Regional/Rural Workforce Initiatives - 2005

May 2006

1. Preamble

The AMA has identified medical workforce shortage as a major health issue. Not only is there a nation-wide shortage of doctors, the overall distribution of doctors is skewed heavily towards the major cities such that regional, rural and remote areas shoulder a disproportionate workforce shortage burden.

Put simply, there is a strong preference amongst much of the current medical workforce to live and work in major cities - with particular preference for the inner suburbs. Given the educational background and the demographics of the current medical workforce - this should come as no surprise. Doctors are no different to any other professional group and evidence throughout the western world shows that attracting young professionals to rural locations is extremely difficult.

Table 11 below is a simple illustration of the current problem with workforce distribution. While it is possible to provide a much more complicated analysis based on other measures, this table provides a useful snapshot of the issue.

Table 11: Distribution of Medical Workforce in Comparison to the Australian Population[1]

Area % pop'n % medical workforce
Major Cities 66.3% 79.8%
Inner Regional 20.7% 13.5%
Outer Regional 10.4% 5.5%
Remote 1.7% 0.8%
Very Remote 0.9% 0.4%

It should be noted that the distribution of the medical workforce will always be biased to the major cities and large regional towns because some specialty services can only be supplied there.

In efforts to address these imbalances, the Government has adopted a variety of measures. Evidence suggests that these are now starting to have an impact, particularly in the area of increased student enrolments. 25% of medical school students came from rural areas in 2001, compared to just 8% in 19962. In the medium to long term, this may deliver a much fairer distribution of the medical workforce. However, with long lead times involved in training the medical workforce more needs to be done in the short to medium term to address the current imbalance.

The debate is not just about numbers. It is also about the right skill mix. Rural medicine, in particular, requires strong procedural skills - with primary care practitioners representing the backbone of rural health care. With strong trends toward sub-specialisation, and declining numbers of rural GPs who are practising proceduralists the problem facing regional and rural communities is even more acute than the above table would suggest.

The Commonwealth Government has responded to the general workforce shortage problem by, amongst other things, announcing a number of new medical school places. By 2008, the annual medical school intake will potentially be around 2200 students3, compared to around 1500 in 2003. While this is welcome, there is ongoing concern about the ad hoc nature of some of these announcements, the lack of any co-ordinated plan outlining how the clinical placements of these students will be accommodated in an already stretched public hospital system and whether there will be a sufficient number of quality post graduate training positions available when these students enter the medical workforce.

Unfortunately, the Government has now turned to a draconian policy of unfunded bonding of medical school places when trying to distribute the medical workforce more equitably. Given that the pattern of medical school enrolments has shifted dramatically, with a big increase in enrolments of students from rural areas - it is strongly arguable that this move is highly unnecessary as existing policy settings were having a significant and positive desired effect.

The AMA emphatically supports the right of doctors to live and work where they choose and to have the freedom to exercise their clinical judgement. That said, the profession has a responsibility to ensure that there is equitable community access to a well-trained medical workforce.

There are several points where policy makers can influence both the supply and distribution of medical practitioners. These include:

- medical school intakes and selection practices
- training curricula and program requirements
- recruitment and retention initiatives for medical practitioners
- flexible work arrangements allowing a better balance between work and personal/family commitments
- development of improved work practices and the provision of appropriate resources to support medical practitioners in the delivery of health care
- access to services, resources and amenities - community and professional alike
- reducing compliance costs involved in delivering healthcare and running a small business.

2. Overseas experience

To date, no country has developed a package of policy initiatives that have been shown to completely address problems in the distribution of the medical workforce. However, there seems to be several emerging lessons:

- the early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enrol in medical schools are the most likely of all initiatives to increase the workforce in these areas
- proper medical infrastructure, a strong training experience, and access to community and professional resources, and continuing medical education are essential to the provision of a rewarding professional and personal experience
- consideration must be given to not only the needs of the medical practitioner, but also their family - particularly with respect to access to employment opportunities, health and education, and social amenities
- a critical mass of doctors within a region is important in improving the viability of a practice, as well as enhancing professional development
- appropriate remuneration and incentives are essential to attract and retain medical practitioners
- bonded students who are treated fairly and provided with appropriate incentives and support can make an invaluable contribution to the development of a sustainable rural workforce. The bonding of students without access to financial and other types of support is counterproductive and can force people to leave the medical workforce or to consider practice in other countries.

3. Why are medical workforce shortages worse in regional and rural areas?

There are a number of fundamental reasons why regional and rural areas are not getting their fair share of the medical workforce. These include:

- inadequate remuneration
- work intensity
- red tape
- lifestyle factors
- professional isolation
- poor employment opportunities for other family members, and in particular practitioners partners
- under-representation of students from regional/rural background (noting that this mix is changing, however, the benefits will take some time to be realised)
- continued withdrawal of services from such areas
- lack of critical mass of similar doctors
- hospital closures
- downgrading of other services
- limited educational opportunities
- long hours/rosters

- inefficient administration in public hospitals.

4. Solutions

The AMA believes that a combination of policy initiatives can be applied in order to provide regional and rural areas with a more equitable share of the medical workforce. In outlining these policy measures, it is important to recognise that the problem cannot be addressed overnight. Rather, the results will be delivered in an incremental fashion. Importantly, they are sustainable solutions that do not impose unreasonable conditions on doctors such as unfunded bonding - to which no other section of the workforce is subject.

It is worthwhile to note that some of these measures are equally relevant to the medical workforce in metropolitan areas, including improved remuneration to general practitioners, better management of hospitals and more flexible training arrangements. Even though some measures are not specific to regional/rural areas, they will still have a positive impact and have been included in this position statement on that basis.

5. Education and training initiatives

5.1 Undergraduate Education

5.1.1 Medical schools should have a student mix that reflects the proportion of regional/rural people in the Australian population. Subject to appropriate academic benchmarks, this should be achieved through the establishment of specific enrolment targets, the beneficial weighting of enrolment criteria in favour of regional/rural students or some combination of these. Commonwealth and state/territory Governments should cooperate to ensure that rural secondary school students are aware of the opportunities to enter medical school.

5.1.2. The Commonwealth should expand access on a means tested basis to existing scholarship programs (eg Rural Australia Medical Undergraduate Scholarship Scheme) for students from regional and rural Australia who are accepted for enrolment in medical schools in order to reduce the entry barriers they face to taking up a career in medicine.

5.1.3 All bonded medical school places should be scholarship based or provide relief from HECS fees. Greater flexibility should be incorporated into the bonded scholarships program by allowing students to access smaller scholarship subsidies in return for a reduced return of service requirement. The return of service requirement should not exceed the length of the medical degree and any service in a rural area after graduation should count towards the bonded period. Some flexibility should be allowed in recognition of an individual's personal and family circumstances.

5.1.4 The AMA supports the use of programs that provide relief from HECS debts to encourage doctors to work in regional and rural areas. Such programs should reduce HECS debts based on each year of service in a regional or rural location.

5.1.5 The AMA supports the establishment of regional/rural clinical schools by existing Medical Schools in partnership with regional/rural communities.

5.1.6 The establishment of new medical schools is resource intensive and costly. Wherever possible, Governments should take advantage of economies of scale and existing infrastructure by expanding places at established medical schools.

5.1.7 Where a new medical school is proposed it must be able to demonstrate that it will have the appropriate infrastructure available to support students and if so that it is located in a region of workforce need, with an appropriate student mix that may assist in addressing the long term workforce needs of that region.

5.1.8 The establishment of medical schools or the expansion of medical school places must be considered as part of a broader workforce planning process, which takes into account the infrastructure and resource implications for undergraduate, prevocational and vocational training.

5.1.9 Undergraduate education models should provide medical school students with strong early exposure to regional/rural medicine and, in particular, procedural medicine. This will foster an interest in regional/rural medicine as well as better equip graduates to face the challenges of regional/rural medicine.

5.1.10 Students should be provided with access to structured mentoring programs to assist them in developing an interest in rural medicine

5.1.11 The AMA believes that there is a strong link between the health of Indigenous people in rural communities and their access to Indigenous health professionals. Indigenous groups are significantly underrepresented in the medical workforce and to address this key problem, the Government should allocate 50 fully funded scholarship places annually for Indigenous medical school students, rising to 100 in the 2008/2009 Federal Budget4. These places should be subject to appropriate academic benchmarks.

5.1.12 Students should be provided with cultural awareness training in order to better equip them to provide appropriate medical care to the rural indigenous population.

5.2 Postgraduate Medical Education

5.2.1 Provided it is consistent with the development of appropriate clinical skills, postgraduate medical training programs should include a regional/rural medical service component, with junior doctors having the ability to pursue more advanced training in regional/rural medicine through their relevant Medical College.

5.2.2 Trainees should be encouraged to undertake rotations to regional/rural areas as part of their training program. The rotation should be included in the Post Graduate Medical Education/Medical College accreditation processes. Provided it meets the requirements of the training curriculum, trainees may elect to serve longer periods in regional/rural areas.

The latter option should be available on a voluntary basis and trainees should not be compelled to serve extended periods in regional/rural areas by using de-facto workforce measures such as rural pathways.

5.2.3 Medical Colleges face additional challenges and costs in establishing suitable training posts in regional/rural areas. Where appropriate, Medical Colleges should be able to access specific funding to assist in meeting such costs.

5.2.4 When on rotation, trainees should have access to mentoring programs to assist them in making a smooth transition to the regional/rural medical workforce. These programs should be co-ordinated by the trainee's employer, and where appropriate developed in consultation with the relevant Medical College.

5.2.5 Trainees are covered by a variety of employment arrangements and undertaking hospital rotations, or applying for employment at a regional/rural hospital in order to satisfy their vocational training requirements often involves the interruption/loss of employment entitlements such as sick leave and annual leave. Innovative arrangements need to be identified that allow for portability of entitlements, which ensures that trainees are not disadvantaged by undertaking regional/rural service.

5.2.6 Prior to appointment, trainees must be given relevant information regarding any rotations they will be required to undertake during their employment. Reasonable notice should be provided when a doctor will be required to undertake a rotation and consideration of a doctor's personal/family circumstances must be taken into account wherever possible.

5.2.7 Trainees should be provided with comprehensive assistance when they are required to undertake a rotation that requires them to move away from their usual place of residence. This assistance should be based on the principle that the relocation should be cost neutral to the trainee.

5.2.8 With increasing opportunities to deliver training in private clinical settings appropriate support for private practices should also be provided.

5.2.9 The Commonwealth and State/Territory Governments should co-operate in order to set aside specific funding to establish additional training positions in regional/rural areas with appropriate infrastructure and supervision.

5.2.10 General Practice is acknowledged as one of the major planks of regional/rural healthcare. Existing pre-vocational training programs for general practice should be expanded significantly to allow a GP rotation to become a standard part of pre-vocational training. This will provide trainees with greater exposure to general practice and encourage the expansion of the GP workforce.

5.2.11 In light of the changing expectations and personal circumstances of men and women entering the medical workforce, the growing participation of women in medicine

and increasing numbers of post-graduate medical school graduates, Medical Colleges must ensure that access to part time and flexible training arrangements is improved, and that trainees are not unnecessarily penalised when their training is interrupted due to personal or family circumstances.

5.3 Continuing Medical Education

5.3.1 Regional/rural practice often requires doctors to treat conditions with less support than would otherwise exist in a metropolitan region. The development of appropriate CME resources and training programs, along with access to locum support is essential to the maintenance of high standards of care.

5.3.2 Training providers need to expand the suite of distance learning tools to assist doctors in these locations to develop their skills on an ongoing basis, and links to Rural Clinical Schools should be encouraged.

6. Remuneration and incentives

6.1 All stakeholders should acknowledge the importance of appropriate remuneration levels, not only for doctors working in private practice but also for doctors working in the hospital sector.

6.2 The seven tier structure for Medicare rebates, fully funded and appropriately indexed, should be introduced in order to more properly reflect the nature of primary care delivery, allow GPs to charge an appropriate fee for their services without the fear of leaving patients with high out of pocket costs, and improve incomes for GPs in general so as to attract more doctors into general practice. This will both benefit patients and improve the image of general practice as a career choice.

6.3 Employers should offer competitive salary packages to doctors in order to attract them to work in regional/rural areas and specific funding grants should be available to employers to assist them with developing appropriate remuneration packages to attract medical practitioners. Depending on the location of the employer and workforce need, packages should include:

- market rates of pay
- government funded locum leave and locum subsidy
- accommodation or accommodation assistance
- fee assistance for the education of the doctor's children
- return airfares to place of origin
- home access to broadband internet services - including satellite where appropriate
- assistance with continuing medical education, including fees, attendance at conferences etc
- additional leave entitlements
- childcare facilities or access to subsidised assistance
- assistance with finding suitable employment for other family members

- flexible, family friendly working arrangements.

6.4 The AMA supports the payment of financial incentives to doctors who are in or relocate to areas of workforce need, including upfront subsidies along with regular payments to assist with the cost of running a regional/rural practice. This includes PIP rural loadings.

6.5 The Government should broaden and properly index the range of retention incentive payments, particularly for those approaching retirement. A growing proportion of the medical workforce is over 55 years of age and will be lost to the medical workforce in the near future, without adequate numbers of new doctors coming through to replace them.

6.6 Incentives to encourage doctors working part time to increase their hours should also be considered, including re-skilling where necessary.

7. Family support

7.1 The decision for a doctor to relocate or practise on a medium to long-term basis in rural areas obviously has a significant impact on their family. Where a partner works or children are at school there may be considerable direct or opportunity cost and loss of amenity from a decision to move to rural practice. Simply paying a medical practitioner more, while helpful, does not address the full dimensions of the problem and ignores significant factors in any individual's decision-making process when considering rural practice.

7.2. There should be adequate compensation, support and access to re-training if required, so that a partner or spouse can remain employed in an acceptable occupation if their partner moves to a remote area. Job seeking assistance should also be offered if required.

7.3 If the family requires assistance to maintain a child in school in a larger town or city centre, there needs to be school fee assistance, given the possible requirement for boarding and other increased services or tuition.

7.4 Where a family is fragmented by a decision for a parent or partner to take up rural practice, there should be funding for at least one return trip home for family members during the doctor's tenure.

8. Hospital work practices and infrastructure

8.1 Governments must ensure that regional/rural hospitals are properly resourced with adequate infrastructure, information technology support and staffing to ensure that doctors work in an environment that is conducive to delivering:

- a strong and relevant training experience to junior doctors, with adequate supervision
- an environment to develop their procedural skills

- opportunities for professional development
- safe working hours.

8.2 The efficient use of the skills of the medical workforce is a critical measure to enhance the delivery of healthcare services throughout the country. Doctors should not be burdened with an undue administrative workload that reduces their capacity to deliver clinical services.

8.3 Where appropriate, work practices should be reviewed in consultation with clinicians to ensure that doctors are not undertaking tasks that could be more appropriately handled by nursing or clerical staff.

8.4 Hospitals should support a broad role for Visiting Medical Officers to encourage teamwork, the sharing of information and ideas and skills development for VMOs and salaried doctors alike.

8.5 Hospitals should provide safe workplace facilities and accommodation at an appropriate quality in accordance with the AMA Position Statement - "Workplace Facilities and Accommodation for Hospital Doctors"[5].

8.6 Hospitals must value medical staff and provide them with a good working environment. They must consult with doctors on all issues affecting patients and they should ensure that the Director of Medical Services holds appropriate clinical qualifications and is able to provide an effective point of liaison.

9. Community funded facilities

9.1 The Commonwealth Government should establish specific funding grants to allow local governments in regional/rural areas to purchase facilities to support medical practitioners such as housing/practices/equipment, so that practitioners can operate a practice on a walk-in walk out basis. The costs of establishing a practice have been nominated as one of the major disincentives to doctors who might otherwise relocate to an area of workforce shortage.

10. Outreach programs

10.1 Outreach programs to provide funding assistance for specialists visiting rural and remote areas are a valuable means to enhance the delivery of services in these areas. These programs should be adequately funded and based upon the following principles:

- services must be directed to communities where an unmet need is established by the local medical practitioners
- services must be designed to fit in with local healthcare services, and wherever possible they should include up-skilling and other measures to enhance the sustainability of local medical services
- funding must be available to existing outreach services

- there should be strong Medical College involvement in outreach programs in order to encourage greater participation
- service should not be withdrawn without consultation with the local practitioner.

11. Red Tape

11.1 It is estimated that up to 25% of a GP's time is spent in non face-to-face activities related to the delivery of primary care - not including bureaucratic and business processes6. The same survey found that doctors ranked administrative problems in their top five problems in running a practice.

11.2 An AMA survey found that 52% of GPs spend between 5 and 10 hours per week completing paperwork. A separate survey estimated that around half of all GPs spend more than 3 hours per week on completing paperwork associated with blended payments alone7. The Productivity Commission in its review of the GP administrative burden estimated that in 2002 red tape cost each Australian GP an average of $13,000 per annum[8].

11.3 Reducing red tape and bureaucracy, and providing more opportunities for GPs to spend face-to-face time with patients must be a key priority. It will improve the image of general practice and allow GPs to increase their patient load.

12. Nurses

12.1 The employment of general practice nurses (GPN) should be encouraged, including through continuation and expansion of financial incentives to general practice. GPs should be able to claim a wider range of Medicare funded services for work carried out by their general practice nurses. A generic general practice nurse item or items under the MBS should be established, in consultation with the profession, that allow the practitioner to allocate clinical tasks on the basis of agreed practice protocols. A generic item number would allow practices to utilise their general practice nurse for clinical tasks that are appropriate to the needs of the community the practice serves.

12.2 The structure of existing practice nurse subsidies discriminates against smaller practices and for each GP they represent less than 20% of the basic salary cost of employing a practice nurse. This inherently disadvantages smaller towns where small practices often carry a heavy workload. Subsidies should reflect the cost of employing nurses, they should be properly indexed and subsidies should be provided with ongoing certainty for the practice.

12.3 Special circumstances often give rise to a broader clinical role for some GPNs in some practices. Such situations serve to emphasise the vital importance of specific practice protocols in clearly outlining what a GPN within the practice may or may not do, most particularly in relation to clinical care.

12.4 The AMA does not support a role for independent nurse practitioners. This, however, does not preclude the capacity for highly skilled nurses, working as part of a collaborative primary care team led by one or more GPs to be supported in the delivery of services to remote areas where access to health care is often very difficult. These nurses should:

- have appropriate clinical experience and training
- be supported through the provision of appropriate communication technologies to ensure that treatment can be properly co-ordinated with the supervising GP(s)
- be governed by appropriate clinical decision making protocols developed by GPs in consultation with clinicians.

12.5 Training of general practice nurses, a pre requisite for expansion of their clinical roles in primary care is not affordable for many practices. As an example, practices in RRMAs 3-7 are eligible to use the MBS GP item for practice nurses to undertake pap smears. Many practices have said that the costs of training for the practice nurse in compliance with eligibility to use this item are too costly. This is particularly so when weighed against other training opportunities related to the priority needs of its patient population.

12.6 There is a real need to provide financial assistance to support the further training of general practice nurses, the objective of such training being expansion of the clinical role of general practice nurses. Provision of this financial support should be flexible enough to allow practices to train or up-skill their practice nurses consistent with the priority needs of the community that the practice serves.

13. Rosters

13.1 Doctors in regional/rural areas often face high on-call demands. This is undesirable from both the perspective of patient safety as well as effective service delivery.

13.2 Existing competition laws prevent doctors entering into effective rostering arrangements to provide comprehensive medical services to their local community, particularly with respect to after-hours services and covering absences when doctors take leave. Registering business names in a joint venture has been shown to be an effective strategy in some situations.

13.3 The AMA believes that considerable community benefit would flow from allowing doctors to establish viable rostering arrangements, which include reasonable agreement over what fees would be charged. This would encourage doctors to co-operate in order to provide their local community with better access to round the clock healthcare - and address one of the major disincentives to regional/rural practice being a high on-call workload.

13.4 In light of the above, the Australian Competition and Consumer Commission (ACCC) should work with stakeholders to develop a simple notification process along the

lines of the collective bargaining notification for small businesses recommended by the Dawson Review of the Trade Practices Act.

14. Locum Services

14.1 Locum services are also a key element to addressing the problems of high workload and little prospect of relief for rural/regional practice. Rural Workforce Agencies and Medical College programs are an important source of locum doctors and Commonwealth Government funding should continue to support such programs, and where appropriate be increased based on the needs of particular communities.

14.2 The AMA supports existing exemptions allowing junior doctors access to provider numbers for locum services in areas of need/district of workforce shortage, however, the process of accessing provider numbers is lengthy and involves too much red tape - which in turn discourages junior doctors from participating. Initiatives to simplify these processes need to be explored.

14.3 Junior doctors working in locum services should be able to access VR rebates, and the application and approval process should also be simplified in order to reduce the red tape barrier.

15. Overseas Trained Doctors

15.1 OTDs form an important part of the medical workforce. To ensure high standards of patient care in regional/rural areas and to provide better support for OTDs in their work, the AMA believes that the following measures are necessary[9]:

- consistent and transparent standards of assessment for OTDs across Australia, with the Medical Colleges having responsibility for assessing overseas qualifications and determining additional training or oversight required;
- introduction of streamlined processes of assessment including the pre-recognition of some qualifications;
- ensuring that OTDs have access to support mechanisms including mandatory orientation, continuing medical education, bridging courses, assistance with exams, mentoring, community facilities and services,
- ensuring that OTDs have access to working conditions that are equal to comparable Australian trained doctors in like locations;
- streamlining of Area of Need and District of Workforce Shortage definitions with a requirement that an objective assessment be undertaken of the reasons for not filling a position with an Australian resident doctor before recruiting an OTD.

16. Telemedicine

16.1 The development of medical and communication technology has the potential to deliver significant benefits to regional/rural medicine. Governments need to work with

stakeholders to encourage the innovative use of these technologies and in doing so need to consider:

- policies that promote access to relevant community infrastructure including high speed internet access
- initiatives including funding for community based facilities, or assistance with the purchase of infrastructure
- promotion of collaborative initiatives between clinicians to foster telemedicine
- raising the awareness of available technologies and providing access to training in the use of such technologies.

17. Benefits of regional/rural practice

17.1 Rural practice is a rewarding experience and does have lifestyle advantages. Stakeholders need to counter the negative perceptions surrounding regional/rural practice by highlighting the more positive aspects. Governments have committed money in the past for campaigns to encourage people to enter particular professions or training programs such as apprenticeships. Consideration should be given to running similar campaigns highlighting the advantages of regional/rural practice.

18. Access to community services

18.1 Governments have consistently withdrawn or rationalised services in regional/rural areas. This only makes it more difficult to attract doctors, and other groups to these areas. Before withdrawing such services, a public interest test should be applied to ensure that communities are not denied reasonable access to services. Consideration should also be given to imposing a moratorium on the withdrawal of Government businesses as a strategy to maintain medical services.

18.2 Governments should provide businesses with access to suitable incentives to relocate to regional/rural areas in order to encourage investment and employment and generate new economic activity, which will support improved local infrastructure and amenities.

References:

1 These statistics are drawn from the Australian Institute of Health and Welfare publication "Medical Labour Force 2001".
2 Media Release, Minister for Health and Ageing 27 November 2002.
3 This assumes that all full fee paying places for domestic students are taken up under the Government's higher education changes.
4 Source AMA 2004 Discussion Paper "Healing Hands - Aboriginal and Torres Strait Islander Workforce Requirements"
5 AMA 1999 Position Statement Workplace Facilities and Accommodation for Hospital Doctors, available from www.ama.com.au

6 An Analysis of the Widening Gap between Community Needs and the Availability of GP Services - A report to the Australian Medical Association by Access Economics Pty Ltd, Canberra, ACT. February 2002
7 Australian Doctor Survey May 2002.
8 General Practice Administrative and Compliance Costs. Research Report. Productivity Commission, 31 March 2003.
9 For further detail, refer to the AMA 2004 Position Statement on Overseas Trained Doctors