Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Practitioners in Rural Areas

Question no: 1

OUTCOME 12: Health Workforce Capacity

Hansard Page: 17

Question:

Senator McKENZIE: How about grouping of the data maybe not by specific towns but in the cohort itself and deriving some sort of measure that would give us the information we need without necessarily going town by town?

CHAIR: Before you start doing that, could you look at whether you can provide the data without having to breach the Health Insurance Act or a particular act and, if you cannot, then aggregate it.

Answer:

The Department of Health and Ageing abides by the secrecy provisions within section 130 of the *Health Insurance Act 1973* (HIA), which govern the use and disclosure of Medicare information. The definition within the Privacy Act relates to "information about an individual whose identity is apparent, or can reasonably be ascertained". Secrecy provisions restrict disclosure of statistics for small areas that might enable the identification of an individual patient or an individual practitioner.

National GP Full time Workload Equivalent (FWE) growth (2009-10 to 2011 Qtr 3**)

Area	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
RA 2-5*	8.4%	6.7%	6.5%	4.0%	8.6%	5.0%	4.8%	N/A	6.9%

**Classified as Rural and Remote*
*** 15 months reporting*

Percentage of small size towns (population 1K to 10K) with GP FWE increase**

Area	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
RA 2-3*	65.4%	50.0%	68.5%	64.1%	67.9%	55.6%	33.3%	N/A	61.7%

**Towns within Inner and Outer Regional*
*** 15 months reporting*

Percentage of medium size towns (population 10K to 30K) with GP FWE increase**

Area	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
RA 2-3*	71.4%	80.0%	50.0%	42.9%	50.0%	100%	100%	N/A	67.8%

**Towns within Inner and Outer Regional*
*** 15 months reporting*

Percentage of large size towns (population greater than 30K) with GP FWE increase**

Area	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
RA 2-3*	100%	100%	85.7%	N/A	50.0%	100%	100%	N/A	90.9%

**Towns within Inner and Outer Regional*
*** 15 months reporting*

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Practitioners in Rural Areas

Question no: 2

OUTCOME 12: Health Workforce Capacity

Hansard Page: 15

Question:

Senator Moore asked:

We have just had evidence from the University of Queensland that says the data that indicates 7.5 per cent from Queensland against his university is not correct. Where does that data come from and, when there is an error, how do you correct it?

Answer:

Data relating to the proportion of rural origin students for the MTRP 14th report were provided to the Department of Health and Ageing by Medical Deans Australia and New Zealand Inc (MDANZ).

MDANZ has advised that the University of Queensland supplied data on commencing medical students, showing a 7.5 per cent proportion of rural origin students.

Should the University of Queensland wish to correct this figure, the University should formally advise MDANZ, who will forward this information to the Department for amendment.

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Professionals in Rural Areas

Question no: 3

OUTCOME 12: Health Workforce Capacity

Hansard Page: 23

Question:

Senator McKenzie asked:

When are the Strategic Plans for Medicare Locals due?

Answer:

The due dates for submission of the Medicare Locals Strategic Plans are as follows:
Tranche 1 – 30 September 2011
Tranche 2 – 30 March 2012
Tranche 3 – 30 September 2012

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Practitioners in Rural Areas

Question no: 4

OUTCOME 12: Health Workforce Capacity

Hansard Page: 16

Question:

Senator Moore asked:

....the statement in the department's submission that there was full consultation and people seemed happy with it, which is mind-blowing. We would like to know their names! I know that is a slight exaggeration, but we are interested in what you are doing with it and also the fact that you did consult and people did seem happy with it. Why is there now this disquiet across the board?

Answer:

The Department's submission to the inquiry refers to broad consultation that took place with peak bodies and relevant stakeholders when undertaking the Audit of Health Workforce in Rural and Regional Australia. In response to the Audit findings and subsequent review of health programs, the Rural Health Workforce Strategy was developed in consultation with a group of six key rural health stakeholders. The group comprised:

- The Rural Doctors Association of Australia
- The National Rural Health Alliance
- Council of Remote Area Nurses
- Rural Health Workforce Australia
- Australia Rural Health Education Network
- Services for Australian Rural and Remote Allied Health

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Practitioners in Rural Areas

Question no: 5

OUTCOME 12: Health Workforce Capacity

Hansard Page: 18

Question:

Senator McKENZIE asked: I just have a question around how many overseas trained doctors we have in the regions working as GPs at the moment.

Senator BOYCE asked: Can you provide it as a percentage of workforces?

Answer:

Proportion of Full-time Workload Equivalent (FWE) overseas trained doctors, by ASGC-RA in 2010-11

	RA1	RA2	RA3	RA4	RA5	Total	RA2-5
FWE* GPs	14,544	3,822	1,587	216	98	20,267	5,723
Overseas Trained FWE* GPs	5,814	1,766	843	105	42	8,570	2,756
Proportion Overseas trained	40%	46.2%	53.1%	48.6%	42.8%	42.3%	48.1%

* based on Medicare billing statistics. 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.

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Practitioners in Rural Areas

Question no: 6

OUTCOME 12: Health Workforce Capacity

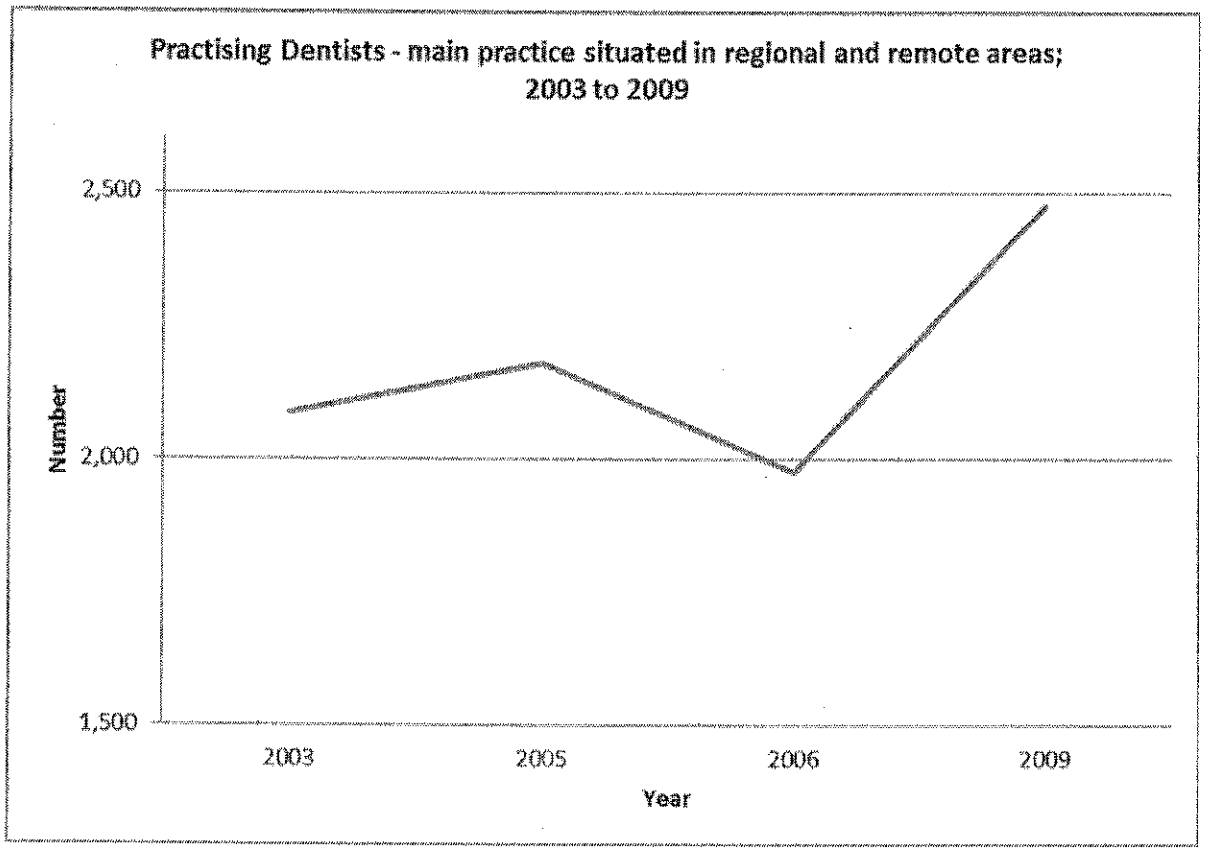
Hansard Page: 25

Question:

Senator McKENZIE asked: Why was there no data in your submission on dentists post 2006? Is there a reason for that?

Answer:

The submission contained the most current data at that time. The 2009 dental workforce data was released by the Australian Institute of Health and Welfare in June 2012. This information is shown in the table below.



Source: *AIHW/DSRU Dental Labour Force survey 2005, 2006 and 2009*

The graph shows that from 2006 to 2009 there was a 25% increase in the number of practising dentists who had their main practice in rural and remote areas of Australia.

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Practitioners in Rural Areas

Question no: 7

OUTCOME 12: Health Workforce Capacity

Question:

Accommodation programs. Is the RCS program that was established in 2000/01 to construct and furnish teaching and learning facilities and student accommodation still ongoing? If not, has it been replaced by something else.

Answer:

The Rural Clinical Schools (RCS) program was established following the 2000/01 Budget to develop and maintain an effective medical student training infrastructure in rural Australia around which the development of the local medical workforce can be assisted and promoted.

Both operational and capital infrastructure funding was provided to universities under the RCS program until 30 June 2011.

On 1 July 2011, the RCS and Rural Undergraduate Support and Coordination (RUSC) programs merged to form the new Rural Clinical Training and Support (RCTS) program. The RCTS program combines the short-term rural placements, rural student admission targets, rural curriculum development and Aboriginal and Torres Strait Islander student support of the RUSC program with the long-term rural placements, rural community focus and research activity of the RCS program.

There is no ongoing capital works allocation under the RCTS program, however universities participating in the program have been eligible to apply for capital works funding through the Australian Government's Rural Educational Infrastructure Development (REID) funding pool.

The REID Pool, established following the 2009/10 Budget, provided capital funding of up to $39.9 million from 2009/10 to 2011/12 for 28 infrastructure projects for universities participating in the RCS, University Department of Rural Health (UDRH) and Dental Training Expanding Rural Placements (DTERP) programs.

Universities have also been able to apply for capital infrastructure funding through the following programs:

Health and Hospital Fund (HHF)
The $5 Billion HHF was established on 1 January 2009 by the Australian Government as part of its broader nation-building infrastructure program.

Across the HHF Rounds, 6 projects for accommodation have been allocated funding of $31.17 million and 5 projects for workforce training have been allocated funding of $57.63 million.

Increased Clinical Training Capacity (ICTC) Program
The ICTC program provided a one-off funding injection of almost $68 million in 2009-10 to increase clinical training capacity across settings and professions for entry level health professionals prior to the establishment of Health Workforce Australia (HWA).

A total of 64 projects were funded including 21 projects that were delivered in regional and rural areas at a total value of $29,830,185 (GST exc).

Innovative Clinical Teaching and Training Grants (ICTTG) Program
The ICTTG program provided funding to eligible organisations for infrastructure projects that increased capacity and improved distribution of clinical teaching and training across the training continuum.

A total of 35 projects were funded. Of these, 16 projects were delivered in regional or rural areas at a total value of $36,331,814.

Health Workforce Australia (HWA) Clinical Training Funding Project
Under the COAG National Partnership Agreement on Hospital and Health Workforce Reform, HWA is providing Clinical Training Funding (CTF). CTF activities that are funded under these agreements include construction of new clinical training facilities and student accommodation to support rural students and clinical placements in rural and remote areas, and the purchase of clinical training equipment. Of the funding of $425 million allocated to CTF activities, $209 million is being provided for capital and establishment projects currently being rolled out by HWA.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into factors affecting the supply of health Services and medical Practitioners in Rural Areas

Question: 8

OUTCOME 12: Health Workforce Capacity

Topic: Workforce and rural distribution

Hansard page: 19-20

Senator: Senator McKenzie

Question:

1. Do we know how many applicants prior to registration there are for the Australian Medical Council (AMC) part 2 among overseas trained doctors?

2. I am just wondering how many times they are able to sit the exam. How many goes do they get, basically?

3. Could we also get an idea of how many people who have been unsuccessful in three or more attempts are practising or not practising in regional areas—if that is possible.

Answer:

The following advice has been provided by the AMC.

1. In 2011 the AMC had a capacity of 1,580 clinical examination places. Some 3,453 IMGs applied for these places, including 2,864 who were applying for the first time and 589 IMGs who were repeat candidates. A total of 1123 first attempt IMGs were accommodated in the examination and 365 repeat candidates.

2. There are no limits on the number of attempts at the AMC MCQ or clinical examinations

3. It is not possible to indicate how many hold limited registration and are practising in regional areas.

   Registration data is not cross correlated with AMC candidate data and it is not possible to easily identify how many candidates with limited registration have failed the AMC clinical examination on three or more occasions. Discussions have taken place between the AMC, the Medical Board of Australia and the Australian Health Practitioner Regulation Agency to include registration data with examination performance data.

   In 2011 of the 365 IMGs who were repeat candidates presenting for the clinical examination, 110 were sitting for their 3rd or subsequent attempt.

   In 2010 of the 351 IMGs who repeated the examination 108 were sitting for their 3rd or subsequent attempt.

Senate Community Affairs Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

10 July 2012

Inquiry into factors affecting the supply of Health Services and Medical Practitioners in Rural Areas

Question no: 9

OUTCOME 12: Health Workforce Capacity

Hansard Page: 19

Question:

Senator BOYCE asked: Could I just ask a technical question. Is full-time workload equivalent the same as full-time equivalent? Is that based on the fact that you would expect a doctor to work from nine to five or see X number of patients or what?

Answer:

Full-time Workload Equivalent (FWE) and Full-time Equivalent (FTE) are standardised workforce measures that convert Medicare claims information into standardised measures of work effort.

FWE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the year. The calculation for FTE is identical although the FTE value for an individual doctor is capped at one (even though some may work well above average levels of output).

FWE is generally considered to provide a better overall indicator of medical workforce supply under Medicare. FTE is an alternative measure to head counts as it measures the number of doctors working full-time and the partial contribution of part time doctors.

A direct measure of the workforce cannot be calculated from Medicare claims data, as there is no record of the time (minutes/hours) spent providing the services.