Submission:
Australian Senate Inquiry on
Factors affecting supply of health services
& medical professionals in rural areas

January 2012

Background

General Practice Victoria is the peak organisation for general practice networks (formerly known as divisions) in Victoria and for the newly formed Medicare Locals. Our response is based on the findings of a joint study with the Rural Workforce Agency of Victoria on the issues, roles and workforce achievements of all 29 Victorian divisions of general practice and on a consultation with the Victorian GP networks/divisions on the Senate Committee's Terms of Reference. As GPV has a key role in supporting the transition to Medicare Locals our response to this inquiry emphasises the potential of Medicare Locals in workforce development.

Response to the Terms of Reference

The factors affecting the supply and distribution of health services and medical professionals in rural areas, with particular reference to:

(a) the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres;

These factors have been very well documented in recent reports and include the following:

- Lack of necessary supports for isolated health professionals: for education, locum services, community integration and (in the case of IMGs) understanding of Australian health system
- Need for further investment in health education in rural environments
- Workforce recruitment and retention strategies are usually conducted in isolation instead of being integrated into a community-wide approach
- Need to continue and strengthen recent efforts to build up a procedural GP workforce.
- Increasing complexity of health care needs of aging population and an ageing health workforce.

(b) the effect of the introduction of Medicare Locals on the provision of medical services in rural areas;

The nationwide network of Medicare Locals is being formed from a broader base of primary health organisations including the divisions of general practice network and state-funded primary health organisations. Medicare Locals will have a brief for identifying population health needs and ensuring the capacity of the primary health care system to meet those needs.

An explicit part of the Medicare Local brief is a workforce development role for primary health care but the details of that role have nowhere been spelt out, apart from a clear role in the coordination of after-hours medical care.

We know from our experience with divisions of general practice/general practice networks how crucial the workforce development role is to the achievement of an adequate primary health care workforce, especially in rural areas.

If properly contracted to do so, Medicare Locals could make a substantial contribution to workforce development at the local level.

The key to a successful role is a consistency of expectations about the components of the workforce role as expressed in the contract with DoHA, adequate resources to perform the role, and technical support to undertake the role (e.g. for workforce data to enable appropriate planning, for sophisticated planning methodologies such as the use of floating catchments to identify real access at the local level; for use of GIS mapping; for synthesis of research on best approaches to recruitment, retention, succession planning, approaches to interprofessional CPD, support for clinical placements etc).

If Medicare Locals are adequately resourced to do so they have the potential to improve local workforce through strategies applied at the levels of community, Medicare Local, health service and individual. Examples of the role at each of these levels are as follows:

- **Medicare Local workforce strategies in partnership with the wider community**

Community-based strategies refer to partnerships between Medicare Locals and other leading organisations in the local community. Two outstanding examples are the Border Recruitment Taskforce – a partnership of local health and education services, local businesses and local government, to focus on attraction and recruitment. The partnership has been highly successful in recruiting health professionals to Albury Wodonga area and supporting their retention. A second positive example is that used in the RWAV Sustainable Communities project, conducted in partnership with some rural divisions. This approach takes a community-wide approach to retention and to succession planning.

- **Medicare Local strategies to support workforce development within their boundaries**

Medicare Locals could continue and expand the work that GP networks/divisions of general practice engaged in at this level. Key amongst them are:

Continuing Professional Development
Divisions of general practice have been essential to overcoming the CPD barriers for GPs and increasingly for private allied health. It is an under-recognised role despite the fact that GP networks (in Victoria at least) provide more than 60% of CPD for GPs (including more than 80% of Category 1 CPD). There is an assumption (but no guarantees) that this role will be continued by the Medicare Locals. The role relies substantially on external sponsorship.

Ensuring the capacity for the continuation of this role under the banner of Medicare Locals is vital to the primary health care workforce. The model also offers scope for extension to other health professions.

Professional networks:
Another useful strategy is the hosting of regular network meetings for professional groups such as practice nurses and practice managers. These are used for updates on health policy including relevant changes to Medicare, dissemination of ideas about systems development, effective approaches to chronic disease management, supervision, and for problem solving. A related strategy involves interprofessional forums to support the development of teamwork in primary care.

Resources
MLs can develop (at national, state and local levels) resources that help with recruitment, retention and support of health professionals. Again, this would build on work conducted by divisions of general practice. For example, West Vic Division developed a training manual for practices to understand the complexities of recruitment and retention. Extending this work to other primary health care professions will be a vital role for MLs.

Brokerage
Divisions of general practice acted as fund-holders for a range of workforce development programs e.g. in the Rural Primary Health Services (formerly More Access to Allied Health Services (MAHS.) Such programs enabled divisions of general practice to play a brokering role to assist with access to health services and a developmental role to integrate general practice with services provided by others. This role should be maintained by Medicare Locals and extended where relevant.

Medicare Local strategies to support individual health services

GP networks/divisions of general practice offered leadership for workforce at the practice level through several approaches. It will be vital to primary health care workforce development in the future to retain this support during and after the shift to Medicare Locals and to ensure that other primary health services receive a similar form of support.

Tailored support to individual practices to assist them develop systems relevant to workforce.
The most notable strategy in this category has been assistance to use Medicare items relevant to practice nursing and chronic disease management. Effective use of these Medicare Benefits Schedule (MBS) items enables a practice to maximise the use of practice nurses and other allied health staff as part of the practice team, thus extending the available workforce and improving access. Some divisions offer a total package of services to assist practices. For example, Eastern Ranges General Practice Association offered Smart Practice, which was designed to look at all aspects of the practice: workforce, facilities, personnel management, IT, infrastructure and communication, and to provide practices with a written report, recommendations and a plan for future development. The program was provided free of charge for practices within ERGPA boundaries and provided an opportunity to assess where the practice was doing well and where it might be able to improve. The program has now evolved to become an on-line resource of 4 modules (Workforce; Continuous Quality Improvement; Business and Patient systems; and Risk Management). The program contains a number of useful and innovative resources which can be downloaded to enhance the day to day running of the practice. .

Divisions assist practices to access funds relevant to workforce development.
These include infrastructure grants to enable clinical placements and the employment of practice teams; grants for supervision training, grants to support coordination of clinical placements. Again, under the banner of Medicare Locals, such assistance should extend to all health services (public and private) that provide primary health care in the community.

Assistance to practices to help them maximise the use of the available workforce
An important strategy for maximising use of available workforce was provided by the Australian Primary Care Collaboratives. The Collaboratives program, run by the Improvement Foundation and implemented with the active support of divisions of general practice, assisted practices to improve their teamwork skills and capacity in the interests of better chronic disease management. A major aspect of the program was the Access Collaborative which gives practices methods to improve their workflow and their allocation of staff resources to match supply and demand over the working week. Successful Access Collaboratives have freed up workforce resources to a significant degree thus improving patient access.

Another example is the work undertaken by the Central Victoria General Practice Network to geographically zone general practices and aged care facilities so that each participating GP elects to attend three or four facilities as close as possible to the clinic. The result is more efficient use of time, especially due to reduced travel time for GPs, with the majority of their aged care patients in only three or four RACFs. GPs then form stronger working relationships with aged care staff.

A variation on this theme occurred in North East Victoria. The usual Medication Advisory Committee for aged care would involve each individual facility meeting with a GP representative. NEV started a regional Medication Advisory Committee rather than one meeting for every RACF thus greatly minimising the demands on the GP representatives.

Assistance to health services with succession planning, especially for small services in isolated rural areas, is crucial. Strategies involve early planning, as well as assistance with the development of flexible workforce policies to enable the part-time employment of older workers have been successful in ensuring continuity of service provision.
Medicare Locals will have a significant role in the promotion and implementation of telehealth strategies which will be vital for improving workforce availability in rural areas.

- **Medicare Local strategies to support individual health professionals**

The key strategy offered by divisions to engage and support individual health professionals is the case management approach whereby a division staff member assists the health professional through the recruitment process (including immigration requirements if that is necessary), with partner and family employment, with settlement into the community, orientation to local health services (and to the Australian health system if that is required). It also includes exam support for those who have not fully qualified. The reason this is defined as mainly individual support is that it also involves assistance to the new recruit if the first placement does not work out. In the interests of retaining the individual within the local area the division gives priority to the wishes of the individual not to the recruiting organisation.

Another important aspect of individual support is assistance to health professionals to access scholarship funds to support clinical placements and further education.

Statewide & national roles to support a local Medicare role in rural workforce development
There is a demonstrable need for Medicare Locals to continue and extend the workforce development role of divisions of general practice. This should be done in partnership with workforce and Medicare Local agencies at national, state and local level.
To ensure the effectiveness of the Medicare Local role in workforce there will be a need for a central agency to provide the following supports:

- Ongoing training and support in the technical aspects of workforce, e.g. methods for effective workforce planning at the local level; policies associated with registration and accreditation, recruitment, and rural workforce incentives
- Development and dissemination of innovative models already in use
- Support to increase clinical placement capacity
- Support to improve health service efficiency (to increase supply and reduce demand)
- Support for the development of strategies that involve local community partnerships to improve recruitment and retention opportunities.

It is vital to ensure that Medicare Locals are enabled to undertake a consistent range of workforce services to support the attraction, retention and integration of the primary health care workforce.

ToR (c) current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:

- **their role, structure and effectiveness**
- **the appropriateness of the delivery model, and**

- **whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes;**

- **their role, structure and effectiveness**

Incentives should be based on a more complex formula that recognises not only geography but also population health needs, socio-economic status, workforce supply, and access to transport. The data and technology exists to enable this analysis to be applied. It would result in better targeting of incentives and could make a substantial difference to access to health services across rural areas.

- **whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes;**

GPV has received many complaints that the revised classification system announced in 2009 was too blunt an instrument to enable appropriate workforce distribution across rural Victoria. The changed classification has resulted in a large area of Victoria falling under the classification of RA2 regardless of differences, within this broad classification, in population size of towns, and differences in the ability of people from one town to the next to access a wide range of health and community services. Representation from Central Victoria General Practice Network and Murray Plains Division of General Practice is illustrative:

> *From both CVGPN and MPDGP we would like to register our concerns to the Senate enquiry regarding the "crude" application of the RA classification system that sees rural communities such as Rochester, Deniliquin, Echuca and Elmore, Heathcote etc be regarded as the same rural categorisation (RA2) as Melton, Sunbury, Ballarat and Bendigo. The GP recruitment and retention incentives programs are applied on a graduated basis according to the relevant RA classification. To therefore apply the same incentives to communities within sight of Melbourne skyscrapers to communities 250kms away from Melbourne is perverse and massive disincentive to attract GPs to those communities so desperately short of accessible locally based medical services.*
> *Equally to provide the same relocation and retention grants/incentives to GPs to work in communities with population bases of over 100,000+ as those available to GPs working in communities of less than 5,000 (and in some instances less than 2,000) is similarly a massive disincentive in a scheme that claims to be designed to improve rural and remote GP service provision.*

The provision of incentives to RA2 communities are appropriate and should not be scaled back but there is need for refinement at two levels. First, there is a need to have a classification system that distinguishes between large regional towns and small rural towns. Secondly, for the purpose of incentives, there is a need to overlay the geographical system with data about health status of local populations, socio-economic status, provision of health services, transport and workforce availability.