Submission by WA Country Health Service to the Community Affairs References Committee – The factors affecting the supply of health services and medical professionals in rural areas.

The geographical landscape of Western Australia (WA) is unique and impacts significantly on the delivery of health services across our vast and diverse state. WA has one central hub of tertiary health centres in Perth, with 6 major regional centres, 15 district hospitals, 50 small hospitals 47 nursing posts, 26 mental health services and community health services in over 53 locations across two and a half million square kilometers.

Aboriginal and Torres Strait Islander people represents 13.2 percent of the population within WACHS regions and represent an even higher percentage of the major users of the health services.

Aboriginal people are disadvantaged in respect to a number of social and economic factors, such as education, income, employment and housing. This places them at greater risk of poverty, violence, ill health and reduced wellbeing. (ABS, Australian Social Trends 2000) and both illness and death rates are significantly higher than those of the non-indigenous WACHS population.

It is recognised that individuals with low social determinants of health require greater health support. They are unable to generate the income of their city counterparts and are unable to access services in isolated areas.

Rural WA relies on internationally trained health professionals to meet the gaps in service. Currently greater than 52 percent of the workforce has primary medical qualifications obtained overseas.

Attracting health professionals to provide services to small regional communities in WA is challenging for a variety of reasons. These include but are not limited to:

- **Lifestyle factors –**
    - Work life balance, with extra after hours and on call commitments a result of limited numbers of health professionals sharing the workload.
    - Cost of living in rural and remote areas is higher than metropolitan area
    - Access to quality housing, sporting and recreational facilities including access to child care is limited in rural areas
    - Limited access to employment opportunities and professional growth for the spouses of health professionals often determines the length of time families stay in rural areas.
    - Access to quality education for children of health professionals. Quality secondary education is variable in rural areas and access to tertiary education extremely limited.
    - Accessing experienced health practitioner locums to backfill the individual to allow holidays is always difficult.

- **Professional Isolation –**
    - Access to experienced personnel to provided ongoing peer support and professional development is limited, often hindered by distance

and accommodation requirements when courses are unavailable via Telehealth or distance education.
    - Limited opportunity to backfill health professionals to allow the individual to leave their communities to attend 1 to 2 days training.
    - Access to multidisciplinary teams for referral of patients is often difficult, often requiring referral to Perth for treatment options.
    - Lack of career development options and succession planning for nurses is also a barrier.
    - International Medical Graduates (IMGs) require orientation to the Australian health care system, ongoing supervision and support to gain general registration. This is difficult to provide in isolated rural locations.

- **Necessary skills and experience**
    - Health professionals in rural and remote locations need to be generalists, with considerable experience who demonstrate both acute and primary health care skills.
    - Medical practitioners are often required to have either post graduate anaesthetic or obstetric procedural skills or both. Practitioners with these skills are in high demand. Once employed in the region they also need to attend regular upskilling events which are generally tertiary based.
    - Upskilling requirements for nurses transitioning to rural communities are significant. Attracting nurses with the requisite skill set is a challenge, as many nurses working in metropolitan and larger sites tend to be specialists, and therefore the transition to rural nursing practice requires significant upskilling and attainment of additional competencies.
    - Limited exposure to rural practice as part of undergraduate education for nurses reduces the likelihood of nurses seeking work in smaller rural communities.

- **Lack of Private facilities in rural areas**
    - Two of the 6 regional hospitals are co-located with private hospitals, all other sites do not provide choice of facility.
    - The bulk of all care in WA is met by state funded facilities.
    - Recruitment of General Practitioners to work in private practice in rural WA continues to be difficult with Rural Health West (RHW) reporting 78 vacancies in December 2011.
    - There is a higher ratio of lower socio economic groups living in rural WA. These individuals do not generally have private health insurance and are reliant on state funded services to manage the higher propensity of chronic illness that is prevalent in these groups.
    - It is acknowledged that rural Australia attracts a reduced amount of Commonwealth funding through Medicare Benefits due to the limited numbers of private GPs and other health professionals.

- **District of Workforce Shortage**
    - To enable IMGs to engage in private medical practice, a declaration of an Area of Need (AoN) by the State and a declaration of a District of Workforce Shortage (DWS) by the Commonwealth is essential. The

State moved some time ago to declare most of the State of WA, with the exception of the metropolitan area and the South West Statistical Area as an AoN. The State is in the process of improving current determinations and extending the period for the further five years. This will provide greater security and stability for applicants from overseas.

- Issues relating to the current Commonwealth processes in determining a DWS have been raised with the Hon Nicola Roxon, Minister for Health and Ageing. The size and distribution of population centres across WA; the natural progression of people from outlying towns coming in to a larger regional centre for medical attention make the practical population catchment of that centre's DWS area bigger than what is used to calculate DWS; the distances between centres; rapid workforce turnover; and the State funding of accident and emergency services appears to contribute to some anomalous situations with the assignment of DWS.
- When employing IMGs it is better for them to be placed in group practices, where they can be supported to deliver services to the smaller networked towns; however current DWS determinants restrict this practice. The Minister for Health and Ageing has agreed to work with WACHS to develop options to remove adverse effect or impacts of DWS on employment of IMGs and their access to the Medicare Benefits Scheme.

- **National Registration Processes**
  - The diverse medical training and experience of IMGs necessitates rigorous and nationally consistent assessment processes to ensure these doctors are able to provide the safe standard of care expected within the Australian health care system. The current processes are time consuming, complex, and expensive, and further restrict the number of IMGs wishing to relocate to Australia.
  - In 2007/2008 (prior to the Nationally Consistent Assessment Process for International Medical Graduates) 195 IMGs were granted in-principle approval to work in country hospitals and rural general practice. In 2009/10, 59 applicants gained limited registration with the Medical Board to work in WA whilst only 53 IMGs gained limited registration in 2010/11.

WA relies on general practitioners (GPs) working in private and corporate practices in the rural and remote towns to deliver primary health care and hospital services. The introduction of Medicare Locals has not had a discernible impact on the supply of health services to rural areas. WACHS expects the Medicare Locals to continue to support the general practice environment in similar ways to the former 'Networks' or 'Divisions' of general practice that received funding from the Commonwealth.

The Medicare Locals model is based on private practitioners providing the bulk of primary health care. This has been shown not to be effective in remote regions, due to the paucity of private practitioners, thus we have concerns that Medical Locals will not address the fundamental inequities for rural and remote regions.

The WA government has demonstrated it's commitment to primary health care in WA with the provision of $565 million package to improve health care for the people of the southern inland area. The Southern Inland Health Initiative (SIHI) is funded under

the Liberal-National Government's Royalties for Regions programme from July 2011. The initiative includes $240 million investment over four years in health workforce and the provision of health services

The initiative is underpinned by sustainable private general practice as the cornerstone of medical services in the southern inland region. The financial and professional incentives attached to the District Medical Workforce Programme will support WACHS and a range of service providers and agencies to deliver integrated services. These focus on building strong teams and networks to support sustainable primary health and emergency care service delivery. This strategy shifts the focus of the health system from hospital to primary care.

I am confident that the incentives available through SIHI for health practitioners to work together within networks will result in greater numbers of medical practitioners and a more robust model for delivery of health services in the areas within the SIHI scope. This new model will result in more doctors working in rural communities, leading a better work/life balance with greater support and less time spent on call.

Stakeholders in WA are committed to developing the future rural workforce, promoting leadership amongst rural doctors and providing ongoing mentorship to those doctors who return to rural practice having undertaken study and/or GP training in a rural area.

The GP Stakeholder Group formed in 2009 with the primary aim to work together to increase the profile of general practice in WA amongst medical students and prevocational doctors, in order to improve the current recruitment of doctors into General Practice. The committee comprises representatives from WACHS, Australian Medical Association (AMA), Aboriginal Health Council of WA (AHCWA), Australian College Rural and Remote Medicine (ACRRM), Royal Australian College of General Practitioner (RACGP), Rural Health West, WA General Practice Education and Training (WAGPET) and WA General Practice Network (WAGPN). This initiative has ensured General Practice is marketed in a consistent, cohesive and professional manner as an intellectually stimulating, well-supported and rewarding career and has ensured students and prevocational doctors have access to information, scholarships and outstanding prevocational training in General Practice to help inform their career decision-making about General Practice.

Interest in general practice is gaining favour with 83 registrars signing up for GP Registrar training with WAGPET for 2011. This is a 22 percent increase from 2010 and a 50 percent increase from 10 years ago. The number of available rural training placements has increased with almost 100 training opportunities available in rural locations. It is acknowledged that practitioners who have opportunity to work in rural locations are more likely to seek ongoing employment in rural areas.

With the number of medical graduates (295 in 2011) increasing by 117 percent since 2008 and numbers expected to increase further it is vital that opportunities are provided to allow these graduates to experience rural WA and in turn consider general practice as a vocation.

WACHS has been preparing for increased Australian medical graduates in the next five years by offering new and innovative training positions. WACHS has initiated

the Rural Practice Pathway (RPP), a collaboration of rural training stakeholders (Rural Health West, WAGPET, Rural Clinical Schools WA [RCSWA], Post Graduate Medical Council of WA [PMCWA] and junior doctor representatives). This pathway combines hospital and community placements and has been developed and modified by WA training stakeholders over a number of years. Funding from the Junior Doctor Business Case ($29 million) and the RPP ($8.5 million) are being utilised to implement the Rural Practice Pathway. The focus is on providing ongoing rural exposure, mentoring and career advice. It refers all doctors to their college of choice and supports ongoing rural opportunities through these college programs.

WACHS has established a Medical Education Unit which will focus on interdisciplinary learning that includes not only the WACHS salaried staff, but also encompasses private practitioner and Aboriginal Medical Services (AMS) staff with education events.

The Universities and RCSWA work closely with WACHS, sharing infrastructure and human resources, with a number of RCSWA staff also employed by WACHS. The RCSWA bring human capital, social capital, financial impacts and research capital to each site. This is a positive for local communities of health professionals (not just salaried doctors) as it improves recruitment and retention and strengthens the whole community for example via Aboriginal health initiatives, research, new health infrastructure etc.

RACGP and ACRRM have established pathways for IMGs who have formal qualifications in general practice and who are seeking work in rural WA. RHW works with practices employing IMGs to support their assimilation to the WA medical workforce.

A number of strategies have been devised in WA to counteract these challenges, many have been outlined above. Others include:

- Encouraging rural high school students to choose science subjects and pursue higher studies in medicine, nursing and allied health disciplines, and
- promoting General Practice as an attractive vocation

The Remoteness Areas classification scheme does not ensure appropriate distribution of funds, as the classifications do not take into consideration other factors such as cost of living at the individual site, and the access to services available at these sites. WACHS has implemented three further levels of classification within the four remoteness categories of Very Remote, Remote, Outer Regional and Inner Regional, however even within WA fair distribution of incentives using Remoteness Area Classification scheme does little to assist with the attraction and retention of health professionals.