

# Chapter 4

## Attempts to address the rural medical skills deficit

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

### Government-led actions and policies impacting on doctor numbers

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

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

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

### *Skilled migration*

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

The number of medical practitioners working in regional, rural and remote Australia has increased steadily during the past ten years. Much of this is attributed to the use of overseas trained doctors who have increased significantly since 2001–02.<sup>3</sup>

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

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

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

4.5 According to Australian Institute of Health and Welfare (AIHW) data (2009), approximately 25 per cent of the medical workforce in Australia are overseas trained. OTDs now comprise 46.2 per cent of GPs in non-metropolitan areas, up from 27.1 per cent in 2000–01.<sup>4</sup> In 2009–10 30 per cent of OTDs were working outside of metropolitan areas.<sup>5</sup> The growing importance of OTDs is underscored by the growth in services they provide to rural and regional communities. According to the Rural Doctors Association of Australia (RDAA):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### ***Incentives: education***

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

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

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

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

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

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

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

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

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

2000.<sup>20</sup> Rural clinical schools are charged with delivering significant components of the medical curriculum in a rural environment, with students undertaking a year or more of their medical training in a rural location. The 2008 report *Evaluation of the University Departments of Rural Health Program and the Rural Clinical Schools Program* found that:

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

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

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

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

4.21 Additional measures under the RCTS include the requirement that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### ***Committee view***

4.26 While the committee is supportive of the efforts of the Government under the Rural Clinical Training and Support in particular, the committee does not believe that four weeks structured rural practice training is sufficient time to expose the student to the full gamut of experience available in rural Australia. The committee also heard of a number of instances<sup>30</sup> where the local community had actively welcomed students and ensured that they had a positive feeling of engagement and connectedness with the area. The committee does not think that four weeks is long enough to foster that level of input from the community.

### ***Incentives: recruitment and retention***

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

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

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

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

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

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

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

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



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

- General Practitioner component: the general practitioner component of GPRIP aims to reward and retain long-serving general practitioners in rural and remote communities. Incentive payments are scaled according to location, length of medical service to rural communities, and clinical workload. Incentive payments can reach \$47 000 per year.<sup>34</sup>
- Registrar Component: the registrar component of GPRIP provides incentive payments to General Practitioner Registrars on the rural or general pathway of the Australian General Practice Training program. Incentive payments are scaled according to location, length of time spent training in rural communities, and the percentage of full-time equivalence while on the training placement.<sup>35</sup>
- Rural Relocation Incentive Grant (RRIG): the RRIG provides grants to GPs practising in rural and remote Australia. Incentive grants are calculated according to the location GPs relocate from and relocate to. The clinical workload following relocation is also a factor. The maximum available grant is \$120 000.<sup>36</sup>

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

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

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

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

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

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

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

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

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



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

#### 4.33 The Rural Procedural Grants Program (RPGP):

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

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

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

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

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

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

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

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

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

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

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

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

4.38 In response to these challenges, the government provides grants to assist medical practices under Primary Care Infrastructure Grants program.<sup>45</sup> This is a scheme under the GP Super Clinics program that the government have spent \$118.5 million on since 2010 to 'upgrade and extend existing local general practices, primary care and community health services, and Aboriginal Medical Services to improve access to integrated GP and primary health care.'<sup>46</sup> The grants are made in one of three categories, up to \$150 000, up to \$300 000 and up to \$500 000.<sup>47</sup>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### ***Initiatives to encourage allied health professions and nurses into rural areas***

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

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

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

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

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

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

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

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

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

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

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

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

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

### *Committee view*

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

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

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

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

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

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

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## Recommendation 5

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

## Recommendation 6

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

## Telemedicine

4.54 The delivery of health services through telemedicine is an area that is being explored more and more by government, education providers, health care delivery services and the public as technology evolves. The introduction of the e-health legislation<sup>59</sup> and the improvements in internet access across the country have the potential to significantly impact the delivery of health services in rural areas.

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

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

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

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

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

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

and video communication in spite of the fact of being inequitably supported.<sup>61</sup>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

### ***Committee View***

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

### **Up-skilling the existing workforce**

#### ***Nurse Practitioners***

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

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

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

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

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

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

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

testing and emergency contraception, and consult GPs about more serious clinical problems.<sup>72</sup>

4.67 Another change has been the growth of the practice nurse workforce following the 2001-2002 Federal Budget, which provided funding for rural practices to assist with employment of practice nurses. In 2007 a national survey of practice nurses estimated that 57 per cent of practices employed a practice nurse, up from 40 per cent in 2003.<sup>73</sup> Research completed at the Australian National University reported high levels of patient satisfaction with the use of practice nurses:

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

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

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

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

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

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

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

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

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

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

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

### ***Other health professionals***

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

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

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

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

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

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

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

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

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

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

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

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

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### ***Committee view***

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

### ***Proposals from the Australian Medical Association (AMA)***

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

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

...

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

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

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

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

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

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

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

### ***Rural Doctors Association of Australia***

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

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

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

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

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

### *Community led initiatives*

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

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

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

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

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

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

### **The efficacy of efforts to increase the rural health workforce**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

#### ***Committee view***

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

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

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

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

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

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

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

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

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

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

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

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

### **Recommendation 7**

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

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