

Submission to the Senate Inquiry on Factors affecting the supply of health services and medical professionals in rural areas

CONTENTS

1. Main Points.....	2
2. Preamble.....	3
3. Background.....	3
4. The purpose of remoteness classifications	4
5. Defining remoteness – main approaches.....	4
6. Factors limiting the supply of health services, medical, allied health and nursing staff to small regional communities compared to other areas.....	8
7. Medicare Locals	21
Attachment A.....	22

1. Main Points

All measures of rural and remote classifications have limitations.

Isolation and access to professional development; workload and remuneration; lifestyle and culture, regulatory barriers and the conceptualisation of the rural and urban based health divide are all factors that affect the provision of services in rural areas.

The limited availability of health related training courses in Tasmania means that in some health disciplines the state is dependent upon interstate or overseas recruitment of graduates.

The AGCS-RA when used as a mechanism to provide incentives to boost the rural and remote medical workforce in Tasmania is wholly inadequate.

Unlike GPs, nursing and allied health practitioners have limited access to income through billing via MBS and there is insufficient clientele in many parts of rural and remote Tasmania to provide a living for health professionals in private practice other than general practitioners.

Remoteness measures insisted upon by centralised government may be anathema to the idea of local planning (by Medicare Locals).

2. Preamble

The Community Affairs Reference Committee has requested submissions pertaining to the Factors affecting the supply 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;
- (b) The effect of the introduction of Medicare Locals on the provision of medical services in rural areas;
- (c) current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:
 - (i) their role, structure and effectiveness
 - (ii) the appropriateness of the delivery mode, and
 - (iii) whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes.
- (d) Any other related matters

3. Background

This paper is prepared against a background of significant change in the organisation and delivery of health care services in Tasmania. National health reforms are being implemented during a time of fiscal challenge and as demand pressures continue to rise. Tasmania's one and only Medicare Local was established on 1 November 2011 and will transition into a new role over the next six to twelve months. Three Tasmanian Local Health Network Networks (to be known as Tasmanian Health Organisations) will be established from 1 July 2012 to be followed by national and state and territory general practice and primary care plans. An updated version of Tasmania's Health Plan (first released 2007) is currently underway and will reflect these changes while recognising the practical limitations imposed by some of the issues identified in this paper. While none of the issues discussed in this paper can be said to be unique to Tasmania, impacts can be felt differentially across the country according to particular jurisdictional characteristics.

This paper proceeds from a simple premise, that is that the provision of health services in rural and remote areas, (RA 3 to RA 5) will always be determined by factors including population trends and levels of community need; distance from other services; cost and clinical support, levels of activity, physical infrastructure and available skilled workforce. It is to the latter of these factors that this paper is principally concerned.

4. The purpose of remoteness classifications

RRMA, ARIA and ASGC Remoteness Areas are geographic classifications used to group areas with similar characteristics. They are used to describe regional differences.

5. Defining remoteness – main approaches

While not the purpose of this paper to explore or document the science underpinning the development of the various indexes used to measure remoteness in Australia, a brief synopsis is required for the purpose of providing perspective for later discussion.

The Accessibility & Remoteness Index of Australia (**ARIA**) was developed in 1999. ARIA calculates remoteness as accessibility to some 201 service centres based on road distances. Remoteness values for 11,340 populated localities are derived from the road distance to service centres in four categories (a weighting factor is applied for islands). Remoteness values for each populated locality are then interpolated to a 1 km grid that covers the whole of Australia and averages calculated for larger areas¹.

- Highly Accessible: meaning relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.
- Accessible: meaning some restrictions to accessibility of some goods, services and opportunities for social interaction.
- Moderately Accessible: meaning significantly restricted accessibility of goods, services and opportunities for social interaction.
- Remote: meaning very restricted accessibility of goods, services and opportunities for social interaction.
- Very remote: meaning very little accessibility of goods, services and opportunities for social interaction

The Rural, Remote, Metropolitan Areas (**RRMA**) classification divides states and territories into metropolitan, regional, rural and remote zones based on population. The zones are:

RRMA 1 - Capital city

RRMA 2 - Other metropolitan centre

RRMA 3 - Large rural centres

RRMA 4 - Small rural centres

RRMA 5 - Other rural areas

RRMA 6 - Remote centres

RRMA 7 - Other remote centres

¹ Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA) Revised Edition Occasional Papers: New Series Number 14 October 2001

The Commonwealths Practice Incentive Program (PIP) offers a number of incentive payments to rural medical practitioners using RRMA. These include:

- Rural Loading
 - Practices participating in the PIP with a main practice location situated outside capital cities and other major metropolitan centres are automatically paid a rural loading. The rural loading recognises the difficulties of providing care, often with little professional support, in rural and remote areas. The PIP rural loading is higher for practices in more remote areas, in recognition of the added difficulties of providing medical care. . To be eligible for this payment a practice must be located in Rural, Remote and Metropolitan Areas (RRMA) 3–7.
- Procedural GP Payments
 - The Procedural GP Payment aims to encourage GPs in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services. To be eligible for this payment a practice must be located in Rural, Remote and Metropolitan Areas (RRMA) 3–7.
- Practice Nurse Incentive
 - The PIP Practice Nurse Incentive aims to encourage general practices in rural and remote areas to employ practice nurses and/or Aboriginal health workers. A payment of \$7.00 per Standardised Whole Patient Equivalent (SWPE) per year is made to practices located in Rural, Remote and Metropolitan Areas (RRMA) 3-7. The payment is capped at \$35 000 per year. Payments are made by Medicare Australia as part of each quarterly PIP payment.

At November 2010, 122 of Tasmania's 165 practices (74 per cent) were approved as eligible for PIP funding. Tasmanian practices received a higher proportion of PIP funding for provision of all after hours care arrangements, eHealth, student teaching, asthma and diabetes sign-on payments, and the domestic violence incentive than the national rate.²

In July 2010, the Australian Government (DoHA) adopted the Australian Standard Geographic Classification System – Remote Area (**ASGCS-RA**) developed in 2001 by the Australian Bureau of Statistics. This geographically based system replaced multiple population based indices hitherto used in rural health workforce planning, including the Rural, Remote and Metropolitan Areas classification (RRMA); Accessibility/Remoteness Index of Australia (ARIA); and ARIA+. The rationale behind the change was driven partly by concerns that population based indices were reliant on too soon out of date statistics and that use of multiple indices caused planning inconsistencies and confusion.³

² PHIT, Vol 4 April 2011

³ National Rural Health Alliance: "A new geographic classification for a new health system": A submission to the Department of Health and Ageing related to its review of remoteness classifications: 22 December 2008

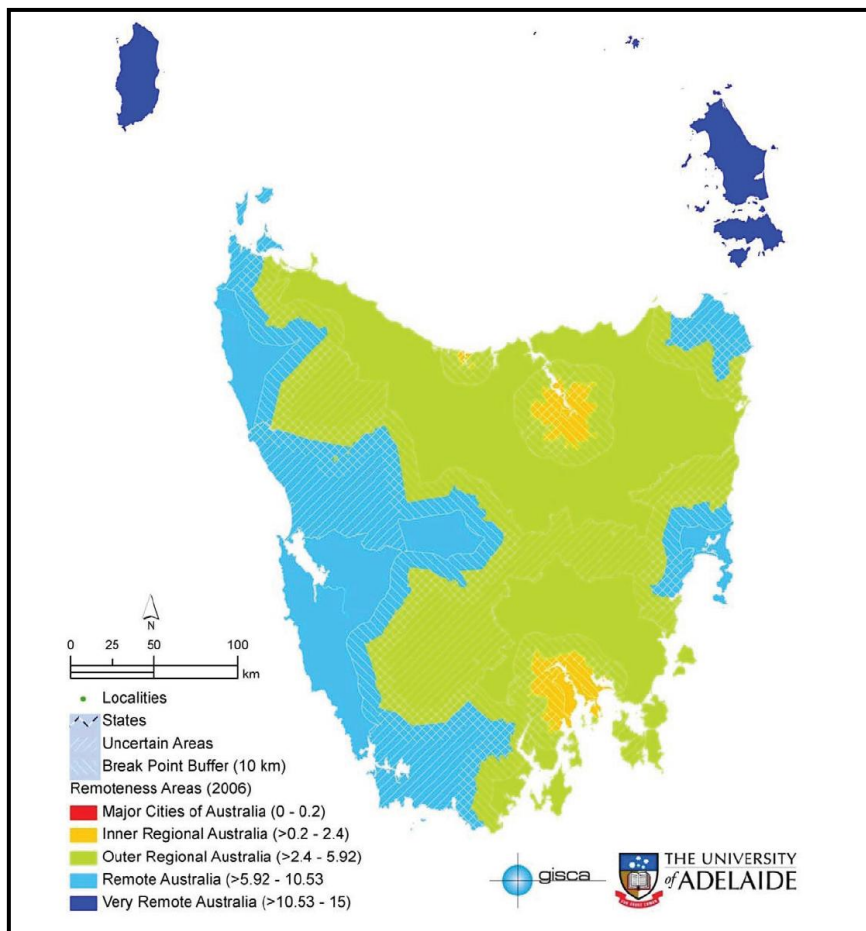
RAs are measures of remoteness calculated in terms of a of road distance from each Australian populated locality to the closest service centres in five size categories. The population sizes of service centres reflect the types and choices of services that are located within them. Road distances within each service centre category are averaged to produce a score or value that determines one of the following remoteness area designations⁴:

- RA 1: Major City
- RA 2: Inner Regional
- RA 3: Outer Regional
- RA 4: Remote
- RA 5: Very Remote

⁴ For more information on RAs and how they are calculated go to www.doctorconnect.gov.au/

In May 2011 the Department of Health and Ageing released a report by the University of Adelaide National Centre for Social Applications of Geographical Information Systems (GICSA) reviewing the ASGC-RA classification system. They found that overall the system appeared to be working well, but identified some problems with regard to boundary issues resulting 'areas of uncertainty' between neighbouring RAs. These 'areas of uncertainty' in Tasmania are shown in Figure I.

Figure I
ASGC-RA Areas of Uncertainty in Tasmania



Other studies have also referred to the limitations of rural and remoteness classification systems⁵. Most indices for example lack socio-economic information (recognised indicators of health and well being status) which may obscure health inequalities in rural communities⁶. In the AGCS-RA, remoteness is measured relative to Australia as a whole rather than on a jurisdictional basis⁷. This means that under the AGCS-RA, Swansea (one and three quarters hour's drive from Hobart) is classed RA 4, the same as Alice Springs which is arguably a lot more remote and with greater need. By contrast under RRMA Swansea is classified as RRMA 3 and Alice Springs RRMA 7. (A summary of concordances between the AGCS-RA, ARIA and RRMA is provided at Attachment A).⁸

Anomalies within and between classification systems can work both in the favour and disfavour of health planners, providers and consumers, an issue to which this paper will return. Overall however it must be noted that the “disaggregated and highly rural nature of the Tasmanian population means that there are significant issues in providing viable and sustainable health services across such a large number of small communities. Services are often quite small, with difficulty in achieving a critical mass in clinical volume and in economies of scale”⁹.

6. Factors limiting the supply of health services, medical, allied health and nursing staff to small regional communities compared to other areas.

There are a number of factors that limit the supply of health services and health professionals to rural and remote areas as compared to larger urban areas.

Health workforce education and training in Tasmania

For health services to be provided to rural and regional areas there must be an appropriately trained and skilled workforce. Tertiary and further education institutions in Tasmania provide a number of health and health related programs as summarised in Table I.

⁵ ABS Census Paper 03/01: ASGC Remoteness Classification: Purpose & use; 2003

⁶ McGrail, M & Humphreys, J “Geographical classifications to guide rural health policy in Australia, Australia & NZ Health Policy, 2009

⁷ Op cit

⁸ In July 2011 the Australian Government introduced the Australian Statistical Geography Standard (ASGS). The new Australian Statistical Geography Standard (ASGS) will use Mesh Blocks; the smallest geographical measurement unit developed by the ABS. Conceptually, the use of Remoteness Areas will remain the same with some changes in methodology.

⁹ Primary Health Services Plan, DHHS, 2007:pp32

Table 1: Health courses in Tasmania

Profession/vocational education/training in:	Available in Tasmania Y/N	Sector
Allied Health Assistant	Y	Polytechnic
Audiology	N	Tertiary
Audiometry	N	Tertiary & polytechnic
Biomedical science	Y	Tertiary
Diabetes Education	N	
Dietetics	N	Tertiary
Exercise physiology	Y	Tertiary
Medicine	Y	Tertiary
Medical radiation science	N	Tertiary
Nursing (enrolled)	Y	Polytechnic
Nursing (registered) incl. midwifery	Y	Tertiary
Nurse Practitioner	N	Tertiary
Oral health (dentistry)		Tertiary
Oral health (dental assistant)	N	Polytechnic
Orthotics & Prosthetics	N	Tertiary
Occupational therapy	N	Tertiary
Paramedical science	Y	Tertiary
Pharmacy	Y	Tertiary
Physiotherapy	N	Tertiary
Psychology	Y	Tertiary
Podiatry	N	Tertiary
Social work	Y	Tertiary
Speech pathology	N	Tertiary

The limited availability of health courses in Tasmania means that in some areas the state is wholly dependent upon interstate or overseas recruitment of graduates. Various efforts are made to overcome this including the provision of clinical placements in Tasmanian health facilities for mainland universities so as to expose students to the Tasmanian lifestyle and encourage them to work in the state after they graduate. However, the broadening of scope of offerings will be important for the state going forward.

Limitations on the supply of tertiary places and post vocational training and clinical placement opportunities means that local demand for health courses can not always be met and where it can 'home grown' graduates in some disciplines especially medicine leave the state to pursue career opportunities. This means that even for those disciplines for which local training is available, qualified health professional must continually be sourced from the mainland and from overseas to fill workforce gaps.

Isolation and access to professional development

One of the challenges of rural practice is being isolated from peers and difficulties accessing training opportunities that keep knowledge and skills current. This is a problem recognised by employers and professional training bodies alike, many of whom have set up professional development and peer support programs using advances in technology such as videoconferencing, live internet streaming and similar to overcome the problems of distance.

Workload and remuneration

High workloads can be a disincentive for health professionals to work in rural areas, directly attributable to recruitment and retention issues. This is often compounded by expectations concerning after hours availability, especially where a health practitioner is a sole practitioner in a community. Compared with urban counterparts, rural clinicians spend a greater amount of time on-call, simply because there are fewer people available to respond to periods of high patient activity, especially in cases of emergency. Remuneration too, frequently does not take into account the various complexities of rural and remote practice. Special tax zones do apply in some parts of Australia and rural salary loadings are sometimes applied by employers but for many within the health workforce there is no monetary recognition of their practice circumstances. There have been calls for many years for rural doctors to be paid differential Medicare payments weighted according to remoteness.

Lifestyle and culture

Access to social and cultural activities and to facilities and services such as choices in education, housing, childcare and other social and community services is a factor that impacts upon health workforce recruitment and retention in rural areas. There is evidence that health professionals in rural and remote areas have similar job satisfaction levels to their urban counterparts but for some professions this does not appear to translate into increasing number is training.

Changing generational expectations with regard to work/life balance is also affecting patterns¹⁰ of work with increasing demands for flexible working hours. This shift means that while numerically there may be more GPs, the overall FTE is rising much more slowly.

Regulatory barriers to overseas trained health professionals

The supplementing of Australia and Tasmania's health workforce through the use of overseas trained professionals has become common practice. However there are many complex and time consuming regulatory hurdles to overcome both at government and accrediting body levels. While no-one would dispute the need to ensure that practicing health clinicians are able to meet contemporary Australian standards, there have been recent criticisms that the system has become too complicated and even discriminatory¹¹.

Tasmania is heavily dependent upon overseas trained doctors to maintain its rural medical workforce. In 2010 IMGs accounted for 29 per cent of the GP workforce. These doctors must meet stringent language proficiency and visa conditions which permits them access to Medicare only if they practice in designated areas of need and workforce shortage and be under clinical supervision until such time as they are able to pass exams and acquire Australian registration. International graduates within Tasmania have significantly higher workforce representation in areas of rural workforce need in outer regional, remote and very remote areas within the State which raises many issues of professional, cultural and familial support.

More generally, *“there remains a fundamental problem in the way in which rural/remote health services and their relation to metropolitan-based services are conceptualised, and in the way this conceptualisation drives service models in rural and remote areas. Rural/remote is often regarded by metropolitan-based service planners and policy-makers as a “diluted” form of the metropolitan situation rather than as a distinctive context of practice with quite different practice, resource, communication and organisational drivers. Often where rural/remote settings are understood as distinctive, they tend to be treated in isolation from the activities of metropolitan services, i.e., as being outside the scope of metropolitan-based service providers or policy-makers. What is required, however, is a re-conceptualisation of the whole service system in which metropolitan and rural/remote are understood as parts of an inter-connected and mutually-supporting, integrated system. Until that concept is realised in practice and policy, workforce problems will continue to plague rural and remote Australia”*¹².

¹⁰ McGrail M, Humphreys J, Joyce C, Scott A, Kalb G. Professional satisfaction and general practice: Does it vary by size of community? Medical Journal of Australia, 2010, 193 (2): 94-98. Medicine Australia Balancing Work & Life Paper

¹¹ Foreign doctors' obstacle course 'a disgrace', The Age, Tom Hyland November 20, 2011

¹² Internal DHHS paper, Atkins K, Dr.

Other factors

“Rural and remote clinicians and their clients face distinctive moral hazards as a result of having a higher level of “public availability” when compared with urban counterparts as a result of the smaller size of communities, higher levels of on-call work, and the multiple roles undertaken. Greater personal knowledge of community members in the context of the intimacy of the therapeutic relationship and multiple obligatory relationships can lead to clinicians being asked to respond to requests for help at any time of night or day; to disclose personal information about a client; or to treat some individuals more favourably than others” ¹³.

The “psychodynamics” of work is poorly understood by service planners. Consequently, the psychological health of rural and remote workers can suffer over the longer-term in response to service delivery demands that do not provide professional (and inter-professional) interaction required, not only for genuinely professional autonomy, but to manage intra-personal and inter-personal conflict. ¹⁴ Additionally,

- *People living in rural and remote areas of Tasmania tend to have less disposable income than their urban counterparts, and so, are less likely to purchase private health services or private health insurance.*
- *Tasmania lacks the population density to attract (and justify financially) a critical mass of specialist health professionals in rural areas. Consequently, many health professionals find that rural practice does not provide sufficient opportunities to exercise and maintain their specialist expertise, and so, is unsatisfying and professionally limiting.*
- *The population is ageing, and so is Tasmania’s rural health workforce. As the rural health workforce ages, individuals seek increased access to health services, and, consequently, some move away from rural areas and into urban areas.*
- *Chronic workforce shortages in Tasmania have resulted in high utilisation of locum doctors and nurses. While locums meet an important short-term need, they typically lack the “corporate memory” and personal investment in a facility or service that is needed to build long-term safety and quality into health services as well as into a satisfying professional life.*
- *In small communities there are fewer people to share the load of civic duties, and this can erode individuals’ free time. Clinicians, like other workers in areas with small populations, often “wear several hats”. For example, a nurse may also be a volunteer ambulance officer; the doctor may also be a volunteer fire fighter; and the paramedic may also be the secretary of the local Rotary. This places extra pressure on the time health professionals have to develop and pursue personal interests.*
- *Health professionals are often among the most highly educated members of the community and so, may be sought out to participate in local decision-making bodies or volunteer groups. Unlike urban areas where there is a wide range of volunteer roles, rural and remote communities have fewer. Reluctance or refusal to participate can be difficult and create conflict in a context where refusal is bound to be well-known and unwelcome, and the impact of inter-personal conflict can be significant.*

¹³ Ibid

¹⁴ Dejours, Christophe and Jean-Philippe Deranty. The Centrality of Work. *Critical Horizons* 11 (2), 2010.

- *Problems of inter-personal conflict in a rural or remote location can have a high impact because they occasionally involve individuals who have moved to such a location precisely because they lack the inter-personal skills to cope with life in more populous areas. However, rural/remote facilities rarely have sufficient Human Resource management support to deal efficiently with difficult cases”.*¹⁵

Remoteness and workforce incentives in Tasmania

With a population of just over 507,000 people, Tasmania is the smallest state in the federation. It occupies a land mass of 68,401 square kilometers. It has a decentralised population, with 49.6 per cent of the population living in the South (62 telephone district), 28.1 per cent in the North (63 telephone district) and 22.3 per cent in the Northwest (64 telephone district). It has the highest median age of all states and territories and is ageing at a faster rate. Concomitantly, the Tasmanian health workforce is also rapidly ageing.

Figure 2

ASGC RA index as applied to Tasmania

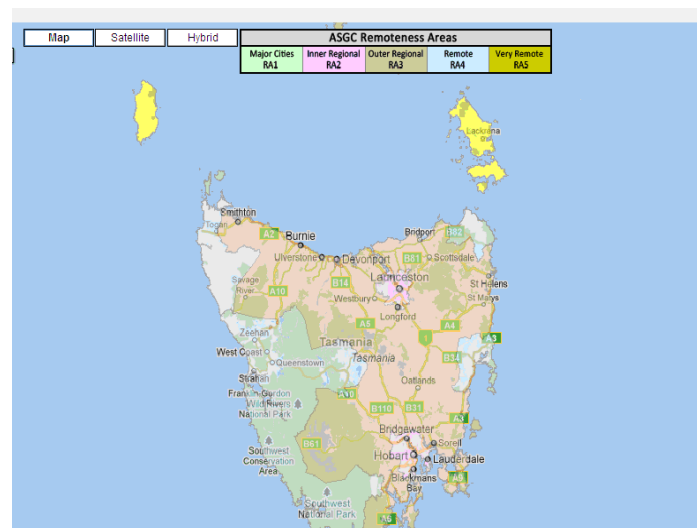


Figure 2 shows the ASGC RA index as applied to Tasmania. Under the AGCS-RA Tasmania does not have a RA I classification, with all its major cities all being classified RA 2, inner regional.

The AGCS-RA and the Tasmanian medical workforce

Under the AGCS-RA the entire Tasmanian health workforce is regional, remote or very remote. This means that general practitioners are eligible for Australian Government incentive schemes even if they live in the capital city, Hobart. These schemes include the Medical Rural Bonded Scholarship Scheme, General Practice Rural Incentives Program, including the General Practitioner (GP) Component, and Rural Relocation Incentive Grant (RRIG). (Details of these incentives by category of RA are at Attachment B.) Generally, these incentives are administered by state and territory GP workforce agencies.

¹⁵ Atkins K, Dr Op cit

Rural specialist services funded by the Australian Government use a mixture of classification systems. The Medical Specialist Outreach Assistance Program (MSOAP) in Tasmania uses ARIA, while the indigenous Chronic Disease MSOAP uses AGCS-RA. The visiting optometry scheme (VOS) uses AGCS-RA

The Tasmanian Government provides incentives to recruit and retain doctors to rural areas. The Rural Medical Practitioners Agreement provides for payment to rural GPs for visiting medical services at rural hospitals in addition to quality & safety payments, procedural allowances and payment for participation in primary health activities in the community. Over and above this, rural medical practices can claim up to \$10,000 per annum for locum support. In kind incentives are also available to rural GPs in Tasmania in the form of practice support, corporate and facility support which can include assistance with accommodation, cost overheads, practice nurse support and provision of consumables.

GPs in Tasmania working in remote and very remote areas experience higher workforce pressures, with some of the highest average number of 3.5 hour sessions being documented for the state¹⁶. These figures are in keeping with findings from the Australian Institute of Health and Welfare Medical Labour Force survey in 2009 which revealed that medical practitioners working in remote/very remote areas worked, on average, 3.2 hours per week more than the national average, with primary care practitioners working an average of 7.3 hours per week more than the national average (45.6 compared with 38.3 hours)¹⁷. Some of these pressures can be explained with reference to a study of general practice activity in the period 1998-2004 which looked at the nature of clinical work undertaken by GPs according to their remoteness based on AGCS-RA and RRMA. Noteworthy from this study was that differences in clinical GP activity were not easily described using RRMA as compared to AGCS-RA.¹⁸

Table 2 shows Tasmanian population, GP distribution by RA and state in patient bed site by RA.

¹⁶ General Practice Tasmania Inc, GP Census, 2010

¹⁷ Bulletin 89, August 2011

¹⁸ "Locality matters: The influence of geography on general practice activity in Australia 1998–2004"
Australian GP Statistics and Classification Centre

Table 2:
Tasmanian population, GP distribution by RA and state in patient bed site by RA.

RA	Population	per cent of Pop	GPs (FTE)	
			No:	per cent
Major city (RA1)	-	-	-	-
Inner Regional (RA2)	328815	64.7 per cent	258.2	71.1
Outer Regional (RA3)	168380	33.1 per cent	96.9	26.7
Remote (RA 4)	7865	1.5 per cent	8.1	2.2
Very remote (RA5)	2583	0.5 per cent		
Tasmania total	507643	100 per cent	363.2	100

The table shows that inner regional Tasmania accounts for more than 71 per cent of GPs with 28.9 per cent servicing Outer regional to very remote areas. Based on similar data, the Tasmanian General Practice Census 2010 makes the observation that; “Due to Tasmania’s capital city and major regional centres attracting the classification of inner regional areas, the proportion of GPs in these areas in Tasmania occurs at a rate 3.7 times the national distribution. Similarly, the distribution of Tasmania’s GPs by outer regional areas occurs at a rate 3.3 times higher than mainland Australia. However, the distribution of GPs in remote and very remote areas is very close to the national rate, reflecting the widespread rural and remote workforce shortages in these areas.” Overall, according to the Tasmanian GP census 2010, Tasmania has 76.4 FTE GPs per 100 000 people compared with the Australian GPs distribution rate of 80.8 FTE GPs per 100 000 populations. However, the Hobart city area (classified as RA 2) has 146.1 FTE GPs for every 100 000.¹⁹ In Launceston, also RA 2 the number is 91.1 FTE per 100 000 with Devonport 87.9 and Burnie 67.7 FTE per 100 000.

The obvious conclusion from this is that the AGCS-RA when used as a mechanism to provide incentives to boost the rural and remote medical workforce in Tasmania is wholly inadequate. It does nothing to address the relative under/over supply of GPs in some areas of Tasmania compared to others of identical remoteness classification.

The AGCS-RA and the Tasmanian nursing workforce

Table 3 classifies nursing numbers by AGCS-RA based on 2006 census figures. As Tasmania has no major cities under this index, the correspondingly named column in the table is assumed to be RA 2, Inner Regional. Figures are for public and private providers

¹⁹ Op cit, GP Census 2010

Table 3:
AGCS-RA and the Tasmanian nursing workforce²⁰

ANZSCO Occupation	Major Cities	Outer Regional areas	Remote areas	Very Remote areas	Total
Enrolled Nurse	252	151	13	3	419
Mothercraft Nurse	12	—	—	—	12
Enrolled and Mothercraft Nurses, nfd	—	—	—	—	—
Midwife	255	87	—	—	345
Nurse Practitioner	10	—	—	—	10
Registered Nurse (Aged Care)	333	193	6	—	532
Registered Nurse (Child and Family Health)	76	32	—	—	108
Registered Nurse (Community Health)	193	114	8	3	318
Registered Nurse (Critical Care and Emergency)	243	73	3	3	325
Registered Nurse (Developmental Disability)	—	—	—	—	—
Registered Nurse (Disability and Rehabilitation)	29	10	—	—	39
Registered Nurse (Medical Practice)	74	42	3	3	122
Registered Nurse (Medical)	101	35	—	—	136

²⁰ AIHW 2009. Health and community services labour force 2006. Cat. no. HWL 43. Canberra: AIHW

Registered Nurse (Mental Health)	145	35	—	—	183
Registered Nurse (Perioperative)	238	65	3	—	306
Registered Nurse (Surgical)	83	30	—	—	113
Registered Nurses, nec	920	311	5	8	1,247
Registered Nurses, nfd	736	289	4	8	1,040
Nurse Educator	47	19	—	—	66
Nurse Researcher	21	—	—	—	21
Nurse Educators and Researchers, nfd	—	—	—	—	—
Nurse Manager	216	64	3	3	286
Nursing Clinical Director	52	15	—	—	67
Midwifery and Nursing Professionals, nfd	9	4	—	—	13

Unlike GPs, nursing practitioners have limited access to income through billing via MBS and there is insufficient clientele in many parts of rural and remote Tasmania to provide a living for health professionals in private practice other than general practitioners.

Under their current Enterprise Bargaining Agreement in Tasmania, nurses are eligible for payment if a remote allowance and professional development package equivalent to \$3000 per annum.

The AGCS-RA and the Tasmanian allied health workforce

Table 4 classifies selected allied health discipline number by AGCS-RA based 2006 census figures. As Tasmania has no major cities under this index, the correspondingly named column in the table is assumed to be RA 2, Inner Regional. Figures are for public and private providers.

Table 4
AGCS-RA and the Tasmanian allied health workforce²¹

ANZSCO Occupation	Major Cities	Outer Regional areas	Remote areas	Very Remote areas	Total
Audiologist	13	3	—	—	16
Clinical Psychologist	141	31	—	3	175
Dietitian	31	6	—	—	37
Occupational Therapist	113	24	—	—	140
Optometrist	55	14	—	—	69
Orthoptist	9	—	—	—	9
Orthotist or Prosthetist	4	7	—	—	11
Physiotherapist	204	65	—	—	269
Podiatrist	43	15	—	—	61
Social Worker	277	91	—	—	371
Speech Pathologist	73	26	—	—	99
Therapy Aide	59	29	—	—	88

Tasmania's Health Plan 2007 refers to the distribution of the allied health workforce in Tasmania as 'uneven' and in this respect it mirrors the rural medical workforce. Outer regional and remote regions of the state contain 36 per cent of the population but only 24 per cent of the allied health workforce. Some professional groups, e.g. orthotics and prosthetics, are based entirely in the larger population centres²².

Unlike GPs, allied health practitioners have limited access to income through billing via MBS and there is insufficient clientele in many parts of rural and remote Tasmania to provide a living for health professionals in private practice other than general practitioners.

²¹ AIHW 2009. Health and community services labour force 2006. Cat. no. HWL 43. Canberra: AIHW

²² Primary Health Services Plan, DHHS, 2007:pp32

There are minimal workforce incentives available for allied professionals to relocate to rural and remote areas: RA 3- RA 5. The Nursing & Allied Health Rural Locum Scheme (NAHRLS) has recently been established by the Australian Government under the national health reform agenda to support nurses, midwives and eligible allied health professionals in rural and regional Australia to access professional development training. The NAHRLS will support and recruit suitable locums to enable rural professionals to leave their post to undertake CPD activities, and enable organisations to back-fill their positions to support ongoing service delivery. Applicants for locum support must be located within the ASGC-RA Categories 2 to 5. The exception to this will be for Aboriginal Medical Services, which may be located in ASGC-RA Categories 1 to 5.²³

The AGCS-RA and the Tasmanian oral health workforce

Table 5 classifies selected oral health discipline number by AGCS-RA based 2006 census figures. As Tasmania has no major cities under this index, the correspondingly named column in the table is assumed to be RA 2, Inner Regional.

Table 5
AGCS-RA and the Tasmanian oral health workforce²⁴

ANZSCO Occupation	Major Cities	Outer Regional areas	Remote areas	Very Remote areas	Total
Dental Assistant	223	88	—	—	311
Dental Hygienist	8	—	—	—	8
Dental Prosthetist	30	12	—	—	42
Dental Specialist	10	—	—	—	10
Dental Technician	27	10	—	—	37
Dental Therapist	35	23	—	—	58
Dentist	100	17	—	—	117
Dental Practitioners	—	—	—	—	—

Table 5 includes public and private oral health workforces. The DHHS purchases emergency dental services from private providers in remote areas of the state using a system of vouchers. There are no workforce incentives available for oral health professionals to relocate to rural and remote areas: RA 3- RA 5.

²³ NAHRLS; <http://www.nahrls.com.au/>

²⁴ AIHW 2009. Health and community services labour force 2006. Cat. no. HWL 43. Canberra: AIHW

7. Medicare Locals

Medicare Locals will play an important role in the planning and coordination of primary care health services into the future. They will be funded by the Australian Government for this express purpose. Whether they are able to approach this task with relative autonomy using planning processes and tools appropriate to their circumstances is yet to be seen. Remoteness measures insisted upon by centralised government may be anathema to the idea of local planning, especially in Tasmania where the entire state will be served by one Medicare Local (albeit with regional branches).

One of the first tasks of Medicare Locals is to investigate access to after hours GP services. In Tasmania rural GPs have had access to GP Assist, a Tasmanian Company owned by Clinical Solutions. For a number of years the Australian Government has funded GP Assist to provide after hours support to rural GPs in Tasmania. This service has in recent times been run parallel to Health Direct, the Australian Governments health information hotline. With the introduction of GP Help Line however, this funding support is expected to be phased out. Specific areas of Tasmania have very limited access to after hours GP support and the future role of Medicare Locals in this and in the delivery of primary care services generally, is viewed with mixed feelings in Tasmania

Attachment A

AGCS-RA; RRMA and ARIA Concordances

Table 9: ASGC Remoteness Areas¹, ARIA² and RRMA³ guide based on 2001 SLA boundaries – Tasmania

SLA code	SLA name	ASGC Remoteness Areas				ARIA class ⁴	ARIA			RRMA class		
		Percentage of population living in each Remoteness Area					Mean	Min.	Max.			
60210	Break O'Day (M)	R	6.8	OR	93.2	MA	3.942	2.451	4.747	R3 ⁶		
60410	Brighton (M)	IR	100.0			HA	1.663	1.417	1.856	M1		
60611	Burnie (C) – Pt A	OR	100.0			A	2.160	2.080	2.406	R2 ⁵		
60612	Burnie (C) – Pt B	OR	100.0			A	2.643	2.175	3.236	R3 ⁵		
60811	Central Coast (M) – Pt A	OR	100.0			A	2.127	2.000	2.259	R3 ⁶		
60812	Central Coast (M) – Pt B	OR	100.0			A	2.502	2.044	2.944	R3 ⁶		
61010	Central Highlands (M)	R	9.8	OR	90.2	A	3.490	2.069	4.919	R3 ⁶		
61210	Circular Head (M)	OR	92.8	R	7.2	MA	4.674	2.999	5.706	R3 ⁵		
61410	Clarence (C)	OR	5.2	IR	94.8	HA	1.616	1.210	2.062	M1		
61511	Derwent Valley (M) – Pt A	IR	100.0			HA	1.610	1.517	1.703	M1		
61512	Derwent Valley (M) – Pt B	OR	66.2	IR	33.1	R	0.7	A	3.361	1.581	4.780	R3 ⁶
61610	Devonport (C)	OR	6.3	IR	93.7	A	1.911	1.780	2.101	R2 ⁶		
61810	Dorset (M)	R	4.0	OR	96.0	A	3.353	2.113	4.890	R3 ⁶		
62010	Flinders (M)	VR	100.0			VR	9.803	9.200	10.010	Rem2 ⁵		
62211	George Town (M) – Pt A	OR	100.0			A	1.999	1.866	2.137	R3 ⁵		
62212	George Town (M) – Pt B	OR	100.0			A	2.148	1.866	2.460	R3 ⁵		
62410	Glamorgan/Spring Bay (M)	OR	38.4	R	61.6	MA	3.780	2.203	5.178	R3 ⁵		
62610	Glenorchy (C)	IR	100.0			HA	1.471	1.210	1.696	M1		
62811	Hobart (C) – Inner	IR	100.0			HA	1.210	1.210	1.210	M1		
62812	Hobart (C) – Remainder	IR	100.0			HA	1.290	1.210	1.581	M1		
63010	Huon Valley (M)	OR	97.2	R	2.8	A	3.027	1.627	4.244	R3 ⁶		
63210	Kentish (M)	OR	100.0			A	2.615	1.874	3.527	R3 ⁵		
63410	King Island (M)	VR	100.0			VR	9.460	9.460	9.460	Rem2 ⁵		
63611	Kingborough (M) – Pt A	OR	3.9	IR	96.1	HA	1.580	1.210	2.532	M1		
63612	Kingborough (M) – Pt B	R	26.4	OR	73.6	A	3.600	1.810	4.010	R3 ⁵		
63811	Latrobe (M) – Pt A	OR	100.0			A	1.932	1.780	2.074	R3 ⁶		
63812	Latrobe (M) – Pt B	OR	100.0			A	2.091	1.855	2.408	R3 ⁶		
64011	Launceston (C) – Inner	IR	100.0			HA	1.210	1.210	1.210	R1 ⁵		
64012	Launceston (C) – Pt B	IR	100.0			HA	1.393	1.210	1.908	R1 ⁶		
64013	Launceston (C) – Pt C	IR	17.4	OR	82.6	A	2.020	1.210	2.482	R3 ⁶		
64211	Meander Valley (M) – Pt A	IR	100.0			HA	1.278	1.210	1.448	R1 ⁷		
64212	Meander Valley (M) – Pt B	IR	6.5	OR	93.5	A	2.737	1.261	4.321	R3 ⁶		
64611	Northern Midlands (M) – Pt A	IR	100.0			HA	1.499	1.221	1.700	R3 ⁶		
64612	Northern Midlands (M) – Pt B	OR	100.0			A	2.815	1.544	4.491	R3 ⁶		

(continued)

Table 9 (continued): ASGC Remoteness Areas¹, ARIA² and RRMA³ guide based on 2001 SLA boundaries – Tasmania

SLA code	SLA name	ASGC Remoteness Areas				ARIA class ⁴	ARIA			RRMA class
		Percentage of population living in each Remoteness Area					Mean	Min.	Max.	
64811	Sorell (M) – Pt A	OR	59.3	IR	40.7	A	2.031	1.729	2.429	M1
64812	Sorell (M) – Pt B	OR	100.0			A	2.378	2.003	2.738	R3 ⁶
65010	Southern Midlands (M)	OR	100.0			A	2.697	1.695	3.723	R3 ⁶
65210	Tasman (M)	OR	92.8	R	7.2	A	3.299	2.500	3.824	R3 ⁶
65411	Waratah/Wynyard (M) – Pt A	OR	100.0			A	2.633	2.080	3.046	R2 ⁷
65412	Waratah/Wynyard (M) – Pt B	R	5.9	OR	94.1	MA	3.616	2.294	4.959	R2 ⁷
65610	West Coast (M)	OR	40.9	R	59.1	MA	5.132	3.272	6.650	R3 ⁵
65811	West Tamar (M) – Pt A	IR	66.6	OR	33.4	A	1.921	1.210	2.618	R1 ⁶
65812	West Tamar (M) – Pt B	IR	25.6	OR	74.4	A	2.082	1.238	2.434	R3 ⁶

Note: The footnotes in this table are listed on page 24. A guide to SLA suffixes is on page 25.

Sources: ABS, DoHA and AIHW.