPs and registrars practising in rural locations.³³ There are three main components within the GPRIP program:

- General Practitioner component: the general practitioner component of GPRIP aims to reward and retain long-serving general practitioners in rural and remote communities. Incentive payments are scaled according to location, length of medical service to rural communities, and clinical workload. Incentive payments can reach \$47 000 per year.³⁴
- Registrar Component: the registrar component of GPRIP provides incentive payments to General Practitioner Registrars on the rural or general pathway of the Australian General Practice Training program. Incentive payments are scaled according to location, length of time spent training in rural communities, and the percentage of full-time equivalence while on the training placement.³⁵
- Rural Relocation Incentive Grant (RRIG): the RRIG provides grants to GPs practising in rural and remote Australia. Incentive grants are calculated according to the location GPs relocate from and relocate to. The clinical workload following relocation is also a factor. The maximum available grant is \$120 000.³⁶

4.30 The Department of Health and Ageing reported that in 2010–11 more than 10 000 practitioners were assessed as eligible for incentives under the GPRIP program.³⁷ In the 2011–12 financial year, \$72.8 million was allocated to the program.

4.31 Rural Health Workforce Australia put it to the committee that the eligibility criteria for some programs in GPRIP are having a negative impact. For example, the committee heard that doctors working in a hospital rather than a private practice may be ineligible for relocation assistance.³⁸

4.32 In order to meet peak demand in regional communities as well as allow local doctors the chance to undertake professional development opportunities or simply have a holiday, the Rural GP Locum Program (RGPLP) commenced in 2009. The RGPLP provides support for rural general practitioners by assisting them in meeting

33 Rural Health Workforce Australia, *Submission 107*, p. 19.

34 Department of Human Services, *General Practitioner Component*, available from: <http://www.medicareaustralia.gov.au/provider/patients/rural-programs/general-practice/general-practitioner.jsp>, (accessed 19 July 2012).

35 Department of Human Services, *Registrar Component*, available from: <http://www.medicareaustralia.gov.au/provider/patients/rural-programs/general-practice/registrar.jsp>, (accessed 19 July 2012).

36 Department of Human Services, *Rural Relocation Incentive Grant*, available from: <http://www.medicareaustralia.gov.au/provider/patients/rural-programs/general-practice/relocation-incentive.jsp>, (accessed 19 July 2012).

37 Department of Health and Ageing, *Submission 74*, p. 11.

38 Rural Health Workforce Australia, *Submission 107*, pp 19–20.

locum costs.³⁹ The RGPLP was described by RHWA as being 'an efficient, effective, and sustainable, national service appreciated by locums, practices and rural communities.'⁴⁰

4.33 The Rural Procedural Grants Program (RPGP):

...provides financial assistance to general practitioners (GPs) who provide procedural or emergency medicine services in rural and remote areas. Grants can assist with the cost of skills maintenance and up-skilling training courses, including course costs, locum relief and travel expenses...The procedural GP component provides a grant for the cost of up to 10 days of training, to a total of \$20 000 per GP per financial year...The emergency medicine GP component provides a grant for the cost of up to three days of training, to a total of \$6000 per GP per financial year.⁴¹

4.34 The HECS Reimbursement Scheme reimburses standard HECS debts of medical students should they choose to train and work in rural and remote communities.⁴²

4.35 To encourage general practice medicine broadly, the Government funds the Practice Incentive Program (PIP).⁴³ The PIP comprises 13 incentives, including a number that have particular relevance for rural and regional practice. The Rural Loading incentive, which automatically applies to practices located outside major metropolitan centres, relates specifically to rural practice. Other elements of the PIP with relevance to rural practice include:

- The Procedural GP Payment that aims to encourage GPs in rural and remote areas to continue to provide surgical, anaesthetic and obstetric services locally in their communities; and
- The Afterhours Incentive Payment (AIP), from 1 July 2013 this funding will be redirected through Medicare Locals who will be responsible for the coordination of after hours services.⁴⁴

4.36 In the 2011–12 financial year, \$28.1 million was allocated to the PIP program, and \$9 million was allocated to the Procedural GP Payment.

39 Department of Health and Ageing, *Rural GP Locum Program*, available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-rgplp>, (accessed 6 July 2012).

40 Rural Health Workforce Australia, *Submission 107*, p. 17.

41 Department of Human Services, *Rural Procedural Grants Program*, available from: <http://www.medicareaustralia.gov.au/provider/patients/rural-programs/rural-procedural-grants.jsp>, (accessed 20 July 2012).

42 Department of Health and Ageing, *HECS Reimbursement Scheme*, available from: <http://www.health.gov.au/internet/main/publishing.nsf/content/work-pr-hecs>, (accessed 20 July 2012).

43 Rural Doctors Association of Australia, *Submission 67*, p. 13.

44 Rural Doctors Association of Australia, *Submission 67*, pp 13–14.

4.37 The committee heard that one of the biggest challenges facing rural practices is the cost of accommodating additional doctors, nurses and other allied health professionals. Limited practice infrastructure also limits teaching opportunities for students and the number of services that can be provided to the community.

4.38 In response to these challenges, the government provides grants to assist medical practices under Primary Care Infrastructure Grants program.⁴⁵ This is a scheme under the GP Super Clinics program that the government have spent \$118.5 million on since 2010 to 'upgrade and extend existing local general practices, primary care and community health services, and Aboriginal Medical Services to improve access to integrated GP and primary health care.'⁴⁶ The grants are made in one of three categories, up to \$150 000, up to \$300 000 and up to \$500 000.⁴⁷

Government-led initiatives to address the shortage of Allied Health Professionals and nurses in non-metropolitan areas

4.39 The committee repeatedly heard that there is insufficient effort put into encouraging allied health and nursing professionals to work in regional and rural areas. The Dietitians Association of Australia argued that:

Allied health is still at the bottom of the priority list and whilst significant steps have been made toward supporting doctors and to a lesser extent, nurses, the flow on to allied health has been minimal.⁴⁸

4.40 In the same vein, the Royal College of Nursing Australia (RCNA) noted:

There remains little evidence of incentives for other health professionals, for example nurses and midwives, to support them in the various roles across primary health care particularly in rural and remote areas.⁴⁹

4.41 It was argued by the Services for Australian Rural and Remote Allied Health (SARRAH) that inequality in accessing incentive programs could be addressed by allowing AHPs to access current programs available to support doctors:

The incentive programs for AHPs are very limited and in fact inequitable when compared to incentives available to doctors and dentists. For doctors and dentists there are a broad range of incentives such as: reimbursement of HECS fees, relocation expenses, family support, rural practice incentive retention bonus payments and support to set up new practices. These

45 Rural Doctors Association of Australia, *Submission 67*, p. 23.

46 Department of Health and Ageing, *GP Super Clinics, Primary Care Infrastructure Grants*, available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics-pcigg2010> (accessed 10 August 2012).

47 Department of Health and Ageing, *GP Super Clinics, Primary Care Infrastructure Grants*, available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics-pcigg2010> (accessed 10 August 2012).

48 Dietitians Association of Australia, *Submission 86*, p. [1].

49 Royal College of Nursing, Australia, *Submission 82*, p. 2.

incentives should be extended to AHPs which would assist with the recruitment and retention rates in rural and remote settings.⁵⁰

4.42 Many other stakeholders, such as the Australian Psychological Society and the Australian Physiotherapy Association (APA), called for the government to extend to AHPs and nurses similar incentive schemes as are presently available to other medical professionals.⁵¹

4.43 The APA's National President Ms Locke related to the committee a common frustration among allied health professionals working in regional areas:

The number of young physiotherapists who say to me, 'This is so unjust. Here I am in the country with my partner [a doctor] who is getting the HECS forgiveness and I am having to pay it, and I am not even earning as much as they are.' I think that is something that we really need to look at across the professions. If you want young people out there in the country then give them a reason to go out there, with their mates, with their partners.⁵²

4.44 It was argued by RHWA that extending the HECS Reimbursement Scheme would be a 'straightforward and very beneficial' way to increase AHPs in rural and remote areas.⁵³ Similarly, the National Rural Health Alliance argued that: '[W]e see no reason why HECS reimbursement should not be available to students of dentistry, and indeed allied health and nursing, as well as medicine.'⁵⁴

Initiatives to encourage allied health professions and nurses into rural areas

4.45 There are some Commonwealth government programs designed to increase the number of AHPs working in non-metropolitan areas. The committee was informed of the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) that encourages rural youth to train in a health profession supported by the provision of entry-level, post-graduate and clinical placement scholarships.⁵⁵

4.46 The Nursing and Allied Health Rural Locum Scheme (NAHRLS) commenced in mid-2011. As reported by the RCNA:

This opportunity aims to provide 750 nursing and midwifery locum placements and 100 allied health locum placements per annum. The placements enable nurses, midwives and eligible allied health professionals in rural areas to take leave to undertake continuing professional development activities and for organisations to back-fill their positions to

50 Services for Australian Rural and Remote Allied Health, *Submission 62*, p. 9.

51 Australian Psychological Society, *Submission 87*, p. 8; National Rural Health Alliance Inc., *Submission 95*, p. 3; Australian Physiotherapy Association, *Submission 71*, pp 5–7

52 Australian Physiotherapy Association, *Committee Hansard*, 5 June 2012, p. 55.

53 Rural Health Workforce Australia, *Submission 107*, p. 23; Australian Physiotherapy Association, *Submission 71*, p. 10.

54 Mr Gordon Gregory, National Rural Health Alliance, *Committee Hansard*, 11 May 2012, p. 26.

55 Services for Australian Rural and Remote Allied Health, *Submission 62*, p. 3.

support ongoing service delivery. It also enables interested nurses, midwives and eligible allied health professionals to experience rural practice through a locum placement.⁵⁶

4.47 It was also reported to the committee that the Pharmacy Guild of Australia manages several programs on behalf of the Department of Health and Ageing to improve the provision of pharmacy services in rural and remote Australia.⁵⁷

4.48 Although these initiatives for AHPs were welcomed by stakeholders, SARRAH expressed concern:

...over the lack of equity when these strategies are compared against the range and volume of programs available to doctors and nurses...For example, applications for the 2012 intake under the Allied Health Clinical Placement Scholarships Scheme, which we administer on behalf of the government, recently closed. For the 150 places under the scheme we had 1,046 applicants, of which 864 were eligible. This scheme encompasses all allied health professionals and targets settings across rural and remote Australia. So, basically we are saying that there are over 700 eligible applicants who were unable to take up a placement in rural and remote Australia. Given that there is a workforce shortage, it is not rocket science to work out one strategy that could be adopted.⁵⁸

Committee view

4.49 The evidence received by the committee shows a large disparity between the support provided for AHPs and that provided for doctors to work in non-metropolitan areas. The committee considers that this situation neither promotes access to quality healthcare in rural areas, nor does it take into account the requirements of team-based patient care.

4.50 The committee is of the belief that most of the existing support mechanisms available for medical specialists should also be available to AHPs and nurses. In particular the committee strongly supports the introduction of a HECS reimbursement scheme for nurses and AHPs for reasons of equity and incentive.

4.51 Given the extensive range of government programs and measures to address different aspects of rural health the committee thinks it would be beneficial if there was an office located within DoHA, similar to the Chief Nurse and Midwife, that would provide a strong voice within government on all issues relating to Australia's rural health workforce.

56 Royal College of Nursing, Australia, *Submission 82*, p. 2.

57 Pharmaceutical Society of Australia, *Submission 83*, pp 6–7.

58 Mr Rod Wellington, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 11 May 2012, p. 2.

Recommendation 5

4.52 The committee recommends that the HECS Reimbursement Scheme available for doctors be extended to nurses and allied health professionals relocating to rural and remote areas.

Recommendation 6

4.53 The committee recommends that the post of Rural and Regional Allied Health Adviser be established within Rural and Regional Health Australia to coordinate and advise on allied health service provision in rural and regional Australia.

Telemedicine

4.54 The delivery of health services through telemedicine is an area that is being explored more and more by government, education providers, health care delivery services and the public as technology evolves. The introduction of the e-health legislation⁵⁹ and the improvements in internet access across the country have the potential to significantly impact the delivery of health services in rural areas.

4.55 The National Rural Health Alliance (NRHA) consider that the 'notion of a universal health service obligation approach to the planning and delivery of health services' is impractical and suggest instead that telehealth, together with other initiatives would provide more effective care:

...there is some enthusiasm for the notion of a universal health service obligation approach to the planning and delivery of health services, described more colloquially as an agreed basket of services appropriate for different communities. In our supplementary submission, we place on record the reasons why the alliance believe this to be an impractical approach. We seek an appropriate balance of local core services, supported by outreach, telehealth and patient's travel assistance, but effective primary or community care services in rural and remote areas can and should take many shapes.⁶⁰

4.56 The role that telephone and video communication can play in assisting health professionals to deliver care to remote areas was also raised by a representative of CRANApplus:

The implication for supporting the health professionals and the opportunities to build on models of health care that are not in the tradition of GP models need to be considered in the best interests of these remote communities. We would like these models to receive greater acknowledgement as they work well, with highly skilled staff who work collaboratively with their health professional colleagues through telephone

59 eHealth, *What is eHealth?*, <http://www.ehealthinfo.gov.au> (accessed 14 August 2012).

60 Mr Gordon Gregory, Executive Director, National Rural Health Alliance, *Committee Hansard*, 11 May 2012, p. 24.

and video communication in spite of the fact of being inequitably supported.⁶¹

4.57 The Clinical Oncological Society of Australia explained that more resources and investment in technology are needed and that e-health and telemedicine can be used to deliver services:

We need to invest in technology. We can deliver care through e-health, through telemedicine. We do not have to do fly in, fly out all the time; there are actually other ways of doing that. But that requires resources and it requires addressing the very basics—somebody to organise a phone call, something to bring the case notes. It is often the weakest link that deserves most attention.⁶²

4.58 Professor Richard Murray, Dean of Medicine and Dentistry at James Cook University described the new services that may be able to be provided through new technologies. Professor Murray also explained to the committee how the use of telemedicine provides local health workers with support and skills:

...there are new technologies—telehealth, for instance. We have lovely examples here. Tele-oncology, for instance, is able to not only provide outreach but skill up the locals so that then the locals can do a lot of the work themselves—without, necessarily, a piece of paper but because of their relationship with GPs, nurses and others in Mount Isa and elsewhere—and the oncologist does not have to visit every week and we do not have to bring the patients in. So those models of telehealth are about strengthening, securing and enhancing skills of people on the ground...⁶³

4.59 The Queensland Alliance for Mental Health (QAMH) went further, explaining that the reality of rural and remote settings requires the use of telehealth:

The reality in mental health services in rural and remote settings is that it must be a partnership between the generalist health care providers and the community agencies, supported by a range of specialist options, including telehealth outreach services and emergency transport evacuation, which can be provided by such groups as the Royal Flying Doctor Service. This is supported in an article, 'Improving the skills of rural and remote generalists to manage mental health emergencies', in *Rural and Remote Health*.⁶⁴

4.60 The QAMH went on to inform the committee of a recent report into mental health service delivery in rural and remote areas of Queensland which identified benefits could be obtained from the use of telemedicine:

61 Ms Gerardine Malone, National Coordinator of Professional Services, CRANaplus, *Committee Hansard*, 11 May 2012, pp 39–40.

62 Professor Bogda Koczwara, President, Clinical Oncological Society of Australia, *Committee Hansard*, 11 May 2012, p. 47.

63 Professor Richard Murray, Dean of Medicine and Dentistry, Faculty of Medicine, Health and Molecular Sciences, James Cook University, *Committee Hansard*, 23 April 2012, pp. 7–8.

64 Ms Catherine O'Toole, State President, Queensland Alliance for Mental Health, *Committee Hansard*, 23 April 2012, p. 28.

The Australasian Centre for Rural and Remote Mental Health report, A framework for mental health service delivery in rural and remote Queensland: a literature review analysing models of treatment options, argues that the GP is most often the centre of care. However, links between GPs and local community services, including the mental health community services, require development and support. This probably goes to the heart of the fact that GPs are actually running businesses, so their focus in the world is slightly different. But that is not to say that GPs would not be interested to see what is happening in their community and how they can use those community initiatives.

Co-occurrence of substance abuse and mental ill health is a particular problem in rural and remote areas, particularly in Indigenous communities. Key issues include the relationship between localised and generalised care options and access to specialist psychiatric secondary services. Developing both parts of the equation requires a different funding and policy setting which nonetheless should be integrated as part of the rural mental health strategy. This report indicates that there have been some favourable findings resulting from the use of telepsychiatric, tele mental health and video conferencing.⁶⁵

4.61 Ms Aileen Colley, Mental Health Services Director of the Townsville/Mackay Medicare Local, like the QAMH, sees telemedicine as an important supplementary service delivery mechanism for rural and remote areas:

To increase the health workforce in rural areas there needs to be incentive payments for nurses and allied health professionals, but there also needs to be other strategies for education, training, mentoring, orientating people to the rural community, housing and the use of telemedicine.⁶⁶

4.62 Dental Health Services Victoria also spoke of the opportunities for training and ongoing learning that telemedicine technology can provide:

...it is fairly clear that there is the lack of support, including from a community point of view... It is also about the professional support—not having access to going off to a lecture in your professional area. So I think a lot of opportunities exist for potentially using innovative e-learning opportunities or teledentistry, I suppose, to help support those practitioners.⁶⁷

4.63 On this theme of using technology to assist in the delivery of ongoing professional development for health practitioners the Rural Health Education Foundation established the Rural Health TV Channel to be broadcast on the new Viewer Access Satellite Television (VAST) platform. This platform 'provide[s] digital

65 Ms Catherine O'Toole, State President, Queensland Alliance for Mental Health, *Committee Hansard*, 23 April 2012, p. 29.

66 Ms Aileen Colley, Mental Health Services Director, Townsville/Mackay Medicare Local, *Committee Hansard*, 23 April 2012, p. 36.

67 Dr Deborah Cole, Chief Executive Officer, Dental Health Services Victoria, *Committee Hansard*, 5 June 2012, p. 47.

TV to people who cannot receive terrestrial digital television and currently reach[es] 75,000 households.'⁶⁸ The Foundation stated in their submission that TV is very effective because the internet in rural areas still has its limitations:

Access to the internet is improving however it is still unreliable and intermittent in rural areas, with slow download speeds meaning that webstreaming is often not feasible due to buffering issues.⁶⁹

Committee View

4.64 The committee considers the expansion of eHealth and telemedicine to be an opportunity to supplement health care delivery across Australia, with particular relevance to rural and remote areas. It should not be considered as a replacement for personally delivered primary health. It has the potential to improve training, access to specialist advice and professional development and will be key in future health care delivery. However it will need to be coordinated with current management systems and agencies such as Medicare to ensure that remuneration as appropriate is delivered, and its potential is realised.

Up-skilling the existing workforce

Nurse Practitioners

4.65 It has been previously noted that in some cases communities lack the population and infrastructure to support specialised practices, and that the existing workforce in non-metropolitan areas is frequently overworked. One way that has been suggested to try and overcome this is by broadening the scope of skills and competencies of the existing workforce, particularly though the nurse practitioner model.

4.66 Proposals to change the scope of responsibilities of various professions are almost always controversial.⁷⁰ However, the policy of changing traditional workforce roles to meet new requirements is not without precedent. The Productivity Commission concluded that the shortage of medical practitioners in rural areas was one of the factors that led to the development of nurse practitioners.⁷¹ This development has been positively received by patients:

Consumers were positive about consulting nurse practitioners for primary health care and felt that they would consult nurse practitioners about more minor illnesses and injuries and reproductive concerns, such as pregnancy

68 Rural Health Education Foundation, *Submission 127*, p. 2.

69 Rural Health Education Foundation, *Submission 127*, p. 2.

70 Productivity Commission, *Australia's Health Workforce*, Canberra, December 2005, pp 249–66.

71 Productivity Commission, *Australia's Health Workforce*, Canberra, December 2005, p. 215.

testing and emergency contraception, and consult GPs about more serious clinical problems.⁷²

4.67 Another change has been the growth of the practice nurse workforce following the 2001-2002 Federal Budget, which provided funding for rural practices to assist with employment of practice nurses. In 2007 a national survey of practice nurses estimated that 57 per cent of practices employed a practice nurse, up from 40 per cent in 2003.⁷³ Research completed at the Australian National University reported high levels of patient satisfaction with the use of practice nurses:

Respondents who care for young children and those aged over 65 years overwhelmingly supported the use of nurses within a primary health-care setting; most said they would be willing to visit a trained nurse instead of the GP...⁷⁴

4.68 The committee heard that there is a poor level of general knowledge within the medical community regarding the scope of practice of nurse practitioners and the role they may play in providing treatment.⁷⁵ However, the committee received evidence that medical professionals are becoming more aware of the expanded role of nurses and the positive impact this can have, with RHWA relating an example of a rural doctor who was initially sceptical about extending the traditional scope of practice of nurses:

...but he has changed, as has his ability to manage his patients because now the nurse in his practice is doing all the diabetes education and she is doing the haemoglobin testing. Approaching that multidisciplinary teamwork together has actually been in the best interests for his patients and he is a lot less stressed.⁷⁶

4.69 While acknowledging the progress that has already been made in expanding the role of nurses through the development of nurse practitioners, RCNA argued that further improvements could be made:

The decision to provide nurse practitioners and eligible midwives access to Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme

72 R.M. Parker, L.E. Forrest, J. Desborough, I. McRae, & T. Boyland, *Independent evaluation of the nurse-led ACT Health Walk-in Centre*, Australian Primary Health Care Research Institute, Canberra, 2011, p. 9.

73 Australian General Practice Network. *National practice nurse workforce survey report 2009*. AGPN, Canberra, 2010; Australian General Practice Network. *National practice nurse workforce survey report 2007*. AGPN, Canberra, 2008; Australian General Practice Network. *National practice nurse workforce survey report 2003*. AGPN, Canberra, 2004.

74 C. Godden, K. Dwan, J. Derret, D. Cox, 'What practice nurses do and what consumers are willing to let them do: an online survey of ACT health care consumers' *Health Issues*, 2010 Spring; (104), pp 32–3.

75 Ms Gerardine Malone, Royal College of Nursing Australia, *Committee Hansard*, 11 May 2012, p. 43.

76 Ms Melissa Cameron, Rural Health Workforce Australia, *Committee Hansard*, 11 June 2012, p. 29.

(PBS) is a strong step in this direction but does not go far enough. New MBS and PBS arrangements for nurses and midwives should not be limited by regulations that tie nurses and midwives to medical practitioners or other unnecessary restrictions that potentially limit public access to their services.⁷⁷

Other health professionals

4.70 The Pharmaceutical Society of Australia also supported initiatives to improve the scope of work of pharmacy technicians under certain circumstances and noted one possible way of improving the provision of pharmacy services to otherwise underserved communities:

Allowing appropriately credentialed pharmacy technicians at remote depots/outstations to provide Pharmacy Only Medicines and dispense Prescription Only Medicines under a pharmacist's supervision through video conference or similar technology such as telepharmacy.⁷⁸

4.71 More commonly however, professional associations opposed attempts to alleviate the skills shortage though the reallocation of responsibilities among the health workforce. For example, the Australian Psychological Society argued that:

Allowing generalist healthcare workers, who are not qualified or registered psychologists, to perform duties outside their area of qualification or specialisation and provide psychological services would also carry the risk of a lowering of standards of care...Psychologists have something unique to offer over and above generic health workers.⁷⁹

4.72 Similarly, the Australian Dental Association argued that increasing the scope of allied dental personnel would not solve the rural medical skills shortage, as there is already a shortage of allied dental personnel. It would also 'detract them from performing their primary function, which is to ensure there is adequate oral health promotion and dental disease prevention within the community.'⁸⁰

4.73 This view was not fully supported by Dental Health Services Victoria's Chief Executive Officer Dr Deborah Cole who told the committee:

Oral health therapists – I include in that dental therapists and dental hygienists – have huge opportunities to provide opportunities in rural communities et cetera. With expanded scope of practice and training to allow them to work to their full scope of practice, which a lot of people do not have the opportunity to do, that is a huge workforce opportunity that is untapped at the moment.⁸¹

77 Royal College of Nursing Australia, *Submission 82*, p. 3.

78 Pharmaceutical Society of Australia, *Submission 83*, p. 4.

79 Australian Psychological Society, *Submission 87*, p. 11.

80 Australian Dental Association, *Submission 73*, p. 7.

81 Dr Deborah Cole, Dental Health Services Victoria, *Committee Hansard*, 11 June 2012, p. 49.

Committee view

4.74 The committee recognises that any reallocation of professional responsibilities will be contentious, and may encounter strong opposition from some groups. However, the committee did not receive any evidence against equipping the existing workforce to as high a level as possible. Furthermore, it is aware of evaluations showing that professionals and patient have been supportive of such initiatives.

Proposals from the Australian Medical Association (AMA)

4.75 The AMA supports moves to make rural practice more attractive by reinvigorating rural generalism to make it a viable option for trainees coming through the system. The AMA has been active for a number of years in attempts to address the issues in rural health delivery. In 2005 they released a *Rural and Regional Workforce Initiatives Position Statement* which contained a number of measures that would address rural workforce shortages and skills gaps. In 2007 they collaborated with the RDAA to develop the Rural Workforce Rescue Package. This package proposes:

...that a two tier incentive package be introduced for rural doctors. The first tier is designed to encourage more doctors to work in rural areas including GPs, other specialists and registrars. It takes into account the greater isolation involved with rural practice.

...

The second tier is aimed at boosting the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills. Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate local services including on call emergency services.⁸²

4.76 The AMA recommends in its current submission that increased funding would meet many of the challenges the workforce currently faces. The list below highlights the areas in need of increased funding according to the AMA:

- increase state and federal funding for rural generalist positions and rural specialist infrastructure;
- improved level of remuneration for generalists to encourage generalist practice, including the removal of anomalies in the MBS that reward sub-specialisation over generalism;
- simplification of the structure of Medicare GP consultation items and improve funding for these, backed by appropriate indexation arrangements;
- the Commonwealth Government makes available more funding for PCIG and NRRHIPF to enhance the infrastructure of existing general practices and their capacity to deliver a broad range of medical services and quality patient care;

82 Australian Medical Association, *Submission 42*, Attachment 1, p. 2.

- adequate compensation, support and access to re-training for spouses;
- school fee assistance to maintain a child in a larger town or city centre;
- expand existing funding for locum services.⁸³

4.77 Other non-direct funding proposals from the AMA include:

- That the status of generalism be elevated and greater exposure to generalist practice during undergraduate medical be facilitated;
- That vocational training models be developed that encourage more generalist careers;
- That the Rural Rescue Package developed by the AMA and the Rural Doctors Association of Australia be adopted;
- Before withdrawing or rationing public hospital services, all layers of Government should conduct a public interest test to ensure that communities are not denied reasonable access to services;
- That the Government works with stakeholders to develop an improved legal framework to underpin more viable rostering arrangements, which include reasonable agreement about what fees should be charged to encourage doctors to cooperate in order to provide their local community with better access to round the clock healthcare;
- A new Medicare provider system be established under which medical practitioners retain a single provider number and each practice location in Australia receives a location specific number.⁸⁴

Rural Doctors Association of Australia

4.78 The RDAA had a specific proposal that would allow a doctor to retain the incentive they receive for working in a rural area for a certain period after they leave. Their suggestion was to provide an incentive payment through as an MBS item which they would receive for five years while working in the rural area, and could retain for a further five years after they left a rural area. Dr Mara explained it in further detail:

Our preferred option is to have a separate item number which is non-rebatable, which is capped to control your investment, which is gradually implemented in areas of greatest needs where, every time a doctor provides a service in general practice in order to encourage that continuity, they get an extra incentive payment automatically paid. Ideally, after a period of time, say, five years they are able to carry that incentive if they want to go back to the city. That would provide a very, very visual transparent, explicit incentive, and they can take that back with them. So if they are in Gundagai for five years, they take that incentive back with them at the end of that five years for five years into wherever they want to practise after that. That is what we need.⁸⁵

83 Australian Medical Association, *Submission 42*, pp 1–7.

84 Australian Medical Association, *Submission 42*, pp 1–7.

85 Dr Paul Mara, RDAA, *Committee Hansard*, 11 May 2012, p. 20.

Community led initiatives

4.79 Individual communities have also attempted to encourage GPs into their communities by reducing the administrative and fiscal burdens on GPs. Dr Hambleton explained the potential disincentive represented by having to establish a private practice:

A doctor thinks, 'It is five years in the bush; maybe I will buy a practice and set it up. But then in five years I'll have invested all this money and I'll be stuck.' So they will not go there in the first place...If you have to own a house and own the practice people might not go there in the first place.⁸⁶

4.80 In order to overcome this, the 'Easy Entry, Gracious Exit' model was developed wherein a not-for-profit entity is contracted to provide practice infrastructure and support staff for GPs so they can focus on patients rather than the business.⁸⁷ Dr Hambleton elaborated on the mechanisms of such a scheme:

It can be a state government or it can be a local council. There are businesses that offer the same corporate type of structure. If there are a few partners you do not have to buy into the practice to work there. They can make rooms available.⁸⁸

4.81 The committee heard of successful programs designed to address some of the personal barriers faced by workers moving to a new community. For example, a program in the Albury-Wodonga region aimed at overcoming many of the personal barriers faced by professionals relocating to rural areas:

[T]he thing that attracts people is not the medicine, because that is much the same; it would be the social life. We find that the partner is more important than the doctor. So we arrange for the partner to be shown the schools, the shops, the university and the sporting facilities. We make a lot of effort...to make them feel they are welcome. We have barbecues; we invite them to homes and have dinners. That has worked very, very well.⁸⁹

The efficacy of efforts to increase the rural health workforce

4.82 The committee received scant evidence of the efficacy of many programs that have been implemented with the stated objective of improving the quantity and quality of the rural health workforce.

4.83 Although some programs appear to have been very successful in meeting their objectives, such as the 10-year moratorium for OTDs, the outcome of many other programs is far less clear. It was noted by the Productivity Commission that:

86 Dr Steve Hambleton, Australian Medical Association, *Committee Hansard*, 11 May 2012, pp 66–67.

87 Productivity Commission, *Australia's Health Workforce*, Canberra, December 2005, pp 214, 226.

88 Dr Steve Hambleton, Australian Medical Association, *Committee Hansard*, 11 May 2012, p. 66.

89 Dr Pieter Mourik, private capacity, *Committee Hansard*, 5 June 2012, p. 58.

...when evaluation does occur, it is usually limited to an assessment of whether a particular program has led to an improvement in targeted workforce outcomes, and does not consider whether it is more or less effective than other approaches for pursuing these outcomes...the lack of rigorous cross program evaluation means that there is still considerable uncertainty about which *broad* approaches are the most efficient and effective for improving health workforce outcomes in rural and remote areas.⁹⁰

4.84 Charles Sturt University (CSU) similarly argued that there is insufficient evidence available to assess the efficacy of existing programs:

The University is not aware of any consolidated or reliable reports on public expenditure on rural health and workforce programs that would enable effective evaluation programs and public accountability to rural communities with respect to performance and expenditure. Information on the goals, performance and funding of rural health and workforce programs highly fragmented and difficult to access in a consistent form for researchers, let alone by [members] of rural communities who wish to independently assess whether programs are achieving articulated goals.⁹¹

4.85 Based on the evidence that is available, CSU contends that: 'there is little data to suggest that any initiatives have significantly improved the flow of Australian trained doctors to rural and remote communities.'⁹² This view was echoed by Professor Humphreys: 'to date there is little quantitative evidence of the effectiveness of workforce incentives in redressing the situation.'⁹³

4.86 According to Professor Humphreys part of the responsibility for the lack of evaluation lies with the Department of Health and Ageing:

[E]valuation by the Department of Health and Ageing is notoriously bad. It is always an after-the-event situation done by a consultant. Good evaluation really starts with the program to establish the baseline figures – so what it is like before you implement a program and whether you can monitor it along the way.⁹⁴

4.87 Professor Humphreys went on to relate his own experience working as a evaluation consultant for the Department of Health and Ageing:

We have battled desperately with this issue of trying to get good evaluation data. We had this nonsensical situation where, in one of the projects that we

90 Productivity Commission, *Australia's Health Workforce*, Canberra, December 2005, p. 238.

91 Charles Sturt University, answer to question on notice, 5 June 2012 (received 29 June 2012), p. [8].

92 Charles Sturt University, answer to question on notice, 5 June 2012 (received 29 June 2012), p. [10].

93 Professor John Humphreys, Centre of Research Excellence in Rural and Remote Primary Health Care, *Committee Hansard*, 5 June 2012, p. 16.

94 Professor John Humphreys, Centre of Research Excellence in Rural and Remote Primary Health Care, *Committee Hansard*, 5 June 2012, p. 21.

were doing which was funded through the Department of Health and Ageing, we had to use part of the money to go through freedom of information to get a document that the department had – the results of an evaluation it had conducted – as part of the building blocks. That is the kind of nonsensical kind of secrecy that goes on in terms of the way consultancies are done.⁹⁵

4.88 Part of the problem with assessing the effectiveness of programs stems from a lack of understanding of existing workforce characteristics, preferences and community needs. It was reported to the committee that evidence available on the factors which influence medical professionals' and AHP's decisions to work in a rural area is 'slender' and in need of urgent updating.⁹⁶ One of the key findings of the *Audit of Health Workforce in Rural and Regional Australia* was that there had been a reliance on 17-year old population figures in developing rural workforce policies.⁹⁷ Given the lack of evidence indicating the causal factors which determine a person's decision to move to non-metropolitan areas as well as uncertainty regarding the efficacy of existing programs, there is a significant need to assess the efficacy of existing programs.⁹⁸

4.89 In 2003 the RDAA completed a study – funded by the Commonwealth government – entitled *The Viable Models of Rural and Remote Practice Project*. The study found that grants and other incentives ranked well down on the list of factors for improving workforce recruitment and retention. Improved remuneration through explicit and transparent Medicare rebates that provide financial incentives to regional doctors was argued to be the most effective way to achieve better remuneration.⁹⁹ However, as was discussed earlier in this chapter, the majority of incentives still take the form of grants and other incentives.

Committee view

4.90 The government is spending a significant amount of money to try and ensure adequate health services in regional Australia. The evidence provided to the committee during the course of this inquiry has highlighted deficiencies in the development and evaluation of these programs. There is an urgent and fundamental need to better understand what programs have been effective and therefore where energy and resources need to be applied.

4.91 New programs should include an evaluation strategy that will allow both assessment of the programs' impact and the creation of information needed to compare cost effectiveness with other initiatives. The government should be prepared to redirect funds from less cost effective programs to the more effective ones, but at

95 Professor John Humphreys, Centre of Research Excellence in Rural and Remote Primary Health Care, *Committee Hansard*, 5 June 2012, pp 21–22.

96 National Rural Health Alliance Inc., *Submission 95*, p. 12.

97 Department of Health and Ageing, *Submission 74*, p. 7.

98 National Rural Health Alliance Inc., *Submission 95*, p. 12.

99 Rural Doctors Association of Australia, *Submission 67*, p. 10.

present it appears difficult to establish which initiatives offer the best value for money for meeting the needs of regional healthcare patients.

4.92 The committee acknowledges the excellent work of the House of Representatives Standing Committee on Health and Ageing, in its report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, tabled in March 2012. Based on the evidence this committee has received, it draws particular attention to the House committee chair's comments in his foreword:

However, it is clear that whilst [International Medical Graduates] IMGs generally have very strong community support, they do not always receive the same level of support from the institutions and agencies that accredit and register them...

[There were] a significant proportion of witnesses describing a system lacking in efficiency and accountability, and importantly, one in which IMGs themselves often had little confidence. Many IMGs also felt that they had been the subject of discrimination, and anti-competitive practices and that this had in some cases adversely affected their success in registering for medical practice in their chosen speciality.¹⁰⁰

4.93 This committee wishes to put on the record its recognition of the work that overseas trained doctors are performing, particularly in regional Australia.

Recommendation 7

4.94 The committee endorses the House of Representatives Standing Committee on Health and Ageing's report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors* and recommends that the Commonwealth Government accept and implement the recommendations contained therein.

100 House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, pp ix–xi.

Chapter 5

Australian Standard Geographical Classification for Remoteness Areas

Introduction

5.1 The Department of Health and Ageing provides incentive payments to doctors based on the geographic area they work in. The greater the relative remoteness of that area, the greater incentive payment they will receive. This chapter discusses how incentive payments are determined and paid to doctors working outside metropolitan areas.

5.2 In order to determine remoteness, the Department of Health and Ageing uses a remoteness classification structure developed by the Australian Bureau of Statistics (ABS), called the Australian Standard Geographical Classification—Remoteness Areas (ASGC-RA). The terms of reference ask the committee to inquire whether this system 'ensures appropriate distribution of funds and delivers intended outcomes.'

5.3 To address this question, the committee first considers geographical classification systems developed and used by the ABS more generally. It then sets out how the Department of Health and Ageing applies the ASGC-RA to determine payments for GPs working outside metropolitan areas. In the second part of this chapter, the committee examines the arguments presented in relation to whether the current structure of incentive payments delivers intended outcomes. The committee concludes that while the ASGC-RA measure is a useful tool to determine remoteness, better outcomes may be achieved if it were overlaid with other measures rather than as the sole determinant of incentive payments.

Need for a geographical statistical classification system

5.4 The ABS developed and uses a geographical classification system for its statistics for two main reasons. The first and most important reason is that such a system helps the ABS provide accurate, representative data to decision makers (an output need). The second reason is that a geographical classification system makes it easier for the ABS to label and use the statistics it collects (an input need).

Statistical output need

5.5 The ABS's role is to provide decision makers with a statistical service. In doing so, it collects and releases survey data. The ABS collects an enormous amount of data, from everyone in Australia in *Census of Population and Housing* (the census) years, and from samples of people at other times. The ABS is often asked to provide data that reflects the characteristics of people across Australia, or in a particular area of Australia. For example, decision makers in government might want to know the age range of people who live and work in a particular place, so they can decide if there should be a school built in the area.

5.6 The ABS needs to be sure that its data is labelled appropriately by location to accurately represent the statistical characteristics of people who live in Australia, or

who live in a specific part of Australia. Decision makers need to develop policy responses based on accurate information about the different characteristics of people living in different areas of the country. The ABS uses a geographical classification system so it can provide decision makers with data that is representative of whichever small or large area of Australia they need to know about.

Statistical input needs

5.7 As well as providing accurate, representative statistics to decision makers, the ABS also needs a system to help it collect and use its own data. For example, the ABS adopted a geographical classification system that has a hierarchical structure. This is efficient for the ABS because a hierarchical structure allows data about small areas to be added together to produce data about large areas. Another benefit of a uniform classification system using numerical data is that it can be integrated into current computer systems.

5.8 In addition, the ABS has certain privacy responsibilities. The ABS is authorised to collect data under the *Census and Statistics Act 1905*, but it must do so in compliance with the *Privacy Act 1988*.¹ This means that the ABS does not ask people to identify themselves and provide their address on surveys, or allow individuals to be otherwise identified. Instead, the smallest unit in the ABS's geographical classification system is especially designed to maximise accuracy about where a person lives while ensuring the privacy of individuals.

Geographical classification systems

5.9 Other organisations use geographical classification systems as well as the ABS. More familiar systems of spatial categorisation include state and territory boundaries, postcodes, electoral divisions and suburbs. These systems each have a specific purpose, for example, postcodes were introduced by the Postmaster General's Department (now Australia Post) to make its own job of mail routing easier.

5.10 Like Australia Post, the ABS has its own geographical classification system. The latest iteration is the Australian Statistical Geographical Standard (ASGS). The ASGS is a new system which the ABS began to progressively release and use from 1 July 2011.² The ASGS supersedes the older Australian Standard Geographical Classification (ASGC). The ABS notes that there are significant differences between the two classification systems,³ which the committee will discuss later in this chapter.

1 Office of the Australian Information Commissioner, *Your Privacy Rights FAQs*, <http://www.privacy.gov.au/faq/individuals/q16>, (accessed 11 April 2012).

2 Australian Bureau of Statistics, *Australian Statistical Geography Standard (ASGS): Volume 1 – Main Structure and Greater Capital City Statistical Areas, July 2011*, <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/0A9EA8C0BC932712CA257801000C6478?opendocument>, 2010, p. 1 (accessed 11 April 2012).

3 Australian Bureau of Statistics, *Australian Statistical Geography Standard (ASGS): Volume 1 – Main Structure and Greater Capital City Statistical Areas, July 2011*, <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/0A9EA8C0BC932712CA257801000C6478?opendocument>, 2010, p. 1 (accessed 11 April 2012).

5.11 The last part of the ASGS to be released will be the Remoteness Area Structure, due in December 2012. The ASGC Remoteness Area (ASGC-RA) Structure has been used by the Department of Health and Ageing to determine incentive payments for doctors since 1 July 2010⁴. The Department previously used the Rural, Remote and Metropolitan Areas (RRMA) system to determine remoteness.

Australian Standard Geographical Classification–Remoteness Area

5.12 The ASGC was developed by the ABS in 1985, and underwent significant change following a review of statistical geography in 1990.⁵ The Remoteness Area structure, which classifies Australian locations according to their relative remoteness, was added in 2001. The ABS had previously used just two labels to describe remoteness, 'regional' and 'urban'.

5.13 The ASGC-RA includes six categories, of which five are relevant⁶ to this chapter:

- Major Cities of Australia (RA-1);
- Inner Regional Australia (RA-2);
- Outer Regional Australia (RA-3);
- Remote Australia (RA-4); and
- Very Remote Australia (RA-5).

5.14 In developing the ASGC-RA, the ABS considered similar work being undertaken by the University of Adelaide's National Centre for Social Applications of Geographic Information Science (GISCA).

ARIA

5.15 In 1998, the then Department of Health and Aged Care engaged GISCA to develop a remoteness index to compare relative access to services. The result was the release of the Accessibility/Remoteness Index of Australia (ARIA) in 1999.

5.16 ARIA is another system that gives each location in Australia a code. Similar to other systems, it has changed over time. The first version of ARIA was applied to data from the 2001 Census. Some improvements were made in the next version, ARIA Plus (ARIA+), which applies to data from the 2006 Census. A new version, ARIA++, will be used for 2011 Census data.

4 Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 68.

5 Australian Bureau of Statistics, *1216.0 - Australian Standard Geographical Classification (ASGC)*, [http://www.ausstats.abs.gov.au/ausstats/free.nsf/0/CEDCA4A828C5BFEBCA25722500049188/\\$File/12160_1994.pdf](http://www.ausstats.abs.gov.au/ausstats/free.nsf/0/CEDCA4A828C5BFEBCA25722500049188/$File/12160_1994.pdf)

6 The sixth category, 'Migratory', is not relevant to this chapter. It is used to describe people who were in transit on Census night.

ARIA+

5.17 At the time of writing, the current version is ARIA+. The process for determining a given location's ARIA+ code has three key steps:

- First, Australia is divided into areas of one square kilometre each;
- Second, the road distance to the closest service centre⁷ from each of those square kilometre areas is measured on a map;
- Third, this road distance is translated into a score between 0 and 15⁸ according to two rules:
 1. The greater the road distance to the service centre, the higher the score. For example, an area 80km from Melbourne would be classified with a higher remoteness score than an area 10km from Melbourne.
 2. The smaller the closest service centre, the higher the score. GISCA identifies five⁹ different sizes of service centres based on population. (For example, if one kilometre square area was located 10km from Melbourne and another area was 10km from Sale, the area 10km from Sale would be classified with a higher remoteness score because Sale has a smaller population than Melbourne).¹⁰

5.18 The above rules are applied by GISCA in a uniform manner to produce an ARIA+ score for each square kilometre in Australia between 0 (high accessibility of services) and 15 (high remoteness from services).¹¹

Development of ASGC-RA

5.19 The ABS considered the ARIA system and decided to incorporate some, but not all, of its components into the ASGC-RA. Like ARIA, the ASGC-RA determined

7 **Service Centres** - are populated localities where the population is greater than 1000 persons (greater than 200 in the case of ARIA++). The Urban Centre/Locality Structure of the 2001 ASGC has been used to define the areal extent and population of these areas. The ARIA+ analysis considers about 730 services centres in determining remoteness values across Australia. These service centres are a subset of the 11,879 populated localities. In instances where the ABS defined Urban Centres are split by a state boarder, such as in the case of Albury and Wodonga, the population and spatial extents for each of these Urban Centres have been combined and treated as one service centre. (Further information on Service Centre Categories is available at http://www.adelaide.edu.au/apmrc/research/projects/category/about_aria.html (accessed 25 July 2012).

8 This was 0 and 12 in the original ARIA.

9 There were only four different sized urban centres in the original ARIA.

10 University of Adelaide, 2011, *ARIA and Accessibility*, <http://www.adelaide.edu.au/apmrc/research/projects/category/aria.htm> (accessed 11 April 2012).

11 University of Adelaide, 2011, *ARIA and Accessibility*, <http://www.adelaide.edu.au/apmrc/research/projects/category/aria.htm> (accessed 11 April 2012).

remoteness based on road distance to an urban centre. However, the ABS decided that five primary categories (rather than 16) were sufficient to its remoteness categorisation needs. It also made other changes:

When developing the ASGC Remoteness classification, the ABS incorporated some fundamental adaptations to the original ARIA. The ABS:

- adopted ARIA Plus rather than the original ARIA to reflect the impact on remoteness of small centres with population between 1,000 and 5,000;
- did not adopt the original classes of remoteness recommended by GISCA and DH&AC [Department of Health and Aged Care]; and
- excluded all reference to 'accessibility' because some experts in the field had a particular view on the meaning of the word 'accessibility'.¹²

5.20 When asked specifically why they did not adopt the original classes recommended by GISCA and the Department of Health the ABS responded:

The class ranges recommended by GISCA/DH&AC were not adopted because their Highly Accessible class groups at least part of what some people call 'regional' Australia with the larger capital cities. While there is no single understanding of what 'regional' means, it is obvious that it does not include these very large urban concentrations. While the new Remoteness Structure does not attempt to define 'regional', ABS has chosen classes of Remoteness which are broadly compatible with at least one common interpretation of 'regional'.¹³

5.21 To convert the 15 ARIA categories into five remoteness scores, the ABS averaged the kilometre square ARIA scores into larger areas. The smallest area in the ASGC Main Structure was a Census Collection District (CD). First, the ABS found the average ARIA score of each CD. Second, the ABS considered how the CDs could best be fit into five remoteness categories. In doing so, the ABS sought to produce a classification system that showed comparative remoteness. It was not seeking to produce a classification system that was necessarily evenly spaced:

[T]he ASGC Remoteness classification groups locations together into comparative classes of remoteness so that data can be collected, analysed and disseminated for broad regions which are more or less remote. Locations within a given remoteness class are not necessarily equally remote but those in the Very Remote Australia class should be more remote than those in the Remote Australia class, etc...

12 Australian Bureau of Statistics, *ASGC Remoteness Classification: Use and Purpose*, [http://www.abs.gov.au/Websitedbs/D3110122.NSF/4a255eef008309e44a255eef00061e57/f9c96fb635cce780ca256d420005dc02/\\$FILE/Remoteness_Paper_text_final.pdf](http://www.abs.gov.au/Websitedbs/D3110122.NSF/4a255eef008309e44a255eef00061e57/f9c96fb635cce780ca256d420005dc02/$FILE/Remoteness_Paper_text_final.pdf), 2001, p. 3. (accessed 11 April 2012).

13 Australian Bureau of Statistics, answer to question on notice, 11 May 2012 (received 31 May 2012).

The break points between classes at the remote end of the spectrum were chosen largely based on the following criteria:

- Contiguity. An attempt was made to minimise discontinuities in the boundaries of regions.
- Broad agreement with the Rural Remote and Metropolitan Areas (RRMA) classification. While the ASGC Remoteness classification is conceptually different to RRMA and there is no direct concordance between the two, break points were chosen which generally recognised differences between areas previously identified in RRMA. For example both classifications single out areas in the south west of Western Australia, western Victoria and far eastern Victoria as being more remote than adjacent areas.
- Minimum population. An assumption was made that Very Remote Australia should encompass approximately the most remote 1 per cent of the population and that Remote Australia and Very Remote Australia together should represent approximately the most remote 3 per cent of the population.¹⁴

5.22 According to the above considerations, the average ARIA scores of Census Collection Districts were further amalgamated into five categories. As a result, six Australia cities were given 'major city' (RA-1) status: Perth, Adelaide, Brisbane, Sydney, Canberra and Melbourne. All other areas of Australia have an index of RA-2 to RA-5, depending on their relative distance from urban centres. This chapter later discusses the Department of Health and Ageing's policy to structure its incentive payments to doctors based on the remoteness score of the locations of the doctor's practice.

Potential for change following the release of the ASGS-RA

5.23 The ABS described briefly the implications of the changes to the new ASGS-RA system in their submission to the inquiry. This system was used to collect the census data in the 2011 Census, however the full effects of the changes will not be realised until late 2012 when the data analysis is complete:

ABS has undertaken a review of the ASGC, and will be implementing a new replacement for the ASGC, known as the ASGS from July 2011. The ASGS will be the basis for the 2011 Census of Population and Housing.

The implications for the remoteness structure are relatively minor. The concepts will remain the same; however a new base unit, the Statistical Area Level 1 will replace the CCD as the building block unit for the remoteness structure.

14 Australian Bureau of Statistics, , *ASGC Remoteness Classification: Use and Purpose*, [http://www.abs.gov.au/Websitedbs/D3110122.NSF/4a255eef008309e44a255eef00061e57/f9c96fb635cce780ca256d420005dc02/\\$FILE/Remoteness_Paper_text_final.pdf](http://www.abs.gov.au/Websitedbs/D3110122.NSF/4a255eef008309e44a255eef00061e57/f9c96fb635cce780ca256d420005dc02/$FILE/Remoteness_Paper_text_final.pdf), 2001, p. 2.

The effects of these changes will not be fully known until after the Census data is processed and a new remoteness structure is released towards the end of 2012. From preliminary investigations there will be less instances of the boundary line of Inner Regional and Outer Regional bisecting towns.¹⁵

5.24 When appearing before the committee the ABS explained the changes in more detail:

Those changes were really about changing a whole lot of other geographical classifications. You may be familiar with census collection districts, the smallest area you can get census data from. All of those areas are going to be changed according to some new classifications. It will not affect the remoteness classification in that we were still proposing releasing it with the same five categories. The unit that we built it up from, instead of being the CD, which was the old census unit, will be the new SA1, which is a replacement unit for census output. We do not expect that those changes will cause a lot of change to the remoteness classification itself, but the remoteness classification is due for update towards the end of this year, the end of 2012, because we do take the new census data and we produce a new list of all the towns of Australia and all their sizes, and ARIA is recalculated based on that information. We then take those ARIA values again and overlay them—in this case it will be with SA1s—to produce the five categories and the new map of remoteness for Australia, which will come out towards the end of 2012.¹⁶

Incentives for GPs to work outside major cities

5.25 In 2006, 68.4 per cent of Australians lived in major cities.¹⁷ People living in such cities enjoy high accessibility of services, including health services. However, people who live in other areas of Australia may find fewer health services are available locally. In order to address workforce shortages and retention in rural areas, the government introduced the Rural Health Workforce Strategy (the Strategy) in its 2009–2010 budget. Delivered by the Department of Health and Ageing, the Strategy includes incentives to GPs to live and work outside major cities.

5.26 Programs funded under the strategy are:

- GP Rural Incentive Program;
- HECS Reimbursement Scheme;
- Bonded Medical Placements;
- Medical Rural Bonded Scholarships;
- National Rural Locum Program;

15 Australian Bureau of Statistics, *Submission 124*, p. 6.

16 Australian Bureau of Statistics, *Committee Hansard*, 11 May 2012, p. 11.

17 The 2011 census data is not yet available. ABS, *Population Distribution, 2006*, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008> (accessed 11 April 2012).

- Rural Locum Education Assistance Program;
- Scaling discounts for overseas trained doctors.¹⁸

5.27 The first four programs listed above apply to Australian doctors and vary according to how remote is the location of the practice. The more remote the location in which the doctor works, the greater the incentive. As discussed briefly in Chapter 4 the GP Rural Incentive Program (GPRIP) provides relocation and retention grants to doctors moving from metropolitan areas (RA-1) to more remote RA-2, RA-3, RA-4 or RA-5 locations. Figure 5.1 shows how these payments vary according to the relative remoteness of the location to which a doctor moves:

Figure 5.1—Relocation and retention payments under the GPRIP¹⁹

	One-off initial relocation grant	Retention payment after 0.5 years	Retention payment after 1 year	Retention payment after 2 years	Retention payment after 3–4 years	Retention payment after 5+ years
RA-2	\$15 000	0	\$2 500	\$4 500	\$7 500	\$12 000
RA-3	\$30 000	\$4 500	\$6 000	\$8 000	\$13 000	\$18 000
RA-4	\$60 000	\$5 500	\$8 000	\$13 000	\$18 000	\$27 000
RA-5	\$120 000	\$8 500	\$13 000	\$18 000	\$27 000	\$47 000

5.28 The HECS Reimbursement Scheme provides an incentive to doctors who work outside metropolitan areas by reducing their HECS obligations. The more remote the area in which a GP works, the quicker the HECS debt will be repaid. Doctors who work in metropolitan areas (RA-1) usually take six years to repay their HECS debts. Doctors who work outside metropolitan areas may be eligible for a reduced HECS liability so the time taken to repay HECS debts is reduced to five years in RA-2 locations, four years in RA-3 locations, three years in RA-2 locations and two years in RA-1 locations.

5.29 The Bonded Medical Placements (BMP) and Medical Rural Bonded Scholarships (MRBS) provide incentives for medical students to commit to working in rural areas. The BMP program provides HECS places to medical students on condition that they work in designated districts of workforce shortage (DWS) for a period of time following graduation. The length of this period of time can be reduced if the recipient works in DWS that are also outside metropolitan areas. The MRBS

18 DoctorConnect, *Scaling for overseas doctors*, <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/scalingForOverseasTrainedDoctors>, (accessed 12 April 2012).

19 DoctorConnect, *GP Component FAQs, What are the incentive payment rates?*, <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/gpComponentFaq>, (accessed 13 April 2012).

works in a similar way, but also provides \$24 000 each year to students while they study and requires six years' return of service in a rural or remote area.

5.30 Return of service obligations are reduced under both programs by 10 per cent if doctors work in RA-2 locations, 30 per cent in RA-3 locations, 40 per cent in RA-4 locations and 50 per cent in RA-5 locations.

5.31 All doctors working outside major cities are eligible to apply for locum assistance. The Rural GP Locum Program (RGPLP) offers subsidies to rural GPs to employ locums to provide cover for them while they take time off or undertake professional development. A further two programs; the Specialist Obstetrician Locum Scheme (SOLS) and the GP Anaesthetist Locum Scheme (GPALS) comprise this package of support. The program is administered by the Rural Workforce Agencies in each state and territory.²⁰

5.32 Different incentives apply to overseas trained doctors (OTDs) and foreign graduates of an accredited medical school (FGAMS). (Hereafter, both OTDs and FGAMS are referred to as 'overseas doctors', as opposed to other doctors practising in Australia, hereafter, 'Australian doctors'.) For their first ten years of service in Australia, overseas doctors are only able to access MBS provider numbers in DWSs. However, if overseas doctors work in districts of workforce shortage which are also located in RA-2 to RA-5 locations, they can reduce this ten year period. Like the return of service obligation of Australian doctors, the ten year period is reduced most quickly for overseas doctors who work in RA-5 locations, and reduced progressively less quickly for those working in RA-4, RA-3 and RA-2 locations.²¹

Use of the ASGC-RA to determine incentives

5.33 The ABS uses the ASGC-RA for its own statistical analysis purposes and suggests it may be too blunt to use as a policy tool in isolation:

[It] is well known that some policy makers use ABS definitions, both geographical and others, to directly target policy. For example, some organizations paid an additional allowance to staff stationed in 'rural' areas based on the definition found in the ASGC Section of State classification. The validity of using the ASGC in this way depends entirely on the relevance of the geographical concept to the desired policy outcomes. It is vitally important that anyone developing policies, funding formulae or intervention strategies understands the alignment, or lack of alignment, between a particular geographical classification and their business objective. No geographical classification should be used as a simplistic

20 DoctorConnect, *National Rural Locum Program*, <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/NRLP> (accessed 25 July 2012).

21 Department of Health and Ageing, *Scaling for overseas trained doctors*, <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/scalingForOverseasTrainedDoctors> (accessed 11 April 2012).

answer to complex questions. In most cases a variety of data overlays will be required to target a particular population.²²

5.34 Almost all submitters who discussed the use of the ASGC-RA noted their general dissatisfaction with the ASGC-RA in determining incentives to encourage greater service delivery in non-metropolitan areas:

The application of the Remoteness Area Classification has not ensured appropriate distribution of funds and should be reviewed.²³

...

The classification system in the health sector—ASGC-RA—used for the distribution of incentives, must be reviewed, and a key criterion of town size added to the formula.²⁴

5.35 This sentiment was echoed by Charles Sturt University's submission:

The key challenge for the Australian health workforce reform is correcting the mal-distribution of rural doctors and other health professionals.

The mal-distribution occurs at two levels: (1) mal-distribution of doctors and health professionals between rural and metropolitan areas; and (2) mal-distribution of doctors and health professionals between Inner Regional, Outer Regional, Remote and Very Remote areas.²⁵

5.36 The RDAA noted that cities such as Hobart, Townsville and Cairns have been assigned a 'more rural' classification than in the previous RRMA system.²⁶ The RDAA consider that this has contributed to inequity and has had a negative budgetary impact:

For RDAA, the key problem with the ASGC-RA is that it gives a large weighting to physical road distance from a capital city and a relatively small weighting to population size...As such, the ASGC-RA can fail to represent the extent of health disadvantage experienced in some rural and remote areas...

In RDAA's view, the GISCA report [2010; discussed following] does not address the major problems that smaller towns face competing with attractions and services available in large regional centres. Unless major changes are made to increase the classification differential between these towns and cities, the small towns will continue to lose out to the major regional cities in attracting much-needed doctors.²⁷

22 Australian Bureau of Statistics, *ASGC Remoteness Classification: Purpose and Use*, Census Paper No. 03/01, 2003, p. 12.

23 Dr Pieter Mourik, *Submission 12*, p. 3.

24 Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 11 May 2012, p. 1.

25 Charles Sturt University, *Submission 68*, p. 24.

26 Rural Doctors Association of Australia, *Submission 67*, p. 15.

27 *Submission 67*, pp 15–16.

5.37 Professor John Humphreys from the Centre of Research Excellence in Rural and Remote Primary Health Care (CRERRPHC) also discussed the effectiveness of using resources in the current manner:

Under the existing ASGC scheme for targeting workforce incentives there are clearly problems. The existing schema is not equitable and, I would argue, is not effective. This is particularly because of the inherent heterogeneity in the ASGC categories 2 and 3...Currently we have a situation where doctors who are practising in large, well-supported communities, in environmentally attractive areas, in resource rich areas—places such as Coffs Harbour, for instance—are eligible for the same types of incentives as those who work in small inland, remote communities. As you will be aware, this is clearly inequitable. It is also an ineffective use of resources.²⁸

5.38 Several submitters to the inquiry, while accepting that ASGC-RA was a useful geographical tool, objected to the use of the scheme as the sole determinant of the rate of incentive payments. The National Rural Health Alliance Inc. (NRHA) were supportive of its use, but stated both in their submission, and in their appearance before the committee that it needed to be supplemented in order to provide equitable outcomes:

The Alliance's view is that, for a number of reasons, the ASGC-RA is the most appropriate basis of a rurality classification system to be used for various purposes, including for the allocation of public resources. However it should be seen as a necessary but not sufficient part of such a classification system. For any particular purpose, ASGC-RA should be augmented by one or more additional filters or lenses suitable for that purpose. For instance, it will make sense for many purposes to add to the basic ASGC-RA ranking or score a measure of population size. Also, for access to GPs, for example, it would make sense to include the existing ratios of GPs to population as happens for the definitions of Districts of Workforce Shortage and Areas of Need...The ASGC-RA system is the baby that needs to be clothed and fed, not thrown out with the bathwater.²⁹

Concerns about disparity between areas classed in the same ASGC-RA category

5.39 The AMA identified that most disparity exists in the classification system RA-3, although there are 'anomalies with the other bands especially the RA-2 (Inner Regional) band.³⁰ The committee received evidence from other submitters about disparities between locations classified RA-2 and RA-3.

5.40 Dr Mara of the RDAA summed up the anomalies currently in the system:

My wife when I was coming here said, 'Just ask them if there is a difference between Gundagai, Cootamundra, Tumut, Cloncurry, Cairns, Coffs

28 Professor John Humphreys, Centre of Research Excellence in Rural and Remote Primary Health Care, *Committee Hansard*, 5 June 2012, p 16.

29 National Rural Health Alliance, *Submission 95*, pp 3–4.

30 Australian Medical Association, *Submission 42*, p. 16.

Harbour, Hobart and myriad other towns that are in the same classification system.' I think if any one of you have visited those communities you would know that there is a difference between a small country town such as Gundagai—where we have a main street, a Chinese restaurant, a cafe and a war memorial—and major regional centres like Coffs Harbour or Wagga Wagga. That crucial difference, which I think we all understand inherently, is not being applied in the current system of incentives or geographical classifications across Australia.³¹

Inner Regional (RA-2)

5.41 General Practice Victoria (GPV) noted that a disparity exists amongst Victorian locations classed as Inner Regional, RA-2.

GPV [General Practice Victoria] has received many complaints that the revised classification system announced in 2009 was too blunt an instrument to enable appropriate workforce distribution across rural Victoria. The changed classification of RA-2 regardless of differences, within this broad classification, in population size of towns, and differences in the ability of people from one town to the next to access a wide range of health and community services.³²

5.42 GPV cited a representation made by Central Victoria General Practice Network and Murray Plains Division of General Practice 'regarding the crude application of the RA classification' that gives communities with population bases ranging from 2 000 to 100 000+ the same relocation and retention grants. GPV then presented the following suggestions:

The provision of incentives to RA-2 communities are appropriate and should not be scaled back but there is a need for refinement at two levels. First, there is a need to have a classification system that distinguishes between large regional towns and small rural towns. Secondly, for the purpose of incentives, there is a need to overlay the geographical system with data about health status of local populations, socio-economic status, provision of health services, transport and workforce availability.³³

5.43 The Young District Medical Centre (NSW) expressed the view that it is difficult to attract GPs, especially those from overseas, because Young is classed in the same category as significantly larger centres including Wagga, Bathurst and Orange.³⁴

31 Dr Paul Mara, Rural Doctors Association of Australia, *Committee Hansard*, 11 May 2012, p. 13.

32 General Practice Victoria, *Submission 49*, p. 5.

33 General Practice Victoria, *Submission 49*, p. 5.

34 Young District Medical Centre, *Submission 37*, p. 2.

Outer Regional (RA-3)

5.44 Outer Regional (RA-3) is used to describe 9.5 per cent of Australia.³⁵ This proportion of the country encompasses a range of locations from cities to small towns. To take Far North Queensland as an example: Cairns, a coastal city of northern Queensland with a population of 153 075³⁶ is classed as RA-3. So too is Mareeba (pop. 21 438),³⁷ an hours' drive away, and Herberton (pop. 974),³⁸ an hour and forty-five minutes from Cairns. No extra incentive applies to a doctor who chooses to establish a practice in Herberton rather than Cairns.

5.45 Mr Hook, the Chief Executive of Tropical Medical Training explained how they as an organisation took a decision to 'top-up' payments to registrars to mitigate for the impact of the classification in North Queensland:

We were worried when Mackay became RA2, and Townsville and Cairns were RA3. We felt that the difference in the RRIPS payments was going to make a draining of registrars out of Mackay. We as an organisation, out of our core funding, without being given any extra money, top up our registrars' RRIPS payments to the equivalent of RA3, just to make sure there is no disparity between the two.³⁹

5.46 One of the factors in the Department of Health and Ageing deciding to use the system was on the grounds of its currency. In the first of the department's two appearances before the committee they defended its decision to use the ASGC-RA by stating that they decided to use it because it was "kept up to date", and would include census data collected periodically by the ABS.⁴⁰

5.47 However, the department did acknowledge that there are issues inherent in the system and concerns have been raised with them:

Senator NASH: Is the department aware of the concerns in the sector about the size of populations and the ability to deliver a service for towns—I am talking particularly about the inner regional areas—that is illogical and inappropriate when it comes to the incentive payment?

35 ABS, *Population Distribution*, 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008> (accessed 11 April 2012).

36 ABS, *3218.0 Regional Population Growth, Australia*, Table 3-Estimated Resident Population, Statistical Local Areas, Queensland, 30 March 2012, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02010-11> (accessed 11 April 2012), hereafter, ABS, *3218.0 Regional Population Growth*.

37 ABS, *3218.0 Regional Population Growth*.

38 ABS, *2006 Census QuickStats : Herberton (L)* (Urban Centre/Locality) 25 October 2007, <http://www.censusdata.abs.gov.au/ABSNavigation/prenav/LocationSearch?collection=Census&period=2006&areacode=UCL326800&producttype=QuickStats&breadcrumb=PL&action=401> (accessed 11 April 2011).

39 Mr Rod Hook, Tropical Medical Training, *Committee Hansard*, 23 April 2012, p. 15.

40 Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 68.

Ms Shakespeare: Yes. It has been raised over the period of time that the system has been operating, since 1 July 2010, and there has been a review.⁴¹

...

We hear from people about their concerns about the RA classification. That is one thing that we have to take into account. Anecdotally, the information we are getting from stakeholders is that it is not really working effectively for them.⁴²

5.48 The review referred to was commissioned by the department in late 2010. GISCA (which developed ARIA) were asked to investigate the effectiveness of ASGC-RA in specific areas that had been brought to the attention of the department:

[The] Department engaged GISCA in the University of Adelaide to investigate 23 small communities that are classified within the same category as larger, better serviced, rural communities and provide advice...

The review was completed by GISCA in early 2011 and identified that overall the ASGC-RA classification system is working well.

Sixteen of the 23 identified communities (69 per cent) had positive improvements in GP FWE numbers which is consistent with the national trend. Of those, 5 communities have shown a significant improvement.⁴³

5.49 The Department of Health and Ageing later noted in its submission that:

Whilst the Government is aware that there is the potential in some rural areas containing large, well serviced centres, to create a disincentive for doctors going to smaller towns outside these centres, the new classification system has only been in operation for just over twelve months. Boundary issues are not uncommon with that of any other geographical classification system.⁴⁴

5.50 The point that the scheme had only been in place for a short time was reiterated in the Department's evidence:

The other thing that the government needs to consider is that this system has not been in operation for very long and workforce programs—have an impact over a long period of time. If we are chopping and changing very quickly it does not allow you to see the impact of the programs.⁴⁵

5.51 The Department announced that a review of workforce programs will commence shortly and implied during their second appearance before the committee that consideration of the effectiveness of using ASGC-RA on its own to determine work force incentives will be considered as part of the review:

41 Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 68.

42 Department of Health and Ageing, *Committee Hansard*, 10 June 2012, p. 16.

43 Department of Health and Ageing, *Submission 74*, Attachment A, p. 8.

44 Department of Health and Ageing, *Submission 74*, Attachment A, p. 9.

45 Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 69.

The department is now commencing a review of all health workforce programs, which include a number that are linked to the use of the RA classifications. For instance, the General Practice Rural Incentives Program is a workforce program. That is where we have incentive payments provided to general practitioners. The amount of that is based on which RA location they are in. We have HECS reimbursement which is scaled according to RA.

Several programs use it as a reference point, so that will be looked at through our review of workforce programs, which we expect will take place over the remainder of the calendar year.

There is certainly an opportunity there for us to get further information from stakeholders about the issues. The issues that have been raised with us are generally about RA2 and RA3.⁴⁶

Other classification systems

5.52 Prior to the introduction of ASGC-RA to determine remoteness for doctors' incentives in July 2010, the Department of Health and Ageing used the Rural, Remote and Metropolitan Areas (RRMA) system. The committee did not receive evidence that this system was preferred:

The departments alternate between RRMA and RA2+. RRMA is the old classification where Alice Springs is RRMA 6, a remote centre, and everything else is RRMA 7. The problem with that is there is no gradient in that between Kintore and Hermannsburg, they are the same, whereas RA2+ is better from that point of view. It has gradients in the remote areas. But there are some concerns—RA2+ is not as good for Alice Springs, for instance, but Alice Springs probably did better than it should have out of RRMA. So I think RA2+ is fairer and better, even though every now and again someone will give an example of where RA2+ does not seem to be working. Overall I think it is better than RRMA was. RRMA is still being used in a lot of areas as well, so there is not a universal agreement.⁴⁷

5.53 The Australian Health and Hospitals Association suggested that the ASGC-RA was limited because it 'does not consider inter town and region differences.'⁴⁸ AHHA suggested instead that:

Funding should be linked to population health needs and address the needs of individuals and communities with respect to their health. There needs to be an alternative classification methodology for assessment and distribution for funds and resources for healthcare using more robust population health models.⁴⁹

46 Department of Health and Ageing, *Committee Hansard*, 10 June 2012, p. 16.

47 Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 20 February 2012, pp 15–16.

48 Australian Health and Hospitals Association, *Submission 72*, p. 14.

49 Australian Health and Hospitals Association, *Submission 72*, p. 14.

5.54 The AMA's submission included a detailed analysis of the effectiveness of the ASGC-RA measure. The AMA identified three issues that it believes are most relevant to discussions about the ASGC-RA: 'the arbitrary effect of bands; relative prices; and reliance on a purely geographical indicator.'⁵⁰ It suggests that the best solution would be to implement a payment formula based not on categories, but on the location of each individual claimant.⁵¹ The AMA also made a number of other recommendations in the case that categories were to be retained in determining GP incentive payments:

The AMA recommends that:

- (1) consideration be given to implementing ARIA scores as a continuous variable instead of grouping localities into ASGC-RA bands;
- (2) failing the adoption of recommendation (1), the fall-back option is to adopt a more granular band structure (more bands, narrower bands);
- (3) there be a great deal more stakeholder engagement in relation to the scales of payment that attach to the ASGC-RA bands (if bands are retained);
- (4) the scales of payment be the subject of regular review and indexation;
- (5) the ASGC-RA system should be retained as the geographic indicator;
- (6) the Government work with stakeholders to ascertain whether ASGC-RA should be supplemented by other indicators, which capture some of the social, professional and economic aspects of remoteness; and
- (7) the Government commission a fully independent review of the impact of ASGC-RA.⁵²

5.55 The work of Professor Humphreys and his team at the CRERRPHC has been widely quoted in this inquiry. The RDAA and the NRHA both discussed the model at the committee's first hearing in Canberra.

5.56 Professor's Humphreys summarised the problem with the ASGC-RA system:

The fundamental problem is that dependence on geographical criteria alone does not adequately reflect the issues that are responsible for the difficulties associated with recruitment and retention of doctors into rural areas.⁵³

5.57 The model proposed by the Professor Humphrey's team (hereafter referred to as the "Humphreys model") is multi-layered, comprising geographical data, population data, and data from the national *Medicine in Australia: Balancing Employment and Life (MABEL)* study. The latter is the results of the survey that examines the professional and non-professional factors that impinge on the decision-

50 Australian Medical Association, *Submission 42*, p. 16.

51 Australian Medical Association, *Submission 42*, p. 18.

52 Australian Medical Association, *Submission 42*, pp 19–20.

53 Professor John Humphreys, Centre of Research Excellence in Rural and Remote Primary Health Care, *Committee Hansard*, 5 June 2012, p 16.

making of a doctor in terms of where, and for how long they practice in a specific area.

5.58 The professional factors, or indicators used in the survey, are termed sentinel factors and according to the CRERRPHC provide 'a more sensitive measure directing where recruitment and retention incentives should be provided, with remoteness only required to discriminate between the smallest communities'.⁵⁴

5.59 These sentinel factors are:

- Total Hours = Total Hours worked in their usual week (excluding after hours on-call);
- Public Hospital = whether the GP undertakes work in a public hospital;
- On-call = whether the GP is called out to attend patients two or more times (per week) after hours;
- Time-off = whether it is difficult for the GP to take time off;
- Partner employment = whether there are good employment opportunities locally for the GP's partner;
- Schooling = whether the choice of schools locally is the answer.⁵⁵

5.60 Based on the results of the exercise the CRERRPHC proposes a 6-level classification model that "provides a better basis for equitable resource allocation of recruitment and retention incentives to doctors based on the attractiveness of non-metropolitan communities, both professionally and non-professionally, as places to work and live".⁵⁶ The model is illustrated in figure 5.2:

54 Centre of Research Excellence in Rural and Remote Primary Health Care, *Submission 32*, p. 2.

55 Humphreys et al, Who should receive recruitment and retention incentives?, *Aust. J. Rural Health* (2012), No. 20, pp 3-10.

56 Centre of Research Excellence in Rural and Remote Primary Health Care, *Submission 32*, p. 12.

Figure 5.2: Proposed new 6-level rurality classification⁵⁷

Proposed new 6-level rurality classification			
New 6 level classification	Population Size	ASGC-RA	Example locations
1	(All)	ASGC-1	Most capital cities, Wollongong, Newcastle, Geelong, Sunshine Coast, Gold Coast
2	>50 000	(All)	Bendigo, Ballarat, Hobart, Mackay, Launceston, Rockhampton, Townsville, Cairns, Darwin
3	15 000 – 50 000	(All)	Coffs Harbour, Shepparton, Mt Gambier, Bundaberg, Busselton, Mildura, Albany, Broken Hill, Whyalla, Burnie, Kalgoorlie, Alice Springs, Mt Isa
4	5 000 – 15 000	(All)	Ulladulla, Sale, Warwick, Ararat, Gympie, Lithgow, Victor Harbor, Port Augusta, Emerald, Bairnsdale, Horsham, Moree, Ayr, Parkes, Broome, Port Lincoln, Esperance, Katherine, Karratha
5	0 – 5 000	ASGC – 2 & 3	Gundagai, Leongatha, Strathalbyn, Pinjarra, Cooroy, Latrobe, Port Sorell, Naracoorte, Bega, Kerang, Chinchilla, Margaret River
6	0 – 5 000	ASGC – 4 & 5	Bourke, Kununurra, Roxby Downs, Charleville, Queenstown, Derby, Tennant Creek, Halls Creek, Ceduna, Nhulunbuy, Weipa

5.61 The NRHA also discussed proposals that they had been working on to improve the scheme. They referred to the Humphreys model :

We have ASGC-RA and population size of the place, which is basically what John Humphreys has got, and then we are adding a third one which is a proxy for whatever it is that makes a particular place attractive or not attractive, because it is a measure of how they have done historically.⁵⁸

...

The alliance has been working on a composite measure, which would include three criteria for any particular place. It is ASGC-RA classification, it is population size and an index reflecting its success in the past in

57 Centre of Research Excellence in Rural and Remote Primary Health Care, *Submission 32*, p. 12.

58 National Rural Health Alliance, *Committee Hansard*, 11 May 2012, p. 27.

recruiting and retaining health professionals. This last is a proxy for the range of variables which results in a particular place being one to which it is easy or difficult to attract and retain staff. Many of the alliance's member bodies have approved this approach, while some others with particular interests in the matter have sought further conceptual work, modelling and more time prior to any public promotion by the alliance of the final measure system.⁵⁹

Committee View

5.62 The committee acknowledges that there will never be a perfect model that does not result in some anomalies as a result of the methodology used. That said, the overwhelming evidence provided to the committee during its inquiry did not support the use of the ASGC-RA scheme in its current form as the sole determinant of classifying areas for workforce incentive purposes. Even the evidence in general support of the scheme was heavily conditional on it being augmented with further datasets to provide a more accurate representation of workforce conditions across the country.

5.63 The committee was impressed with the comprehensive nature of the Humphreys model, and the merging of geographical, population and professional and non-professional indicators certainly seems to provide a more accurate picture of the rural workforce. The committee is also supportive of the use of historical recruitment and retention data when classifying areas as proposed by the NRHA.

5.64 The use of current workforce data is an area the committee would like to see utilised in a revised system. The committee notes that the goal of the incentive program is to encourage doctors to work outside metropolitan areas because these areas have lower service provision. The committee also notes that the DWS measure is used to ensure overseas doctors fill existing gaps in service provision. The key government website that provides information about the Rural Health Workforce Strategy (RHWS), *DoctorConnect*, states that:

DWS is a key mechanism that the Australian Government uses to achieve an equitable distribution of medical services across Australia.⁶⁰

5.65 However, incentives do not currently apply to Australian doctors to work in DWS. Given the aim of the RHWS incentive program is to address service gaps in rural areas, the DWS would help to identify such service gaps alongside the ASGC-RA.

5.66 The upcoming review of the rural health workforce policy area by the department is the ideal opportunity for a broad and comprehensive re-evaluation of the classification schema. The committee is strongly of the view that the current system is untenable and requires amendment. The geographical data from the new ASGS-RA

59 National Rural Health Alliance, *Committee Hansard*, 11 May 2012, p. 24.

60 Department of Health and Ageing, *District of workforce shortage*, <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/dwsFactsheet> (accessed 12 April 2012).

system will need to be augmented with further layers of data. The committee is supportive of the methodology and data utilised by the Humphreys model and would like to see this incorporated into a new scheme.

Recommendation 8

5.67 The committee recommends that the classification systems currently used for workforce incentives purposes be replaced with a scheme that takes account of regularly updated geographical, population, workforce, professional and social data to classify areas where recruitment and retention incentives are required.

Recommendation 9

5.68 The committee recommends that the revised workforce incentive scheme include a comprehensive, public evaluation process.

Chapter 6

The role of universities and medical schools

Current pathways into rural medicine

6.1 The numbers of medical students in Australia has risen significantly in recent years with domestic student numbers at Australian universities rising to 12 946 in 2010 from 8768 in 2006.¹ The Department of Health and Ageing project that by 2014 graduate numbers will have doubled in the space of a decade.²

6.2 According to evidence from James Cook University (JCU) this will place Australia significantly ahead of countries like the US, UK, Canada or New Zealand. However, they maintain that this increase is not reflected across rural areas:

With the increase in medical students in the last decade, we acknowledge that the number of doctors is increasing; however, it is becoming apparent that maldistribution is still a problem. Australia now has more doctors per head of population than at any other time. At about three per 1000, we approach the OECD average, and we have significantly more than the US, UK, Canada or New Zealand. We are still continuing to lift the number of medical students; I think we are up to about 15.9 per 100 000 of population per year, which is the second highest after Austria. However, on the ground it appears that the structural problem is still a geographic maldistribution and distribution of specialist medical workforce. Rural communities still have fewer doctors per 100 000 than metropolitan areas.³

6.3 While these are global figures, and it is not possible to say how many students will go on to become doctors in rural areas, there has been a gradual increase in the number of rural clinical schools across the country and the majority of these are in receipt of government funding through the Rural Clinical School (RCS) program.⁴ There are now 17 RCSs across Australia and they are managed by 16 universities across multiple training locations.⁵ Of the 17 schools, 10 were established in 2000–01 while another four were launched in 2006–07 as a result of a second round of RCS

1 Department of Health and Ageing, *Submission 74*, p. 13.

2 Department of Health and Ageing, *Submission 74*, p. 13.

3 Ms Pam Stronach, JCU, *Committee Hansard*, 23 April 2012, p. 1.

4 Department of Health and Ageing, *Rural Clinical Schools Program evaluation*, 2008, p. 1, [http://www.health.gov.au/internet/main/publishing.nsf/Content/F113F29BD0A03FB8CA2575DE00227803/\\$File/udrh5.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/F113F29BD0A03FB8CA2575DE00227803/$File/udrh5.pdf), (accessed on 2 August 2012).

5 Department of Health and Ageing, *Rural Clinical Training and Support*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/work-st-rcts>, (accessed 1 August 2012).

support.⁶ The objective of the RCS is to increase the exposure of medical students to training in a rural area, and hopefully attract them to rural areas.

6.4 This RCS program is part of the broader Rural Clinical Training and Support Program (RCTS). The RCTS combines the RCS with Rural Undergraduate Support and Coordination Program (RUSC). This program mandates that 25 per cent of medical students must be from a rural background. This approach accords with the submissions from various organisations and individuals that there is a strong body of evidence that students from rural areas are significantly more likely to work in a rural areas than those from metropolitan areas. Rural Health Work Force Australia (RHWA) cited a South Australian review that concluded 'that the likelihood of working in rural practice is approximately twice greater among doctors with a rural background.'⁷

6.5 Ms Stronach from JCU concurred:

There is much national and international evidence now to show that, to increase the rural and medical workforce, you need to select students who have a rural or regional background; train them in a rural or regional area; and give them enough meaningful and appropriate clinical exposure in rural, remote and regional health environments. That is important at both the undergraduate and postgraduate levels.⁸

6.6 The University of Western Australia also cited evidence in their submission that supported the claim that students with rural backgrounds are more likely to work in rural areas:

In a 2003 article for the Medical Journal of Australia (MJA), Laven et.al., revealed the results of their national study on the factors influencing where GPs worked, particularly those in rural locations. The study found that 'GPs who have spent any time living and studying in a rural location are more likely to be practicing in a rural location. Those whose partners have also lived and studied for any period of time in a rural location are six times as likely to become rural GPs than those with no rural background' (Laven et.al., 2003, p.77)...The University of Western Australia recognises that medical students with a rural background are more likely to be interested in working in rural and remote areas their urban counterparts.⁹

6 Department of Health and Ageing, *Rural Clinical Training and Support*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/work-st-rcts>, (accessed 1 August 2012).

7 Rural Health Workforce Australia, *Submission 107*, p. 23.

8 Ms Pam Stronach, JCU, *Committee Hansard*, 23 April 2012, p. 1.

9 University of Western Australia, *Submission 5*, p. 7.

Quota of students from a rural background

6.7 The RUSC program specifies a target of 25% of Commonwealth-supported medical students must be from a rural background.¹⁰ The current program was implemented on 1 July 2011 and all universities offering Commonwealth Supported medical school places are included in the scheme apart from Griffith University who decided to opt out due to its focus on servicing outer-metropolitan regions in Southern Queensland.¹¹

6.8 Despite this program, and the increase in rural clinical schools, there is still a low conversion rate for students graduating and returning to a rural area. Health Workforce Queensland (HWQ) provided the committee with results of a longitudinal study they have been carrying out to measure the proportion of medical graduates from four medical schools that are now working in rural areas. The study measured the proportions from four medical schools—the University of Queensland (UQ), JCU, Griffith and Bond Universities—and the numbers are generally disappointing, with an average across the schools of 5.2 per cent of students now working in rural areas. Although the figures show JCU has an 11.2 per cent conversion rate. The HWQ submission reported the findings:

Health Workforce Queensland has been actively tracking the number of Queensland trained doctors who are currently working in rural and remote locations. Data indicates that of the 5,618 graduates from the University of Queensland, James Cook, Griffith and Bond Universities between 1990 and 2010 only 294 (5.2%) are currently working in ASGC 2 to 5 locations.¹²

6.9 Charles Sturt University (CSU) is a strong proponent of increasing the proportion of students from the current 25 per cent to a figure proportionally more representative of the general population. The most recent figures available have 31.4 per cent of people living outside metropolitan areas in Australia.¹³

6.10 In evidence provided to the committee in Albury, CSU argued not only that 25 per cent was not reflective of the population who live in rural and regional areas but also that the definition of a rural background is also flawed:

10 Department of Health and Ageing, *Rural Clinical Training and Support (RCTS) 2011-2014 – Program Guidelines*, p. 1, available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/1E915ABB10570BF7CA257989000AE7F5/\\$File/Guidelines%20RCTS%202011-14.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/1E915ABB10570BF7CA257989000AE7F5/$File/Guidelines%20RCTS%202011-14.pdf) (accessed on 13 August 2012).

11 Department of Health and Ageing, *Rural Clinical Training and Support (RCTS) 2011-2014 – Program Guidelines*, p. 3, available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/1E915ABB10570BF7CA257989000AE7F5/\\$File/Guidelines%20RCTS%202011-14.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/1E915ABB10570BF7CA257989000AE7F5/$File/Guidelines%20RCTS%202011-14.pdf) (accessed on 13 August 2012).

12 HWQ, *Submission 66*, p. 3.

13 ABS, *Population Distribution*, 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008> (accessed 11 April 2012).

No matter how you define where the regions are, it is closer to 30 per cent of the population of Australia, so for starters 25 per cent does not make a lot of sense.¹⁴

...

As you are aware, there is a 25 per cent target for medical schools to enrol students from rural backgrounds. We would suggest that the definition may not be good and that it only requires five years of residence in a rural area over the course of their life up to that point. That is not a very good definition¹⁵... The definition allows for you to have been born in Broken Hill, for your family to have lived there for five years and for you to move to Melbourne for the rest of your life and you could still be designated as a rural student. It is ludicrous.¹⁶

6.11 However they emphasised that they did not see a definition of a rural background as the most crucial aspect, but indicated that they would like to see 'rural students' defined by a desire to work in a rural area:

A definition would involve a program where you looked at applicants for medical school and discussed with them why they might be designated a rural student. The fundamental issue they would have to convince you of is that they had a rural background, they love rural life, they are rural focused, their families have a rural focus. In other words, you would be looking for evidence that they had a genuine intention, no certainty, to practise their craft in a rural community on graduation¹⁷... We believe that an orientation towards rural practice is actually more important than that definition of rurality.¹⁸

6.12 Dr Lennox from Queensland Health described their approach to the quota for students with a rural background which also does not entail an overly rigid approach:

We have been working very closely with the medical schools, particularly James Cook University, the University of Queensland Rural Clinical School, and through Griffith and Bond medical schools to ensure that we provide maximum opportunities for medical students with a rural background to stream into the pathway. In fact, rural heritage is one of the selection criteria for entry into the pathway. However, we do not disadvantage those who do not have a rural background but have fallen in love with the idea of becoming a rural doctor. In the merit selection process we also recognise what they have done to prepare themselves for rural practice through the medical school years.¹⁹

14 Prof. Klomp, CSU, *Committee Hansard*, 5 June 2012, p. 4.

15 Prof. Vann, CSU, *Committee Hansard*, 5 June 2012, p. 2.

16 Prof. Dwyer, CSU, *Committee Hansard*, 5 June 2012, p. 3.

17 Prof. Dwyer, CSU, *Committee Hansard*, 5 June 2012, p. 3.

18 Prof. Vann, CSU, *Committee Hansard*, 5 June 2012, pp 1-2.

19 Dr Lennox, Queensland Health, *Committee Hansard*, 10 July 2012, p. 4.

6.13 Professor Humphreys from the CRERRPHC expressed his support for the principle of having a target of students from rural backgrounds. However he suggested that this was only one part of the equation:

I have to say I think that program has done very well at the front end of the training spectrum. It has encouraged universities to train their entrance programs, their selection processes; it has created dean's lists and opportunities for disadvantaged rural people. It has done a lot there in terms of early immersion. It is in need of a little bit of scrutiny at the moment, because I think there is a bit of fudging of some of the figures around 25 per cent and what that really means, but effectively it has been a very significant and worthwhile impetus to get the front end of the training spectrum right. Within the graduate and undergraduate medical programs, I think things are going well.²⁰

6.14 There has been some recent controversy around whether all universities subject to the quota have been meeting their target. The publication of the figures from 2010 that detail the numbers of commencing students studying medicine from a rural background stated that only 7.5 per cent of commencing medical students at UQ had a rural background.²¹ The RDAA also reported from the same figures that only nine per cent of students at the University of Adelaide, and 13 per cent of students from the University of Sydney, were from a rural background.²²

6.15 This UQ figure in particular was brought up by CSU in their discussions over an appropriate target:

For medical student entrants in 2012, 141 places that should be occupied by rural students are being occupied by metropolitan or overseas full-fee-paying students. The University of Queensland only has 7.5 per cent. The biggest medical school in Australia only has 7.5 per cent rural.²³

6.16 On the back of that evidence the committee invited the UQ medical school to give evidence. They strongly refuted the claim that they had not achieved the target of 25 per cent, stating that the data was incorrect. Professor Nicholson, the Head and Director of Research from the UQ School of Medicine, took the opportunity to correct the record suggesting that administrative processes were responsible:

The review panel report of 2010 into medical training stated that six medical schools had not achieved the 25 per cent rural background target and that for the University of Queensland it was 7.5 per cent. This hit the press and has caused a great deal of difficulty. This data is incorrect but has been used by some to advocate for changes in the funding model, so I think it is quite important that I set the record straight. I do not know where the 7.5 per cent came from and neither does anybody at the school of medicine, but presumably it came from information provided to MDANZ, which is

20 Prof. Humphreys, CRERRPHC, *Committee Hansard*, 5 June 2012, p. 23.

21 Department of Health and Ageing, *Submission 74*, Attachment A, p. 17.

22 Rural Health Workforce Australia, *Submission 107*, p. 24.

23 Prof. Dwyer, CSU, *Committee Hansard*, 5 June 2012, p. 3.

Medical Deans Australia and New Zealand, by central UQ administration. But the actual situation in 2010 was that we had 25.7 per cent of 138 graduate entry students who had a rural background and there had been a quota in place for a number of years. But the rural background amongst the majority of 178 undergraduate entry students was unknown. So we had a denominator of X and a numerator of Y and ended up with 11.4 per cent, which was technically correct, not 7.5 per cent. But I will be able to produce some data that corrects that.²⁴

6.17 Professor Nicholson also suggested that the changing pattern of the university's entry pathways may also have played a role in the incorrect data collection systems:

It is important to understand there are two entry pathways. One is an undergraduate...[t]he other entry pathway is graduate entry. Initially, the University of Queensland was entirely graduate, but about five years ago they started to introduce the undergraduate program. It started with quite small numbers but then ballooned to become the majority of the entrants. That explains some of the other data I am going to present to you²⁵...After this information came out I initiated a survey of the entire year 1 and year 2 cohorts. That is 609 students. We had a very high response rate of 93.2 per cent. If we look at the rural background by MBBS year, 22 per cent of year 1 and 21 per cent of year 2 students reported having a rural background. This is based on the standard criteria of RA2 to 5 for at least five years since beginning primary school. I am very happy to table that report if the committee would like that.

In addition we have surveyed all students in the undergraduate pre-med course and consistently find around 13 per cent of those have a rural background. There is a clear difference between the proportion with rural background in the undergraduate versus the postgraduate program, but I would like to say very clearly that we are absolutely committed to achieving the 25 per cent target. Quotas will be in place next year for both streams, and we will ensure that the 25 per cent is met or exceeded. Very senior management has taken responsibility for this.²⁶

6.18 The committee also discussed the issue with the Department of Health and Ageing when they appeared for the second time in Canberra. On hearing of the disputed data claims the department said they were 'aware there have been issues with the UQ's reporting under the Rural Clinical Training and Support program. We are working with them again on this year's data, so if that is a continuing problem we can get that sorted out with them.'²⁷

24 Prof. Nicholson, University of Queensland, *Committee Hansard*, 10 July 2012, pp 7–8.

25 Prof. Nicholson, University of Queensland, *Committee Hansard*, 10 July 2012, p. 7.

26 Prof. Nicholson, University of Queensland UQ, *Committee Hansard*, 10 July 2012, p. 8.

27 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 15.

6.19 While the issue of a quota was discussed as a contributing factor in increasing rural doctors, none of the evidence received by the committee suggested that there was one single solution to the problem.

Committee View

6.20 The committee understands the call for an increase to the target for students from a rural background from 25 per cent to a figure more representative of the general population. The contributors who proposed an increase highlighted the performance of some universities in meeting that target. In the case of the University of Queensland, the committee is satisfied that the reported figure was incorrect, though it remains unclear what the accurate figure may be. The committee is not persuaded that increasing the target will mean that universities will then meet that new target. In fact the opposite may occur, given the problems that some medical schools have been facing in meeting the current target.

6.21 The evidence from across the board suggests that while the target should be met and enforced, it is only one element of a complex problem, and by itself holds no promise of an increase in the rate of graduates practicing in rural areas. However the committee heard evidence that suggests that regional universities are more likely to meet the target and consequently provide more graduates that will practise in rural areas. The committee supports meaningful sanctions for those institutions that do not meet the current target, and although it understands that this is now a mandatory target with funding conditions attached, it would like those sanctions to be in the public arena, and would also like evidence of those sanctions being applied where appropriate.

6.22 The committee also considers that the definition of a rural student for the purposes of a quota needs to be reviewed.

Recommendation 10

6.23 The committee recommends the publication of those cases where universities do not meet the target of 25 per cent of medical students from a rural background, and subsequent publication of information about the sanctions that are applied in those cases.

Recommendation 11

6.24 The committee recommends that the commonwealth government explore options to provide incentives to encourage medical students to study at regional universities offering an undergraduate medical course.

Recommendation 12

6.25 The committee recommends that the definition of a rural student for the purposes of a quota be reviewed, and that the review should consider strengthening the definition to only include students who have spent four out of six years at secondary school in a rural area; four out of the last six years with their home address in a rural area; or city students showing 'ruralmindedness',

defined as an orientation to work in rural and regional areas, and demonstrated by a willingness to be bonded.

A multifactorial problem

6.26 CSU referred to reports from RHWA and the Deloitte Access Economics that show the current policies designed to provide enough rural health and medical practitioners are not working:

Some of the figures that have been mentioned, for instance, by Rural Health Workforce Australia and the Deloitte's report, are that possibly only 2.7 per cent of 3,000 medical graduates actually intend to pursue a career in rural practice. We think that is an indictment of the current policy settings. A number of reports have been released over the last several months, but the Rural Health Workforce Australia report on the workforce in 2025 very clearly said that the policy settings are not delivering what is required for rural and regional areas, and are unlikely to unless there are changes to the policy settings into the future.²⁸

6.27 Many submissions and evidence received throughout the inquiry has outlined that the problems of recruiting and retaining rural health professionals are complex and involve a number of factors. The University of Western Australia cited evidence that a student's background is only one of the factors that will impact on the decision of where someone will work after graduation:

The decision of whether or not to work in a rural area is a multifactorial one and the influence of a multifaceted rural backgrounds is only one part of this complex decision making process.²⁹

6.28 This position is supported by the CRERRPHC, which cited a number of studies in its submission that found that there are many variables that influence a practitioner's decision:

Health workforce recruitment studies have highlighted the importance of student background, aspirations and interest in rural practice, needs of spouses and partners, the extent to which the training program has a rural mission, rural mentoring and support systems for students and rural educational experiences as the best predictors for taking up rural practice. While some of these background variables (such as rural background and interest in rural practice) continue to influence practitioner satisfaction in rural practice, other research has found that practice issues such as income and workload were far more significant predictors of practitioner retention in rural areas.³⁰

6.29 Professor Murray, President of the Australian College of Rural and Regional Medicine (ACRRM) and Dean of the JCU's medical school, also acknowledged the

28 Professor Vann, CSU, *Committee Hansard*, 5 June 2012, p. 1.

29 University of Western Australia, *Submission 5*, p. 7.

30 CRERRPHC, *Submission 32*, p. 4.

issues are complex and outlined what the medical schools can do to address some of the issues:

Recruit rurally so that there is a better mix and make sure that you have also got underrepresented groups. Indigenous students, low SES et cetera is part of that. This helps to form a peer culture and a sense of values and belonging. Provide curriculum that is rurally rich with lots of inspiring experience. Our member medical students here, for instance, do not darken the doorstep of a city teaching hospital unless they do an elective. It is a completely different experience, and all of them do 20 weeks of small rural and remote placement. They are making choices, which we are very pleased to see, that are actually extraordinary and unprecedented.³¹

6.30 Professor Murray also described what he sees as a current opportunity being missed with the increase in medical students flowing through the system:

We have engineered a solution to these three problems, which is to more than double the number of medical schools in the country and increase by about 2½-fold in a decade the production of medical graduates so that we will now almost top the OECD...However, we have not built the pipeline so that these new graduates—my new colleagues—will be going into the sorts of careers that we need them to do, that is, careers which are regional and general with a population health and a team orientation...There is an imperative of now.' We call it a national policy emergency. Jobs will be found for these young doctors in training. They will be shoehorned into the big city teaching hospitals supplemented by the big private hospitals. They will be doing transplant matters in their second year. It is a workforce that we do not need and that we will rue for a long time.³²

6.31 As part of the discussion on future health care needs CSU informed the committee of their current proposal to the Commonwealth government to establish a new rural medical school in Orange that would provide placements for both health and medical practitioners, expanding its current campus. The proposal emphasises that future health care needs will be serviced by multidisciplinary primary care teams with a focus on preventative health.

6.32 Unlike the Rural Clinical Schools that primarily service students for rural medicine rotations, the CSU proposal is for a full rural medical school that would introduce a 'six year undergraduate medical program...with the following features':

...an annual intake of 80 students; a Positive Rural Recruitment Program with 60% of students from a rural, regional or Indigenous background or disposed to rural practice; and, streaming of students from their fourth year

31 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, JCU, *Committee Hansard*, 23 April 2012, p. 3.

32 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, JCU, *Committee Hansard*, 23 April 2012, p. 3.

to focus on providing those students committed to rural practice with procedural skills suitable for rural practice.³³

6.33 In addition CSU proposes that health related courses other than medicine would be doubled to 'build the skills and capabilities of graduates for integrated health care' and 'significantly increase the number of rural doctors, nurses and other health and human service professionals in rural areas.'³⁴ The proposal recognises that there are similar professional, social and economic factors that limit the supply of those health professionals in rural areas.³⁵ Of particular importance is the intention to integrate an e-health curriculum into the courses to prepare students for current and future utilisation of e-health and telemedicine.³⁶

6.34 The Commonwealth government does fund the Nursing and Allied Health Scholarship and Support Scheme which is a program that supports allied health and oral health students to undertake a clinical placement in a rural or remote Australian community during their degree. However the committee received evidence that the program was vastly oversubscribed. The allied health component of the scheme is administered by Services for Australian Rural and Remote Health (SARRAH) who pointed out that this is a potential opportunity missed:

...applications for the 2012 intake under the Allied Health Clinical Placement Scholarships Scheme, which we administer on behalf of the government, recently closed. For the 150 places under the scheme we had 1,046 applicants, of which 864 were eligible. This scheme encompasses all allied health professions and targets settings across rural and remote Australia. So, basically we are saying that there are over 700 eligible applicants who were unable to take up a placement in rural and remote Australia. Given that there is a workforce shortage, it is not rocket science to work out one strategy that could be adopted.³⁷

6.35 The Department of Health and Ageing agreed that there are issues around finding clinical placements for postgraduates and pointed out that this is one the reasons why student placements are tightly regulated because of the flow-through of students for periods of 10 years or more that have to be accommodated. In response to questions about the proposal from CSU for a rural medical school, the department discussed the issues that need to be considered:

...Commonwealth-supported medical places are capped under legislation administered by the minister for tertiary education. The views of the Minister for Health are sought on proposals to either establish new medical

33 CSU, *Supplementary Submission 68*, Growing the Next Generation of Rural Health Practitioners, pp 4–5.

34 CSU, *Supplementary Submission 68*, Growing the Next Generation of Rural Health Practitioners, p. 4.

35 Professor Karen Francis, Royal College of Nursing, *Committee Hansard*, 11 May 2012, p. 38.

36 CSU, *Supplementary Submission 68*, Growing the Next Generation of Rural Health Practitioners, p. 4.

37 Mr Rod Wellington, SARRAH, *Committee Hansard*, 11 May 2012, p. 2.

schools with new Commonwealth supported places or to extend the number of places within existing medical schools. The advice that the Minister for Health has been providing for some time now is that the clinical training environment is very stretched and there is not really the capacity to support additional numbers of medical students because of the large expansion over the last few years in the numbers of students training in Australian universities. Also, we now have evidence—modelling, I suppose—provided by Health Workforce Australia that shows that the number of doctors that we are producing and are expected to produce out to 2025 is relatively in balance. There may be a short-term oversupply followed by a fairly small comparative undersupply unless we change policy settings, but governments have agreed that they need to change policy settings rather than continue increasing the number of graduates...

When people are doing their undergraduate training at university, they need access to fairly extensive clinical training placements in order to complete their undergraduate training. That is usually provided through hospitals. Once they graduate, there can be issues with finding places for junior doctors. Again, that is capacity within the large teaching hospitals, generally public hospitals. There is also, once people are going through vocational training, a need to find people access to clinical training, so it is right through the scope of people's training.³⁸

Committee View

6.36 The committee was impressed by the model proposed by Charles Sturt University. The provision of a full scale medical school based in regional Australia would have a significant impact on the numbers of doctors, nurses, allied health and other essential health professionals that would come from rural areas and would therefore be likely to remain in those areas after they complete their training. The inclusion of telemedicine and integrated team based care was also welcomed.

6.37 However the committee is also mindful that the current pressing issue is not the student numbers but the capacity in the system to adequately train those students all the way along a pathway from student to health professional who will work in rural areas.

Student Entry requirements

6.38 Queensland Health gave evidence to the committee that they are going further back in the educational pathway to try and attract rural students into the health sector as a whole:

We have a program which deliberately targets rural based secondary school students to interest them in health careers—not just in medicine but in other disciplines as well. That has been operating over quite a number of years now, so we have a good track record of the number of rural secondary

38 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, pp 20–21.

school students who have now tracked into health careers, and a significant number of those in fact are now moving into rural generalist medicine.³⁹

6.39 There was also some discussion about the standard required for entry into medical schools and whether this should be revised for students from rural areas to take into account educational inequalities outside metropolitan areas. Dr Lennox from Queensland Health described one of their 'affirmative action' programs:

What I can share with greater authority is the selection of secondary school students with a rural background through a program like our Health Careers in the Bush, for example, giving them affirmative action or assistance to enter into vocational training or enter into basic training in health disciplines including medicine, and then, through programs like those of James Cook University—and I think the University of Queensland now are establishing a very strong affirmative action program as well—assisting those students who have not had the best opportunity academically in secondary school or, for that matter, even in primary school to be able to bridge those gaps and move very well into tertiary education and vocational training in medicine. From what I can see, the evidence is very strong that they are very worthwhile programs. I have no doubt that we will see in the end strong evidence coming out of that evaluation that students or trainees with a rural heritage, including an Indigenous heritage, who have tracked through this program will provide exemplary service in the long haul in rural practice in future.⁴⁰

6.40 CSU also supported differential entry requirements for students from rural and regional areas:

...a major driver of university behaviour is about the prestige of student selection on entry, which is not necessarily anything to do with their ability to study the course. Medicine is a very competitive field. Sometimes the argument is put that we cannot let students in from rural and regional areas because they are not sufficiently qualified. My answer would be that they do not meet the market price but the market price is not necessarily an indication of ability. As John pointed out, this was the experience at JCU. There are entrenched factors which reduce the ability of bright students in regional areas to compete. You do need to have some process of affirmative action or at least recognise the educational disadvantage that feeds into this.⁴¹

6.41 Dr Mourik, a consultant obstetrician and gynaecologist in Wodonga suggested a rural loading for rural students would be effective:

Any government program which supports rural students being accepted into Medicine needs to be enhanced. Rural students in secondary schools are disadvantaged compared to city students, so a rural loading of the TER

39 Dr Lennox, Queensland Health, *Committee Hansard*, 10 July 2012, p. 4.

40 Dr Lennox, Queensland Health, *Committee Hansard*, 10 July 2012, p. 6.

41 Professor Vann, Charles Sturt University, *Committee Hansard*, 5 June 2012, p. 5.

scores would improve the number of rural students entering medical studies and subsequently returning to the country after they graduate.⁴²

6.42 Dr Mourik further expanded on his submission when giving evidence to the committee:

I do not think you have to be that smart to be a doctor, but you do have to work hard. We know that rural students who go to rural secondary schools do not have the same teaching as the [...] schools in the city. So there must a loading for rural students.⁴³

Committee View

6.43 The committee strongly supports the efforts of Queensland Health, James Cook and Queensland University in their affirmative action programs. The introduction of options for underprivileged young people to enter a career in health and the provision of appropriate support throughout their training is highly commendable. The committee urges other regional and rural institutions and appropriate education providers to examine ways that can increase the opportunities of young people in the health field, with the added benefit of increasing the likelihood of retaining a health workforce if they are sourced locally.

Teaching and mentoring places for medical students

6.44 There are a number of barriers in current pathways for medical students to practise in rural areas. One of the most significant issues is whether the number of internship places for medical students can keep up with the recent expansion in medical graduates.

6.45 The internship is the first year out of medical school and is followed by one or more years as a Resident Medical Officer, or 'resident'. Both of these stages usually involve work rotations in clinical departments in the public hospital system.⁴⁴

6.46 There has been recent media coverage of an article in the Medical Journal of Australia that claims that there will not be enough intern places available for the number of graduates leaving medical school.⁴⁵ The AMA concurred with the assertion. Catherine Joyce from Monash University suggested that 'what we need to

42 Dr Pieter Mourik, *Submission 12*, p. [2].

43 Dr Pieter Mourik, *Committee Hansard*, 5 June 2012, p. 61.

44 AMA, *Becoming a doctor and bonded medical school places - a guide for prospective medical students*, http://ama.com.au/node/4130#Undergraduate_medical_Education, 31 October 2007, (accessed on 4 August 2012).

45 ABC News AM, *Not enough internships for medical graduates*, <http://www.abc.net.au/am/content/2012/s3550909.htm>, 23 July 2012, (accessed on 4 August 2012).

explore is a wider range of settings in which these internships take place', and this call was supported by Catholic Health.⁴⁶

6.47 Professor Nicholson from UQ discussed the reliance on major teaching hospitals for post graduate training which excludes rural and regional hospitals:

...postgraduate training is not done by the universities; it is done by the colleges and they basically rely on the state teaching hospitals. There need to be positions in the hospitals that are fully funded for training. Going back to my experience in Geelong, there was no position. I established the position where essentially the senior doctors paid the salary of the registrar in order to get somebody through, you needed to use innovative schemes. It was not considered reasonable or proper to train somebody in a regional hospital. I am sure that you will find that the vast majority of training positions in all states, including Queensland, are situated in metropolitan teaching hospitals.⁴⁷

6.48 Professor Nicholson argued that this has direct consequences on efforts to entice doctors and specialists into rural areas:

One of the drivers is that some students want to work rurally but want to train in surgery, so they hang about metropolitan teaching hospitals. Then they get married, get a mortgage and that is the end of it.⁴⁸

6.49 The RDAA discussed the broadening of the settings of training postgraduate rural doctors:

The Rural Doctors Association has published a set of national principles on the pathway for advanced training. That set of principles clearly identifies that there is an issue in some states for the availability of training positions that are required to do rural medicine and that other states may have to be brought in to provide some of that access. It is the same with the Northern Territory, for example, where we do not have the number of public hospitals required. So we believe that doctors should be able to move within that pathway into those other areas as the training simply may not be available in some of the smaller states. It may have to be provided by other areas with more regional hospitals.⁴⁹

6.50 The issue of training for potential rural GPs becomes more acute at the registrar level, when training in rural medicine is normally delivered by GPs in community practices. Dr Mara from the RDAA commented on the difficulties and pressures that are placed on GPs in these scenarios:

46 ABC News AM, *Not enough internships for medical graduates*, <http://www.abc.net.au/am/content/2012/s3550909.htm>, 23 July 2012, (accessed on 4 August 2012).

47 Prof. Geoff Nicholson, UQ, *Committee Hansard*, 10 July 2012, p. 14.

48 Prof. Geoff Nicholson, UQ, *Committee Hansard*, 10 July 2012, p. 14.

49 RDAA, *Committee Hansard*, 11 May 2012, p. 17.

I personally, in my practice, would not be able to take on an intern in their vocational training year. The registration requirements, the risk requirements and the other arrangements for their training are very difficult to supervise. But I know that some practices are geared up to do it and they do it very effectively and very well.⁵⁰

6.51 The AMA in their submission commented on the impact of the age profile of doctors in rural areas who are often relied upon to provide training and mentoring services as part of rural clinical rotations:

The average age of rural doctors in Australia is nearing 55 years, while the average age of remaining rural GP proceduralists – rural GP anaesthetists, rural GP obstetricians and rural GP surgeons – is approaching 60 years. This means that the ageing of the health workforce has serious implications for sustainable health service delivery and for the supervision and mentoring of trainees and new graduates into the future. These issues impact on the health workforce nationally and in all settings, but are even more pressing in regional, rural and remote areas.⁵¹

6.52 The Royal College of Physicians commented on how valuable the increase in University Rural Clinical Schools has been in providing the opportunity for training to be delivered in a rural or regional setting by senior professionals:

These have provided education and training opportunities in regional communities for some years and have enabled senior professionals to engage in supporting the teaching and training of local or temporary residents and trainees and is a win for both the professional community, the general community and the students who wish to study, work or live in a community which they have grown up in.⁵²

6.53 The City of Mount Gambier, in discussing the success of the Flinders University Rural Clinical School, added that:

These facilities enable students to experience the benefits of rural living and medical practice informing them about placements in the country on completion of their studies thereby improving the capacity of the region to deliver medical services in our region. Without this, rural areas tend to lose potential medical professionals from their own populations when they are required to relocate to major capital cities for their education needs.⁵³

6.54 However this can also cause difficulties in supplying the colleges with adequate teaching resources. Dr Mourik described the situation in Albury Wodonga:

I am teaching women's health at the university, and that is one of the best initiatives the federal government has done. It really does work well, except it lacks teachers. Out of the eight O&G specialists in this town I am the

50 RDAA, *Committee Hansard*, 11 May 2012, p. 17.

51 AMA, *Submission 42*, p. 2

52 Dr Leslie Bolitho, Royal Australian College of Physicians, *Committee Hansard*, 11 May 2012, p. 53

53 City of Mount Gambier Council, *Submission 89*, p. 1.

only one who does teaching—and it is onerous—because they are too busy doing the work...[w]e lack the teachers, and there is no incentive for teachers.⁵⁴

6.55 A report from the Rural Doctors Workforce Agency in South Australia emphasised how important it is that young doctors studying at postgraduate years one and two (PGY1 and 2) are provided with training from existing GPs in a rural setting because 'there are no GP role models or champions in metropolitan hospitals'.⁵⁵ This view that hospitals are not appropriate for training GPs is supported by a study by NSW Health that found that:

...the current NSW hospital service model does not meet the accreditation requirements of ACRRM or the RACGP to enable GP trainees to complete all of their GP training in a hospital setting. Continuity of care is considered a necessary part of GP training and primary care under both College programs and NSW hospitals do not meet this training requirement.⁵⁶

6.56 The Australian College for Rural and Remote Medicine (ACRRM) emphasised the need to invest in teaching, and in situ mentoring capacity in rural areas:

...we do need to invest more in developing the infrastructure for teaching out there, really developing the mentoring and the supervision type levels. We would like to be providing a higher level of mentoring and supervision, particularly mentoring for overseas trained doctors, but, again, we have not got funding to do that. You do need to. Infrastructure for training in rural is essential.⁵⁷

6.57 Dr Kirkpatrick from the Royal Australian College of General Practitioners described the current situation for GP practices across the country that have the capacity to teach:

We would like to see the number of rural places and the length of rural placements increase, but it cannot be without support for supervisors. We are already stretching our teachers, but there are only some 1,500 general practices in Australia that teach. One of the things that we need to do is to make teaching valuable to the teacher, but not to the detriment of providing health care within the community.⁵⁸

54 Dr Pieter Mourik, *Committee Hansard*, 5 June 2012, p. 59.

55 Rural Doctors Workforce Agency, *R2RGP, Road the General Practice*, June 2011, p. 3.

56 NSW Health, *Securing a Stable Medical Workforce for NSW Rural Communities*, August 2011, p. 5.

57 Ms Dianne Wyatt, Australian College for Rural and Remote Medicine, *Committee Hansard*, 5 June 2012, pp 14-15.

58 Dr Kathryn Kirkpatrick, Royal Australian College of general Practitioners, *Committee Hansard*, 5 June 2012, p. 36.

6.58 Dr Kirkpatrick also pointed out that there are developments overseas to provide the teaching skills at an early stage that will increase the capacity for students now to become skilled teachers later in their career:

Can I say that in Britain they are mandating education and teaching models for all of their medical students and registrars so that everybody has some degree of understanding of educational method and how to teach. In Australia there is an understanding that everybody will teach but often times there is no 'teach the teacher'. It is becoming recognised as a need but it has not been a mandated activity.⁵⁹

6.59 Ms Bell from the Central Australian Aboriginal Congress informed the committee of the particular difficulties with regard to providing teaching and mentoring opportunities in their delivery of Aboriginal health services:

A challenge for us, when we are dealing with that number of trainee positions, is that we do not have adequate training facilities for when they are onsite. For instance, having four registrars and four trained supervisors who look after each of them becomes an issue for us in ensuring adequate space and opportunity for them beyond the clinic. That has been an ongoing issue for us over the last three or four years of being recognised as a training facility. Even though we only receive these trainees, there is an impact on our environment when we have them there on site, and we do not have adequate facilities to look after them in a way that students need to be looked after when they are there.⁶⁰

Committee View

6.60 Effective translation of medical students into rural and regional practice requires appropriate support at all stages in the training and placement process. There does not appear to be adequate systems that will support the internships, rotations, or mentoring of the expanding number of medical students. The committee did not receive detailed evidence on the funding and policy mechanisms that support internships and workplace training, but the situation will need to be improved in regional areas if the current drive to expand the number of students is going to translate into actual health professionals working on the ground.

6.61 The committee is looking forward to the Department's forthcoming review of rural health and would like to see a full exploration of ways in which blockages in the system such as the shortage of rural clinical placements can be addressed. Support for training providers, be they public or private hospitals or GPs in rural communities is essential. Infrastructure funding is important to support these providers, but simple steps like introducing the UK's recent policy of incorporating teaching training into

59 Dr Kathryn Kirkpatrick, Royal Australian College of general Practitioners, *Committee Hansard*, 5 June 2012, p. 36.

60 Ms Stephanie Bell, Central Australian Aboriginal Congress, *Committee Hansard*, 20 February 2012, p. 3.

the medical curriculum could also provide local GPs with the tools and confidence to provide high quality training in a local setting.

Recommendation 13

6.62 The committee recommends that the Commonwealth, state and territory governments review their incentives for rural GPs with the aim of ensuring that rural GPs who provide training to pre-vocational and vocational students are not financially disadvantaged.

Recommendation 14

6.63 The committee recommends the Commonwealth government consider the establishment of a sub-program within the National Rural Locum Program that would provide support for rural GPs to employ locums specifically to enable the GP to deliver training to pre-vocational and vocational medical students in rural areas.

Accommodation issues during clinical placements

6.64 A number of contributors to the inquiry discussed the difficulties that doctors and other health practitioners encounter in securing accommodation during clinical rotations and placements in rural areas. The situation seems to be *ad hoc*; there are no significant Commonwealth government policy drivers in place,⁶¹ and there is a lack of coherent strategy across the medical school sector.

6.65 Dr Mourik described what his students regularly encounter when trying to access affordable accommodation:

They find their own accommodation. A couple of students just got digs with the midwives. Some of them share houses.⁶²

6.66 He also suggested that significantly lower incomes for rural practitioners are a real barrier to attracting doctors to rural areas:

How many years have we been talking about rural loading? We pay the same insurance as a city obstetrician and our income is about one-third. We can cope with a half, because the cost of houses and land and other expenses is less, but not three or four times...We cannot attract a young person here when they have HECS, a partner, two kids and a dog. By the time they are a senior registrar or graduate as a specialist, they do not want to come here and earn one-third of the income they can earn in the city. We cannot attract them.⁶³

6.67 Dr Lennox from Queensland Health informed the committee that there is some provision for accommodation as students move through the training pathway as part of their rural generalist model:

61 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p.21.

62 Dr Pieter Mourik, *Committee Hansard*, 5 June 2012, p. 59.

63 Dr Pieter Mourik, *Committee Hansard*, 5 June 2012, p. 59.

The key elements of this pathway is that trainees are able to progress to the completion of training in-service with Queensland Health. So as they progress through the pathway, they have an entitlement to accommodation, particularly when they are appointed in the rural locations. Their appointment as a senior medical officer provisional fellow entitles them to accommodation by the health and hospital service in which they are located.⁶⁴

6.68 The University of Queensland also has some provision for accommodating its students, particularly if they are in rural areas:

Part of our funding requirements is that the students are not disadvantaged, so there are a number of models. There is a rental subsidy. We do home stay. They could be put up in Queensland Health facilities. In a few places like Roma we have our own facilities... At all the other sites the 120-odd students are essentially given free accommodation for the year or two years.⁶⁵

6.69 SARRAH described the accommodation provided through the the Nursing and Allied Health Scholarship and Support Scheme. The scheme supports allied health and oral health students to undertake a clinical placement in a rural or remote Australian community as part of their degree.⁶⁶ The rural placement:

...entails students in their third or fourth year going out to a rural and/or remote location for up to a maximum of six weeks—an accommodation, travel and sustenance allowance is paid. Generally, that costs around about \$11,000 per placement. It has been running for two or three years only.⁶⁷

6.70 JCU also highlighted that difficulties in training medical practitioners in rural areas are equally applicable to training the broader health workforce including nurse and allied health practitioners:

Just focusing on the training of the broader health workforce—medical, nursing, allied health—for rural service, there are significant costs associated with training health professional students in rural, regional and remote locations. These include all the common ones: the provision of the teaching infrastructure, the difficulty in attracting and obtaining appropriately trained supervisory staff, the travel costs for your staff and your students, accommodation costs—which are a huge gate that is holding back being able to place more students in small rural towns—and costs for students in having to maintain two residences. At JCU we expect our students to do a long placement in at least one rural area. We expect that of all our health professional students.⁶⁸

64 Dr Dennis Lennox, Queensland Health, *Committee Hansard*, 10 July 2012, p. 3.

65 Prof. Geoff Nicholson, UQ, *Committee Hansard*, 10 July 2012, p. 10.

66 SARRAH, *Nursing and Allied Health Scholarship and Support Scheme (NAHSSS)*, <http://www.sarraha.org.au/site/index.cfm?display=74996>, (accessed on 4 August 2012).

67 Mr Rod Wellington, SARRAH, *Committee Hansard*, 11 May 2012, p. 3.

68 Ms Pam Stronach, JCU, *Committee Hansard*, 23 April 2012, p. 2.

6.71 Tropical Medical Training, which manages the placement of a significant cohort of JCU postgraduate students, also highlighted the importance of accommodation and in the placement of all health practitioners and the work that it has carried out:

There is also mapping about all the accommodation that is being provided over the year and who owns it—which university, which medical school and or which physiotherapist school, and where we can place the doctors.⁶⁹

...

Obviously, especially with the mining boom at the moment, it is very hard to get trainees into some of our western towns. It is \$1,200 a week for rent, which is fairly hard to sustain... so accommodation is a big issue, whether it is renting or actually buying a building, which might be cheaper in the long run, so that people have somewhere to stay.⁷⁰

6.72 Health Workforce Queensland described the situation as being not only difficult to house health practitioners on clinical placements, but also having to provide appropriate professional infrastructure for visiting practitioners:

Infrastructure accommodation is on a couple of levels. There is the need for overnight accommodation for all health professionals. You have heard the horror stories about the cost in mining towns. It is not only a matter of availability; it is also about quality and safety. You need to be mindful of those things. The other one which goes with it is the clinical space for the health professional and the teaching space as well.

Then, on top of that, you have got fly-in fly-out services. There are a number of very successful programs run across the country called the SOAP programs, Specialist Outreach Assistance Programs—specialist outreach programs—and others. They bring people into town, which is wonderful, but if you have not got a second, third or fourth consulting room or a bed or this or that or high speed internet then it is actually problematic. I mentioned Cherbourg before and I would like to mention it again. There are something like 72 services going into that community, but put 72 single professionals in a row and then try to put them anywhere.⁷¹

6.73 The housing difficulties for Aboriginal Health Workers was also highlighted by the Aboriginal Medical Services Alliance of the Northern Territory:

One of the biggest hindrances is housing. It is the policy of this government in the Northern Territory to supply housing for police, for Aboriginal community police officers, for nurses and for doctors, but it is an explicit policy of this government not to supply Aboriginal health worker housing. Apart from the fact that this is really discriminatory given that these other professions—including health professions—get housing, we have lots of places where housing is so overcrowded that Aboriginal health workers

69 Mr Ian Hook, Tropical Medical Training, *Committee Hansard*, 23 April 2012, p. 13.

70 Dr Rod Nan Tie, Tropical Medical Training, *Committee Hansard*, 23 April 2012, p. 17.

71 Mr Ian Mitchell, Health Workforce Queensland, *Committee Hansard*, 23 April 2012, p. 27.

basically have to go to the clinic in the morning to shower and get changed into clean clothes, because their own living conditions are too poor and too crowded.⁷²

Committee View

6.74 The committee acknowledges that a placement program can only work effectively if students have somewhere to live while undertaking it. The committee notes that existing programs and stakeholders are seeking to address this issue. Given the number of students coming through the system who will require appropriate, and importantly, secure accommodation and support as part of their rural placements and clinical rotations, it is imperative that adequate policies and programs are established to manage the increasing demand. While it may be argued that accommodation issues are not unique to health workers it is an obvious impediment to increasing the health workforce in rural areas and one that requires a whole of government approach involving federal, state and other key stakeholders.

6.75 The specific issue of housing for Aboriginal Health Workers needs to be addressed. The committee is aware of the difficulties this causes in Aboriginal communities, both for staff working in remote communities and for attracting staff to those communities. The committee urges to Commonwealth government and the state and territory governments to work together to address this need.

Recommendation 15

6.76 The committee recommends that a coordinated accommodation strategy for be developed for rural health workers, including Aboriginal Health Workers, in the government's forthcoming review of rural health programs.

72 Mr Chips Mackinolty, Aboriginal Medical Services Alliance of the Northern Territory, *Committee Hansard*, 24 February 2012, p. 3.

Chapter 7

Medicare Locals

7.1 In August 2011 the Commonwealth, state and territory governments around Australia finalised the National Health Reform Agreement (the Agreement). One of the initiatives in the Agreement is the establishment of Medicare Locals to operate from 1 July 2012.¹ The Agreement explains the role and functions of Medicare Locals:

Medicare Locals will be the GP and primary health care partners of Local Hospital Networks, responsible for supporting and enabling better integrated and responsive local GP and primary health care service to meet the needs and priorities of patients and communities.

...

The strategic objectives of Medicare Locals are:

- Improving the patient journey through developing integrated and coordinated services;
- Providing support to clinicians and service providers to improve patient care;
- Identifying the health needs of their local areas and development of locally focused and responsive services;
- Facilitating the implementation of primary health care initiatives and programs; and
- Being efficient and accountable with strong governance and effective management.²

7.2 The Department of Health and Ageing elaborated on the role of Medicare Locals for the committee:

The Medicare Locals have been tasked to do a number of things, one of which is to look at the health needs and requirements of the population within their area, also, to look at the professional services that are available. That includes general practice, allied health, community health, [and] specialists working in the community.

...

What Medicare Locals are particularly looking at is patient flow, and how we look at the barriers between primary care and secondary care and ensure that there are pathways that link primary and secondary care together.³

1 Council of Australian Governments, *National Health Reform Agreement*, 2011, p. 50.

2 Council of Australian Governments, *National Health Reform Agreement*, 2011, p. 50.

3 Mr Mark Booth, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 74.

7.3 Medicare Locals will have to provide a 'Needs Assessment Report' that will inform the planning and priority setting activities.⁴ The Department of Health and Ageing has developed a range of tools and materials to support Medicare Locals in this task with the intention of disseminating 'a comprehensive health needs assessment framework for Medicare Locals to implement in a consistent and systematic way'⁵ by July 2012.

7.4 Due to the relative novelty of Medicare Locals, the majority of the evidence received by the committee was tentative in reaching any conclusions on their effectiveness. For instance, the National Rural Health Alliance (NRHA) stated 'little is currently certain about the impact of the introduction of Medicare Locals on the provision of health services.'⁶ The committee was informed by CRANaplus that 'it is really too early to tell'⁷; and the NSW Rural Doctors Network stated that '[i]t is too early to tell what the effect of the introduction of Medicare Locals on the provision of medical services in rural areas will be.'⁸

7.5 There was broad, if conditional, support for the new arrangements. The Royal Australasian College of Physicians 'cautiously [welcomed] the introduction of Medicare Locals'.⁹ Likewise, the QAMH expressed hope that Medicare Locals would be able to develop networks between different types of service providers to create better health outcomes for communities.¹⁰ The NRHA also reported that regional communities have high hopes for the Medicare Locals scheme:

There are, as we said, major expectations of [Medicare Locals], but we believe that they are real, they are with us, they are happening, and we should be taking every opportunity to make it work in rural areas...There are lots of issues but we, the Alliance, take the view that this is, if you like, the focal point now of all the effort that has been put into health reform over the last three to five years and we want to make every effort to make it work best for people in rural and remote areas.¹¹

4 Department of Health and Ageing, *Background Paper: Medicare Locals Health Needs Assessment and Planning*, http://www.agpn.com.au/_data/assets/pdf_file/0011/40331/20120106_BRF_Background-Paper-Medicare-Locals-Health-Needs-Assessment-and-Planning.pdf, (accessed 30 July 2012).

5 Department of Health and Ageing, *Background Paper: Medicare Locals Health Needs Assessment and Planning*, http://www.agpn.com.au/_data/assets/pdf_file/0011/40331/20120106_BRF_Background-Paper-Medicare-Locals-Health-Needs-Assessment-and-Planning.pdf, (accessed 30 July 2012).

6 Mr Gordon Gregory, NRHA, *Committee Hansard*, 11 May 2012, p. 24.

7 CRANaplus, *Submission 26*, p. 6.

8 NSW Rural Doctors Network, *Submission 18*, p. 3.

9 Dr Leslie Bolitho, Royal Australasian College of Physicians, *Committee Hansard*, 11 May 2012, p. 54.

10 Ms Catherine O'Toole, QAMH, *Committee Hansard*, 23 April 2012, p. 28.

11 Mr Gordon Gregory, NRHA, *Committee Hansard*, 11 May 2012, p. 25.

7.6 The RCNA, while noting that it is too early to assess the efficacy of the program, expressed hope that positive outcomes could be achieved:

In relation to Medicare Locals, it is acknowledged that their introduction is at various levels of implementation. At this point it is too early to determine the effect they will have on the provision of health service in rural areas. RCNA continues to endorse Medicare Local partnerships, inclusive membership and skills based corporate governance arrangements and engagement with health service users. Achieving the goals of improving Australia's primary healthcare infrastructure and better integrating service delivery requires broad engagement with health professionals working in the sector.¹²

7.7 The Council of Ambulance Authorities Inc. informed the committee that Medicare Locals have the potential to improve patient outcomes, saying:

Medicare locals are an opportunity to support coordinated, client-focused health service delivery in all parts of Australia. The extent to which this opportunity will be realized remains to be demonstrated but it is there to be grasped.¹³

Key issues raised during the inquiry

7.8 Although there is as yet no concrete evidence regarding the efficacy of Medicare Locals, the committee did hear a number of specific concerns regarding the program. Central issues raised include:

- (a) Medicare Locals' management of after-hours services;
- (b) communication and consultation;
- (c) information management;
- (d) the administration of Medicare Local areas;
- (e) monitoring and evaluation.

After-hours service provision

7.9 The provision for after-hours care will be transferred wholly to Medicare Locals from 1 July 2013 with the cessation of existing after hours and Practice Incentive Program (PIP) payments.¹⁴ It is intended that the service will be added and integrated with the current *healthdirect Australia* service which provides telephone based nurse triage information and advice. According to the Department of Health and Ageing's website people who may need medical attention at night or at the weekend should follow these steps:

12 Professor Karen Francis, Royal College of Nursing, Australia, *Committee Hansard*, 11 May 2012, p. 39.

13 The Council of Ambulance Authorities Inc., *Submission 6*, p. 7.

14 Department of Health and Ageing, *Establishment of Medicare Locals and better access to after hours care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01#2>, (accessed on 30 July 2012).

- (a) contact their local general practice and have their call referred as necessary to *healthdirect Australia*
- (b) have their condition assessed by a nurse, who will determine whether the patient should have their call transferred to an online GP
- (c) be provided with appropriate advice and options by the nurse if the patient is not referred on to a GP
- (d) where patients are referred on to the GP, the GP will provide further medical advice and treatment options.
- (e) To ensure appropriate continuity of care, a record of all GP consultations will be sent electronically to the patient's usual GP the following morning.¹⁵

7.10 Medicare Locals will be funded to ensure the availability of face-to-face after hours service in their area and the after-hours MBS items will remain unchanged.¹⁶ Doctors will not be directly financially affected if they provide after-hours care.

7.11 The RDAA is strongly opposed to Medicare Locals taking over this role. They made the point in their submission that they oppose Medicare Locals as fund holders in general, and as administrators of after-hours care in particular.¹⁷

7.12 In their submission they highlighted a potential conflict of interest as one of their concerns:

Under the new process, PIP will be replaced by locally-based arrangements for allocating funding that will be determined by the Boards of Medicare Locals. The potential for conflicts of interest is substantial. Many health professionals sitting on such Boards will have a private practice, or be affiliated with a private practice, that may wish to seek funding from Medicare Locals. Requiring the CEO or Board of a Medicare Local to make decisions about allocating funding to a Board member is less than ideal.

...

There is a real potential for a conflict of interest where the Medicare Local is a fund holder and also becomes a service provider. What happens where a Medicare Local establishes a new after-hours service in a community because the local medical practice did not provide this service, and some time later the practice is purchased by a doctor who wants to compete with the Medicare Local in terms of providing afterhours services?¹⁸

15 Department of Health and Ageing, *Establishment of Medicare Locals and better access to after hours care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01#2>, (accessed on 30 July 2012).

16 Department of Health and Ageing, *Establishment of Medicare Locals and better access to after hours care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01#2>, (accessed on 30 July 2012).

17 RDAA, *Submission 67*, p. 26.

18 RDAA, *Submission 67*, p. 27.

7.13 The submission continues to discuss the effects that a Medicare Local deciding to discontinue an after-hours service will have on the long-term viability of rural general practices. The RDAA also expressed fears that federal/state relations and responsibilities will be impacted:

RDAA has concerns that the new arrangements will create an environment that allows for cost-shifting to occur from State Governments to the Federal Government. With Medicare Locals now funded for the planning and funding of local face-to-face after hours services, State Health Departments may step away from afterhours industrial agreements. If this occurs, afterhours services in some rural and remote communities may collapse.¹⁹

7.14 The view of the RDAA was echoed by Dr Meagher from the Young District Medical Centre who expressed disappointment that support proposed to be provided by Medicare Locals would not match actual need:

Primarily their first interest was in after hours and we believed it. The health minister said that should be one of their first goals. Their interest in what they call after hours is supplying services. They said they would pay for staff between five o'clock in the evening and eight o'clock in the evening and that is where the money will go so that we can offer an after hours service. To us that is more a convenience service. There are also hospital staff working at that time. Really, the after hours that we need help with is the 24-hours a day, particularly those antisocial hours.²⁰

7.15 Orbost Regional Health provided an example of this uncertainty caused by the introduction of Medicare Locals:

[W]e currently receive Medicare Out of Hours funding and use this to ensure 24 hour cover 365 days of the year in a very large geographical area. No one in living memory can recall a time when we have not delivered on this. However we are about to lose the direct allocation of this money to the Medicare Local. We will have to apply for this money and we assume will be successful as we are the best mechanism for 24 hour cover in the subregion. We are now dependent on a new and unproven entity to make the correct decision and this makes us feel vulnerable.²¹

7.16 In response to the concerns raised during the inquiry the Department of Health and Ageing accepted that many of the concerns were caused by a lack of certainty about the role and ultimate service provision of the Medicare Locals:

I think the issue of concern comes down to the lack of certainty about what will happen come 1 July next year, which is why we are trying to make sure the planning and decision making on funding will be done sooner rather than later. GPs who are currently providing a good service will continue to

19 RDAA, *Submission 67*, p. 28.

20 Dr William Meagher, Young District Medical Centre, *Committee Hansard*, 11 May 2012, p. 31.

21 Orbost Regional Health, *Submission 16*, p. [3].

be funded to provide a service. We are trying to reassure them that that will happen but they obviously want greater clarity on that.²²

7.17 In light of the comments from the Young District Medical Centre's experience in applying for funding for after-hours service provision the department reiterated their definition of after-hours:

Mr Booth: We normally define after hours as after six and going through the weekend.

Senator MOORE: So not five to eight.

Mr Booth: No.²³

7.18 However, the Department did defend the potential of the Medicare Locals to both address the gaps in after-hours service provision, and to alleviate some of the pressure on rural GPs:

...there are a lot of places in Australia where we are not getting those services provided and the direct provision of GP after hours services by GPs currently is below 30 per cent. A lot of locum services and so forth are used to provide after-hours services...²⁴

What you tend to find, and I think this is where some of the concerns have been raised, is that in a lot of rural areas you actually tend to have quite good after hours services because the local GPs are the only people available and they tend to be available 24 hours a day. That is obviously an issue for them.²⁵

7.19 The Department also expressed their hopes that services currently working well in a community would retain their funding because one of the roles of the Medicare Locals in this respect is to work with the local GPs to improve access to after-hours services:

Because we are requiring the Medicare locals to work with the GPs in their communities to come up with plans about how they are going to ensure better access to after-hours services. If, for example, a GP after hours service is working well in a particular community, we would expect that service to continue to be funded. Those plans will come back to us for approval and it will be quite transparent and public about what services are going to be funded going forward.²⁶

Communication and consultation

7.20 The most common concern that the committee heard regarding the Medicare Locals scheme was that there had been a lack of communication regarding how the

22 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 22.

23 Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 74.

24 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 22.

25 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 21.

26 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 22.

program would operate and what implications it would have for the existing regional medical workforce.²⁷ The Victorian Healthcare Association expressed this frustration, stating '[t]he Federal Government urgently needs to provide more details on the role Medicare Locals will play in identifying and resolving workforce shortages.'²⁸

7.21 Evidence received from the Australian Association of Social Workers suggests that to date there has been insufficient communication with key stakeholders leaving them unsure of what Medicare Locals will mean for their members:

It is essential that allied health professionals are involved in the governance and organisational structure of Medicare Locals to ensure that Medicare Locals represent a range of primary health care interventions and that communities benefit from full access to allied health as well as to medical services. It will be important for Medicare locals to offer allied health services as core to their operations, in parallel with medical services. This recognises the fact that primary health care covers a range of services to consumers, of which, medical care constitutes one component. This requires allied health professional bodies to have input at a high level.²⁹

7.22 Similarly, the NRHA reported:

I have had a lot of GPs ask me what I know about the Medicare Locals. For instance, at the moment they might have a diabetes nurse in their clinic who is the only one in the town. Will they lose that person and have that resource taken away from them because this is a more attractive thing that is going on than in the GP clinic? If we have only a given number of physiotherapists, allied health people, psychologists et cetera, are they all now going to be torn between too many places?³⁰

7.23 The Australian College of Rural and Remote Medicine reported some concern among its constituents that Medicare Locals may threaten the place of GPs as the principal health provider:

[T]here is still a feeling of uncertainty about Medicare Locals. In rural and remote Australia your local GP is pivotal to the whole of the healthcare system within that community. They are key people within that sector. There is certainly some feeling around that that may be challenged within those systems. I still do not think there is a clear understanding of what Medicare Locals are going to be doing and what their fund-holder role is. There still seems to be some mixed concerns around that and the message is still coming from our members that this is an area of concern losing that pivotal role within the community.³¹

27 Mr Gordon Gregory, NRHA, *Committee Hansard*, 11 May 2012, p. 27.

28 Victorian Healthcare Association, *Submission 2*, p. 3.

29 Australian Association of Social Workers, *Submission 96*, p. 4.

30 Ms Anne Handley, NRHA, *Committee Hansard*, 11 May 2012, p. 26.

31 Ms Dianne Wyatt, Australian College of Rural and Remote Medicine, *Committee Hansard*, 5 June 2012, p. 13.

7.24 The AMA also emphasised the importance of GPs to the overall success of the Medicare Local program:

With delivery of primary health care services being the central plank of the operations of Medicare Locals, the AMA supports a governance structure that ensures a significant presence of local GPs on Medicare Local Boards and all key committees established by the Boards...The current Medicare Local model being implemented by the Commonwealth does not encourage/prioritise strong GP involvement and to that extent the AMA believes that they will result in poorly targeted services and the diversion of resources away from patient care.³²

7.25 In contrast, the North Queensland Combined Women's Services expressed some concerns regarding the makeup of the Medicare Locals board for Townsville–Mackay, noting that it was heavily weighted towards GPs to the exclusion of other health professionals:

[I]t is quite GP-driven. So everything revolves from the GP out, rather than, perhaps, from another place to the GP...The board is made up of five GPs and two non GPs, and one of those positions is not filled, it would appear. So that strength is very much a clinical practice. I notice that of all the mental health professions that employ, there are no social workers there.³³

Information management

7.26 Concern was expressed by CRANaplus that the introduction of Medicare Locals may result in the development of information silos:

With each [Medicare Local] focussing on Population Health Planning it is quite likely that each region will once again have differing quality data with no real effort to look at the whole picture especially in the remote sector.³⁴

7.27 In contrast, the General Practice Network Northern Territory indicated that the introduction of Medicare Locals may increase the sharing of information within their Medicare Local area:

[F]rom a workforce agency perspective, that is certainly going to help us build the whole multidisciplinary approach...It will also open the door for a lot more information and data sharing. Whilst we have tried, I think you still get those pockets of people who want to keep information to themselves and not necessarily be open about sharing.³⁵

32 AMA, *Submission 42*, pp 9–10.

33 Ms Catherine Crawford, The North Queensland Combined Women's Services, *Committee Hansard*, 23 April 2012, p. 41.

34 CRANaplus, *Submission 26*, p. 6.

35 Miss Angela Tridente, General Practice Network Northern Territory, *Committee Hansard*, 24 February 2012, p. 14.

Administration of Medicare Local areas

7.28 The committee heard concern that the vast geographical spread of some Medicare Local areas, as well as their boundaries, may impact on the ability of some Medicare Locals to effectively deliver appropriate health outcomes. Representatives from Tropical Medical Training observed:

I think the Commonwealth really does not have a good understanding of really how large this region is...To put a Medicare Local, for example, in Cairns and expect it to deal with Cape York, the Torres Strait, Innisfail and the west up into the highlands, where there are communities of interest, diversity, cultural land and the various players – the sensitivities of the Apunipima Cape York Health Council and other significant players like Wuchopperen, who have significant services in the lower end.

...

Why would you put a Medicare Local in Townsville and expect it to administer Mackay, when Mackay as a health district itself is significant going from Bowen way down past Sarina and out west to Moranbah? That could have easily been a Medicare Local on its own.³⁶

7.29 Concern was also raised by the CRERRPHC in relation to the boundaries of Medicare Local areas:

[I]n some rural and remote areas, Medicare Locals have been established that bear no relationship to the functional operation of health services or natural; geographic and demographic catchments. Simply imposing catchments on the basis of administrative boundaries (such as ABS units) is likely to render them dysfunctional in operation.³⁷

7.30 A related view was put forward by representatives from RHWA who argued that rural health may not receive the necessary attention in areas where a Medicare Local areas cover both metropolitan and non-metropolitan areas:

We are hearing concerns about continuity of services and the fact that Medicare Locals have such a broad charter that their overall focus on rural and remote may be diluted. In a number of states the Medicare Locals spread from city to bush.³⁸

7.31 The large size of the Medicare Local areas also raised concerns about whether or not service planning could truly be considered 'local', with the Tasmanian Government Department of Health and Human Services noting that:

Remoteness measure insisted upon by centralised government may be anathema to the idea of local planning, especially in Tasmania where the

36 Mr Ian Hook, Tropical Medical Training, *Committee Hansard*, 23 April 2012, p. 9.

37 CRERRPHC, *Submission 32*, p. 6.

38 Ms Margie Mahon, RHWA, *Committee Hansard*, 5 June 2012, p. 25.

entire state will be served by one Medicare Local (albeit with regional branches).³⁹

7.32 A number of concerns were raised about the administration of the Medicare Local program as a whole. It was noted by Dental Health Services Victoria that 'each one of them seems to be reinventing the wheel'.⁴⁰ On a related matter, the Australian Physiotherapy Association reported that 'the governance structure for Medicare Locals are multiple and varied'.⁴¹

7.33 Similarly, RHWA observed that:

[T]here appear to be different approaches being taken by different Medicare Locals and that there is some general confusion as to what their roles will be in supporting a local rural and remote health workforce. While a 'local' approach to cater to 'local' needs is to be supported, it would be unfortunate if there were great inconsistencies between areas in terms of the basic workforce support functions of Medicare Locals. The health workforce drawing pool is truly an international one and Australia needs to maintain a concerted and cohesive approach.⁴²

Monitoring and Evaluation

7.34 The CRERRPHC argued that it will only be possible to assess the impact of Medicare Locals through a national evaluation framework:

[T]he essential issue here is that we require a comprehensive and nationally consistent evaluation framework that is based on the stated policy objectives of the Medicare Local program in order to be able to make an assessment of effectiveness in years to come.⁴³

7.35 The need for regular and timely evaluation was also emphasized by SARRAH and General Practice Queensland.⁴⁴

7.36 The Department of Health and Ageing said that the monitoring and evaluation of the Medicare Locals applies in a variety of ways. They pointed out that all applications, establishment and strategic plans were approved by the department, and then performance agreements were put in place. They then discussed the role of the National Health Performance Authority and the planned comparative assessment program:

...of course we also have the National Health Performance Authority, which is going to be doing healthy communities reports on Medicare locals, which is not just looking at the performance of Medicare locals but, rather, the health of the population within those regions. It looks more at efficiency,

39 Tasmanian Government Department of Health and Human Services, *Submission 69*, p. 21.

40 Dr Deborah Cole, Dental Health Services Victoria, *Committee Hansard*, 5 June 2012, p. 46.

41 Mr Jonathan Kruger, APA, *Committee Hansard*, 5 June 2012, p. 55.

42 RHWA, *Submission 107*, p. 17.

43 Centre of Research Excellence in Rural and Remote Primary Health Care, *Submission 32*, p. 6.

44 General Practice Queensland, *Submission 60*, p. 4; SARRAH, *Submission 62*, p. 9.

effectiveness, quality, patient experience and population health indicators as well. We will be able to look at the overall performance of Medicare locals within a geographic area and be able to do comparative analysis between different Medicare locals in terms of what is working and what is not and how we achieve good practice.⁴⁵

Committee view

7.37 Like the majority of submitters to this inquiry, the committee is of the view that the newness of the Medicare Local program makes it impossible to adequately assess its effectiveness at this time.

7.38 To be successful the program will require careful and intensive management to ensure that all the key stakeholders are adequately considered and consulted. According to many of the witnesses and submitters there has been a lack of communication between Medicare Locals and affected stakeholders regarding how the Medicare Locals program will operate, and what it will mean for their businesses. Greater effort needs to be expended to ensure that the necessary information is available for interested stakeholders.

7.39 However the committee shares the cautious optimism of the potential for Medicare Locals to fill the gaps between local hospital networks, and GP community care provision. The inclusion of all health stakeholders needs to be ensured and an open approach to innovative delivery models should be embraced. Evidence from bodies such as the Council of Ambulance Authorities in providing community paramedicine⁴⁶ illustrates that having a broader fund holder like a Medicare Local that can look beyond siloed budgets can benefit health care provision and improve health outcomes in rural areas.

7.40 In the committee's view the needs assessment element of the Medicare Local program is the singularly most important aspect of their work as it will provide the strategic overview that has been missing to date. The timely dissemination of the results of the needs assessments can ensure the constructive input of many of the key stakeholders. The uncertainty over the provision of after hours service provision is an area that requires evidence based decision making as quickly as possible to dispel the fear and anxiety that has been expressed over the status of existing services. In the medium to long term the regular dissemination of the monitoring and evaluation of the programs nationwide will also ensure that best practice is shared and replicated across the country.

Recommendation 16

7.41 The committee recommends that where existing after hours services are operating effectively there should be no disruption to their administration or funding.

45 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 23.

46 Council of Ambulance Authorities, *Committee Hansard*, 5 June 2012, p. 43.

7.42 In the medium to long term the regular dissemination of the results of monitoring and evaluation of the programs nationwide will ensure that best practice is shared and replicated across the country.

Recommendation 17

7.43 The committee recommends that Medicare Locals Needs Assessment Reports are made public and a process of engagement and consultation is undertaken.

7.44 A range of evidence has been mentioned in preceding chapters that identified potential gaps or overlaps between current policies and programs. The committee is also aware that Medicare Locals are expected to conduct needs assessments that include:

- [the] analysis of service gaps and identification of evidence-based strategies to improve health outcomes and the quality of service delivery in local area populations;
- joint service planning with Local Hospital Networks and other organisations; and
- [a focus on] early achievements and tangible outcomes in facilitating a reduction in inappropriate or inefficient service utilisation and avoidable hospitalisations.⁴⁷

7.45 According to evidence from Department of Health and Ageing, Medicare Locals are being tasked with firstly identifying gaps in service delivery between primary and secondary care through their Local Needs Assessment, and then breaking down the barriers to ensure there are pathways that link primary and secondary care together.⁴⁸ One of these barriers is the mismatch that sometimes occurs between Commonwealth and state or territory health policy and resourcing. The committee is of the view that this particular barrier should be addressed at a national level rather than locally. However the Needs Assessment Reports prepared by Medicare Locals will be a valuable resource from which to identify potential inter-jurisdictional issues.

Recommendation 18

7.46 The committee recommends that the Department of Health and Ageing prepare a brief for COAG's Standing Council on Health on existing or emerging gaps affecting the delivery of health services to rural and remote communities caused by mis-alignment between Commonwealth and state policy, including options for measures to remediate such gaps. The brief is to be based on engagement with relevant stakeholders, including state and territory governments, Medicare Locals, representatives of peak bodies such as RDAA,

47 Department of Health and Ageing, *Guide and Template for Medicare Locals Needs Assessment Report*, version 1.0, p. 1.

48 Mr Mark Booth, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 74.

SARRAH and NRHA at both national and state level, and to be provided on at least a bi-annual basis.

**Senator Rachel Siewert
Chair**

APPENDIX 1

Submissions and Additional Information received by the Committee

- 1** Dr Virginia Wrice
- 2** Victorian Healthcare Association
- 3** Dr Timothy Wood
- 4** Dr Tilak Dissanayake
- 5** The University of Western Australia
- 6** The Council of Ambulance Authorities Inc.
- 7** RWM Consultancy
- 8** Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- 9** Dr Rosalind Menzies
- 10** Riverina Institute TAFE NSW
- 11** Dr Rhys Henning
- 12** Associate Professor Pieter Mourik
- 13** Dr Philip Dawson
- 14** Dr Peter Lake
- 15** Mrs Patricia Coloe
- 16** Orbost Regional Health
- 17** NT Health Workforce as a unit of GPNNT
- 18** NSW Rural Doctors Network
- 19** Dr Martin Byrne
- 20** Dr Louise Marsh

- 21 Dr Leslie Woollard
- 22 Dr Andrew Egan
- 23 Dr Gilbert Wallace
- 24 Dr Geoff White
- 25 Dr Ewen McPhee
- 26 CRANaplus
- 27 Clinical Oncological Society of Australia
- 28 Australian Federation of AIDS Organisations
- 29 Associate Professor Alan Chater
- 30 Dr Michael Williams
- 31 Dr Daniel Manahan
- 32 Centre of Research Excellence in Rural and Remote Primary Health Care
- 33 Dr Ka Chun Tse
- 34 Dr Aniello Iannuzzi
- 35 NSW Health
- 36 Townsville-Mackay Medicare Local
- 37 Young District Medical Centre
- 38 Dr Lachlan Lipsett
- 39 Dr Colin Pate OAM
- 40 Dr Elizabeth Dodd
- 41 The Royal Australian College of General Practitioners
- 42 Australian Medical Association
- 43 Rural Doctors Association Victoria
- 44 Optometrists Association Australia
- 45 Dr Christine Lucas

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- 46** Australian Paediatric Society
 - 47** Dental Health Services Victoria
 - 48** Central Loddon Mallee Medical Workforce Group
 - 49** General Practice Victoria
 - 50** Cessnock City Council
 - 51** Dr Tony Lian-Lloyd
 - 52** Broken Hill City Council
 - 53** Dungog Shire Council
 - 54** Western District Health Service (WDHS)
 - 55** Dr. Paul Beiboer
 - 56** The Council of the Shire of Brewarrina
 - 57** Upper Hunter Shire Council
 - 58** Royal Flying Doctor Service
 - 59** Tropical Medical Training
 - 60** General Practice Queensland
 - 61** Mr Peter McInerney
 - 62** Services for Australian Rural and Remote Allied Health
 - 63** Dr Peter Chilcott
 - 64** Catholic Health Australia
 - 65** The Hon Bruce Scott
 - 66** Health Workforce Queensland
 - 67** Rural Doctors Association of Australia
 - 68** Charles Sturt University
 - 69** Tasmanian Government Department of Health and Human Services
 - 70** South East Regional Organisation of Councils

- 71 Australian Physiotherapy Association
- 72 Australian Healthcare and Hospitals Association
- 73 Australian Dental Association Inc.
- 74 Australian Government Department of Health and Ageing
- 75 Dr John M Bouilly
- 76 The Royal Australasian College of Physicians
- 77 Speech Language Therapy Strategic Leadership Network, Education Queensland
- 78 Exercise and Sports Science Australia
- 79 Mr Christoph Ahrens MD
- 80 General Practice Registrars Australia
- 81 WA Country Health Service
- 82 Royal College of Nursing, Australia
- 83 Pharmaceutical Society of Australia
- 84 Ms Karen Hutchinson
- 85 Mr Chris Littlemore
- 86 Dietitians Association of Australia
- 87 Australian Psychological Society
- 88 Dr Geoff Courtis
- 89 City Of Mount Gambier
- 90 Dr Cameron Robertson
- 91 Cherbourg Hospital
- 92 Warrumbungle Shire Council
- 93 Faculty of Medicine, Health and Molecular Sciences, James Cook University
- 94 Dr Kyle Sheldrick

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- 95** National Rural Health Alliance Inc.
- 96** Australian Association of Social Workers (AASW)
- 97** East Grampians Health Service
- 98** Dubbo City Council
- 99** Great Lakes Council
- 100** Confidential
- 101** Confidential
- 102** Name Withheld
- 103** Mr R. Frank Gorman
- 104** Name Withheld
- 105** Name Withheld
- 106** Ms Tracey Jacobson
- 107** Rural Health Workforce (RHW)
- 108** Name Withheld
- 109** Lachlan Shire Council
- 110** Australian Institute of Health and Welfare
- 111** South Australian Government
- 112** Victorian Government
- 113** Stawell Medical Centre
- 114** Name Withheld
- 115** Dr Jim Wilhelm
- 116** Confidential
- 117** Dr Rob Oswald
- 118** Drs Geoffrey Symons, Mark Lang, Sue Boyer
- 119** Name Withheld

- 120 Mrs Susan Spinner
- 121 Dr Ian Dumbrell
- 122 Department of Health, Northern Territory
- 123 The Pharmacy Guild of Australia
- 124 Australian Bureau of Statistics
- 125 Australian College of Rural and Remote Medicine
- 126 Queensland Health
- 127 Rural Health Education Foundation
- 128 Confidential
- 129 Confidential
- 130 Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- 131 Queensland Rural Medical Education (QRME)
- 132 Dr Kathryn Antioch

Additional Information Received

- 1 Additional Information tabled by Professor John Humphreys on 5 June 2012
- 2 Additional Information tabled by the Council of Ambulance Authorities on 5 June 2012
- 3 Additional Information tabled by the Rural Doctors Association of Australia on 11 May 2012
- 4 Additional Information tabled by Professor John Humphreys on 11 May 2012
- 5 Additional Information tabled by Professor John Humphreys on 5 June 2012
- 6 Additional Information tabled by Dr Pieter Mourik on 5 June 2012
- 7 Additional Information from The Womens Centre, received 26 April 2012
- 8 Additional Information from the Aboriginal Medical Services Alliance Northern Territory, received 24 February 2012

Answers to Questions on Notice

- 1** Answers to Questions on Notice received from General Practice Network NT, 24 February 2012 hearing
- 2** Answers to Questions on Notice received from the Department of Health, Northern Territory, 5 April 2012 hearing
- 3** Answers to Questions on Notice received from James Cook University, 23 April 2012 hearing
- 4** Answers to Questions on Notice received from Health Workforce QLD, 23 April 2012 hearing
- 5** Answers to Questions on Notice received from the Australian Medical Association, ACT, 11 May 2012 hearing
- 6** Answers to Questions on Notice received from the Royal Australasian College of Physicians, 11 May 2012 hearing
- 7** Answers to Questions on Notice received from Services for Australian Rural and Remote Allied Health, 11 May 2012 hearing
- 8** Answers to Questions on Notice received from Rural Doctors Association of Australia, 11 May 2012 hearing
- 9** Answers to Questions on Notice received from Department of Health and Ageing, 11 May 2012 hearing
- 10** Answers to Questions on Notice received from Department of Health and Ageing, 11 May 2012 hearing
- 11** Answers to Questions on Notice received from Department of Health and Ageing, 11 May 2012 hearing
- 12** Answers to Questions on Notice received from the Australian Physiotherapy Association, 5 June 2012 hearing
- 13** Answers to Questions on Notice received from Charles Sturt University, 5 June 2012 hearing
- 14** Answers to Questions on Notice received from Dr Pieter Mourik, 5 June 2012 hearing
- 15** Answers to Questions on Notice received from the Council of Ambulance Authorities, 5 June 2012 hearing
- 16** Answers to Questions on Notice received from Rural Health Workforce Australia, 5 June 2012 hearing

- 17** Answers to Questions on Notice received from the Royal Australian College of General Practitioners, 5 June 2012 hearing
- 18** Answers to Questions on Notice received from Dental Health Services Victoria, 5 June 2012 hearing
- 19** Answers to Questions on Notice received from Department of Health and Ageing, 10 July 2012 hearing

APPENDIX 2

Public Hearings

Monday, 20 February 2012

Gumtree Room, Chifley Alice Springs Resort, Alice Springs

Witnesses

Central Australian Aboriginal Congress

Ms Stephanie Bell, Chief Executive Officer
Dr John Boffa, Public Health Medical Officer

Friday, 24 February 2012

Legislative Assembly, Darwin

Witnesses

Aboriginal Medical Services Alliance of the Northern Territory

Mr Chips Mackinolty, Manager, Research Advocacy Policy

General Practice Network Northern Territory

Miss Angela Tridente, Manager, Northern Territory Health Workforce and Member Services

Northern Territory Department of Health

Ms Patricia Morayne Wake, Director Remote Health
Ms Nikla Louise Walford, Acting Executive Director Health Services
Dr Anthony Joseph (Jo) Wright, Director, Activity based Funding

Monday, 23 April 2012

Mercure Hotel, Townsville

Witnesses

Townsville/Mackay Medicare Local

Ms Aileen Colley, Mental Health Services Director

The North Queensland Combined Women's Services

Ms Catherine Lynnette Crawford, Coordinator

Tropical Medical Training

Mr Ian Hook, Chief Executive Officer
Dr Rodney Nan Tie, Director of Training

Health Workforce Queensland

Mr Chris Joseph Mitchell, Chief Executive Officer

James Cook University

Professor Richard Murray, Dean of Medicine and Dentistry, Faculty of Medicine, Health and Molecular Sciences
Ms Pamela Jayne Stronach, Faculty Executive Officer, Faculty of Medicine, Health and Molecular Sciences

Queensland Alliance for Mental Health

Ms Catherine E O'Toole, State President

Friday, 11 May 2012

Parliament House, Canberra

Witnesses

Department of Health and Ageing

Mr Lou Andreatta, Assistant Secretary
Mr Mark Booth, First Assistant Secretary
Mr Paul Cutting, Acting Director
Ms Kerry Flanagan, Deputy Secretary
Ms Penny Shakespeare, Acting First Assistant Secretary

Royal Australasian College of Physicians

Dr Leslie Edward Bolitho, President-Elect
Mr Sasha Grebe, Director, Professional Affairs, HR and Advocacy

Young District Medical Centre

Dr Tom Douch, General Practitioner
Mr David Kay, Practice Manager
Dr William Meagher, General Practitioner

Royal College of Nursing

Professor Karen Francis, Chair, Rural Nursing and Midwifery Faculty

Ms Kathleen McLaughlin, Deputy CEO, Director, Operations and Professional Services

Dr Jane Mills, Advisory Committee Member, Rural Nursing and Midwifery Faculty

National Rural Health Alliance

Mr Gordon Gregory, Executive Director

Ms Anne Handley, Policy Adviser

Mrs Helen Hopkins, Policy Adviser

Australian Medical Association

Dr Steve Hambleton, Federal President

Mr Warwick Hough, Senior Manager, General Practice, Legal Services and Workplace Policy Department

Dr David Rivett, Chair, AMA Rural Medical Committee

Rural Doctors Association of Australia

Ms Jenny Johnson, Chief Executive Officer

Dr Paul Mara, President

Services for Australian Rural and Remote Allied Health

Ms Sheila Keane, Board Member

Mr Rod Wellington, Chief Executive Officer

Clinical Oncological Society of Australia

Professor Bogda Koczwara, President

CRANaplus

Ms Gerardine Malone, National Coordinator of Professional Services

Australian Bureau of Statistics

Mr Alister Nairn, Director, Geography

Ms Gemma Van Halderen, Program Manager, Demography, Regional and Social Analysis Branch

Dr Gilbert Hugh Murray Wallace

Tuesday, 5 June 2012

Robert Brown Meeting Room, Albury City Council Building, Albury

Witnesses

Rural Health Workforce Australia

Ms Melissa Cameron, Director of Workforce Programs

Ms Margie Mahon, Director of Workforce Programs

Dental Health Services Victoria

Dr Deborah Cole, Chief Executive Officer

Ms Nicola McCormick, Executive Director, Workforce

Royal Australian College of General Practitioners

Dr Lauren Cordwell, Manager, National Rural Faculty

Dr Kathryn Anne Kirkpatrick, Chair, National Rural Faculty

Charles Sturt University

Professor John Dwyer, Professor of Medicine and Executive Consultant to the Medical School

Professor Nicholas Klomp, Dean, Faculty of Science

Professor Andrew Michael Vann, Vice-Chancellor

Centre of Research Excellence in Rural and Remote Primary Health Care

Professor John Humphreys

Australian Physiotherapy Association

Mr Jonathon Kruger, General Manager, Advocacy and International Relations Division

Ms Melissa Locke, National President

Dr Pieter Mourik

Council of Ambulance Authorities

Mr Gregory Philip Mundy, Chief Executive Officer

Australian College of Rural and Remote Medicine

Ms Dianne Wyatt, Strategic Projects Manager

Tuesday, 10 July 2012

Parliament House, Canberra

Witnesses

Dr Christoph Ahrens

Department of Health and Ageing

Mr David Butt, Deputy Secretary

Mr Adam Catchpole, Director, Rural and Regional Health Australia

Mrs Elizabeth Murray, Director, Health Workforce Division

Ms Penny Shakespeare, First Assistant Secretary, Health Workforce Division

Queensland Health

Dr Denis Lennox, Executive Director and Senior Adviser, Medical Services, Office of Rural and Remote Health

University of Queensland

Professor Geoffrey Charles Nicholson, Head and Director of Research, Rural Clinical School