Health Workforce
Queensland

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8th May 2012

Ian Holland
Secretary
Senate Community Affairs Committee - Rural Health inquiry
PO Box 6100, Parliament House
Canberra ACT 2600

Dear Mr Holland

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

I am writing to provide supplementary information as requested by the Committee during the Townsville Public Hearing on 23rd April 2012.

1. **Minimum Data Set - Queensland Rural Medical**

The Minimum Data Set report for Queensland is compiled and published annually as well as a National MDS collation from all Rural Workforce Agencies. [Please find attached]

2. **Health Service Planning - Regional Health Service Planning – Bowen Basin Project**

This project aims to develop a Regional Health Services Plan for the delivery of sustainable, efficient and appropriate health care services to the region, including local models of medical and health service delivery which would then be integrated into an overarching regional model.
The collaborative Planning process will provide the Bowen Basin and its local communities with realistic models of service delivery that can be implemented in partnership with multiple stakeholders (private health, public health, industry, local government, state government, federal government, community). It will seek to promote alignment, collaboration and creative resource sharing. The Plan will focus on developing innovative, realistic and affordable solutions to the issues identified, and empower communities to determine and support their health care services into the future. [Please find attached a Media Release]

3. **Benign Corporate Entity to 'rescue' and support towns where a General Practice closes or is at risk of 'closure'**

The concept is to create a 'benign corporate' model that support rural and remote towns where a General Practices is closing. The entity would own and operate General Practices and associated Primary Health Care services in a 'rescue and recovery' strategy. The entity would then continue to operate or seek to 'transfer' the Practice to another incoming Health Professional or provider so that the practice returns to the private sector.

Rural Workforce Agencies are well placed to provide this style of practice management and support, for example; New South Wales (NSWRD) http://www.nswrdn.com.au/site/index.cfm?display=57813
South Australia (RDWASA) http://www.ruraldoc.com.au/services/business-services-for-practices/

The major tangible outcomes and deliverables for communities from the implementation of a 'benign corporate' model will be;

- The creation of sustainable rural regionalised primary health care service.
- A comprehensive plan for the coordinated provision of health services within the geographic area.
- Increased retention of GPs considering retirement (may keep them longer) and this is of critical importance to the retention of mentor, supervisor and trainers for the future workforce.
- Enhanced attractiveness of GP/PHC in the entity's location due to the supportive environment for practice and training.
- Increased stability and certainty for training and mentor arrangements.

I will forward to you my suggested alterations to the Hansard records of my contributions to the Hearing in a separate letter.

Yours sincerely

Chris Mitchell
Chief Executive Officer

Medical Practice in rural and remote Queensland

Queensland Minimum Data Set Report

at 30th November 2011

Health Workforce Queensland

Suggested citation

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Health Workforce Queensland Minimum Data Set Report – 30th November 2011

1. Introduction

For the 2001-2004 triennium, as a part of their contractual agreement with the Department of Health and Ageing (DoHA), Rural Workforce Agencies (RWAs) in all states and territory were required to collect and report a minimum, specified set of data in relation to the rural and remote General Practice workforce in locations classified RRMA 4 through RRMA 7.

Undertaken individually by each RWA, de-identified data were compiled nationally through Rural Health Workforce Australia (RHWA) to provide a comprehensive portrayal of the Australian rural and remote medical workforce.

The data were first compiled at a national level in December 2001 and were updated on an annual basis as at 30th November each year. Data in relation to the number of medical practitioners, country of basic medical qualification, residency status, age, gender, procedural skills and length of stay in current location are largely derived from databases maintained by each RWA. Data in relation to primary income source, models of service provision, clinical and total hours worked are largely self-reported and may be incomplete due to non-responses and/or missing data.

Each RWA normally surveys rural and remote medical practitioners in their state/territory in the latter part of each year. Core questions for the Minimum Data Set (MDS) have been developed and standardised among the states/territories. In addition, states/territories have the flexibility to incorporate additional questions should they wish. While the annual MDS survey is a major component of the data reported, all RWAs utilise additional resources to verify and validate their data. It should also be noted that the number of doctors reported reflect the more stable elements of the rural and remote medical workforce and do not include transient, short term service providers (e.g., locum tenens).

Current and accurate information in relation to the rural and remote medical workforce is essential for the day to day operations of RWAs and as such, all RWAs have agreed to continue to collect MDS data. Changes to the rural classification introduced from the 1st July 2010 now require RWA's to collect workforce data for ASGC2 to ASGC5 locations.

Data provided in this report is for Queensland only and was current as at 30th November 2011. However, due to changes in the rural classification system from RRMA to ASGC, practitioner numbers and trends will not be directly comparable with previous reports.

2. Number and type of Medical Practitioner by ASGC

Data indicated that as at 30th November 2011, the number of medical practitioners currently in ASGC 2 to 5 locations was 1707. This represents an increase of 41 practitioners (2.46%) compared with numbers reported as at 30th November 2010. Table 1 presents the total number of medical practitioners working in ASGC 2 to 5 locations in Queensland by practitioner type as at 30th November 2011. Table 2 provides a breakdown of this distribution by gender and ASGC. Table 3 provides a breakdown of employment type by Division of General Practice. Table 4 provides a breakdown of employment type by Medicare Local.

Table 1: Employment type by ASGC-RA

Employment Type	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
GP/Company	2	0	0	0	2
RMO	1	8	3	2	14
MS	5	8	2	2	17
RFDS	0	17	11	0	28
MORPP	7	16	7	2	32
ACCHS	14	24	4	0	42
MSRPP	10	20	14	10	54
SMO	18	39	5	11	73
General Practitioner	844	560	33	8	1445
Total	901	692	79	35	1707

Legend

RMO	Resident Medical Officer (includes JHO, SHO, PHO etc.)
MS	Medical Superintendent
RFDS	Royal Flying Doctors Service
MORPP	Medical Officer with Right of Private Practice
ACCHS	Aboriginal Community Controlled Health Service
MSRPP	Medical Superintendent with Right of Private Practice
SMO	Senior Medical Officer
General Practitioner	General Practitioner

Table 2: Gender by ASGC-RA

ASGC-RA	Female	Male	Total
ASGC-RA 2	331	570	901
ASGC-RA 3	265	427	692
ASGC-RA 4	28	51	79
ASGC-RA 5	8	27	35
Total	632	1075	1707

Table 3: Employment type by Division – ASGC-RA 2 to 5

Division	ACCHS	G P	MORPP	MS	MSRPP	RFDS	RMO	SMO	Total
SEPHCN	0	3	0	0	0	0	0	0	3
GPpartners	0	9	0	0	0	0	0	0	9
SEA_GP	3	6	0	0	0	0	0	0	9
GCDGP	0	10	0	0	0	0	0	0	10
MBGPN	0	30	0	0	0	0	0	0	30
CQR	1	28	6	0	11	0	1	4	51
IWMDGP	0	46	4	0	3	0	0	0	53
NWQPHC	2	61	4	4	9	7	0	5	92
CapDGP	2	127	0	0	1	0	0	0	130
MackayHC	4	124	0	2	0	0	1	9	140
SunCDGP	0	142	0	0	1	0	0	0	143
GP Connections	4	151	0	0	1	0	0	2	158
GPLWB	1	170	5	0	6	0	0	0	182
Rhealth	3	113	12	6	19	4	3	25	185
TGPN	5	200	0	0	1	0	0	0	206
FNQ	17	227	1	5	2	17	9	28	306
Total	42	1447	32	17	54	28	14	73	1707

Table 4: Employment type by Medicare Local – ASGC-RA 2 to 5

Medicare Local	ACCHS	GP	MORPP	MS	MSRPP	RFDS	RMO	SMO	Total
Gold Coast	0	10	0	0	0	0	0	0	10
Central and North West	2	14	4	1	6	7	0	1	35
Metro South	3	35	0	2	0	0	0	2	42
Metro North	0	41	1	0	1	0	0	0	43
West Moreton-Oxley	0	66	4	0	3	0	0	2	75
Sunshine Coast	0	142	0	0	1	0	0	0	143
Central Queensland	3	152	2	0	9	0	1	4	171
Wide Bay	1	170	5	0	6	0	0	0	182
Darling Downs-South West	7	216	11	4	19	4	3	23	287
Far North Queensland	17	227	1	5	2	17	9	28	306
Townsville-Mackay	9	374	4	5	7	0	1	13	413
Total	42	1447	32	17	54	28	14	73	1707

3. Workloads

Estimates of Full Time Equivalents (FTEs) and Full Time Workload Equivalents (FWEs) as used by the Medicare Australia (MA) in calculating GP medical service provision are based solely on the number and the dollar value of claims made by a provider over a given reference period (usually 12 months). While these can be useful measures of overall service provision under Medicare, they do not reflect the number of hours worked in providing medical services, or services provided that are not claimed and/or are not claimable through Medicare Australia. For example, a medical practitioner is classified as full-time by Medicare Australia if the Schedule fee value of services processed over a 12 month period is $100,024[1]

[1] MBS Statistics, March 2011

(2008-2009) or more for that practitioner. Similarly, a Full Time Workload Equivalent (FWE) value is calculated for each doctor by dividing the doctor's Medicare billing (Schedule fee value of claims processed by Medicare Australia during the reference period) by the mean billing of full-time doctors for reference period. For the 2008-2009 reference this value was $278,990[2].

An alternative measure of service provision is number of hours worked. The Australian Bureau of Statistics (ABS) defines full-time work as being 35 hours per week or more and part-time work as less than 35 hours. It is this measure that has been chosen by Health Workforce Queensland to differentiate between full-time and part-time service provision.

An estimate of full-time/part-time medical service provision utilising ABS benchmark was undertaken based on self reported clinical hours worked. Data was available for 69.3% of the total number of practitioners. Data as displayed in Table 5 indicates that 69.2% of respondents worked 35 hours a week or more in the provision of routine clinical GP services.

Table 5: Self-reported clinical hours

Clinical hours	Frequency	Percent
<20 hours	109	9.2
20 to 35 hours	255	21.6
35 hours plus	819	69.2
Total	1183	100.0

It should be noted that hours reported are for those worked in GP practice only and should not be interpreted as total hours as hospital hours, travel, teaching, supervision time etc. are not included. The average number of clinical hours reported was 38 hours per week (N=1183).

A further breakdown of self-reported clinical hours by gender is displayed in Table 6 below.

Table 6: Self-reported clinical hours by gender

Clinical hours		Female	Male	Total
<20 hours	Count	60	49	109
	% within gender	13.3	6.7	9.2
20 to 35 hours	Count	154	101	255
	% within gender	34.1	13.8	21.6
35 hours plus	Count	238	581	819
	% within gender	52.7	79.5	69.2
Total	Count	452	731	1183
	% within gender	100.0	100.0	100.0

Self reported total hours were also explored. In addition to clinical hours, these hours may include hospital hours, time spent in travel between practices, population health, teaching, administrative or representative work. Data was available for 72.9% of practitioners. Table 7

[2] Ibid

displays self-reported total weekly hours while Table 8 displays total hours by gender. The average reported total hours were 45.4 hours per week (N=1246).

Table 7: Self-reported Total hours

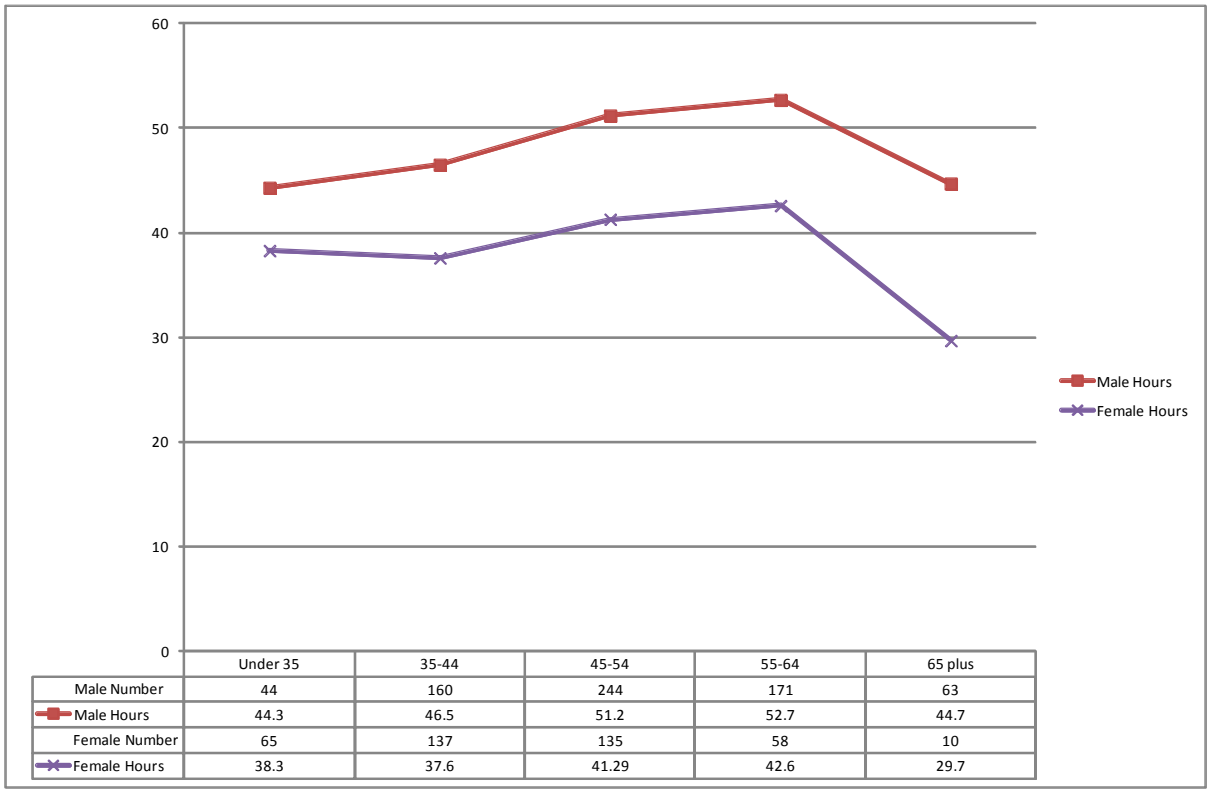
Total Hours	Frequency	Percent
<20 hours	36	2.9
20 to 35 hours	160	12.8
35 hours plus	1050	84.3
Total	1246	100.0

Table 8: Self-reported total hours by gender

Total Hours		Female	Male	Total
<20 hours	Count	26	10	36
	% within gender	5.6	1.3	2.9
20 to 35 hours	Count	109	51	160
	% within gender	23.4	6.5	12.8
35 hours plus	Count	331	719	1050
	% within gender	71.0	92.2	84.3
Total	Count	466	780	1246
	% within gender	100.0	100.0	100.0

A more refined breakdown of average total hours by gender and age categories is presented in Figure 1.

Figure 1: Average total hours worked per week by gender and age category (N=1087)



	Under 35	35-44	45-54	55-64	65 plus
Male Number	44	160	244	171	63
Male Hours	44.3	46.5	51.2	52.7	44.7
Female Number	65	137	135	58	10
Female Hours	38.3	37.6	41.29	42.6	29.7

These data appear to be in line with national trends that suggest that female practitioners tend to work less hours compared with their male counterparts.[3,4] Explanations for these differences have been well documented and reported in a considerable number of studies and will not be explored further in this analysis.

4. Length of stay in current principal practice

In Queensland, the average length of stay in current principal practice was 5.9 years. A more refined breakdown by duration and ASGC-RA is provided in Table 9.

Table 9: Length of stay in current practice by ASGC-RA

ASGC-RA	<6mths	6-12mths	1-2yrs	2-3yrs	3-5yrs	5-10yrs	10-20yrs	20+ yrs	Total
2	67	102	128	100	146	183	112	61	899
3	79	79	105	69	125	134	64	37	692
4	14	10	20	7	8	7	10	3	79
5	5	6	8	3	8	1	3	1	35
Total	165	197	261	179	287	325	189	102	1705

[3] Commonwealth Department of Health and Aged Care. (2001). *The Australian Medical Workforce. Occasional Papers New Series No.12, August 2001*. Canberra: CDHAC.
[4] Australian Medical Workforce Advisory Committee. (2005). *The General Practice Workforce in Australia: Supply and Requirements to 2013, AMWAC Report 2005.2*. Sydney.

Data indicates that 78.8% of practitioners have practiced in their current rural and remote locations for more than a year. Approximately 21.2% are relatively new and have been at their current practice for less than 12 months. While these data provide a guide, they do not take into account movements between practices and ASGC-RA.

5. Age and gender by ASGC

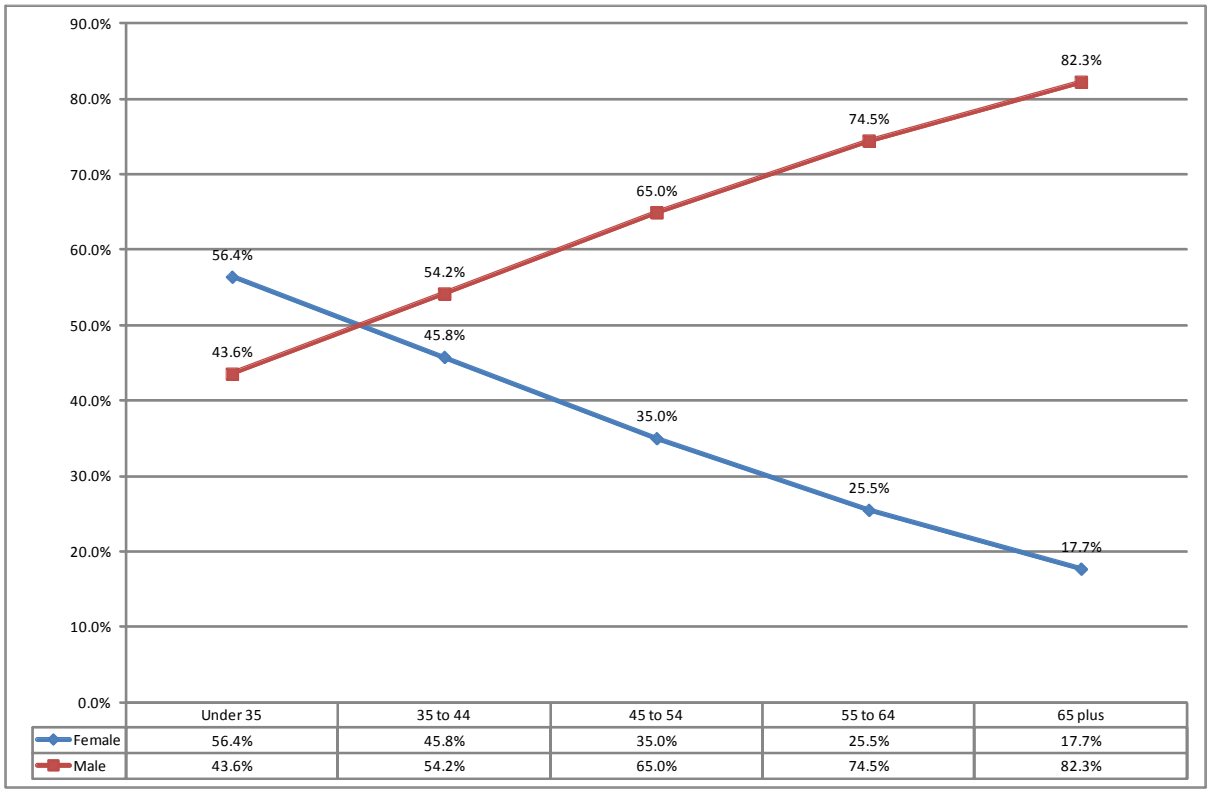
For Queensland the average age for male practitioners was 50.1 years (N=763) and 45 years for females (N=458). The overall average age was 48.2 years (N=1221). Table 10 displays gender by age category by ASGC.

Table 10: GP age categories by gender and ASGC (N=1221)

ASGC-RA	Gender	Under 35	35 to 44	45 to 54	55 to 64	65 plus	Total
	Female	38	83	81	42	10	254
	Male	35	99	150	107	32	423
2	Total ASGC-RA 2	73	182	231	149	42	677
	Female	32	64	60	18	4	178
	Male	21	77	104	59	28	289
3	Total ASGC-RA 3	53	141	164	77	32	467
	Female	8	7	4	1	0	20
	Male	4	7	9	14	3	37
4	Total ASGC-RA 4	12	14	13	15	3	57
	Female	1	4	0	1	0	6
	Male	1	4	6	1	2	14
5	Total ASGC-RA 5	2	8	6	2	2	20

Figure 2 displays the distribution of GPs by gender across a selected number of age categories. These data suggest that females are more broadly represented in the under 45 age categories.

Figure 2: Proportion of male and female practitioners across age categories (N=1221)



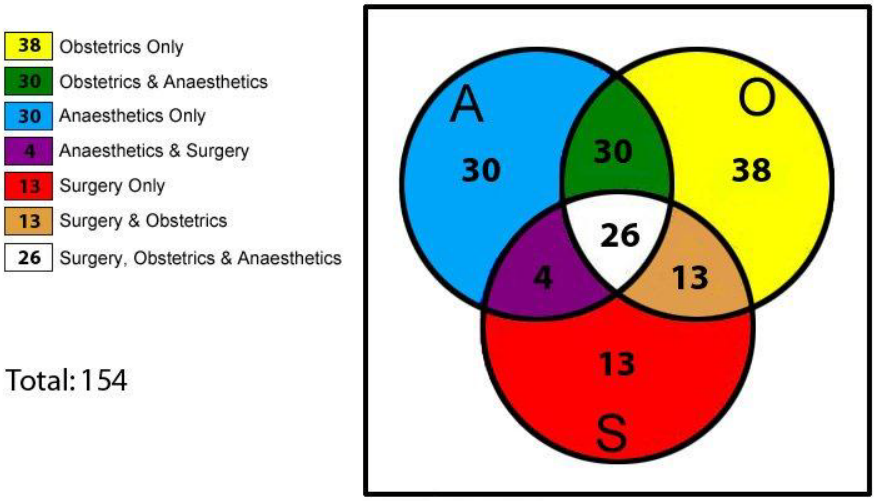
6. Known number of procedural practitioners

Data in relation to the provision of procedural services in rural and remote Queensland may be incomplete due to non-respondents, although the number of proceduralist GPs in rural and remote Queensland is fairly well known. Senior Medical Officers (Generalists) employed by Queensland Health and providing procedural services in towns with a population greater than 12,000 are not included in the data shown below. The known number of practitioners providing specified procedural services as at 30th November 2011 is detailed in Table 11. In many cases it is possible for a practitioner to perform a number of procedures e.g., Anaesthetics and Obstetrics or Obstetrics and Surgery for example. The number of known procedural practitioners as detailed in Table 11 (N=154) is therefore less than the total number of procedures documented (N=253). A Venn diagram illustrating practitioners undertaking single and/or multiple procedures is displayed in Figure 3.

Table 11: Number of practitioners undertaking procedural work by type and ASGC-RA

	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
Anaesthetics	24	48	10	8	90
Obstetrics Normal Delivery	29	55	15	8	107
Operative surgery	20	31	2	3	56
Known Proceduralists	46	80	17	11	154
Total Practitioners	901	692	79	35	1707
Percent procedural	5.11%	11.56%	21.52%	31.43%	9.02%

Figure 3: Venn diagram illustrating numbers undertaking single and/or multiple procedures (N=154)



7. Emergency Care and Aboriginal Health provision

Practitioners were also asked if they provided regular Emergency care or Aboriginal Health care services. The number of respondents indicating that they provide these services by ASGC-RA is detailed in Table 12 below.

Table 12: Number of practitioners providing regular Emergency Care or Aboriginal Health services

Services	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
Emergency Care	359	302	52	24	737
Aboriginal Health	284	280	50	24	638

8. Types of practice

Type of practice by ASGC-RA was also explored. There were 523 doctored practices in rural and remote Queensland. Table 13 displays the number of solo and group practices by ASGC-RA for the period ending 30th November 2011.

Table 13: Practice type by ASGC-RA

Practice Type	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Grand Total
Group	196	138	20	5	359
Solo	69	64	16	15	164
Grand Total	265	202	36	20	523

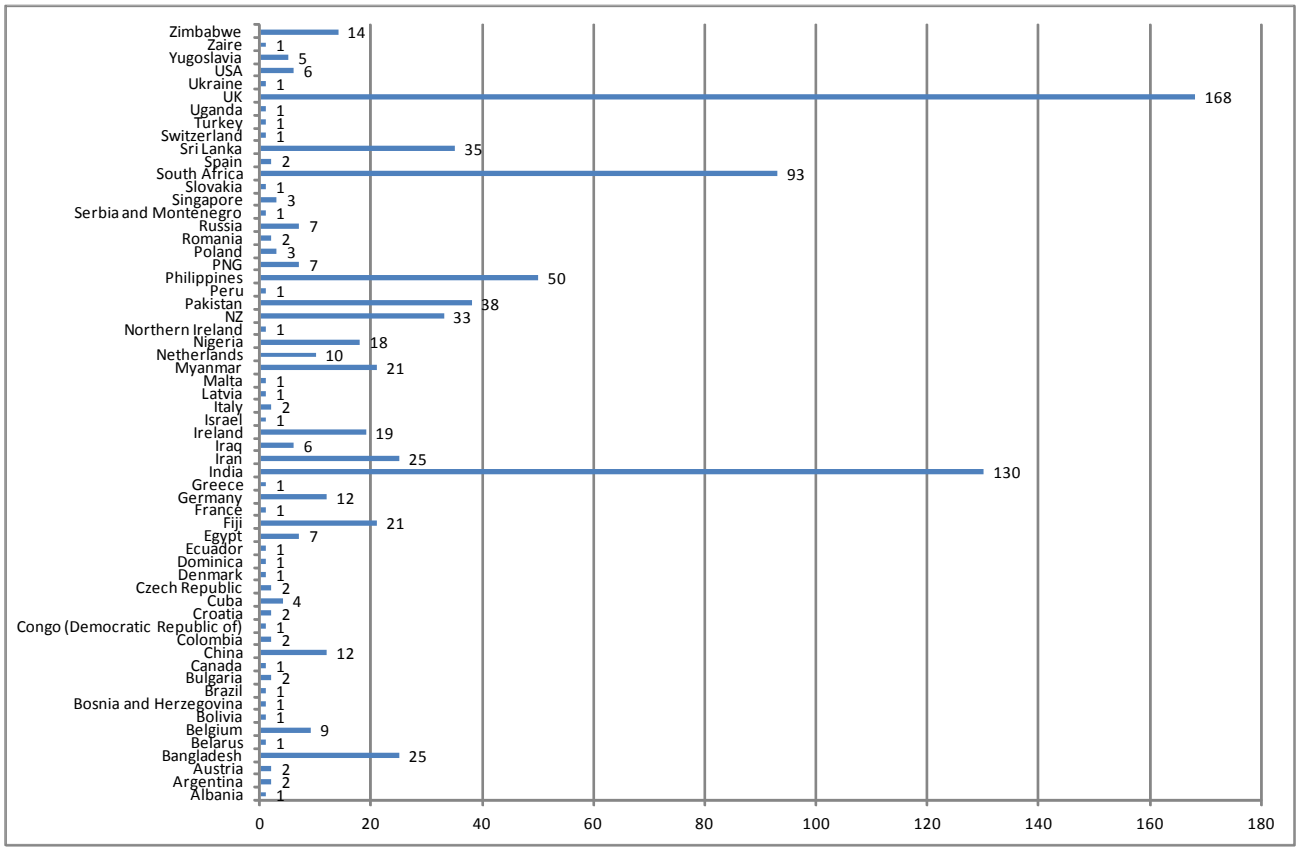
9. Country of basic medical qualification

Data indicates that 51.6% (N=878) of the current rural and remote medical workforce in Queensland are Australian trained. The other 48.4% (N=823) have obtained their basic medical qualification overseas. The largest proportion of Overseas Trained Doctors (OTDs) obtained their basic training from the United Kingdom (20.4%) followed by India (15.8%) and South Africa (11.3%). It also needs to be acknowledged that many Overseas Trained Doctors are Australian citizens or Permanent Residents and have practiced medicine in this country for many years. Temporary Resident Doctors (TRDs) comprise 11.0% (N=187) of the current Queensland rural and remote medical workforce. Table 14 provides a breakdown by citizenship status and number of Australian/Overseas Trained Doctors. Figure 4 provides a breakdown of country of basic medical qualification for overseas trained doctors. Citizenship status and country of basic medical qualification could not be determined for 7 practitioners.

Table 14: Citizenship status and number of Australian/Overseas Trained Doctors

ASGC-RA	Citizenship			Total	% Temporary
	Australian	Permanent	Temporary		
2	552	248	100	900	11.1%
3	455	156	80	691	11.6%
4	52	21	4	77	5.2%
5	25	4	3	32	9.4%
Total	1084	429	187	1700	11.0%
				Number	Percent
Aust Trained Doctors				878	51.6%
Overseas Trained Doctors				823	48.4%
				Number	Percent
Overseas Trained and Australian citizens or permanent residents				636	77.3%
Overseas Trained and temporary residents				187	22.7%

Figure 4: Country of basic medical qualification for non-Australian trained doctors (N=823)



10. University and year of graduation for Australian trained doctors

As of 30th November 2011, there were 878 Australian trained doctors working in rural and remote locations in Queensland. Six hundred and fifty one (74.4%) obtained their basic medical degree from Queensland universities while 224 (25.6%) obtained their basic medical qualification from other Australian Universities. Data was unavailable for three practitioners. University and year of graduation for Australian trained doctors is displayed in Table 15.

Table 15: University and year of graduations for Australian trained doctors (ASGC-RA 2-5)

	ANU	Flinders	Griffith	JCU	Monash	Notre Dame (WA)	Adelaide	Melbourne	Newcastle	Sydney	Tasmania	UNSW	UQ	UWA	Total
1954										1					1
1959										3			1		4
1961							1						1		2
1962								1					1	1	3
1963													2		2
1964							1						2		3
1965													3		3
1966													5		5
1967								1					5		6
1968										1			8		9
1969												1	4		5
1970							1	1		2		2	2		8
1971					1					3		1	7	1	13
1972										1			10		11
1973					2					1			7		10
1974							1	2			1	1	16		21
1975					1		1	1		1	1	1	18	1	25
1976								1				3	19		23
1977					2						1		23		26
1978					2			4		3	1	3	25	1	39
1979					1			1		2		1	22		27
1980							2			1		1	29		33
1981					1			2		1	1		27	2	34
1982		1					2						19		22
1983							1	1		3	1		21	2	29
1984		1			1		2	2					10	1	17
1985							2	2				1	15	1	21
1986					2		1			1	2	1	20		27
1987					3					1		1	15		20
1988							1			2		1	9	1	14
1989					2				3			1	11		17
1990								1	1	3			5		10
1991		1						0	1	1	1	1	6	1	12
1992								1				1	14		16
1993								4	1	1		0	19		25
1994							1		1			1	10	1	14
1995					3		1		4				7		15
1996		1			5		2						11		19
1997										1		2	11		14
1998					2		1	1	1			1	12		18
1999									1			2	13		16
2000							2					1	15	1	19
2001		1			1				2				17		21
2002					1			1		1			15		18
2003		1			3				2			1	10		17
2004					1		2	1			2		20		26
2005				17				2	1		1		20		41
2006		3		17					1		4	1	12	2	40
2007	1			9	1			1				1	20		33
2008	2		2	6		1		1					5	1	18
2009		1							1				1		3
Total	3	10	2	49	35	1	25	32	20	34	16	31	600	17	875

11. Registration categories, District of Workforce Shortage, Area of Need

Due to changes in the provider number legislation introduced in 1996, overseas trained medical practitioners are usually required to work in a District of Workforce Shortage (DOWS) for a specified period of time (normally 10 years). These DOWS are normally, but not exclusively in rural and remote locations. There are in addition, other medical workforce regulations that limit locations where some Permanent Resident and Australian trained doctors must practice in order to access Medicare. Data indicate that there are 167 practitioners (9.82%) registered under the Limited AON category who must practice in an area of need/DOWS. Data was not available for six practitioners. It is not possible to determine the number of General and other category registrants who are subject to area of need/district of workforce shortage restrictions. Table 16 provides a breakdown of registration categories by ASGC-RA.

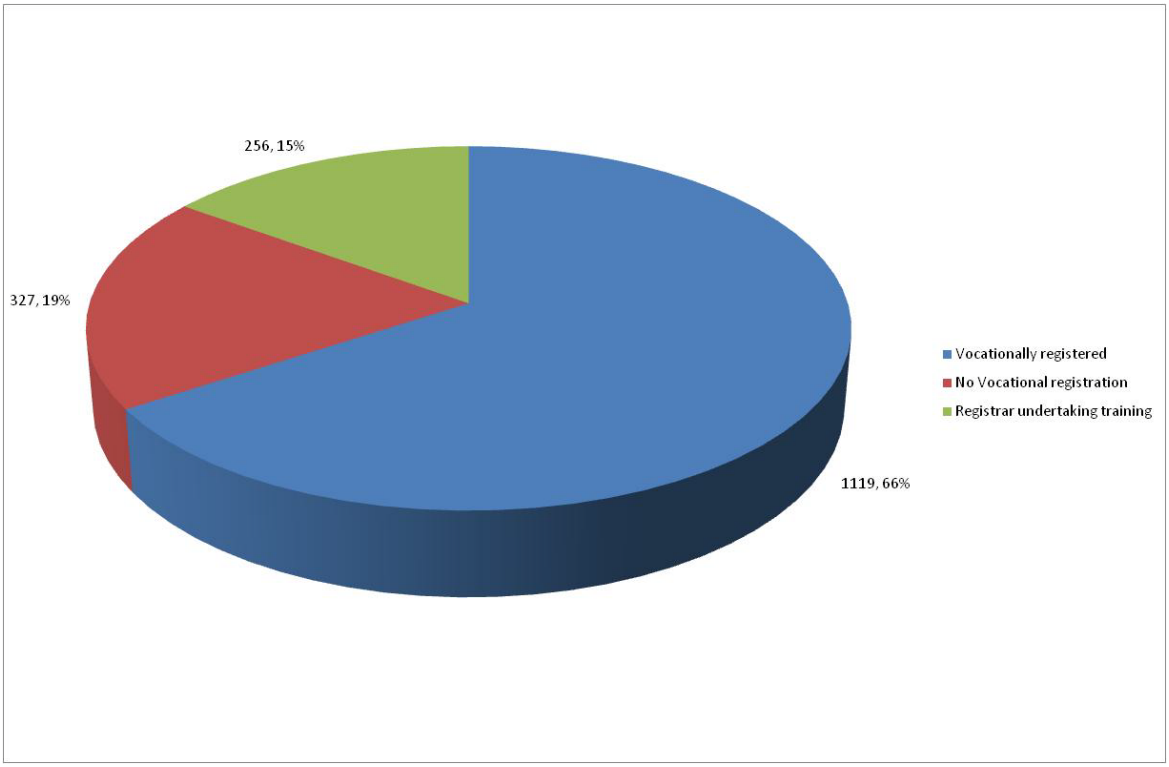
Table 16: Registration categories by ASGC-RA

	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
General	195	170	33	11	409
General-Specialist GP	471	359	32	16	878
General, Specialist	1	4	1	0	6
Limited	1	3	0	0	4
Limited AON	90	70	4	3	167
Specialist GP	143	85	7	2	237
Total	901	691	77	32	1701

12. Vocational Status

Current data indicates that 65.8% per cent of medical practitioners in rural and remote Queensland are vocationally registered. Registrars undertaking training comprise a further 15.0%. Approximately 19.2% of the rural and remote medical workforce in ASGC-RA 2 to 5 locations do not have vocational registration. Data was not available for 5 practitioners. Figure 5 displays known vocational status.

Figure 5: Vocational Status



13. Doctor Turnover

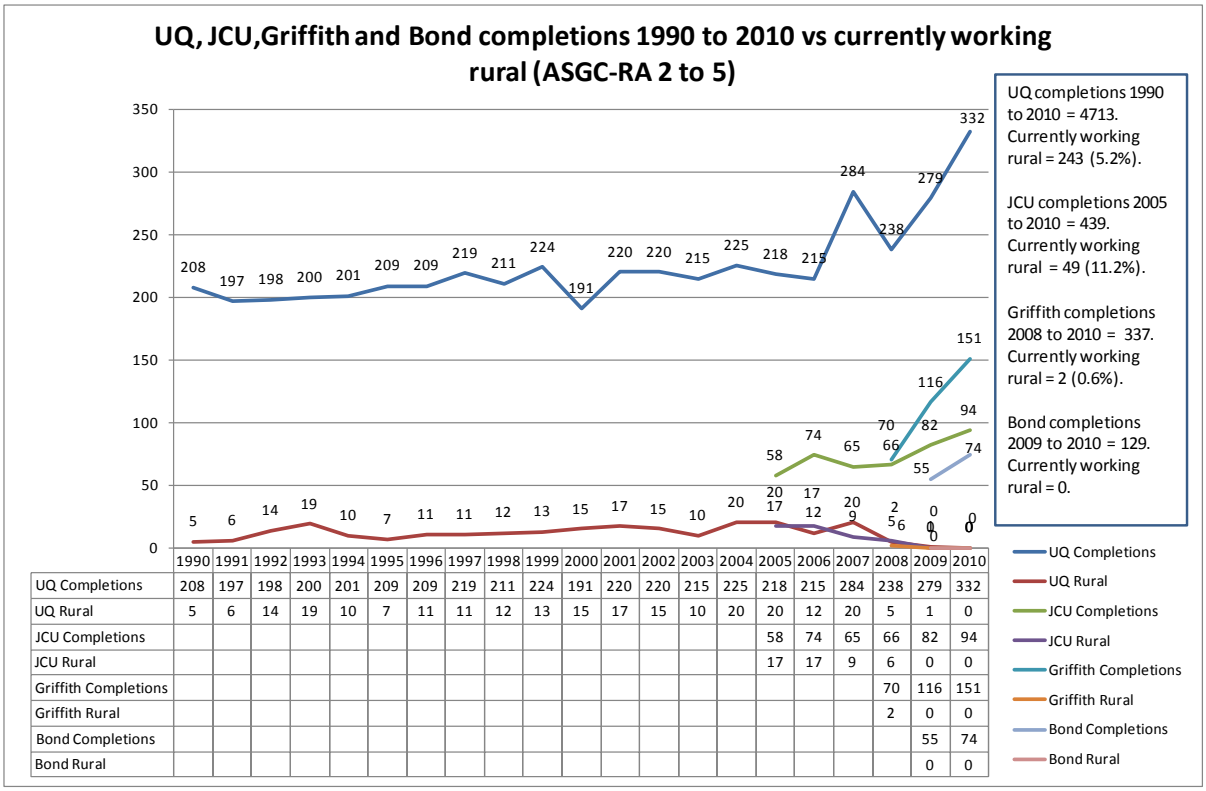
As at 30th November 2010, there were 1666 medical practitioners working in ASGC 2 to 5 locations in Queensland. By 30th November 2011, 245 of these practitioners were no longer working in ASGC 2 to 5 locations.

As at 30th November 2011, there were 1707 medical practitioners working in ASGC 2 to 5 locations in Queensland. Two hundred and eighty six of these practitioners were new or returning and not working in ASGC 2 to 5 locations as at 30th November 2010.

14. Tracking

Over the past several years, Health Workforce Queensland has been actively tracking the number of Queensland trained doctors who are currently working in rural and remote locations. Data indicates that of the 5618 graduates from the University of Queensland, James Cook, Griffith and Bond Universities between 1990 and 2010 only 294 (5.2%) are currently working in ASGC 2 to 5 locations. We acknowledge that over this period, many Queensland graduates may have served in rural and remote areas; however the numbers currently working in ASGC 2 to 5 are relatively low. Figure 6 displays the number of Queensland medical graduates by year from 1990 to 2010 and the number currently working in ASGC 2 to 5 locations as at November 2011. These data do not include Queensland trained doctors working in regional hospitals in towns with a population greater than 12,000.

Figure 6: Number of Queensland medical graduates currently working in rural and remote locations as at November 2010 for years 1990 to 2010



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
UQ Completions	208	197	198	200	201	209	209	219	211	224	191	220	220	215	225	218	215	284	238	279	332
UQ Rural	5	6	14	19	10	7	11	11	12	13	15	17	15	10	20	20	12	20	5	1	0
JCU Completions																58	74	65	66	82	94
JCU Rural																17	17	9	6	0	0
Griffith Completions																			70	116	151
Griffith Rural																			2	0	0
Bond Completions																				55	74
Bond Rural																				0	0

15. Notes on Queensland data

Queensland data includes 104 state salaried doctors (Residential Medical Officers, Senior Medical Officers and Medical Superintendents) who do not have the right of private practice. However, due to the differing nature of medical service provision in Queensland, it is estimated that over 75 percent of these doctors provide primary care/GP type services in their communities. In the absence of a reliable method of differentiating their degree of primary care provision, they have been included in the current dataset. The negative aspect of this inclusion is that it probably does provide an overestimate of primary care/GP type services currently available in rural and remote Queensland.

In a change from previous compilations, Queensland Health salaried doctors in towns with a population greater than 12,000 are not enumerated in this report.

16. Summary

The data provided in this report have been based on elements considered essential to understand the composition and workforce attributes of the Queensland rural and remote medical workforce. While the data may differ to that produced by Medicare Australia, we believe that it is probably more valid and current as numbers reported reflect 'on ground' realities and are based on local knowledge of medical provision in communities. Measures such as FTE and FWE are based on the number and value of claims processed by Medicare and often do not capture the full extent of medical service provision in rural and remote communities. Health Workforce Queensland is satisfied that the collated data provides an

accurate portrayal of medical service provision in rural and remote communities as at the 30th November 2011 reporting date.

As indicated in the introduction, many aspects of the data contained in this report are not solely dependent on survey response but are derived from known working data maintained by Health Workforce Queensland. Survey responses are largely used to validate and update known data. Survey response rate for the current data collection period to 30th November 2011 was 52.7%.

Trends evident in this report include:

- A 2.46% increase in practitioner numbers between 30th November 2010 and 30th November 2011 (N=41).
- A relatively high number of solo doctor practices – 31.4% (N=164)
- A small increase in the number/percentage of overseas trained doctors in ASGC 2 to 5 locations.
- A continuation of national trends with increasing number of female practitioners in lower age groups.
- A continuation of trends that suggest that female practitioners tend to work less hours compared with their male counterparts.
- Enumeration of known procedural practitioners.

17. Terminology

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AGDoHA	Australian Government Department of Health and Ageing
AMWAC	Australian Medical Workforce Advisory Committee
ASGC-RA	Australian Standard Geographical Classification – Remoteness Areas index
CDHAC	Commonwealth Department of Health and Aged Care (now Australian Department of Health and Ageing)
CDoHA	Commonwealth Department of Health and Ageing
DoHA	Department of Health and Ageing
FTEs	Full-time equivalents (calculated on HIC billings of $100,024) for 2008-2009
FWEs	Full-time workload equivalents (calculated on average HIC billings for full-time doctors - ($278,990 for 2008-2009 reference period)
MA	Medicare Australia (formerly Health Insurance Commission)
RFDS	Royal Flying Doctor Service
RRMA	Rural Remote and Metropolitan Area Classification
RHWA	Rural Health Workforce Australia
RWA	Rural Workforce Agency
MSRPP	Medical Superintendent with Right of Private Practice
MORPP	Medical Officer with Right of Private Practice

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Appendix 1

ASGC-RA 2 to 5 data 2010 to 2011

	2010	2011
Total practitioners	1666	1707
Percent female	36.7	37.0
Percent male	63.3	63.0
Average age female	44.5	45
Average age male	49.6	50.1
Average GP clinical hours	38.3	38.0
Average total hours	47.1	45.4
Average length of stay in current practice (years)	5.6	5.9
Overseas trained doctors	770	823
Temporary Resident doctors (included above)	207	187
Proceduralists General Anaesthetics	97	90
Proceduralists Obstetrics (Normal delivery)	112	107
Proceduralists Operative surgery	51	56
Known Proceduralists (practising in at least one procedural field)	164	154
Proportion Proceduralists	9.84%	9.02%
Proportion vocationally registered	67%	65.8%
Proportion non-vocationally registered	20%	19.2%
Proportion Registrars	13%	15%
Number of GPs working in solo practices	153	164
Number of GPs working in group practices	1513	1543

Historical trend data based on RRMA 4 to 7 locations between 2003 and 2009

	2003	2004	2005	2006	2007	2008	2009
Total practitioners	931	965	993	1015	1081	1130	1169
Percent female	30.6	30.7	31.6	31.5	33.4	33.9	34.5
Percent male	69.4	69.3	68.4	68.5	66.6	66.1	65.5
Average age female	41.7	42.5	43.2	43.4	43.9	44.4	44.6
Average age male	46.2	47.2	46.7	47.2	47.9	48.4	49.0
Average GP clinical hours	40.8	40.6	40.5	39.9	39.0	39.2	39.3
Average total hours	48.9	49.0	48.9	48.2	47.2	47.1	47.2
Average length of stay in current practice (years)	5.8	5.9	5.9	6.0	6.0	6.0	6.1
Overseas trained doctors	388	406	433	476	540	591	579
Temporary Resident doctors (included above)	177	189	185	197	229	266	222
Proceduralists General Anaesthetics	77	84	80	84	86	88	84
Proceduralists Obstetrics (Normal delivery)	118	125	125	129	125	132	127
Proceduralists Operative surgery	69	67	60	68	68	67	60
Known Proceduralists (practising in at least one procedural field)	168	170	165	183	177	186	172
Proportion Proceduralists	18.0%	17.6%	16.6%	18.0%	16.4%	16.5%	14.7%
Proportion vocationally registered	56%	56%	55%	54%	52%	54%	58%
Proportion non-vocationally registered	34%	34%	34%	33%	35%	34%	30%
Proportion Registrars	10%	10%	11%	13%	13%	12%	12%
Number of GPs working in solo practices (123)	118	132	135	135	112	110	123
Number of GPs working in group practices (244)	813	833	858	880	969	1020	1046

Appendix 2

Rural, Remote and Metropolitan Area Classification (RRMA) and Accessibility/Remoteness Index of Australia (ARIA)[5] and ASGC-RA

Many regional programs are targeted at areas of geographic disadvantage and the convenient label of being 'rural' areas often refers to these areas. However, there is not a generally accepted or generally applicable definition for the Australian context that can be used to identify rural areas. As a result, the RRMA classification has been widely used to determine eligibility of an area for program funding. The RRMA classification was used to assign each SLA (based on 1991 boundaries) to one of 7 categories that were further aggregated into three basic zones (Metropolitan, Rural, and Remote).

The seven RRMA categories are:
1. Capital Cities (Metropolitan Zone)
2. Other Metropolitan Centres (Metropolitan Zone)
3. Large Rural Centres (Rural Zone)
4. Small Rural Centres (Rural Zone)
5. Other Rural Areas (Rural Zone)
6. Remote Centres (Remote Zone)
7. Other Remote Areas (Remote Zone)

The use of the word 'rural' in several of the category names of the RRMA classification was not originally intended to be a definition of rurality. However, over time, RRMA category names have evolved into a simple and convenient way of interpreting rurality. Many programs that have to make decisions on eligibility for assistance are constrained by legislation and policy to using RRMA categories that 'define' rural areas. Within the Commonwealth Department of Health and Ageing administration of regional assistance will move from the use of the RRMA classification to use of ARIA over time.

In May 2009, the Australian Government announced that Rural, Remote and Metropolitan Areas (RRMA) system will be replaced by the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system. The ASGC-RA has been developed by the Australian Bureau of Statistics, uses 2006 Census data, and is widely used by Commonwealth and state agencies. Full implementation of the ASGC-RA classification commenced on 1st July 2010.

ASGC-RA is derived from the ARIA+ classification developed by GISCA. ARIA+ like its predecessor ARIA, is an unambiguously geographical approach to defining remoteness. ARIA+ is a continuous varying index with values ranging from 0 (high accessibility) to 15 (high remoteness), and is based on road distance measurements from 11,879 populated localities to the nearest service centres in five size categories based on population size. 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).[6]

Service Centres - are populated localities where the population is greater than 1000 persons. The Urban Centre/Locality Structure of the 2001 ASGC has been used to define the real extent and population of these areas. The table below shows the population break points that were used to group Urban Centres into the five Service Centre categories. The ARIA+ analysis considers about 730 services centres in determining remoteness values across Australia. These service centres are a subset of the 11,879 populated localities. In instances where the ABS defined Urban Centres are split by a state boarder, such as in the case of Albury and Wodonga, the population and spatial extents for each of these Urban Centres have been combined and treated as one service centre.

[5] Commonwealth Departime of Health and Aged Care (2001). Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA). Occasional Papers: New Series Number 14.
[6] GISCA(u.d.) About ARIA+ (Accessibility/Remoteness Index of Australia). Available http://www.gisca.adelaide.edu.au/products_services/ariav2_about.html

Service Centre Category	Urban Centre Population
A	*250,000 persons or more*
B	*48,000 – 249,999 persons*
C	*18,000 – 47,999 persons*
D	*5,000 – 17,999 persons*
E	*1,000 – 4,999 persons*

The ARIA+ methodology regards services as concentrated into Service Centres. Populated localities with populations of greater than 1000 persons are considered to contain at least some basic level of services (for example health, education, or retail), and as such these towns and localities are regarded as Service Centres. Those Service Centres with larger populations are assumed to contain a greater level of service provision. A total of 738 Service Centres, classified by their population into five categories, were used in the ARIA+ methodology.

From ARIA, the department of Health and Ageing developed its five-level classification (also called ARIA), and from ARIA+, the Australian Bureau of Statistics developed its six-level classification, the Australian Standard Geographic Classification (ASGC) Remoteness Structure.[7] A broad comparison of these systems is displayed below.

Remoteness classifications

	RRMA			DoHA ARIA			ASGC Remoteness		
Broad Category	**Fine Category**	**Population (000,000)**	**%**	**Category**	**Population (000,000)**	**%**	**Category**	**Population (000,000)**	**%**
Metropolitan	Capital Cities	11.6	64	Highly Accessible	14.9	81	Major Cities	12.1	66
	Other Metropolitan centres	1.4	8						
Rural	Large Rural centres	1.1	6	Accessible	2.2	12	Inner Regional	3.8	21
	Small Rural centres	1.2	7				Outer Regional	2.0	11
	Other Rural centres	2.4	13	Moderately Accessible	0.8	4			
Remote	Remote centres	0.2	1	Remote	0.2	1	Remote	0.3	0.3
	Other Remote areas	0.3	2	Very Remote	0.2	1	Very Remote	0.2	0.2
							Migratory	<0.1	

Note: This table is a rough guide only; the various classes in each classification are not equivalent.
Source: AIHW Population Estimates; AIHW Australia's Health 2002.[8]

[7] Australian Bureau of Statistics (2001). *Outcomes of ABS views on remoteness consultation, Australia*. ABS Cat No 1244.0.00.001. Canberra, ABS.
[8] Australian Institute of Health and Welfare (2002). *Australia 's health 2002*. Canberra: AIHW.

February 21 2012

BOWEN BASIN LEADERS COMMISSION HEALTH PROJECT

The Bowen Basin Leadership Group has commissioned Health Workforce Queensland to develop a regional health services plan for the delivery of sustainable and appropriate health care services, right across the region.

Health Workforce Queensland is part of a network of Rural Workforce Agencies within Australia funded by the Australian Government Department of Health and Ageing.

It was originally established to help address the critical shortage of rural and remote General Practitioners in Queensland and to promote greater health service options for country Queenslanders.

'We believe they have the skills, knowledge and experience to deliver a plan that will meet the needs of our communities,' said Mayor of the Central Highlands Regional Council Peter Maguire.

The project, which will cost around $200,000, is being funded by key members of the Leadership Group, including the Banana, Isaac and Central Highlands Councils, and resource companies with interests in the region.

Chair of the Group, Central Highlands Regional Council Mayor Peter Maguire, said that they had long held the view that the delivery of health services has been one of the major issues impacting on local communities.

"A key focus of the project will be on consulting with local community representatives and service providers about their priorities, plans and capacity for future service delivery," said Cr Maguire.

"There will also be an emphasis on developing options for implementing a plan that is realistic, sustainable and affordable.

"The aim is not to come up with a model that would compete with or duplicate existing services, but rather seek to identify ways in which both services both public and private could be coordinated to obtain maximum benefit to communities."

Rio Tinto, which manages the Clermont, Blair Athol, Kestrel and Hail Creek mines in the region, is a major partner in the project.

Rio Tinto's Principal Adviser for Communities in the Bowen Basin Sam Faint said that improving access to primary and secondary health services will have significant benefits for employees and their families, and the communities in which they live and work.

'Timely, affordable access to appropriate health care will improve the quality of life for all Basin residents," said Ms Faint.

"It will also assist businesses large and small to attract and retain workers in this region."

BHP Billiton Mitsubishi Alliance (BMA) has also committed to the Bowen Basin wide study as well as a complementary study focused on Moranbah and Dysart medical services. Health Workforce Queensland has also been commissioned for the additional study which may assist with the integration of key findings back into the Bowen Basin wide study.

BMA's Asset President, Stephen Dumble said "We're committed to working in partnership with government, industry and community to undertake important regional health services planning. The complimentary studies demonstrate a proactive self-help approach across these partners in order to clearly identify models of health service delivery to benefit the communities in the Bowen Basin."

The Mayor said that the BBLLG also saw that improved access to health services will also provide significant social benefits to the region.

'If we want to continue to attract families to live here, we need to demonstrate that they will have access to good quality health services, whether it's rehabilitation from a sporting injury, dental care or having a baby.'

The project will commence in the coming months and will be overseen by a steering committee comprising members of the Bowen Basin Local Leadership Group.

The Bowen Basin Leadership Group, comprising Banana, Isaac and Central Highlands Regional Council mayors, mining company representatives, the Construction, Forestry, Mining and Energy Union (CFMEU), state government departments and community members, was established under the Sustainable Resource Communities Partnership Agreement.

ENDS

For further information please contact CEO of Health Workforce QLD, Chris Mitchell on 3105 7800, or CHRC Mayor, Peter Maguire on 4982 8333.