rural health workforce
AUSTRALIA

SUBMISSION TO THE SENATE COMMUNITY AFFAIRS COMMITTEE

THE FACTORS AFFECTING THE SUPPLY OF HEALTH SERVICES AND MEDICAL PROFESSIONALS IN RURAL AREAS

January 2012

making healthcare accessible

Rural Health Workforce (RHW) is a national not-for-profit organisation that seeks to improve community access to primary healthcare services in rural and remote Australia.

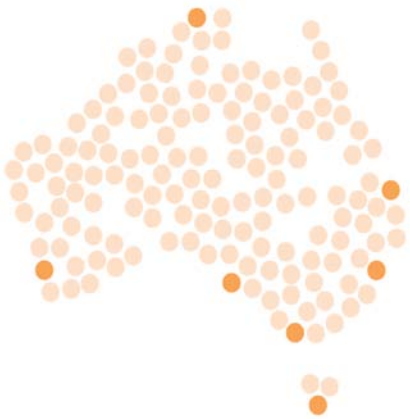
We are funded by the Federal Department of Health and Ageing (DoHA) to whom we provide policy and program advice.

RHW is the peak body for the seven Rural Workforce Agencies (RWAs) that operate in each State and the Northern Territory. These agencies directly recruit and support health professionals in rural and remote communities.

This federal network provides a unique insight into factors affecting the supply and retention of the health workforce in rural and remote Australia. As well as delivering national programs to support recruitment and retention of existing health professionals, RHW is the auspicing body for the National Rural Health Students Network. We work closely with the future workforce population, encouraging them to aspire towards rural and remote practice within their career mix.

Our submission has been developed in consultation with the Rural Workforce Agencies (listed below) and complements any individual submissions made by them.

NSW Rural Doctors Network
Rural Workforce Agency, Victoria
Health Workforce Queensland
Rural Doctors Workforce Agency (SA)
Rural Health West (WA)
NT Health Workforce
Health Recruitment Plus (TAS)



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1. Executive Summary

There is a glaring disparity between the overall picture of health services in Australia and rural and remote areas where the health outcomes are not on par with other Australians. The demand for health services and providers, including GPs, nurses and allied health professionals, in rural and remote areas of Australia outstrips supply.

Although the number of GPs practising in rural and remote areas has grown over the past nine years, the rise has not been sufficient to remedy the much lower GP-to-population ratios evident in small rural and remote communities. Without the significant influx of overseas trained doctors, the situation would be far worse.

Factors contributing to an inadequate supply of GPs include 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.

A range of incentive programs to redress this imbalance are provided by the Australian Government as well as at the State and Territory level. The Rural Health Workforce network plays an essential role in consolidating a number of Commonwealth and State programs and projects into a comprehensive package tailored for individual GPs. Incentives often only work when offered in conjunction with other elements of a package.

Some incentives are not operating to their potential and could be amended, or better implemented, to increase their efficacy. It should also be recognised that while incentives to pull GPs to rural areas will always be important, the policies that have often had the greatest impact on GP numbers have involved a level of coercion - for example, Medicare Provider Numbers being allocated to overseas trained doctors who are willing to practise in an area of need.

Changes to the ASGC-RA scheme have led to some anomalies which can hinder the recruitment of GPs to rural and remote areas. A process to review this scheme and embed another layer which considers factors of need could address many of these issues. Policies and incentive programs need to support a modern approach to providing health care services in rural and remote Australia. An increased focus on primary care requires models which allow health practitioners flexibility in their working arrangements. These professionals also need to be able to readily work in inter-disciplinary teams to deliver health outcomes and be supported to access appropriate Continuing Medical Education.

2. Key Recommendations

Recommendation 1: That the eligibility criteria for the Rural Relocation Incentive Grant (RRIG) Component of the General Practice Rural Incentives Program (GPRIP) be changed to include medical practitioners who are undertaking vocational training to gain Fellowship of Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM) .

Recommendation 2: That the eligibility criteria for Rural Relocation Incentive Grant (RRIG) Component of the General Practice Rural Incentives Program (GPRIP) be relaxed to allow medical practitioners who have provided locum services (in the past 12 months) for up to 40 days in the same ASGC–RA category, or higher, to which they apply to relocate, and who meet all other eligibility criteria, to be deemed eligible for the RRIG.

Recommendation 3: That the Rural Relocation Incentive Grant (RRIG) guidelines be changed to provide for doctors to apply for the grant within three months of having moved to the new location.

Recommendation 4: That the criteria be amended to make the Rural Relocation Incentive Grant (RRIG) available to International Medical Graduates (IMGs) who are Vocationally Registered and that non Vocationally Registered IMGs be able to access, at no cost, training to obtain Vocational Registration.

Recommendation 5: That Government appropriately fund, on a sustained basis, rural GP recruitment programs such as those provided by Rural Health Workforce.

Recommendation 6: That the HECS Reimbursement Scheme, currently offered to medical students, be expanded to other health professions.

Recommendation 7: That the rural background intake quota to medical schools should, at a minimum, reflect the proportion of the population living in rural Australia.

Recommendation 8: That Universities be held accountable to their rural intake goals and should a University be consistently unable to fill this quota, the funding associated with these rural intake places be transferred to other Universities which can demonstrate their ability to recruit more students of rural origin.

Recommendation 9: That the Australian Government review the Standard Geographical Classification – Remoteness Areas (ASGC-RA) scheme with a view to instigating a process by

which other factors affecting need are assessed in conjunction with the remoteness of communities.

Recommendation 10: That the 10 Year Moratorium in relation to International Medical Graduates (IMGs) is retained as an important policy tool for tackling workforce maldistribution.

Recommendation 11: That Australian Government develop policy which supports improved practice management and practice viability interventions in vulnerable rural and remote communities to facilitate continuity of access to primary care services.

Recommendation 12: That redesigned policy and funding arrangements be developed to ensure health professionals across the disciplines can work effectively together and that they are supported to do so through appropriate administrative and technical support services.

Recommendation 13: That a benchmarking framework be developed to allow localised and longitudinal demand and supply analyses to inform national policy and programs and that Rural Health Workforce's federal network be considered as a means of undertaking this research.

3. Introduction

Rural Health Workforce (RHW) is pleased to provide this submission to the Senate Community Affairs Committee Inquiry: *The factors affecting the supply of health services and medical professionals in rural areas.* For more than 10 years our federal network of Rural Workforce Agencies has been the main source of recruitment and retention services for health professionals in rural and remote Australia. In addition, our network has recently expanded its remit to recruit and support the nursing and allied health workforce. This submission and its recommendations are based on our experience and expertise in what works and what does not.

Rural Health Workforce's role is to develop solutions to improve the recruitment and retention of the health workforce throughout rural and remote Australia. As a peak body, Rural Health Workforce represents the seven Rural Workforce Agencies that operate in each State and the Northern Territory. Our member agencies directly recruit and support health professionals in rural and remote communities. Our program activity includes the recruitment of Australian and overseas trained doctors, locum support and encouraging university students to pursue rural health careers.

Rural Health Workforce is also the auspicing body for the National Rural Health Students' Network (NRHSN), with a membership of more than 9,000 undergraduate medical, allied health and nursing students from 29 Rural Health Clubs at universities across the country. The NRHSN is the only national multi-disciplinary health student network of its kind.

Rural Health Workforce therefore has a unique insight into the needs and interests of the future rural and remote health workforce. The NRHSN aims to increase interest in rural health amongst university undergraduate health students, raise awareness about health courses amongst rural high school students and strengthen the knowledge, understanding, career motivation, and commitment to work in rural areas of Australia.

4. Demand and Supply Context

Australia enjoys a high quality healthcare system and performs well internationally in health indicators such as life expectancy, infant mortality and number of doctors per capita. However, Australian policy makers face challenges in continuing to deliver a high quality health service to all citizens. These challenges include meeting increasing demand for services, funding, and workforce availability and distribution.

There is a glaring disparity between the overall picture of health services in Australia and rural and remote areas where the health outcomes are not on par with other Australians.

People living in rural areas tend to have shorter lives and have higher levels of illness and disease risk factors than those in major cities. From 2004 to 2006, there were about 4,600 excess deaths outside of major cities - that is, deaths above the number expected if these rural areas had the comparable rates to the major cities.[1]

Aboriginal and Torres Strait Islander people have a shorter life expectancy compared to other Australians, a 10 year gap against the wider population, and the burden of disease experienced by Indigenous Australians is estimated to be two and a half times greater than that in the wider Australian population[2].

Not only do we need more absolute numbers of health professionals in rural and remote Australia to address maldistribution, but because of the poorer health of rural and remote communities, we also need an increase in the number of health professionals per capita. There is, therefore, a dynamic relationship between supply and demand but demand for services continues to outstrip supply.

4.1 Distribution

Australia has experienced a maldistribution of health professionals and shortages in rural and remote areas for more than 40 years. In this respect it is analogous to a 'chronic disease' to be 'managed' rather than an acute illness to be 'cured'. It is an issue which Australia experiences in common with many developed nations such as the UK and Canada. In contrast to these countries however, Australia has made some valuable inroads to addressing the issue through a range of strategies.

While there is an acknowledged worldwide shortage of health professionals, in Australia the shortage is exacerbated by maldistribution of the health workforce. There are vastly insufficient numbers of GPs and other health professionals in rural and remote Australia. Due to the fact that General Practice in Australia is based on private practice, where those health professionals choose to work is an individual decision (with the exception of some International Medical Graduates). The Australian health workforce, of more than 462,000 people working in the health services industry, is divided into three main categories with nursing by far the largest at 54%. Medicine and allied health are similar with about 11% and 14%, respectively[3].

As Australia has a small business model of General Practice rather than, say, the salaried model that prevails in the UK and Scandinavian countries, the Federal Government has fewer direct policy levers over this part of the primary health system. This is becoming

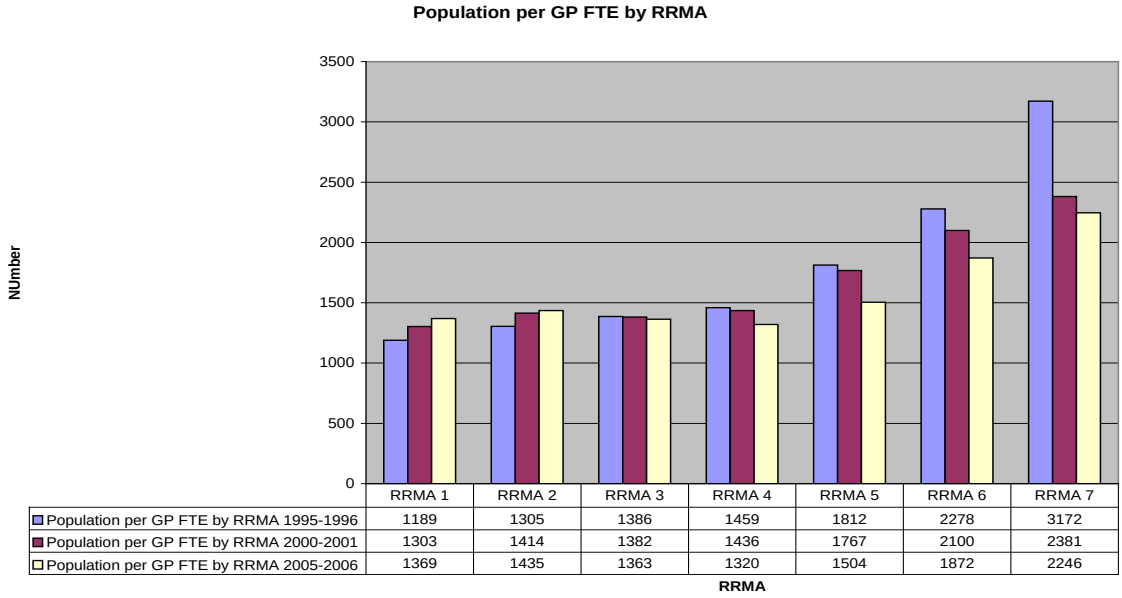
[1] Australian Institute of Health and Welfare 2010, Australia's Health 2010

[2] ABS, Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, 2005–2007 (cat. no. 3302.0.55.003)

[3] Australian Institute of Health and Welfare. Australia's health 2006. AIHW catalogue no AUS 73. Canberra, ACT: AIHW, 2006.

increasingly challenging as the healthcare system looks to primary healthcare as the key to future health policy directions. In reality, while incentives and support mechanisms will always be important, it is Government policies that have an element of coercion that have been most effective in delivering GPs to areas of need, such as the 10 Year Moratorium.

Focussing on a snapshot of vacancy rates tells us very little about the complexity of the issue of GP shortages in rural and remote Australia. One way of increasing our understanding is to look at what has been happening over time. The following chart tracks GP/population ratios based upon census statistics and by rurality[4]. Unfortunately, changes to the RRMA classification system means that it is not possible to have a consistent dataset for the period prior to and since that change in July 2009.



	RRMA 1	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7
Population per GP FTE by RRMA 1995-1996	1189	1305	1386	1459	1812	2278	3172
Population per GP FTE by RRMA 2000-2001	1303	1414	1382	1436	1767	2100	2381
Population per GP FTE by RRMA 2005-2006	1369	1435	1363	1320	1504	1872	2246

Figure 1: Population per full time equivalent GP by rural classification[5]

As the above chart indicates, over the 10 years to 2006 there had been an improvement in population per GP ratios in small rural and remote communities. However, despite this, there remains a significant gap between the population per GP ratio in rural and remote areas when compared with urban areas. The 2009 AIHW Medical Labour Force Survey shows that the supply of full time equivalent (based on a 40-hour working week) employed medical practitioners (specialists, hospital non-specialists, GPs) is significantly higher in urban areas[6]:

[4] Rurality is based on RRMA (Rural, Remote & Metropolitan Areas classification). Broadly, RRMA 1 and RRMA 2 are metropolitan area, RRMAs 3, 4 and 5 are regional, rural and small rural and RRMAs 6 and 7 are remote and very remote respectively. This system has been replaced by ASGC-RA which uses a different basis for defining rurality and now classes RA 2 – RA 5 as levels of rural and remote.

5 Data compiled by RHW from Census and the GP statistics on the Department of Health & Ageing website.

[6] Australian Institute of Health and Welfare 2011. Medical Labour Force 2009. Bulletin no. 89. Cat. no. AUS 138. Canberra: AIHW.

- Major cities: 392 FTE medical practitioners per 100,000
- Inner Regional: 225 FTE medical practitioners per 100,000
- Outer Regional: 206 FTE medical practitioners per 100,000.
- Remote / Very Remote: 246 FTE medical practitioners per 100,000

It should be noted when these ratios are analysed taking into account the 7.3 extra hours per week worked by rural medical practitioners (45.6 compared with 38.3 hours) they translate into lower rates of practitioners to population. The approximately 19% extra in working hours per week for rural practitioners is a significant amount of workload. It is also worth considering the rate of full-time equivalent GPs, or primary care medical practitioners as referred to by AIHW, to population which illustrates the reliance of rural communities on GPs due to a lack of specialist services.

- Major cities: 110 FTE primary care medical practitioners per 100,000
- Inner Regional: 102 FTE primary care medical practitioners per 100,000
- Outer Regional: 106 FTE primary care medical practitioners per 100,000.
- Remote / Very Remote: 143 FTE primary care medical practitioners per 100,000

It must be understood that GPs in rural towns often provide many additional services to their communities as compared with urban GPs. These services include on-call, hospital emergency and ward rounds and attending accidents. In stark contrast, in metropolitan areas there are plenty of additional services (such ambulance, well-staffed hospitals, after-hours services) and so GPs are not responsible for meeting these demands. Furthermore, the sparse nature of remote regions of Australia means that a lower ratio of GPs to the population is compounded by the larger geographic areas covered. Thus, access needs to be seen as both related to numbers of healthcare professionals and the geographic distance people live from those health care professionals and their services.

Simple ratios such as these above also need to be considered in light of differences in health status between the different geographic regions. People in rural and remote areas have, in relative terms, worse health outcomes than people in major cities and are therefore more in need of health services and rely on GPs for much of their health care.

Although the number of GPs continues to grow, this growth does not indicate increased availability of GPs over time, as the growth in the medical workforce has not kept pace with the rate of population growth. Over the decade from 1996-97 to 2006-07 the FWE of GPs increased by 10.9%, while the population increased by some 13.0% resulting in an overall decrease in the supply.

The shortage of doctors would be far more severe if not for the effect of policies to recruit IMGs. This dramatic rise in the number of internationally-trained rural and remote GPs is testimony to policy changes over the past decade. By effectively linking provider numbers to districts of workforce shortage and areas of need, governments have been able to focus the practice of IMGs 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 element of compulsion via Medicare can have in appropriately directing the GP workforce to where it is needed.

The following chart shows the changes across Australia in the 10 years to 2006 in rural and remote areas in relation to the proportions of Australian and internationally-trained medical graduates. Whilst similar data is not available for subsequent years, as at February 2008, there were 3,028 overseas trained GPs in private practice nationally and of these 1,437 worked in rural and remote areas. Medicare data shows that more than 41% of doctors working in rural and remote areas are trained overseas.[7]

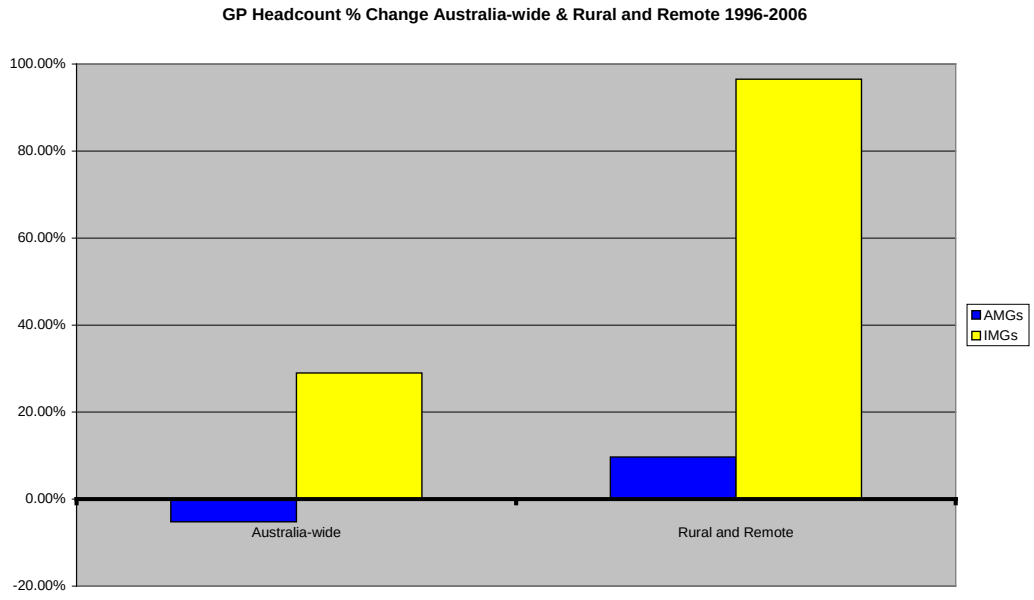


Figure 2: Change in Australian Trained and Overseas Trained GPs 1996 – 2006 – Australia-wide and rural and remote[8]

As this chart indicates, taking Australia as a whole over a 10-year period to 2006, the number of Australian-trained GPs (AMGs) declined while those from overseas increased by almost 30%. But as a subset, the rural and remote picture shows a more dramatic change in the landscape with an increase in Australian-trained GPs just under 10% but that this was far outweighed by a doubling in the number of internationally-trained GPs.

[7] Australian Institute of Health and Welfare 2011. Medical Labour Force 2009. Bulletin no. 89. Cat. no. AUS 138. Canberra: AIHW.

[8] Based upon data from Department of Health and Ageing (2007), General Practice Statistics.

5. Factors Limiting Supply

The factors contributing to the declining level of Australian-trained rural and remote GPs are complex and include: ageing and retirement of the GP workforce; inadequate numbers of medical graduates choosing General Practice, and of those, fewer still choosing rural practice; increasing numbers of GPs seeking to work part-time; the lack of attraction of solo practices and; the overall decline of some rural communities.

5.1 Ageing Demographic

In South Australia it was determined that 26% of their rural and remote GPs will retire over the next five years[9]. In addition, Tasmania has estimated that 40% of their current rural and remote GPs will be aged over 60 years within 10 years.[10] These state analyses are likely to be indicative of the situation Australia-wide and are predictive of a significant reduction of the existing rural and remote GP workforce in the near future. Proactive policy intervention to provide adequate supply into the rural health workforce will be necessary into the future. Without that, country people will face continued inequitable access to healthcare services.

> "You're able to do an enormous amount of good by being a GP up here. All of what I see is real medicine for people who really need it"
>
> – **Dr Trevor Lord**, Kimberley Aboriginal Medical Services Council, WA

It should be noted that an ageing demographic also characterises nursing and allied health workforces. A 2008 survey of the rural allied health workforce in New South Wales, to inform recruitment and retention, showed that more than a quarter of the sample, which included 1,879 respondents from more than 21 different allied health occupations, planned to retire within the next 5 to 10 years.11 As with GPs, there is a need to increase the number of young allied health personnel in rural and remote Australia and to support their career aspirations. These data show that while recruitment of new workforce into rural and remote areas is important, efforts to improve retention and support those who are already in rural and remote areas is critical. Retention of the existing health workforce is often overlooked as a mechanism for increasing workforce supply.

A range of inter-related factors impacts on the retention of health workforce in rural and remote areas. These include professional, environmental and personal issues all of which need to be considered in any analysis of supply issues. As the World Health Organization has

[9] Rural Doctors Workforce Agency (2007), Rural and Remote General Practice Workforce Participation and Medical Practice Composition in South Australia

[10] Source: Health Recruitment Plus Tasmania.

[11] Survey of the rural allied health workforce in New South Wales to inform recruitment and retention, Australian Journal of Rural Health, Volume 19, Issue 1, February 2011

noted, '*As causes for retention are likely to be rooted in both personal and work-related factors, strategies must address these multiple causes simultaneously'*.[12]

5.2 Professional Issues

The trend increasingly in primary healthcare is towards teamwork and multi-disciplinary approaches. Yet many rural and remote practices consist of solo practitioners working long hours, including in some cases arduous on-call arrangements. This model of practice makes the healthcare needs of a population extremely vulnerable to sudden changes, such as retirement, death or illness of the practitioner.

We also know this mode of practice is antithetical to the expressed wishes of more recent graduates and those GPs who are looking to change their working patterns. There needs to be considerable attention paid to how these opposing trends can be reconciled. This will involve attention being paid to models of practice ownership as well as service mix. As pointed out by the National Rural Health Students' Network: "*As the future health workforce, we want to train and work in interdisciplinary teams. We want models of employment and care which will afford us a good balance of career flexibility and security; we want collegiality; and we want to practice to the full scope of our professional training*."[13]

Research has demonstrated that for rural general practice to be viewed as a viable career option there is a need to ensure that there are a variety of engagement models available to attract the current generation of students.[14] These new models need to demonstrate competitive remuneration and conditions of engagement similar to those offered to the more traditional specialist positions.

This applies to other health professionals as well. For example, the 2008 Rural Allied Health Workforce Survey found that, other than retirement, the second most frequent reason for intending to leave was 'better career prospects'. Retention strategies should address the need for flexible employment arrangements and access to continuing education and professional development. [15]

Work issues such as inadequate remuneration, lengthy working hours, significant on call arrangements, lack of locum relief and inflexibility of working hours can be significant barriers to the supply of doctors. For instance, primary care practitioners in Remote/Very

[12] World Health Organization. Improving Health Worker Performance: in Search of Promising Practices. Geneva: WHO, 2006.
[13] Internal Paper, National Rural Health Students' Network, Nov 2011
[14] Road to Rural General Practice The Rural Doctors Workforce Agency Report on the Rural Pathway Project, June 2011
[15] Survey of the rural allied health workforce in New South Wales to inform recruitment and retention, Australian Journal of Rural Health, Volume 19, Issue 1, February 2011

Remote areas are working an average of 19% or 7.3 hours per week more than the national average (45.6 compared with 38.3 hours).[16] These factors can be intensified by a loss of anonymity and a sense of always being "on-call" for emergencies in small communities. The *flipside* of this negative is the sense of commitment, involvement and satisfaction which many GPs appreciate about rural practice.

> "What we do is 'cradle to grave' medicine. I have delivered children, watched them grow up, pulled them into line when they ran a bit feral as teenagers, and cared for their grandparents in their terminal hours ... there is a sense of belonging in a rural community which brings one much privilege, but that also entails a sense of commitment"
> – **Dr Tony Lian-Lloyd**, Quorn SA

While some rural practices are able to utilise public funding to provide an excellent income for the GP in remote and disadvantaged communities, this is very difficult within a fee-for-service framework. The poor financial rewards currently associated with this valuable work is a significant disincentive for those considering working in a rural or remote area.

What Factors Affect Retention?

- **Professional**
  Workload, professional isolation, locum access, low remuneration, access to CME, access to specialists
- **Family & Personal**
  Lack of opportunities for spouse & children, isolation
- **Community/Resources**
  Loss of anonymity, lack of facilities – cultural, educational, infrastructure, conflict within medical community

Source: Bilby L, Recruiting and Retaining General Practitioners in Rural Areas: Evidence Based

Locum support is seen as being one of the key support mechanisms to retain doctors enabling them to have a break away from their practices and pursue training and professional education. It is also helps to cover the practice in the case of illness. The importance of support to ensure that the doctor themselves stays in good health and spirits cannot be underestimated as this can help to prevent burn-out.

Professional isolation can be a critical factor for doctors who may be hundreds or even thousands of kilometres from the nearest hospital or specialist services. While there is scope for increased use of telemedicine to ameliorate this isolation, better funding models need to be developed and better telecommunications are required to fulfil this potential.

Although offering a wider scope of practice and rewarding patient relationships, rural practice can be perceived as not offering adequate professional development opportunities and career progression. Access to adequate Continuing Medical Education (CME) and

[16] Australian Institute of Health and Welfare 2011. Medical Labour Force 2009. Bulletin no. 89. Cat. no. AUS 138. Canberra: AIHW.

professional development opportunities are seen as being one of the most important factors in recruiting and retaining doctors. Initiatives to address these issues, such as the programs offered through the Australian College of Rural and Remote Medicine (ACRRM), should be supported to ensure that rural and remote GPs have the time and funds required to take up the opportunities available. Delivery mechanisms which bring vocational and professional training to regional areas will assist in making them more accessible.

The proportion of the clinical workforce comprising primary care practitioners declined from 44.8% of the clinical workforce in 1999 to 38% in 2009. Over the same period specialists-in-training increased from 9.7% to 13.5%[17]. Local graduates appear to be increasingly turning away from general practice which in itself reduces the potential pool of rural GPs. Given this trend away from General Practice, it is important that encouragement be given to graduates to choose a generalist training pathway to progress their career. [18]

> "I'll probably stay here forever. The people are fantastic, the environment is beautiful and you get to practise a variety of tropical medicine – some of which is very unusual"
> – Dr Satbir Aulakh, Overseas Trained Doctor, Humpty Doo NT

In some quarters of the medical profession, there is a tendency to "look down" on rural practice. This perception needs to be overcome with all facets of medicine respecting rural practice for the professionally diverse, challenging role it is. It is recognised that the status of rural General Practice needs to be enhanced and recognised and a number of initiatives are underway that are aiming to achieve this goal.

"*Coupled with rural training, there is a need to describe and promote rural general practice as a prestigious and highly valued specialty career*." [19] It is in the interests of the whole medical profession, and in line with the ethics of medicine serving the society which invests heavily in health services, for the maldistribution of doctors to be overcome.

5.3 Working / Living conditions

The environment in which GPs are required to live and work has a significant impact on their retention. Indeed, there is some evidence to indicate that for some professions, non-financial incentives related to working and housing conditions have greater potential than financial rewards to influence decision-making relating to length of stay[20]. Conversely, the

[17] Australian Institute of Health and Welfare 2011. Medical labour force 2009. Bulletin no. 89. Cat. no. AUS 138. Canberra: AIHW

[18] GPET (2007), 2007 AGPT Selection Outcomes Report. p. 6

[19] Road to Rural General Practice The Rural Doctors Workforce Agency Report on the Rural Pathway Project, June 2011

[20] Wilkinson D, Symon B, Newbury J, Marley JE. Positive impact of rural academic family practices on rural medical recruitment and retention in South Australia. The Australian Journal of Rural Health 2001.

attractions of rural living can be a cleaner environment, greater sense of community and access to natural attractions and outdoor pastimes. These attributes are built upon in Rural Health Workforce campaigns to encourage city based GPs to consider trying rural practice.

Issues such as the lack of employment opportunities for spouses and educational opportunities for children are other matters to be addressed for a doctor (or other health professional) re-locating to a rural region. Lack of appropriate housing is also an issue, in some cases such as Western Australia lack of availability is coupled with unaffordable housing especially in the mining areas. The lack of housing can often be an even bigger issue in trying to place allied health professionals, nurses and GP registrars.

Practice management issues can have a significant impact on retention with a well-managed practice able to help to settle in a new doctor, manage any professional conflicts and provide a well-run administrative system which allows the doctor to concentrate on clinical work. The administrative burden of running a small or solo practice, which is essentially a small business, can be heavy. These issues are dealt with in further detail below.

In a broad sense, the infrastructure, services and community strength of rural and remote Australia will continue to have a significant impact on recruitment and retention of health professionals. Continual improvement in telecommunications, transport, education and other services are required to make rural Australia a preferred place to live and work. Individual communities have demonstrated, often in conjunction with the relevant Rural Workforce Agency, that a concerted effort to demonstrate openness to new people and ways of working, and to welcome and support health professionals pays dividends in retaining high quality health services.

Our federal network provides enormous assistance to GPs working in rural and remote Australia through the provision of site visits to prospective practices, assistance to help orient doctors and their families to a rural life and ongoing professional support.

6. Medicare Locals

Medicare Locals have only recently been established with a small number commencing in 2011 and the remainder rolling out by mid-2012. Therefore is not possible to provide feedback on the effect of Medicare Locals in the provision of medical service in rural areas. It will be at least two to three years before even the initial impact can be gauged.

It is important that Medicare Locals are structured to build and enhance the prior work of Divisions of General Practice, including a local structure for implementation of various funding streams and support for existing GPs, GP practices and associated health professionals.

It has been noted that there 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. Opportunity for collaboration between the Rural Health Workforce federal network and the Medicare Local network exists.

Our member Rural Workforce Agency network is a repository of significant expertise in health professional recruitment and retention for rural and remote communities and is uniquely equipped to provide rural health workforce solutions across States and the Northern Territory. The Rural Workforce Agencies network possesses the right balance between critical mass, necessary for navigating the extremely complex health professional regulatory environment, and the necessary detailed knowledge and understanding of different regional contexts.

Movement of health professionals into rural and remote locations is a complex process involving much more than monetary incentives. The nuances surrounding the decision process of a professional (and family members) relocating can be considerable and these continue beyond recruitment into retention. Hence the "horsepower" of our network is an important ongoing element that Medicare Locals may benefit from, through collaboration.

The combination of the national and State/Territory perspective is very important in many instances. For example, one federally funded workforce support program is the Rural Health Workforce Rural GP Locum Program (RGPLP). This is delivered by the Rural Workforce Agencies network, through Rural Health Workforce. The RGPLP program is an efficient, effective, and sustainable, national service appreciated by locums, practices and rural communities. A truly national perspective cascades down, with the Rural Workforce Agencies being able to match locums to GP practices in regions right across their respective States and the NT. Their deep market knowledge across the population of practices, in all regions, means there is an ability to prioritise and direct the locums towards rural practices known to be most in need, for instance, solo practices and towns with less than three doctors. Locums sometimes convert to permanent recruits. In such cases, through working alongside a locum, the agencies are able to facilitate ready access to possible recruitment opportunities across an entire national rural and remote network.

7. Incentive programs

The incentives and support programs available to rural and remote health professionals need to be viewed in a holistic way since one will often not work unless offered in conjunction with others. Similarly, a particular combination will not work for all situations. Just as both the individual circumstances of doctors, and characteristics of rural communities vary, so does the package of incentives required to encourage a doctor to stay in the town. Our federal network of Rural Workforce Agencies provides an invaluable service by bundling national programs together and providing local contextualisation to ensure that they are relevant to the individual rural or remote practitioner's needs.

The Regional, Rural and Remote Health Workforce Strategy Background paper, produced by Health Workforce Australia (HWA), provides useful background as to current thinking about best practice rural and remote health delivery in Australia and internationally[21]. HWA notes some strategies recognised as working well including:

> "The variety of practice means there's never a dull day; you experience everything from emergency treatment through to acute and chronic care"
>
> – **Dr Emma Cunningham**, GP Registrar, Cooma NSW

- Promote, value and support generalist practice in all professions
- Expand existing roles, eg Nurse Practitioners, paramedic role expansion
- Develop new support and assistant roles, eg Physician Assistants, peer support workers
- Sustain what has worked in the past such as GP proceduralists
- Address attraction and retention of health professionals through a range of initiatives, eg selection of students, incentives, support, coercion (bonded scholarships), exposure to rural practice and rural location of training.

7.1 Efficacy of programs

In addressing Part (c) of the Terms of Reference for this inquiry, Rural Health Workforce focuses on the incentives which fall largely within the jurisdiction of the Australian Government. We acknowledge that there are also many incentives offered at State and Territory level which seek to address the shortage of rural health professionals. The incentives directly offered by the Australian Government are mainly done so through the Rural Health Workforce Strategy (RHWS).

[21] Health Workforce Australia (2011), National Regional, Rural and Remote Health Workforce Strategy Draft Background Paper, HWA, Adelaide.

Incentives range from measures to recruit a fully-fledged doctor to a community right now, through to incentives to increase the number of doctors able and willing to practice in a rural area in several years' time. Moreover, there are incentives which are directly monetary in nature and others which provide non-financial benefits. The various incentives come into play at different points in the GPs career, from medical student onward.

7.1.1 Financial Incentives - Retention

Financial incentives alone are not sufficient to retain a GP in an area of need but they do form part of the fabric of an overall package which may do so. They also have a positive effect on the morale of GPs who feel supported and valued through the provision of an incentive package. Since July 2010, the **General Practice Rural Incentives Program (GPRIP)** has been the main structure for delivery of direct Commonwealth incentives to rural GPs, including relocation and retention grants for doctors and registrars. It is designed to provide a consistent set of incentive payments applied on an equivalent basis for GPs and registrars practising in rural locations.

The level of incentives is based on the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system, the ramifications of which is discussed in further detail below. GPRIP payments are made in one of two ways: either directly to the GP on the basis of Medicare data (central payment system), or, for those services not provided services through Medicare (eg salaried doctors working in Aboriginal Medical Services) a flexible payment mode facilitated through the Rural Workforce Agencies. The latter picks up anomalies in service provision where the Medicare data does not adequately measure the service. This process of delivery of the incentives generally works well.

7.1.2 Financial Incentives - Recruitment

The eligibility criteria of GPRIP prevents it being as useful as it should be in recruiting doctors. For instance to be eligible for the **Rural Relocation Incentive Grant (RRIG)** the doctor must already have Fellowship of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM) and have provided at least one Medicare service in the place they are moving from. In practice, this excludes many doctors wishing to relocate to rural or remote areas. For instance, doctors who may be working in a hospital, rather than private practice, or an IMG.

Recommendation: That the eligibility criteria for the Rural Relocation Incentive Grant (RRIG) Component of the General Practice Rural Incentives Program (GPRIP) be changed to include medical practitioners who are undertaking vocational training to gain Fellowship of RACGP or ACRRM.

There are also examples of doctors who go to a region to do a short-term locum and decide to move there permanently, yet because they have not worked in that area for more than 20 days, they are not eligible for the relocation grant. This type of transfer should be encouraged rather than impeded.

Recommendation: That the eligibility criteria for Rural Relocation Incentive Grant (RRIG) Component of the General Practice Rural Incentives Program (GPRIP) be relaxed to allow medical practitioners who have provided locum services (in the past 12 months) for up to 40 days in the same ASGC – RA category, or higher, to which they apply to relocate, and who meet all other eligibility criteria, to be deemed eligible for the RRIG.

A further impediment to the efficacy of the RRIG is that in order to be eligible, doctors must apply within the 90 days before relocation. In a situation where demand and supply of GPs can be fluid, this requirement can impede doctors being placed in areas of need in a timely manner. On occasion, the pattern of events does not follow a neat path and doctors may be required to move before having time to apply for the relocation grant even though this does enhance his or her capacity to take up the new position.

In addition, where doctors are unaware of the grant until after they move, and then are made aware of it, it can actually be a damaging process to learn that the person has just missed out on up to $120,000 because the communication conduits had not reached them prior to them making the decision. This is not a good start for making a doctor feel valued for moving to a rural or remote community. There are numerous examples of concerned doctors contacting Rural Workforce Agencies about this administrative anomaly which arises through no fault of the doctor.

In an example seen by a Rural Workforce Agency, a doctor relocated from Perth to rural Tasmania. Prior to relocating he was unable to identify which practice he would be relocating to as he wanted to examine a few first. He undertook detailed due diligence, visiting practices to find the best fit, which is to be encouraged, and then chose a practice. Because he could not nominate exactly which practice he would work in before he moved, he became ineligible for the grant. Yet it is just this kind of careful consideration on the part of the doctor which is likely to ensure success of the move and retention of that professional in a rural area.

Recommendation: That the Rural Relocation Incentive Grant (RRIG) guidelines be changed to provide for doctors to apply for the grant within three months of having moved to the new location.

The objective of the General Practice Rural Incentive Program is to increase the number of rural medical practitioners, GP and specialists through the provision of incentive grants. However, overseas trained doctors are not eligible for relocation grants available through the Rural Relocation Incentive Grant (RRIG). As overseas trained doctors are generally required to work in a District of Workforce Shortage, this criteria discriminates against overseas trained doctors compared with their Australian counterparts.

Recommendation: That the criteria be amended to make the Rural Relocation Incentive Grant (RRIG) available to IMGs who are Vocationally Registered and that non Vocationally Registered IMGs be able to access, at no cost, training to obtain Vocational Registration.

7.1.3 Non-Financial Incentives - Retention

There is a range of incentives which are essentially non-monetary in nature which play a vital role in recruitment and retention of health professionals. The Rural GP Locum Program and the Rural Locum Education Assistance Program (RLEAP) are designed to assist in overcoming the issues of lack of locum support and the cost associated with engaging a locum. The programs work well but there remains a need to continually renew and increase the number of doctors who are able to obtain locum support. Rural Health Workforce manages the Rural GP Locum Program.

"One of the main reasons I do locum work is because I want to support rural and remote communities. The best way I can do this is by stepping in so local doctors can have a holiday with their families, and return to their towns feeling refreshed and reinvigorated"
– **Dr Rajen Pillay**, locum, VIC

"If we didn't have someone like Rajen, local doctors would burn out or take leave, forcing us to close the health service. That of course has knock-on effects for neighbouring community health services which would have to shoulder the load"
- **Kathy Huett**, CEO of East Wimmera Health Services, VIC

Only a small proportion of the 6,467 rural and remote GPs are able to receive locums under this program due to funding constraints. Rural Health Workforce delivers well above its targets in terms of delivering rural locum placements within its funding parameters. However, with additional funding we could deliver substantially more locum placements than the 2,529 days of subsidised locum relief which were delivered to high need practices (eg solo practices and towns with less than three doctors) by the Program between December 2009 to June 2011.

Rural Health Workforce has been very successful at attracting locums to the locum pool and could easily double the number of rural GPs supported if funding were available. Financial assistance is required to enable smaller practices, which are not in high turnover situations,

to be able to afford to engage a locum as required. The potential for a sole GP to burn out can be very high without any support to take a break. For many small or solo practices, the decision for a doctor to take a break or attend a training event may require them to leave a community without a doctor for that period of time. This is a decision most do not take lightly and many will not leave their community unattended, with the result that the GP works for extended periods of time without adequate breaks which is unsustainable.

Programs such as the federally funded Rural Health Workforce "Go Rural" campaign and "Rural Champions Program" are designed to increase awareness among city and internationally based doctors of the benefits of rural practice whether it be permanently or as a locum. It is premised on the need to personally introduce and encourage doctors who have had little exposure to country life, to rural practice. They are by necessity very hands on and resource intensive but have been shown to be necessary as a long term education and recruitment campaign.

Such programs are an important part of the fabric of recruitment and retention programs. The opportunity to present a national campaign to city based doctors, medical students and registrars is an excellent opportunity to not only attract them to rural practice but to address some myths about rural Australia and to develop city-rural professional relationships and build respect for the doctors working in rural and remote Australia.

Recommendation: That Government appropriately fund, on a sustained basis, rural GP recruitment programs such as those provided by Rural Health Workforce.

The availability of other health professional team members based locally, along with professional support has a significant impact on the retention of doctors. Yet, unfortunately, many of the programs that are aimed at supporting GPs are not available to the other health disciplines. This is problematic as 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.

7.1.4 Non-Financial Incentives - Recruitment

Bonded Scholarships and **Bonded Places** ensure that at least some medical graduates will commence practice in a rural area. Students accepting the places or scholarships commit to working for six continuous years in a District of Workforce Shortage (which may be a metropolitan area), less any credit obtained through Scaling, after completing their medical training. These schemes are seen as being very valuable in addressing long-term doctor shortages.

The HECS Reimbursement Scheme which reimburses a proportion of a medical student's HECS debt for every year they train or work in rural and remote communities is an important tool in recruitment. Under the scheme, doctors can reduce the period for reimbursement of the cost of their medical studies from 5 years to 2 years, depending on the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) location of their training or practice[22]. However the efficacy of this scheme is impacted by changes to the ASGC-RA scheme as discussed below. Expanding this scheme to other professions would be straightforward and very beneficial.

Recommendation: That the HECS Reimbursement Scheme, currently offered to medical students, be expanded to other health professions.

It is necessary for resources to provide support, mentoring and supervision to the early career graduates who move to rural areas to perform their return of service obligation. The increased number of medical students in the pipeline now represents a great opportunity to boost the number of medical professionals adequately trained and enthused to go into rural practice.

To make sure that the Government's investment in these initiatives bears fruit, the students involved need to be supported through their studies, rural placements and post graduate years one and two training. The NRHSN plays a valuable support role to students and through its increasingly active Alumni Program, support for early career graduates in their career decision making phase.

The Department of Health and Ageing provides universities with funding for a number of initiatives specifically targeted at recruiting Australian medical students to rural and remote practice, including the Rural Clinical Schools and the University Departments of Rural Health programs[23]. These form part of the infrastructure which attracts rural students to medicine and all medical students to rural practice.

Rural intake policies to increase number of students of rural origin into health professions are recognised as an important long-term strategy in increasing the number of professionals wishing to work in the bush. Research demonstrates that the most significant predictor of working in rural Australia is time spent living in rural Australia as a child. *" There is consistent evidence that the likelihood of working in rural practice is approximately twice greater among doctors with a rural background"*[24] They have an intrinsic grasp of the culture of

[22] DOHA website: www.health.gov.au/internet/otd/publishing.nsf/Content/HECS, viewed 10 Dec 2010

[23] Rural Health Workforce, (2007). Supports Available for Rural and Remote GPs. www.rhwa.org.au

[24] Laven, G, and Wilkinson, D, 2003, Rural doctors and rural backgrounds: How strong is the evidence? A systematic review, Department of General Practice, University of Adelaide and University of South Australia, South Australia, Australian Journal of Rural Health vol. 11.

rural society which gives them a head start, by and large, compared with those of urban origin.

However in order to be able to enter medicine, rural high school students, especially Indigenous students, need to be made aware of the opportunities for medical training, receive mentoring and adequate high school standards to even consider it as an option. Rural Health Workforce advocates continued support for programs that promote early engagement with health careers in both primary and secondary education such as through high school visits (such as conducted by the NRHSN across Australia) and mentoring. There is a call from health students for rural intake schemes to be expanded to cover all health professions where there is a clear need demonstrated.

While policies have been enacted by Government to require that 25% of entrants for Medicine should be from a rural background, these policies are not working as intended. Many Universities are failing to meet that target with figures from the Medical Review Training Panel showing, for example, that in 2010 only 7% of medical entrants at the University of Queensland were from a rural background. For the University of Adelaide the figure was 9%, while the University of Sydney reported 13%. Given the importance of rural intake strategies as part of the long-term solution to rural health shortages, this situation cannot be allowed to continue.

Recommendation: That the rural background intake quota to medical schools should reflect the proportion of the population living in rural Australia.

Recommendation That Universities be held accountable to their rural intake goals and should a University be consistently unable to fill this quota, the funding associated with these rural intake places be transferred to other Universities which can demonstrate their ability to recruit more students of rural origin.

8. Distribution mechanisms

In any consideration of the incentives to recruit and retain health professionals in rural areas, it is essential to understand the role that our federal network of Rural Workforce Agencies play in consolidating a number of Commonwealth and State programs and projects into a comprehensive package tailored for individual GPs. The importance of the Rural Workforce Agencies being the administering body is that they provide ongoing and continual support for rural GPs and their families. This support ties together undergraduate and early career support with recruitment, education progression and retention. Having this coherence and continuity greatly enhances the effectiveness of what could otherwise be seen as a number of small, disparate programs.

The recruitment of the right health professional to suit a particular community, practice and work environment is crucial. Rural Workforce Agencies have witnessed many situations where insufficient care was taken in aligning the needs of the practice / community with the interests of the candidate leading to a split, sometimes difficult, between the incoming doctor and the practice after a relatively short period of time. With experience amassed over many years and in various circumstances, Rural Workforce Agencies case manage the recruitment of health professionals, especially when these are IMGs who often have a greater need for support in settling into a new country.

Even for Australian Medical graduates (AMGs) the social dislocation and family considerations in undertaking long-term rural places can be challenging. Apart from the unfunded, incidental support provided by Rural Workforce Agencies to early career GPs, there is little support, and there are few retention strategies targeted to these people once they graduate from university. The development of a National Rural Health Students Network (NRHSN) Alumni Program would provide valuable extra support when early career graduates are making career decisions, keeping rural and remote opportunities front of mind. Such a program would provide support to a range of professions including medical, nursing and allied health. There is a clearly described need for there to be extra support extended during the crucial decision making period, for example medical students graduate from university and undertake their post graduate year one and year two training (PGY1 and PGY2).[25]

It is important to see the provision of incentives and support programs aimed at rural doctor recruitment as being a continuum from undergraduate programs such as scholarships and rural placements at university, through to financial incentives for the post graduate workforce and practice management support and locum relief once the doctor graduates and commences working. The Federation's network provides support such as the NSW Rural Resident Medical Officer Cadetships which provide financial support for the final two years of their medical degree to help defray costs associated with their move to the country. There is scope for a strengthened role for Rural Workforce Agencies in providing a longitudinal, lifetime case management approach to encourage students and early career doctors through a complex system to ultimately become a rural practitioner.

Combined with the extensive NRHSN national activities in 29 Rural Health Clubs located at Universities across Australia, Rural Workforce Agencies have the capacity to be a one stop shop for any students in health professions to find out about relevant scholarships, placement support, professional events and rural site visits. By working in conjunction with other organisations with roles in this space, the Rural Workforce Agency could assist the student to navigate the various options open to them and bundle incentives with a view to

[25] Road to Rural General Practice The Rural Doctors Workforce Agency Report on the Rural Pathway Project, June 2011

fostering a long term commitment to rural health. The existing infrastructure and links which the NRHSN has form a solid basis for such an initiative. It may also maximise the current opportunity of an excess of students in the pipeline in relation to placement opportunities in metropolitan areas by drawing them to a positive experience via a rural placement.

9. ASGC – Remoteness Areas Pathway

The impact of moving from the Rural, Remote and Metropolitan Areas (RRMA) to the new Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) scheme has had varying impacts in different jurisdictions. However, in all jurisdictions the impact has been to significantly increase the number of doctors eligible for assistance without corresponding increases in funding for that assistance. Under ASGC-RA, 2,000 more GPs are classified as rural GPs, yet the Rural Workforce Agencies received not one more cent in funding to support these extra GPs.

In terms of recruitment and retention, the new ASGC-RA system is having varying impacts across the country. In WA for example there has been little impact with the exception of some individual anomalies. Yet the NT Health Workforce now supports the recruitment and retention of GPs in capital city Darwin, population 127,000 with no additional funding. The NSW Rural Workforce Agency, NSW Rural Doctors' Network (RDN), has needed to introduce a Priority Towns classification within RA 2 for some of its program areas. Otherwise, to provide services across the whole of RA 2 would dilute its effectiveness in recruiting and retaining GPs in areas of greater social and professional isolation. While this solution works, it is internal to RDN and does not address the issue of some large regional centres having the same (or higher) RA classification than smaller towns. Nor does it apply to Australian Government programs such as GPRIP.

Importantly, there have been inconsistencies created, primarily in the lack of discrimination within RA 2. The same ranking now applies to, for example, Hobart as for small communities in rural Tasmania. Similarly, the same incentives now apply to, for example, Darwin as for places like Alice Springs/Santa Teresa. GPs seeking to relocate to a rural area now see that the incentives to move to some much more attractive towns are the same as more remote places. For example the following very different places are all RA3:

> Darwin, Cairns, Townsville, Moree, Narrogin, Roma, Albany, Wellington, Narromine, Ballimore, Mount Beauty, Swan Hill, Broken Hill, Burnie and Balranald.

Towns which are quite different in their need and level of difficulty in attracting health professionals now sit in the same band so a doctor considering relocation to a rural community in need of a GP will be offered the same incentive to a more attractive location.

For the same reasons, the changes to the classification have led to a loss of incentive for registrars to move to more remote areas to do a placement.

Scaling in terms of remoteness is an important incentive which is applied to a range of Australian Government programs that have a return of service obligation. It increases the attractiveness of working in the most remote and rural areas by fast tracking the return of service obligation based on the Remoteness Area (RA) category in which the recipient is working. The greatest reward is available to those willing to work in the most remote locations of Australia. It is important that this scaling and the integrity of the classification is maintained.

The issue of determining the geographic basis for the eligibility for incentive programs is complex and yet it is essential to assist in creating the right incentive signals to medical professionals. There is a need to consider rurality, as the ASGC-RA system does, but also 'need' in terms of the population and existing access to services in that community. The Accessibility/Remoteness Index of Australia (ARIA+), the basis for the ASGC, is clearly devoid of a consideration of need, "*it () is a purely geographic measure of remoteness, which excludes any consideration of socio-economic status, rurality and populations size factors (other than the use of natural breaks in the population distribution of Urban Centres to define the service centre categories)*;[26]"

The use of ASGC-RA alone to direct incentives to address deficits in services is problematic as identified by the Australian Institute of Health and Welfare, *"The validity of these remoteness classifications in a given application (say, describing statistics or allocating funding) is greatest when the issue of interest is affected only, or mainly, by remoteness. Caution is required when other influences (for example, socioeconomic status, health outcomes, Indigenous status and local town size) are thought to play a role in the issue of interest (this may be the case, for example when analysing death rates, retention of GPs, etc."*27

As there is an increase in the maldistribution of health workforce between inner capital cities and outer suburbs, we are very concerned that more incentives will be offered to entice doctors into outer metropolitan areas, thereby diluting our ability to recruit to rural and remote areas. It is imperative that the needs of outer metropolitan suburbs are not considered in isolation, but in relation to our geographically isolated rural and remote communities.

[26] GISCA (u.d.) About ARIA+ (Accessibility/Remoteness Index of Australia). Available http://gisca.adelaide.edu.au/projects/category/about_aria.html

[27] Rural, regional and remote health - A guide to remoteness classifications, March 2004, Australian Institute of Health and Welfare, Canberra

Recommendation: That the Australian Government review the Standard Geographical Classification – Remoteness Areas (ASGC-RA) scheme with a view to instigating a process by which other factors affecting need are assessed in conjunction with the remoteness of communities.

10. International Medical Graduates (IMGs)

In rural and remote Australia, because of the restrictions upon right to practice through provider numbers, IMGs now constitute some 41% of the workforce, compared with 25% a decade ago.[28] Rural and remote communities are reliant on IMGs to deliver their health services.

For individual IMGs who are seeking to relocate to rural or remote Australia and work as GPs, our network of Rural Workforce Agencies provide a case management approach to help them navigate the organisations and pathways. Rural Workforce Agencies have dedicated expert staff to provide this service. They are required to keep up to date with changes across the Australian Medical Council, Medicare, the Australian Health Practitioners Regulation Agency, Department of Immigration and Citizenship, the Colleges (RACGP/ACRRM), the Department of Health and Ageing and State and Territory Health Departments.

International medical recruitment continues to be central to Australia's efforts to redress rural health inequality. Beyond the cultural enrichment which ensues when people from other countries join the Australian community; it is apparent that overseas trained doctors continue to make a vital contribution to the wellbeing of the Australian community. Increasingly, IMGs are becoming the new mainstay of the GP workforce in regional centres, and rural and remote settings. Examples abound where IMGs have served to retain rural health services which otherwise would have proved unsustainable.

The 10 Year Moratorium remains the key policy instrument by which IMGs are directed to regions that suffer the highest levels of health workforce shortage. It is a practical necessity in an era of increasing urbanisation which sees rural communities worldwide suffering intractable health workforce shortages. In the absence of other solutions actually delivering doctors to the bush right now, the lever of compulsion via the Moratorium is one of the most effective solutions and must be maintained.

[28] Department of Health & Ageing (2007), General Practice Statistics.
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/General+Practice+Statistics-1

In summary, the main reasons for endorsing the continuation of the 10 Year Moratorium are:

1. The IMG recruitment strategy, and by implication the Moratorium, has been successful in increasing the number of general practitioners (GPs) practicing in rural Australia. Department of Health and Ageing GP statistics reported 5,886 rural/remote GPs were participating in Medicare in 2000/01 and there were 7,385 GPs participating in 2008/09. This is an increase of 1,499 of which 82% (n.1,240) can be attributed to IMGs[29]. The GP to population ratio in rural Australia has improved markedly over this period and this is largely due to the influx of IMGs into these regions.

2. Compulsory rural service (CS) schemes such as the 10 Year Moratorium are a practical necessity in the absence of better alternatives. The World Health Organisation report of 2010 alluded to 70 countries that have operated compulsory service schemes to ensure rural health services are available.

3. IMG recruitment is beneficial for the nation and the medical profession. A diverse multiracial health workforce is consistent with the composition of the Australian population in general[30]. It is highly appropriate that the demographics of the health workforce fully reflect that of the community it serves.

4. Rural practice for IMGs is generally a positive and rewarding experience. To illustrate this, of the 96 IMGs who completed the 5-Year Overseas Trained Doctors Scheme in Western Australia, 70 of them are still practicing rurally, that is 73%. This is suggestive of a high degree of satisfaction.

An area of grave concern is that IMGs are increasingly choosing to work in outer metropolitan areas which are also districts of workforce shortage. There are now more doctors subject to the Moratorium working in the city than there are in the country[31]. For each IMG who relocates from overseas to a metropolitan area, that is one less doctor able to be recruited to a rural or remote community. The Five Year Overseas Trained Doctor Recruitment Scheme (5-Year Scheme) provides incentives for Overseas Trained Doctors (OTDs) to work in some of Australia's smaller rural communities.

Recommendation: That the 10 Year Moratorium be retained as an important policy tool for tackling workforce maldistribution.

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[29] Frehywot et al. 2010, 'Compulsory service programmes for recruiting health workers in remote and rural areas: Do they work?, *Bulletin of the World Health Organization*, vol. 88, no. 5,

[30] Refers to a study conducted by RHWA to inform DoHA as to the level of rural retention associated with the 5 Year OTD Scheme (2010).

[31] Australian Government Department of Health and Ageing (2008). Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra.

11. Practice Management

General Practices in rural and remote areas are essentially small businesses which require the management of multiple issues such as linking into hospital services, staffing, business administration, medical indemnity insurance issues and so forth. The long-term viability and sustainability of rural general practice is supported by strong practice environments.

The practice in which doctors operate is a key fundamental on which retention of rural GPs balances. A well-managed practice, providing a positive, supportive environment is much more likely to be able to recruit and retain high quality staff.

However, not only are most GPs not trained to run businesses but a significant number of them no longer wish to do so. Many recent graduates are expressing a preference to either be an employee or to work within a framework whereby some other agency undertakes those administrative and business functions[32].

The next generation of GPs prefer positions where there is established infrastructure and practice management systems to enable them to focus on clinical rather than administrative work. Indeed, older health professionals are also increasingly reviewing their working arrangements. This will lead to fewer and fewer GP principals over the coming years.

While this will be less of an issue in the metropolitan and larger rural areas where larger practices can be sustained with just one practice principal, this issue is critical to the sustainability and viability of small rural and remote area practices.

What makes a Positive Workplace?

- Leadership is adequate and present
- The workplace values, respects and empowers their staff
- The Practice invests in the future
- The Practice encourages a learning and sharing environment
- The Practice has adequate systems and infrastructure
- The Practice has a connection with the community

In order to attract GPs into smaller rural and remote areas, alternative models of practice ownership or auspicing will need to be developed such that GPs are able to be offered employment contracts with the administrative and financial burden removed. One such model is the 'benign corporate' model. This is a significant contrast to the private model which has traditionally dominated general practice.

[32] See for example, Joyce et al (2007), "Riding the wave: current and emerging trends in graduates from Australian university medical schools", MJA Vol. 186, No. 6 pp. 309-312 and Ken Mackey in ARRWAG (2003), Getting Doctors to the Bush: The Proceedings of the ARRWAG National Health Policy Forum. p. 15

Other models include developing networks of practices across a rural region to build the critical mass of patients and health professionals required, and focussing the administrative services in one area. In addition, walk in – walk out models where an independent entity manages the practice will need to be facilitated so that GPs will relocate to our needy rural and remote areas, if only for a relatively short time, without having to invest in the practice's infrastructure.

Tasmanian Practice Management Experience

In an example of the impact of practice management on retention, in 2007 Health Recruitment Plus Tasmania began a focus on assisting practices with management by providing professional development, management tools, webinars and workshops for practice managers. Since that time an 85% retention of doctors brought into rural areas has been observed, with 75% of those remaining in same practice.

The Rural and Remote Medical Services (RaRMS) established by the NSW Rural Doctors Network, has demonstrated that it is possible to recruit and retain doctors in a number of locations in the face of adversity. It is an Easy Entrance-Gracious Exit model in which a not for profit organisation administers the surgery for GPs who have their own clinical practice and pay for the administrative services.

Recommendation: That Government develop policy which supports improved practice management and practice viability interventions in vulnerable rural and remote communities to facilitate continuity of access to primary care services.

12. Multidisciplinary Approaches

The development of teams of people to provide rural and remote health services is essential to allow peer support, part-time arrangements and time away from the practice by being able to share on call arrangements. It is important to look at a diverse array of mechanisms whereby this can be achieved – such as hub and spoke arrangements. For example, within the larger rural centres, the development of networks of services that are able to share the more specialised elements of a team (allied health and specialists) will support a critical mass of both patients and health professionals for outlying regions as well.

There have been major inroads over recent years to support team-based practice under the Medicare model. However, there is a clear need to redesign these policies to allow better

and more appropriate implementation in rural and remote areas. Currently, Medicare is both very doctor-centric and very urban-centric. Medicare has been adapted to allow for rebates for consultations with a variety of other health professionals, but such consultations are dependent upon doctor referrals. This model needs to be made more flexible to suit the diverse circumstances of rural and remote communities.

The development of these multidisciplinary approaches will require a concerted effort between the Commonwealth and the States to ensure that funding mechanisms do not act as deterrents to collaborative arrangements.

Our federal network of Rural Workforce Agencies collect comprehensive annual data on the rural and remote health GP workforce across their jurisdictions[33]. This is an excellent resource which to date has not been used effectively by national agencies to inform GP workforce planning across Australia. This data incorporates a significant understanding of what is happening within local communities.

Alongside this localised data, there needs to be developed a national benchmark of service access and provision. A national benchmark of health services (and health professionals to provide them) has been attempted before with some reference to socio economic disadvantage and community morbidity[34.] However, we have an urgent need for a revised, comprehensive framework in order to identify which communities are in need of assistance. This will allow us to clearly identify where the most dire rural health workforce shortages are, and to align them with community health needs.

This analysis needs to occur at a local level, as well as at the aggregated level precisely because of the complexity surrounding supply and demand of health services. It may be that the federal network of Rural Workforce Agencies is the vehicle by which some of this planning can take place.

Indeed, place-based health planning represents a holistic approach that goes beyond the traditional population-based approaches to include such factors as local demographics, socio-economic status and environmental factors within a partnership framework involving local, state and national agencies.[35]

Recommendation: That a benchmarking framework be developed to allow localised and longitudinal demand and supply analyses to inform national policy and programs and that Rural Health Workforce's federal network be considered as a means of doing this research.

[33] Deeble, J and Pope, J, (2003), Reality Bites: Rural and Remote GP Workforce Information

34 For example New South Wales Rural Doctors Network (2001), General Practice Workforce Plans for Rural and Remote New South Wales 2002 – 2012

[35] Yeboah, D.A., (2005), "A framework for place based health planning", Australian Health Review Vol. 29, No, 1. pp. 30-36.

13. Conclusion

An imbalance in the demand and supply for GPs and health professionals more broadly in rural and remote Australia is serious and at risk of becoming worse given the aging profile of the rural and remote workforce. It is imperative that the policies put in place by governments to address the issues operate to the very best effect possible. There are a number of factors affecting health workforce distribution and corresponding policy options for addressing them. Improvements have been identified in a number of areas.

It is timely therefore that the Senate Community Affairs Committee reviews the factors affecting the supply and distribution of health services and medical professionals in rural areas so that rural Australians receive equitable health services in the future. Rural Health Workforce plays a vital role in sustaining the workforce and looks forward to continuing to work with Government and others to make healthcare accessible to people in rural and remote Australia.