The RACGP National Rural Faculty

The Royal Australian College of General Practitioners

6 January 2012

Committee Secretary
Senate Standing Committees on Community Affairs
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Dear Senators,

Senate Community Affairs Inquiry
The factors affecting the supply of health services & medical professionals in rural areas

The RACGP National Rural Faculty thanks the Senate Community Affairs Committee for the opportunity to contribute to discussions regarding rural health services and workforce supply.

The RACGP is the specialist medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

The RACGP represents over 20,000 members in urban and rural areas working in or towards a career in general practice making the RACGP Australia's largest professional general practice organisation. Our membership includes over 4,400 general practitioners living and working in regional, rural and remote Australia.

Please find attached our submission to the inquiry. The National Rural Faculty Board would welcome an opportunity to present to the Senate Committee during the hearing process.

For enquires related to our submission please contact Ms Lauren Cordwell, Manager National Rural Faculty on or email:

Yours sincerely,

Dr Kathryn Kirkpatrick
Chair, National Rural Faculty

The Royal Australian College of General Practitioners

The RACGP National Rural Faculty

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Submission to the Senate Community Affairs Reference Committee

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

6 January 2012

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Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Senate Community Affairs Committee for the opportunity to contribute to discussions regarding rural health services and workforce supply.

The RACGP is the specialist medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

The RACGP vision for a *Healthy Profession, Healthy Australia* focuses on ensuring our members are appropriately resourced and remain at the centre of an effective and efficient health care system. Equitable access to quality general practice is key to supporting our overall vision.

The RACGP National Rural Faculty (NRF) recognises the challenges specific to rural general practice and endeavours to provide advocacy and support for GPs working in rural and remote locations. The NRF currently has over 7,600 members including more than 4,400 GPs living and working in regional, rural and remote Australia.

How well the health system responds to current and emerging pressures in regional, rural and remote Australia is a central focus for the NRF. It is through close consultation with the profession that the NRF is well placed to provide valuable input to future health initiatives.

The following submission outlines a number of areas currently limiting health service supply and workforce expansion in rural areas. The NRF Board would welcome an opportunity to present these views to the Senate Community Affairs Reference Committee during the hearing process.

Executive Summary

A key aim of the NRF is to ensure health reforms and programs are responsive to the **diverse challenges** faced by rural general practitioners. Our submission therefore centres on ensuring the inquiry leads to increased support for rural general practitioners and their communities, and works to address current barriers to recruitment and retention.

Throughout the paper, the NRF has identified a number of key areas that require increased policy attention in order to address the significant rural health inequities and workforce capacity concerns. These are summarised below, specifically there is a need for Government to:

- Develop targeted strategies to secure a **well-trained rural GP workforce with procedural and advanced skills** to meet community need;
- Shift from simplistic measures of generic **workforce need** to analysis based on local assessment and context, particularly in defining rural GP workforce requirements;
- Deter the perceived need for the development of **short-term, state-based** medical workforce initiatives;
- Effectively finance patient care addressing the gap between Medicare rebates and the **real cost of a consultation** for all GPs;
- Provide stronger incentives to work in rural and remote areas by moving away from the current funding and delivery models to support for **more flexible ways of working**;
- Further invest in **rurally oriented medical education** and rural term experience at all levels in the medical education continuum;
- Ensure and support the **expansion of clinical training** capacity in general practice;
- Provide **more support structures** during rural term experience ensuring quality training with strong rural curriculum and increased rural clinical attachments;
- **Improve coordination** of rural placements across the training continuum while respecting local knowledge of training capacity and quality;
- Extend the **rural student intake** guideline for universities from 25% to 33% in line with regional population distribution;
- Diversify the **training pathways** to expand the availability and flexibility of procedural and advanced skill training.
- Ensure adequate support and supervision for **International Medical Graduates** (IMGs);

Addressing demand

Urban-rural health disparities in Australia, including health status, life expectancy and prevalence of disease, are widely documented. While it is clear that there are many economic, social and environmental factors that influence health outcomes in rural communities, general practice has a central role to play in improving the quality of health services to these communities.

Despite significant investment and many reforms, long standing health disparities remain for rural communities when compared with health status measures (such as life expectancy and the prevalence of disease). Some recent reforms show promise, for example the Health Workforce Australia's (HWA) Rural and Remote Health Workforce Innovation and Reform Strategy. It is hoped implementation of the Strategy will make rural and remote health a priority, based on local needs assessment.

For the one-third of Australia's population that live in regional, rural and remote areas, securing a sustainable rural health system including a rural health workforce that enables improved health outcomes must be a priority.

The growing demand for health services and the associated pressure on health systems will be compounded by broader socio-economic concerns including the ageing population, the impact of climate change and workforce capacity issues. While the increased demand for health services will be Australia wide, it is the nature of rural and remote communities – distance between communities and the access to services (including adequate workforce) which need to be addressed in order to help reduce the poorer rural health outcomes.

Investment in primary care improves health outcomes and reduces mortality[i], compared with the same dollar investment in hospital and specialty services, therefore investment in rural general practice and increasing the capacity of rural general practice will with local needs assessment go a long way to improving the health outcomes for rural and remote Australians.

Skill recognition

Securing a strong future for the profession implies increased attractiveness including recognition within the health system of the skills of rural general practitioners which may be context specific. [ii] The specific skills of a rural and remote GP may comprise general practice and primary care, an advanced skill mix including hospital practice (secondary care) as well as one or more of the following anaesthetics, obstetrics, surgery, emergency medicine, palliative care, paediatrics to name a few, which ensures rural communities have access to the types of services readily available in cities.

Recruitment and retention

Tackling the complexities of recruitment and retention to rural and remote general practice is required. The factors affecting recruitment and retention are widely documented and include:

- Adequate housing and infrastructure (practice and hospital);
- Continuing Professional Development (CPD) close to place of employment;
- Cost and time to keep up skills and the lack of recognition of cost of travel from remote areas to attend CPD;
- Spouse employment opportunities;
- Education opportunities for children;
- Issues of professional isolation;
- Safe working hours and locum relief; and
- Policies that support "easy entry, gracious exit"; [iii]

More flexible funding arrangements are required to encourage and facilitate uptake of teaching and supervision roles in general practice. Initiatives that increase general practice training capacity by attracting new GP supervisors and retain and motivate experienced GP teachers must be a priority.[iv]

To address increasing demand for medical training in the clinical general practice setting, there is a need for a commitment to strategies that provide adequate remuneration for teaching in the practice. The NRF has undertaken significant policy work (including financial modelling for supervision) in this

area and would be pleased to share this with the Committee. Other policy responses will need to address the broader barriers and clinical workloads that restrict participation in teaching including practice location, size and infrastructure constraints (The NRF recognises the success of the federally funded rural infrastructure grants and supports expansion of the program). The strong reliance in the past on 'altruistic motivators' cannot be relied upon in the long-term.[v]

Policy inconsistencies

State-based medical workforce initiatives (e.g. Queensland Health Rural Generalist Program) are working as deterrents to the recruitment and retention of rural general practitioners. Rural general practitioners support the longer term needs of rural communities and their roles and skills need to be valued over the, unevaluated state based initiatives.

Incentives to go rural

The service and structural constraints in delivering quality primary care for rural and remote communities are wide-ranging and include the capacity of the hospital system to enable the delivery of secondary care, a recognised attraction to rural practice. To attract the general practitioner to rural practice, the service and structural constraints need to be minimised. Investment in infrastructure and services for rural general practice needs to be targeted to existing practices in areas of identified need while giving attention to "easy entry, gracious exit". It is important that funding is not directed to untested new policies including fund holding by Medicare Locals, but rather further investment in and enhancement of evaluated programs that have produced workforce increase. Rural health needs targeted and importantly separate interventions to address the barriers and issues specific to regional, rural and remote areas. There should be quarantined funding for rural and remote health in all initiatives based on local needs assessment.

Further effort is required to ensure improved coordination of rural placements across the training continuum (undergraduate, prevocational and postgraduate) particularly at the practice level.

There are a substantial number of existing Government initiatives, rural retention and direct assistance payments, differentiated by the degree of rurality or remoteness. These include the numerous Practice Incentive and Service Incentive Payments; Rural Procedural Grants Program; and General Practice Rural Incentives Program. Given the Government has made a significant investment in these programs, the NRF recommends a full independent audit of all rural incentive programs to evaluate their effectiveness and uptake in order to enhance the existing programs. The NRF would be pleased to support the Committee in undertaking this work.

Policy approach

The success of future rural health reforms will depend on first establishing a national approach to analysis and agreed benchmarking to determine service need and workforce shortage. Current measures (such as GP to population ratios) are coarse measures that lack sensitivity and specifity, failing to capture local need and skill mix. Local needs assessment (e.g. by Medicare locals), unified analysis and agreed benchmarks will help to improve health outcomes and reduce inequalities by

directing resources in a consistent and fair manner. For real change, national leadership will be required to ensure consistency across states.

It is important to recognise that solutions must be developed in line with the realities of rural practice. There is already a significant GP procedural workforce decline and strategies are required to ensure a well-trained and supported workforce for the future. General practitioners with advanced skills including procedural skills fill the gap in rural areas, where access to specialist services is limited.

RACGP Response to the Senate Inquiry

Why do we need a well-trained rural health workforce?

It is clear that those living in regional and remote areas, compared with major cities, generally have **poorer health outcomes** when compared on specific health status measures, such as life expectancy and the prevalence of chronic disease.[vi] The key health challenges impacting on the supply of health services for regional, rural and remote communities are dominated by:

- issues of generally poorer health outcomes;
- the burden of disease and injury;
- inequitable access to health care;
- resourcing for services;
- cost pressures associated with distance and rural isolation; and
- Inequitable distribution of health funding.

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

In determining the overall disease burden, cancer and heart disease are among the two leading cause of burden nationally, with an expected likely rise in the number of people with diabetes, predominantly due to higher obesity levels. In terms of differentials, national data show regional areas account for 33.1 per cent of the burden and remote areas 2.5 per cent with males experiencing more of the burden than females. Of the ten leading specific causes, Type 2 diabetes is the leading cause of burden in remote areas. The total burden per head of population increases with remoteness, with remote populations having a 26.5 per cent greater burden than populations in major cities.[viii]

For regional, rural and remote areas the prevalence and burden of chronic disease is compounded by the availability of and access to health services. Geographical location impacts, transport and access to appropriate services are major impediments to accessing quality health services in these areas and generally there is an under-supply of facilities and health care professionals also impacting on service waiting times.

1. Factors limiting supply

There are a number of known factors impacting the supply of health services and health workforce in rural areas. These issues are discussed below.

1.1 GP shortages

There are significant health **workforce shortages** in regional, rural and remote areas. National health workforce figures show the number of GPs in proportion to the population decreases significantly with greater remoteness, with hours worked by rural GPs increasing with rurality and remoteness. A recent

national audit (Department of Health and Ageing 2008) confirmed that current supply of health professionals (particularly general practice) is not sufficient to meet current need. The modest growth in general practice in remote Australia was due to restrictions on Medicare provider numbers for international medical graduates who are subject to the 10 year moratorium. There is a strong reliance on international medical graduates in regional, rural and remote areas, where they represent 41 per cent of the general practitioner headcount.[ix]

Currently, some incentives to provide relief or to temporarily address shortages in remote areas are creating unintended disincentives to practice on more permanent basis. For example, locums working the same hours as permanent doctors can be remunerated up to $10,000 more per month. Further, locums receive other inducements, including unlimited return flights, and no overheads in terms of accommodation and business operating expenses.

In contrast, permanent doctors in some remote areas, e.g. Port Headland, endure substandard costly accommodation, incur expensive utility costs, and receive one return flight to Perth per annum. Recruitment could be improved by consistent standards for safe accommodation offered to rural doctors. Perhaps those responsible for health workforce recruitment and retention could look to the models for recruitment and retention of workers used by mining companies in remote Australia.

Other important considerations include safe work environment; security of tenure; ease of transfer; spouse employment; access to quality education (adult and child); and childcare provision. It is well documented that a positive rural clinical experience for students increases the likelihood of return to practice in a rural or remote community. The positive experience is influenced by adequate accommodation and transport; access to high speed broadband, functioning clinical environments with an enthusiastic supervisor and mentor and working in a health care team. Students also report greater satisfaction with a rural placement if there are multiple students placed together. Investment in processes to ensure the positive, rural clinical placement may well contribute to the next generation of rural general practitioners.

In developing a workforce policy response, there is a need to consider the advanced skill sets practised by GPs in rural areas as this will influence the clinical load seen in the practice. Rural general practitioners with advanced skill sets enables practice outside of the consulting room e.g. minor surgery (within the practice), hospital inpatients, emergency medicine delivered in the hospital, anaesthetics, obstetrics and gynaecology as well as surgery. This issue is discussed at section 1.3.

1.2 GP workforce with advanced skills

Central to the retention issue, is the need for greater recognition in the wider health system of the **advanced skills** of rural GPs.[x] Future policy must bring about broad based and comprehensive change to provide a 'critical mass of GPs with advanced skills'[xi] to meet patients' needs in rural communities.

A relatively new development, a response from the states seeking to address workforce pressures, is the emergence of a workforce model termed 'rural generalist'. This is a state health department workforce solution, with perceived success in Queensland due to lucrative salaries which cannot be matched by private general practice. It should also be noted that the term 'rural generalist' represents a state jurisdictional industrial term and is not a recognised medical speciality by the Australian Medical Council. The training endpoint is the specialist qualification in general practice.

The hospital basis of some of the training models and potential for reduced community based general practice training is a concern. In some models, community based medicine aspects of training are neglected in the pursuit of hospital based skills, which in turn locks doctor into a particular type of hospital centred practice, to the detriment of general practice consulting skills.

There is a need for a well-trained general practice workforce with advanced skills including procedural skills in rural communities.[xii] Research undertaken by the RACGP National Rural Faculty has found that many graduates of the Fellowship in Advanced Rural General Practice have undertaken training in more than one advanced skill.[xiii] But Robinson et al (2010) contribute a gradual decline in the volume and complexity of procedural work to:

- The rise of specialisation;
- Shifts in community demography;
- Changing medical practices;
- Fear of litigation;
- Centralisation of services, infrastructure and other costs.

Other contributing factors are attributed to the specialist domination of undergraduate and PGY1 training and the economic imperative to deny GPs adequate procedural training.

To address the considerable decline in rural procedural services there needs to be more effort at a broader policy level to address barriers and challenges to skill acquisition e.g. access to training posts for general practice registrars. Competition for advanced skills posts will only increase with the increase in other medical specialty training places. Workforce interventions alone cannot shift some of the current impediments to service provision. These are widely documented for rural general practice and include, but not limited, the following areas or issues:

- ageing workforce;
- Remuneration not commensurate to extended scope of practice;
- Closure of facilities and downgrading of services and lack of appropriate infrastructure;
- Exposure to procedural work to maintain skills, costs and time in retaining skills, insurance costs and litigation concerns;
- The need for greater locum relief; support to undertake Continuing Professional Development (CPD) and challenges related to long hours, distance, physical and professional isolation.

For practicing rural GPs, there is a need to diversify the training pathways to expand the availability and flexibility of procedural training. This would enable greater take up as the current arrangements which require rural GPs to leave their country practice for a 6 to 12 month term, together with incurring significant pay decreases to undertake such training, are too restrictive and are not viable for many. The NSW Rural Generalist Training Program is an example of a program that could be replicated elsewhere to enable access to advanced training for GPs.

1.3 Rurally oriented medical education

Further investment and effort in rurally oriented medical education in rural environments and rural term experience is required. There are already many effective existing reforms and policies such as the Australian General Practice Training (AGPT) rural pathway for general practice registrar training, undergraduate rural clinical schools, increases in training places but for retention **more support structures** are required during rural term experience.

For rural GP workforce recruitment strategies, it is important to build on the current training structure (matching learning needs as the first priority) while aligning training positions with ongoing employment, yet without compulsion. Ensuring that the focus remains on local enrichment, community based general practice, the needs of the medical student and general practice registrar and quality training instead of being driven by centralised placement. Flexibility of choice against identified workforce and service needs must be balanced with the reality of limited resources and the need to attract and retain individuals whilst ensuring a framework of support. The approach should support a mentoring model whilst also allowing for breadth of experience in rural and remote areas.

It is essential that General Practice be involved in rurally oriented undergraduate medical education in addition to postgraduate education. This requires consideration of teaching capacity, adequate remuneration for GPs for teaching roles (expanded later in this submission), funding for coordination of rural placements at the practice level (not just a central placement officer), funding for academic support for rural GPs and the primary health care team who teach students. Improved coordination of undergraduate (medical students), prevocational (intern and junior doctors) and postgraduate (general practice registrars) placements is also important, with equitable remuneration for teaching at all levels of training to avoid competition between these groups.

Whilst there has been considerable effort by Government to attract medical students to rural general practice in recent years, there is potential for these gains to be short lived unless there is a targeted strategy to specifically ensure the sustainability in the longer term of rural general practice. These efforts are negated by the denial of procedural training to undergraduates who are deprived the surgical and obstetric training once normal (pre Gorton Scheme).

2. Effectiveness of current approaches

2.1 Recruitment and retention

2.1.1 Enhance and extend existing programs

It is important to evaluate the policies that may already be having an impact – expanded university places and increased general practice training positions as well as the use of bonded programs and other incentives to encourage recruitment to rural and remote practice with retention in those locations (for example, John Flynn Placement Program, Medical Rural Bonded Scholarships, Rural Australia Medical Undergraduate Scholarships) before instituting other programs or changes. Many of these programs will have long term effects and as yet it is still too early to know the full benefit or otherwise of the programs and policy initiatives.

The NRF suggests continued focus on strategies that recruit students from rural backgrounds, regionalise medical education and training and fund regional infrastructure for that training. It is important to highlight that the expansion of any program cannot occur without support for the mentors and supervisors who provide medical training in the clinical practice setting. GP supervisor numbers need to reflect any increased training numbers coming through.

There is substantial evidence that students coming from rural backgrounds are more likely to return to rural areas after they graduate[xiv] [xv] [xvi]. The Australian Government could further promote policy based on rural origin and address the differences between universities in rural entry schemes to medical schools across the country. The current Rural Clinical Training and Support (RCTS) Program

guidelines require Universities to maintain an intake of at least 25% rural origin students for the Commonwealth Supported Places in their medical schools. An extension of this guideline to 33%, to bring rural student intake into line with the percentage of the population which lives in rural and remote communities is recommended.

In addition, ensuring quality training with strong rural curriculum – medical school, prevocational and vocational, increased rural clinical attachments in general practice including attachments to Aboriginal Community Controlled Health Services or Aboriginal Medical Services. Expanding and enhancing, through funding support, student based programs such as the National Rural Heath Student Network (NRHSN) and the General Practice Student Network (GPSN), which provide a peer to peer marketing system for careers in rural health and general practice respectively, is important to ensure these networks are used effectively.

The NRHSN is the peak body providing a voice for health students who are passionate about improving the health workforce and has over 9,000 student members from 29 Rural Health Clubs at universities across the country. The GPSN is a national student-run organisation using a peer-to-peer marketing model that seeks to foster interest in general practice and promote it as a specialty of choice and has over 7000 members in medical schools at 20 university campuses across Australia.

2.1.2 Careers in rural general practice

2.1.2.1 Recruitment

The research is not clear on proven motivators to rural practice. However, it is generally thought that lifestyle factors together with the opportunity to manage complex health presentations and use advanced skills, working in health care teams, the strong non-procedural and procedural mix as well as continuity of care and diversity in hospital settings are major motivators. Therefore targeted **marketing strategies**, led by Government, to better promote rural general practice as a career option in high school and early in medical school should be enhanced.

While it is important to retain the current financial incentives to encourage more undergraduates to pursue rural careers, further effort could be undertaken to recruit early (in schools) or to reach the late decision makers (medical students, junior doctors) at various points throughout the education and training continuum. As outlined earlier, the broader sector recognition of the extended skills and value of rural general practice is also central to the recruitment issue.

Some strategies to **influence the career choices** towards rural practice or to facilitate a rural connection could include:

- Targeted recruitment through engaging early in rural high schools;
- Attracting more rural GPs to academic roles (strategies for research and educational development); [xvii]
- Mentoring programs to link students early to a rural GP, rural location or specific field (Aboriginal and Torres Strait Islander Health) eg John Flynn Placement Program;
- Stronger commitment to mentoring students from rural backgrounds and support for the supervisors and mentors who undertake those roles;
- Ensuring more frequent rural clinical attachments built in to the training structure.[xviii]

- Enabling health systems in rural and remote settings to be responsive to the career preferences and expectations of generation Y so that they can be best placed to attract the future health workforce.

In terms of **direct funding incentives** considerations could also be given to:

- Decreasing student debt by locking into rural pathway;[xix]
- Providing direct incentives to medical schools to meet specific rural targets;[xx]
- Increasing rural clinical training capacity (supervisors) across the training continuum (medical students, junior doctors and registrars);
- Continuing investment and commitment to strategies that seek to recruit Aboriginal and/or Torres Strait Islander students (investment in entry – full financial scholarships) to rural practice.[xxi]

2.1.2.2 Retention

The Australian Medical Council (AMC) has accredited the RACGPs Fellowship program (FRACGP) as the specialist qualification for General Practice. Successful completion certifies competence to deliver unsupervised general practice services in any general practice setting in Australia – urban, regional, rural or remote.

In recognition of the training which may be undertaken by doctors in preparation for rural and remote practice, the **Fellowship in Advanced Rural General Practice** (FARGP) is offered by the NRF on behalf of the RACGP.

The FARGP program builds seamlessly on the FRACGP and includes advanced skill training posts in anaesthetics, obstetrics, surgery, Aboriginal and Torres Strait Islander health, mental health, paediatrics, emergency medicine, adult internal medicine and small town rural general practice. This is a member funded program, with Australian General Practice and Training (AGPT) providing funding for the advanced skills training post element only.

In terms of outcomes, peer reviewed research (2005) of FARGP graduates showed that 66-70% of graduates continued to deliver the advanced rural skills in which they trained and 96.3% of graduates reported an increase in confidence in their ability to deliver general practice services in rural and remote settings.

In addition to ensuring excellence in training for rural and remote practice, there are a number of known factors which influence retention. These have been noted earlier in the paper and include issues around housing and infrastructure; working in teams; safe working hours; locum relief for regular leave; CPD close to where the doctor works; education for children; spouse employment; “easy entry, gracious exit”; and access to hospital to provide secondary level care. It is also evident that while financial incentives are an inducement to practice in rural and remote Australia it is not the only factor. Recruitment and retention policy strategies need to multifactorial and coordinated across jurisdictions.

2.2 Support for International Medical Graduates (IMGs)

Rural and remote Australia depends on international medical graduates to supply its medical services. IMGs represent 41% of the rural medical workforce. IMGs are often recruited to work in the most

difficult environments, unsupported and unsupervised. Specific and tailored responses (some of which have already been successfully trialled by the RACGP as one off programs) are required to ensure that **IMGs are better supported** in orientation to the Australian healthcare system and culture and to gain the RACGP fellowship.

A recent successful strategy was the RACGP **IMG Peer Mentoring Project** undertaken in 2009-10 led by the NRF who through a Commonwealth grant established a peer mentor network for IMGs new to the Australian healthcare system. The pilot project aimed to provide a professional peer to help orient IMGs to the Australian healthcare system, support them to achieve recognition as a GP and to facilitate their adaption to local culture.

As part of the pilot project the NRF trained 64 mentors all of whom were experienced general practitioners and Fellows of the College and had a similar pathway to fellowship as their mentees. Mentors were matched with a mentee by late December 2009 and were funded to provide up to 10 hours of mentoring. In most cases this was a combination of face-to-face meetings and regular telephone or electronic media contact.

An evaluation of the program was conducted by Red Tree Consulting which is available on the College website. One of the key recommendations of the external evaluation was to ensure the College continued its work to nurture collegiality amongst IMGs by facilitating, networking and publicly valuing IMGs contributions to the profession.

Another successful program, the RACGP **IMG Fellowship Support Grant**, supports IMGs undertaking the Practice Eligible Pathway who are working in an area of need or at risk of losing their Australian Health Practitioner Regulation Agency (AHPRA) registration. This grant is sourced from funding from the Commonwealth and has enabled more than 300 grants up to the value of $3,500 to be made available to IMGs to help prepare for Fellowship exam segments, via examination support workshops and individually tailored learning programs. At December 2011, 60 IMGs in the program had successfully completed all 3 segments of the RACGP Fellowship exam.

Deregistration has significant ramifications for the general practice workforce and communities, especially in rural and remote Australia. IMGs are the backbone of rural health care and funding must be allocated to ensure they receive adequate support and supervision. The College would urge the Senate Committee to ensure continued funding for training programs and institute recurrent funding for the IMG peer support program.

3 *Appropriateness of delivery models*

3.1 Expansion of clinical training

Federally funded programs have increased the number of medical students, and those undertaking prevocational and vocational training without adequate consideration of the training capacity of general practice including rural general practice. Without a multifaceted, coordinated approach to increased training capacity in general practice, it is unlikely there will be increased recruitment to rural general practice. Positive rural experience, such as rural placements, is an integral component of recruitment of health practitioners to rural practice and is one the leading factors in take up of rural practice by students[xxii] [xxiii].

Although Government sought to fix a supply or distribution problem through increasing general practice training positions as well as general practice experience for medical students and prevocational doctors, it has not fully considered the impact of increased training demand on an ageing and depleted rural GP workforce, compounded by the poor remuneration for teaching. To meet growing demand, the expansion of clinical training capacity in regional, rural and remote areas is essential to the success of recruitment strategies.

National figures show of the 9600 general practices in Australia, there are about 1305 general practices supporting medical students, 38 supporting junior doctors and 1933 involved in general practice vocational training. With an estimated 3000 medical students, 900 interns and over 600 registrars requiring placement in general practice (by 2012) it is easy to see training positions fall short of requirement in terms of teaching capacity and that more sites need to be secured.[xxiv]

In taking on teaching roles, significant conflicts exist in a system that provides for salaried supervisors (in hospitals) set against a system reliant on private businesses with a fee-for-service arrangement. New financial arrangements will be required for rural and remote practice which equate to earning while consulting to encourage general practitioners to undertake clinical training and supervision roles and enhance clinical training capacity. The current arrangements are inadequate and there will be a need to harness existing expertise in rural and remote areas to meet need.

Current teaching incentive payments are inadequate with incentives for supervisors needing to be adjusted to a rate commensurate to earning while consulting. A **new funding model** for clinical attachments in general practice is required across the training continuum allowing for multiple rotations (medical students, junior doctors and general practice registrars) which would expand the educational role in rural practices and fulfil the training needs of an expanded sector brought about by recent policy.

Increased training capacity can occur by increasing the number of GPs who teach, retention of semi-retired general practitioners as teachers, adequate remuneration and academic and pastoral support. An impediment to the retention of **retired and semi-retired GP's** is the national registration arrangements (registration fee, CPD requirements, recency of practice) which require review. Retired and semi-retired medical practitioners should be supported to continue to contribute to their specialty, especially in teaching and supervisory roles. Currently, there are no policy initiatives targeting this retention issue.

4 Classification scheme

4.1 Determining Need

Doctor patient ratios currently used to determine workforce need are broad stroke, nonspecific and insensitive. The ratio does not reflect the skill mix of the doctors nor the local health care needs or disease burden.

There has been no serious attempt to formulate a patient needs based system which reflects the Australian population health needs – urban and rural. The "Reforms" of recent times have failed to deliver a rational basis for the provision and funding of health care. So called reform has not focussed on patient needs but has focussed on cheaper "alternatives" to GPs, hospital based care without due recognition of community and primary care. The needs of rural and remote communities with a burden

of acute as well as chronic problems cannot be provided for by a doctor-patient ratio adequate for an urban population, nor by the transfer of rural hospital beds to urban hospitals.

Communities with an over-representation of illnesses such as Obesity, Diabetes, Hypertension, Heart Disease both Ischaemic and Rheumatic, Renal Failure, Sexually Transmitted Diseases, Psychiatric illness, Alcohol, Tobacco and illegal substance abuse, domestic violence and childhood abuse and neglect, poor nutrition and sanitation, low levels of education and high levels of violence require levels of health care which governments, so far, have been unable to secure.

In rural and remote communities a ratio of doctors to patients must take into account the number and type of services required daily, including the daily emergency load, the urgent and the less urgent consultations and the unmet need of regular chronic disease reviews. Team management requires medical oversight to ensure coordination, supervision and evaluation of patients' wellbeing, particularly in communities with poorer health literacy. Many patients are reluctant to seek treatment outside their communities, and require well trained doctors with a broad range of skills to provide care in the local area as well as properly equipped and staffed hospitals.

To find a national solution for workforce planning, there is a need to first measure local community requirements (access and quality of services, infrastructure, and workforce supply including skill mix), patient population analysis (health status, socioeconomic factors) and geographic considerations (distance constraints) in a consistent and nationally agreed manner. All data sets must identify Aboriginal and/ or Torres Strait Islander patients and health professionals and capture cultural aspects of the broader community to inform research and planning for specific groups.

Nationally consistent data sets will **determine agreed disadvantage** and set priorities and inform resource allocation in a nationally consistent manner rather than ad hoc state priorities.

4.2 Determining workforce shortages

It is widely accepted that the inadequacies of the current **1:1400 universal benchmark** used in determining shortages on GP to population ratio in both urban and rural settings has led to significant policy failure particularly in shifting the many rural urban health disparities.

Doctor patient ratios currently used to determine workforce need are broad stroke, nonspecific and insensitive. The ratio does not reflect the skill mix of the doctors nor the local health care needs or disease burden.

Any policy developed to address the rural workforce shortage must ensure the assessment skill mix and training requirements including procedural and advanced skill training to meet community need and not necessarily community expectation. The use of unrefined numbers, such as the GPs per 100,000 population ratio, does not reflect the local need or the skill mix of the doctors nor can it capture complexities around caseload particularly for rural communities. For example, when there is a procedural GP who undertakes anaesthetics, surgery and/or obstetrics there is usually a colleague to undertake the complimentary skill so at any one time there will be two doctors out of the practice for an emergency, obstetric or surgical case.

These situations have far reaching implications, in this case it implies for an emergency where there are only two doctors in the town, that they cancel or rebook the patients booked for consultations at the surgery and either the doctors come back from the hospital and work into the night clearing the

backlog or they work longer the next day. Ideally, the town has a third or fourth doctor to pick up the load at the practice during an emergency.

Simplistic measures also fail to recognise differentials in caseload, for example, the procedural GP carries a different clinical load which does not equate to four or six patients an hour. Likewise GPs with hospital admitting rights/nursing home patient load may not be in the practice 10 or 12 sessions per week. GPs with admitting rights may see hospital patients before or after two full sessions at the surgery. GPs per 100,000 population and measures of FTE (full time equivalent) are insensitive measures of need without local data. There may be a role for Medicare Locals in capturing this essential data.

The current Health Workforce Australia Rural and Remote Health Workforce Innovation and Reform Strategy, in its background papers (against Domain 4), identifies the need to shift from simplistic measures in determining need and shortages toward analysis based on local need and context. The RACGP would urge the Senate Community Affairs Committee to support this policy change and support our call for more appropriate measures in determining rural GP workforce shortages.

4.3 Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA)

No rural and remote classification system is perfect however the ASGC-RA classification system has major flaws - in particular the Inner Regional (RA2) zone where there is grouping of small towns (Benalla population 10,000) with cities (Rockhampton population 77,000 or Hobart 214,000). The shift from the RRMA classification system in July 2010 resulted in places like Hobart receiving the same retention and relocation incentive payments as rural doctors providing primary, emergency and other procedural care in isolated towns. This essentially extended rural incentive payments to more than 2,000 additional doctors nationally who are not necessarily providing services to rural and remote communities.

Many isolated rural towns previously classified under the Rural, Remote and Metropolitan Areas (RRMA) system as RRMA 4-to-7 were reclassified as RA2 (Inner Regional) or RA3 (Outer Regional) placing them in direct competition with large regional cities and as a consequence removed some of the incentive to work more rurally. There are many anomalies including a GP on Rottnest Island receiving higher incentive support payments than a GP in Kalgoorlie; Townsville GPs (population 185,000) receiving the same incentive support payments as GPs in Moranbah, a town of 7,200 people 200km from the Queensland coast; and in the small rural town of Hay, NSW, local doctors only need to move across a road to go from RA3 (outer regional) to RA4 (remote).

A national approach to analysis and benchmarking is essential for rural workforce policy. The RACGP National Rural Faculty supports an approach that goes beyond the current locational aspects. The complexity of the issue requires a measure that encompasses geography with broader health service elements against both community need and patient population analysis (as outlined at 4.1 and 4.2 above).

Rural incentive programs are administratively tied to the ASGC-RA system and discrepancies (particularly in RA2 inner regional) lead to anomalies in allocation of these financial resources. Although there has been an allocation of funds to rural incentive programs, the funds are not necessarily reaching those most in need but instead work as a disincentive to taking on a rural practice in these smaller towns.

Government is encouraged to revise the system so that GP rural incentive payments reward those working in rural and remote towns who provide primary care, emergency and other advanced skills. Further, there is a need to provide an equitable and distinct differential between regional, rural, remote and very remote. No system is perfect and without regular review will not reflect the local population change let alone its health needs.

5 Other matters

5.1 Medicare Locals

The Commonwealth States and Territories Heads of Agreement (National Health Reform) signed on 13 February 2011, stated that “Medicare Locals will identify local health care needs and service gaps, and will have the responsibility and flexibility to address these needs through co-ordinating and funding services”.

To avoid fragmentation of patient healthcare, close consultation with the medical profession will be required. It is essential that GPs retain a strong leadership role and that general practice remains at the centre of an integrated primary healthcare system.

The effect of introduction of Medicare Locals on the provision of medical services in rural and remote areas remains to be seen. The impact that fund holding will have in primary health care is unclear. The impact on primary health care services in rural areas will depend largely on the location of the networks and the will to work with communities to improve their health.

Concluding comments and recommendations

In addressing the key factors limiting supply of GPs, there is a need for Government to secure a well-trained rural GP **workforce including procedural GPs** for the future. In order to achieve this, there must be a stronger commitment to rurally oriented medical education in rural environments, rural term experience for recruitment and specific retention strategies to sustain the existing workforce.

At the core of the training issues is the need for **expanded training capacity** and adequate remuneration for teaching as well as coordination of rural placements (across the training continuum). There is a need to diversify the training pathways to expand the availability and flexibility of advanced skill and procedural training. Efforts must also be made to limit the capacity of the states in creating professional divisions through short term workforce solutions.

There will be a need to move from the current funding and delivery models to **more flexible ways of working**. It is clear the current ASGC-RA system is affecting some of the rural reforms, is too broad and is diluting the available rural incentive payments. The ASGC-RA is flawed, however no system is perfect. There are overlays/filters in the existing ASGC-RA which can help remove some of the anomalies.

The success of Medicare Locals will largely depend on the location of these networks. If rural and remote health is not made a priority then the success of this model in improving rural and remote health outcomes is doubtful.

To overcome long-standing rural and remote disparities, (both health outcomes and medical workforce) rural health reform must lead to increased support for rural general practitioners and their communities and work to address current barriers to recruitment and retention. Consolidated strategies that seek to address rural and remote community “need” not necessarily “want” identified through local needs analysis are required.

A national approach to analysis in determining need and workforce shortage is an imperative for the success of the reform effort.

Avoiding instituting any new rural incentive programs or duplicating existing programs without first completing sound evaluation of all existing programs and identify those **rural incentives programs** that have true potential to succeed.

The RACGP National Rural Faculty commends the Senate Community Affairs Committee for its commitment to addressing the barriers to rural health service provision and improvement in rural and remote health workforce. The NRF Board would welcome an opportunity to present to the Senate Committee during the hearing process.

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