Australian Government

Department of Health and Ageing

Mr Ian Holland
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Senate Community Affairs References Committee
Parliament House
CANBERRA ACT 2600

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Dear Mr Holland

Thank you for your letter of 8 November 2011 inviting a submission to the Senate Community Affairs References Committee inquiry into the factors affecting the supply of health services and medical professionals in rural areas.

Please find attached the Department of Health and Ageing's submission to the inquiry.

Yours sincerely

Kerry Flanagan
Deputy Secretary

January 2012

Encl.

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Department of Health and Ageing Submission

Senate Community Affairs References Committee

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

January 2012

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Introduction

Australia's health system

Australia's health system is world class, supporting universal and affordable access to high quality medical, pharmaceutical and hospital services, while helping people to stay healthy through health promotion and disease prevention activities. It achieves this through a mix of public and private health care provision that enables Australians to receive quality and comprehensive health care.

Through the Medicare system, the Australian Government subsidises access to primary care providers, including medical practitioners, and to a range of specialist and diagnostic services. The Pharmaceutical Benefits Scheme (PBS) provides subsidised access to scheduled medicines. The Australian Government also contributes funding to private health insurance and public hospitals.

State and territory governments are the main providers of publicly provided health services. They are primarily responsible for the operation and funding of public hospitals and a range of public and community based health services.

Private practitioners deliver a significant proportion of primary and secondary medical, dental and allied health services in the Australian health system. Private practitioners include those providing front-line care to patients – such as general practitioners (GPs), pharmacists, dentists, some nurses – and those providing referred services, such as medical specialists. Patient access to these services in many cases is subsidised by Medicare.

The Commonwealth invests in rural health through a range of mechanisms, including:

- Work in conjunction with states and territories
- Targeted programs and investments in capital expenditure and infrastructure
- Targeted capacity development; and
- Investing in measures to improve access through telehealth and ehealth.

This submission does not include aged care or reference to multi-purpose services (MPS) that deliver aged care services to rural locations.

Distribution of the workforce

The provision of quality, accessible health care is a major challenge facing governments around the world. Demand for health services is increasing as populations age and more people are living with chronic disease. Compounding this is the ever-increasing cost of medical care as technologies and medicines continue to advance. Historically, access to services has diminished with distance from major centres, and some rural and remote areas find it particularly difficult to attract suitably qualified health practitioners. [1]

[1] Australian Institute of Health and Welfare; Rural Health Webpage; 2011.

The number of general practitioners (GPs) per 100,000 head of population varies from under 60 in very remote Australia through to almost 200 GPs per 100,000 people in major cities. The majority of allied health workers also work in metropolitan locations.[2]

Attracting and retaining health practitioners in under-serviced areas is critical to ensuring all Australians are able to access high quality, timely health care. Successive governments have given priority to policy interventions designed not only to ensure that Australia has sufficient numbers of qualified practitioners, but also to ensure that they are working where they are most needed.

Australian Government interventions intended to build the workforce include support for education and training of health professionals (such as university places and scholarships) and arrangements that allow practitioners from overseas to live and work in Australia. Interventions to address maldistribution include incentives to work in areas that are difficult to recruit to, and restriction on where some practitioners are able to work. This submission will deal with such targeted rural programs.

Health Workforce Shortages

Historical Background – Limitations to Health Services in Australia

As at June 2009, 68.6% of the population resided in Australia's major cities. Of the total population, 29.1% resided in regional areas and just 2.3% lived in remote or very remote Australia.[3]

In addition, the proportion of Indigenous Australians in rural and remote locations is much higher than in major cities. Forty five percent of the total population in very remote areas is Indigenous, as opposed to only 1 % in major cities.[4] However, most Indigenous Australians reside in metropolitan areas.

Rural and remote communities experience particular issues and challenges associated with their geographic isolation. As such, health services in rural and remote areas are very different to their city counterparts. Facilities are generally smaller and more dependant on primary care services, but play a vital role in the provision of community-wide integrated health services that may include mental health services, oral health, community and aged care and social services.

Audit of Health Workforce in Rural and Regional Australia 2008

In 2008, the Department conducted an Audit of the Health Workforce in Rural and Regional Australia. The audit incorporated broad consultation with peak bodies and relevant stakeholders, and aimed to determine the number and distribution of the health workforce, particularly doctors, nurses and other health professionals currently working in rural and regional Australia, describe the current workforce supply, and also to identify where health workforce shortages existed.

Key findings from the Audit were that:

- the supply of health professionals is not sufficient to meet current needs;
- the supply of health professionals in many rural and regional areas is low to very poor; and

[2] A National Health and Hospitals Network: Further investments in Australia's health, 2010.

[3] Australian Bureau of Statistics; Regional Population Growth, Australia; 2009-10.

[4] Australian Institute of Health and Welfare; Rural, regional and remote Australia: a study on mortality; 2007.

- there had been a reliance on 17-year old population figures in developing incentives for doctors and other rural workforce policies.

Although the report found that the medical workforce in rural and remote Australia had increased modestly in preceding years (mostly due to Medicare provider number restrictions for Overseas Trained Doctors), this growth did not indicate increased availability of GPs over time, as the growth in the medical workforce did not keep pace with the rate of population growth.

Access to services was found to be dependant not only upon the number and distribution of health professionals, but also by the logistical challenges of servicing highly dispersed populations over wide and diverse geographical areas.[5]

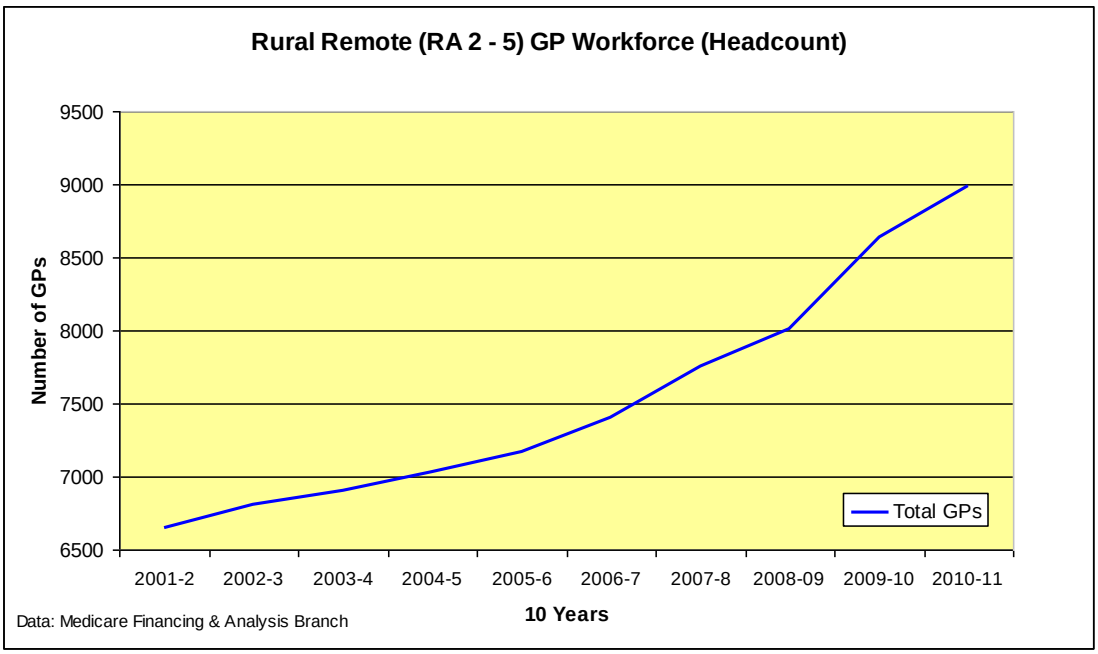
In response to the audit and the subsequent review of rural health programs, development began on the *Rural Health Workforce Strategy* (RHWS) and the consolidation of rural programs. Further discussion of the RHWS can be found on page 10 of this submission.

Health workforce policies

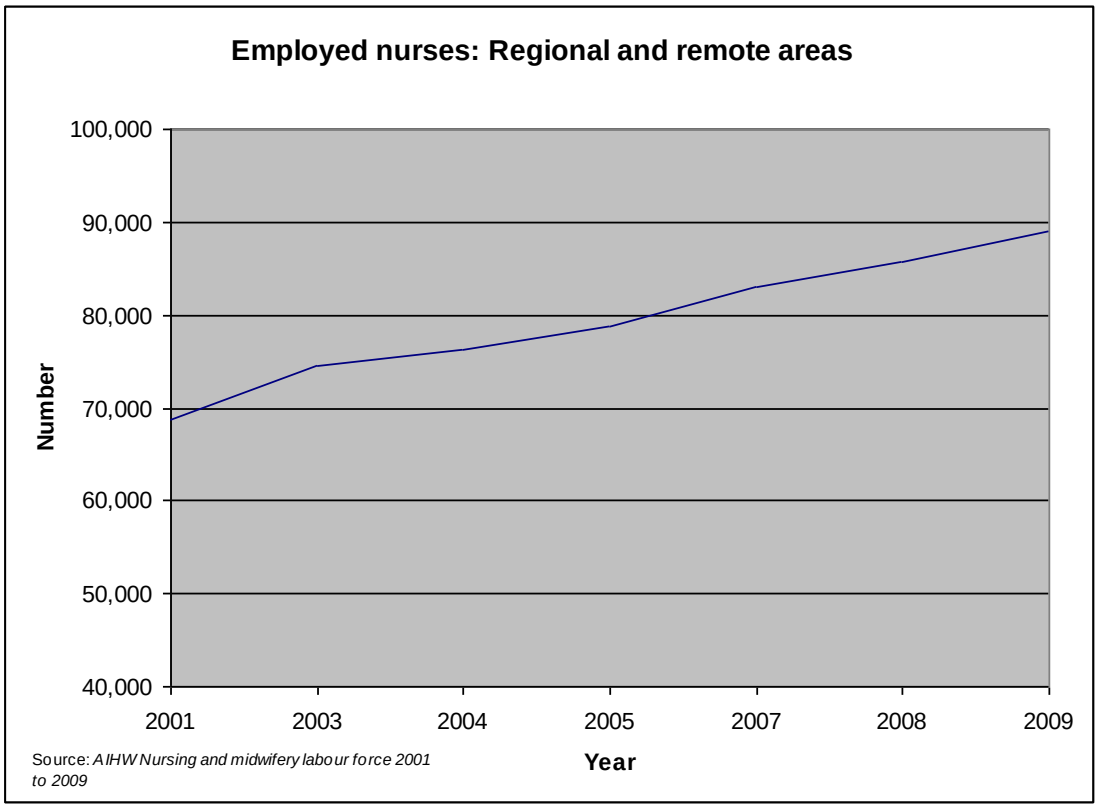
Successive Commonwealth, state and territory governments have, through COAG implemented a number of key measures to address health workforce shortages in rural and remote Australia. These have been mainly focused on addressing supply and distribution issues. A table at **Attachment A** outlines some of the key health initiatives since 1984.

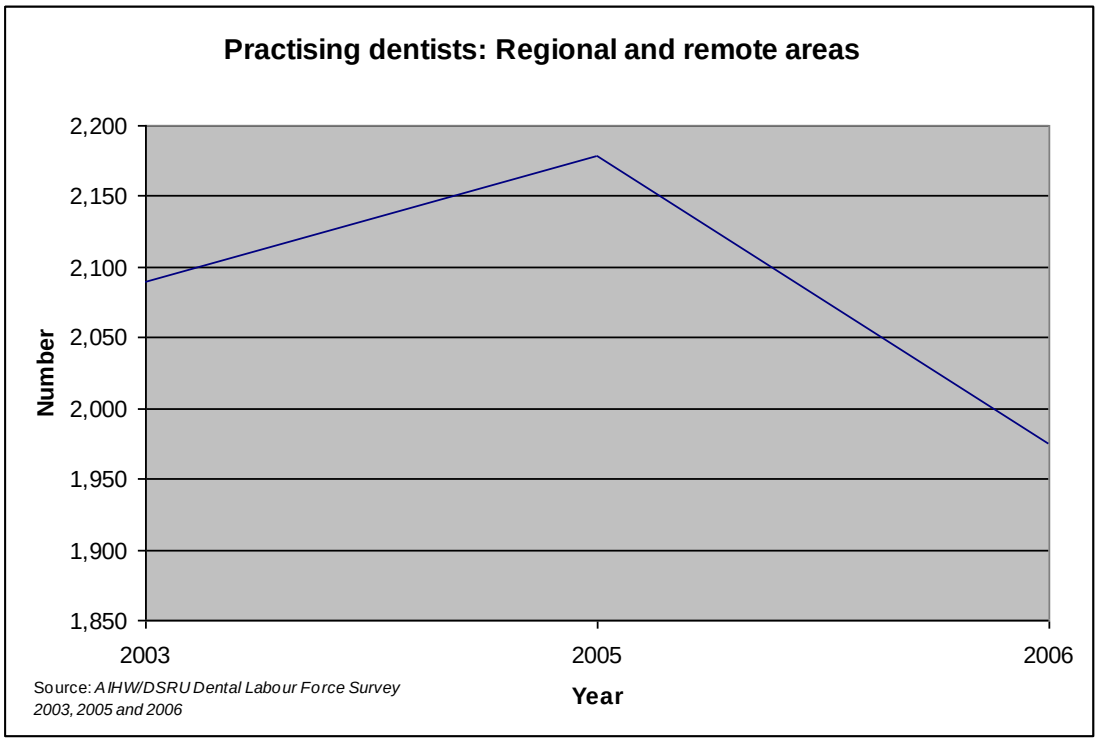
Impact of health workforce policy

The overall impact of government intervention has seen an improvement in the health workforce over time. The number of medical practitioners working in regional, rural and remote Australia has increased steadily during the past ten years. Much of this is attributed to the use of overseas trained doctors who have increased significantly since 2001-02.



[5] Report on theAudit of Health Workforce in Rural and Regional Australia, 2008.


Employed nurses: Regional and remote areas
100,000
90,000
80,000
70,000
60,000
50,000
40,000
Number
2001
2003
2004
2005
2007
2008
2009
Year
Source: AIHW Nursing and midwifery labour force 2001 to 2009

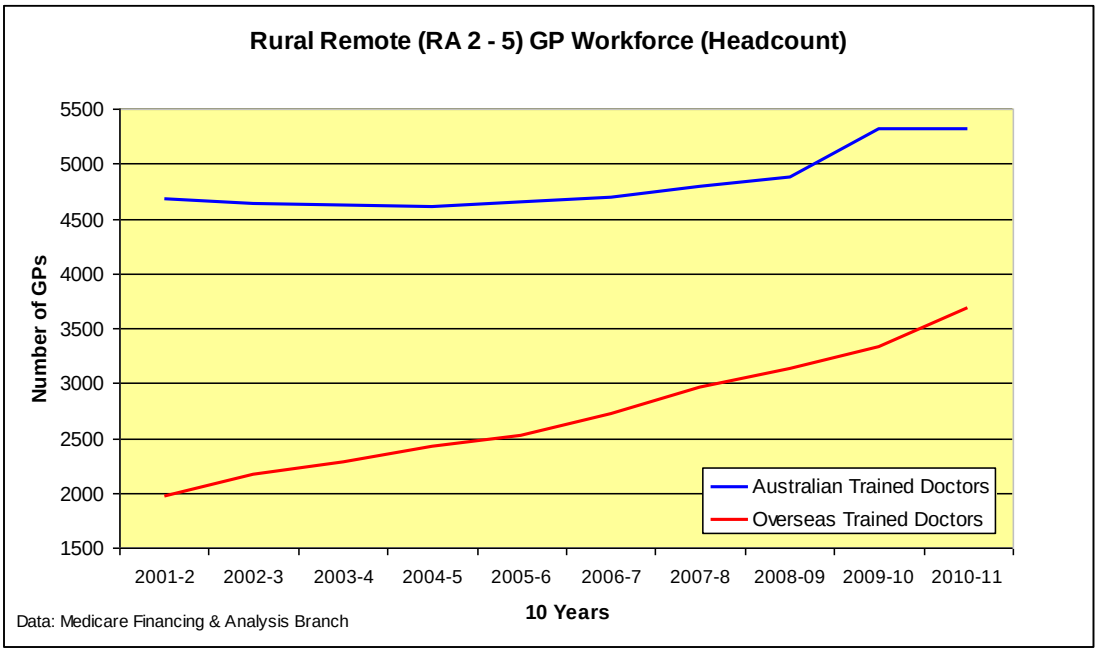

Practising dentists: Regional and remote areas
2,200
2,150
2,100
2,050
2,000
1,950
1,900
1,850
Number
2003
2005
2006
Year
Source: AIHW/DSRU Dental Labour Force Survey 2003, 2005 and 2006

Overseas trained doctors

Overseas trained doctors (OTDs) are those who obtained their primary qualification overseas. According to the Australian Institute of Health and Welfare data (2009), based on the place of first medical qualification, approximately 25% of the medical workforce in Australia are overseas trained. Introduced in 1996, Section 19AB of the *Health Insurance Act 1973* is a mechanism used to distribute the workforce more evenly. Under s19AB, to gain access to Medicare benefits, OTDs must practise in a district of workforce shortage (DWS) for a period of ten years (commonly referred to as the *ten year moratorium*).

In 2009-10:

- 30% of OTDs (based on fulltime workload equivalent FWE)) were working in regional, rural or remote areas
- OTDs comprised 46.2% of FWE GPs in regional, rural and remote areas compared to 27.1% in 2000-01.



Individual programs that have contributed to the overall impact are described in this chapter, which addresses targeted health workforce programs and their performance, to date.

During the next four years, the Australian Government will invest more than $4.8 billion in targeted rural and regional health programs, in addition to funding provided though national programs such as the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). In 2011-12, the Government's investment in targeted rural and regional health programs will exceed $1.2 billion. Regional health investments are targeted towards:

- Improving access to appropriate health and medical services, including health promotion and prevention;
- Investing more effectively in regional health infrastructure;
- Strengthening workforce education and training; and
- Addressing workforce shortages through better workforce distribution and support

Key investments in 2011-12 include:

- $10 million to improve regional health infrastructure though the National Rural and Remote Health Infrastructure Program;
- $96 million to support a range of measures to improve health outcomes for rural, regional and remote Aboriginal and Torres Strait Islander communities;
- $18.8 million to improve the recruitment and retention of general practitioners in rural, regional and remote areas though the Rural and Remote General Practice program;
- $126 million to encourage the development of the medical, nursing and allied health workforce in rural, regional and remote Australia though the Rural Health Multidisciplinary Training Program; and
- $15.8 million to support access to mental health services for rural, regional and remote communities.

Rural Health Workforce Strategy (RHWS)

In response to the audit of the health workforce and the subsequent review of rural health programs, the $134.4 million RHWS was announced as part of the 2009-10 Federal Budget. The RHWS utilised several existing workforce programs and introduced a number of new initiatives. The RHWS is underpinned by two key reforms:

- Transition of program eligibility to a new geographic remoteness classification system; and

Scaling or gearing of incentives and return of service obligations to provide greatest benefits to the most remote communities where there is the greatest need.

The Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA)[6] system updated the existing methodologically flawed and out of date classifications used, such as Rural Remote and Metropolitan Areas (RRMA), the Accessibility/Remoteness Index of Australia (ARIA) and GP Access/Remoteness Index of Australia (GPARIA). ASGC-RA is seen to be the most up to date and accurate geographical classification system available, as such the Government is seeking to transition all rural programs to ASGC-RA in the near future.

Since the introduction of the rural workforce incentive programs in 2010, concerns have been raised by key stakeholder groups that the classification system, which categorises communities into remoteness areas is disadvantaging some small rural communities across Australia.

In late 2010, the Department engaged the National Key Centre for Social Applications of Geographic Information System (GISCA) in the University of Adelaide to investigate and provide advice in reference to 23 small communities that are classified within the same category as larger, better serviced, rural communities. GISCA, the spatial experts in this field. completed the review in early 2011. The review identified that overall the ASGC-RA classification system is working well.

Whilst there is the potential in some rural areas containing large, well serviced centres, to create a disincentive for doctors going to smaller towns outside of these centres, the new classification system has only been in operation for just over twelve months. Boundary issues are not uncommon with that of any other geographical classification systems.

[6] ASGC-RA provides five levels of geographical classification; 1 (Major Cities), 2 (Inner Regional), 3 (Outer Regional) 4 (Remote), 5 (Very Remote).

There is a commitment to ensuring the integrity of the ASGC-RA by not undermining the system through making arbitrary changes for specific locations. Further information about the development and benefits of ASGC-RA is at **Attachment B**.

The Department is closely monitoring data to determine the effectiveness of the new programs and the ASGC-RA system. Data currently indicates that performance against key indicators has been positive thus far.

Data[7] for 2010-11 indicates that:

- Full time Workload Equivalent (FWE) GPs increased from 19,729 in 2009-10 to 20,267 in 2010-11– an increase of 2.7%.
- FWE GPs in regional, rural and remote locations (ASGC-RA 2-5) increased from 5,481 in 2009-10 to 5,723 in 2010-11 – an increase of 4.4%.
- FWE GP Registrars in ASGC-RA 2-5 increased from 602 in 2009-10 to 636 in 2010-11 – an increase of 5.6%.
- FWE OTDs ASGC-RA 2-5 increased from 2,534 in 2009-10 to 2,756 in 2010-11– an increase of 8.8%.

Measures under the RHWS have been in operation for at least one year and have delivered pleasing results. For example:

The **General Practice Rural Incentives Program (GPRIP)** provides incentives to encourage medical practitioners to move to and / or remain in a regional, rural or remote area. In 2010/11:

- More than 10,000 practitioners were assessed as eligible for incentives for the period which is almost 8,000 more than those deemed eligible under the previous program and classification system.

The **Rural GP Locum Program** helps to maintain and improve access to quality medical care in rural communities. In 2010/11:

- 265 targeted GP locum placements delivered 1,866 locum service days in regional, rural and remote communities.

Under the RHWS, the **HECS Reimbursement Scheme** has introduced 'scaling' to fast-track the repayment of medical school study for doctors practicing in outer regional, remote or very remote areas. In 2010/11:

- 523 participants received reimbursement incentives.

The **Scaling incentive for OTDs** enables a reduction of the ten year moratorium for participants practising in a regional rural or remote location. In 2010/11:

- At least 2,147 OTDs have shortened the length of time during which they are restricted to working in a district of workforce shortage.

[7] Numbers are based on Medicare billing statistics.

In order to address some of the preconceived notions regarding rural practice, the Department has conducted a range of communication activities under the RHWS. These activities are aimed at demystifying rural practice and promoting the benefits of regional, rural and remote opportunities. This includes the Rural Health Champions Project, a select group of medical professionals who speak, write and blog about their experiences in rural practice.

In 2011, the Department commenced the 'Go Rural' project, where Rural Workforce Agencies in each state and the Northern Territory conduct a variety of events to promote rural practice. Events in Tasmania and New South Wales have successfully taken place and future events will occur in 2012. In addition, the RHWS conference kits and DVDs are utilised at conferences and events throughout Australia to promote rural practice and remove negative preconceptions.

More detail about programs under the RHWS is at **Attachment C**.

Current trends in the distribution of the health workforce by ASGC-RA

Full-time Work Equivalent (FWE*) GPs by ASGC-RA

	RA1	RA2	RA3	RA4	RA5	Total	RA2-5	% in RA2-5
2009-10	14,248	3,667	1,525	208	81	**19,729**	5,481	27.7%
2010-11	14,544	3,822	1,587	216	98	**20,267**	5,723	28.2%
% change on 2009-10	↑2.1%	↑4.2%	↑4.1%	↑3.8%	↑21.0%	↑**2.7%**	↑4.4%	

Full-time Work Equivalent (FWE*) GP Registrars by ASGC-RA

	RA1	RA2	RA3	RA4	RA5	Total	RA2-5	% in RA2-5
2010-11	490	439	167	23	7	**1,126**	636	56.5%
% change on 2009-10	↑12.1 %	↑7.1%	↑7.1%	↓17.9%	↓12.5 %	↑**8.3%**	↑5.6%	

Full-time Work Equivalent (FWE*) GPs with overseas place of basic qualification by ASGC-RA

	RA1	RA2	RA3	RA4	RA5	Total	RA2-5	% in RA2-5
2010-11	5,814	1,766	843	105	42	**8,570**	2,756	32.2%
% change on 2009-10	↑5.5 %	↑9.4%	↑7.7%	↑0%	↑31.3%	↑**6.5 %**	↑8.8%	

**Numbers are based on Medicare billing statistics. Given the high proportion of casual and part-time practitioners accessing Medicare, 'head count' of GPs generally overstates the workforce supply in Australia. Full-time Workload Equivalent (FWE) is a standardised measure used to estimate the workforce activity of GPs and adjusts for the partial contribution of casual and part-time doctors.*

Other Targeted Rural Programs

It is recognised that people living in rural areas may not be able to obtain an adequate level of access to health care in comparison to people residing in metropolitan areas. As such, the Government has implemented a wide range of programs designed to assist in the supply of medical services in regional, rural and remote areas, now and into the future. These include programs specifically aimed at improving infrastructure, increasing the supply and available services in rural areas and those that are focused on education and training.

The Commonwealth also funds a range of stakeholders to deliver a variety of services to regional, rural and remote communities. Detail of key stakeholders is at page 17 of this submission.

Examples of some recent achievements by such programs include:

- The Medical Specialist Outreach Assistance Program (MSOAP) delivered
    - 1,328 services in 2010/11; and
    - 541 services through the MSOAP Indigenous Chronic Disease program.
- The Visiting Optometrist Scheme (VOS) provided:
    - 1,800 outreach optometric services through Core VOS; and
    - 290 outreach services through the VOS Indigenous expansion
- In 2010/11 40,981 patients attended Royal Flying Doctors Service clinics
- There are currently 72 active grants under the National Rural and Remote Infrastructure Program (NRRHIP).
- 16,715 patients were assisted at 159 operational locations under the Rural Women's GP service in 2010/11.
- As of 25 November 2011, the Remote Area Health Corps (RAHC) had placed a total of 1,206 health professionals into short-term placements in the Northern Territory since October 2008.

A summary of the rural workforce programs can be found at **Attachment C.**

Education and training programs

Students play an important role in the future supply of health professionals in rural areas.

Medical schools and medical student numbers have increased significantly from 2006. Medical student numbers have risen from a total of 10,849 (8,768 domestic) in 2006 to 15,397 (12,946 domestic) in 2010. In addition to the additional numbers, students are also being provided the opportunity to undertake some of their study in a rural or remote location. This may, in turn encourage students to consider a career in rural practice following completion of their study.

When medical graduate numbers start to plateau from 2014 (onwards) at around 3,800), Australia will have more than doubled graduates over a decade and almost tripled graduate numbers since 2001.

The development of the Rural Clinical Schools (RCS) Program in 2000-01 enabled the construction and furnishing of teaching and learning facilities and student accommodation in dozens of rural and regional locations across Australia.

The Rural Clinical Training and Support (RCTS) Project, an amalgamation of the Rural Clinical School and Rural Undergraduate Support and Coordination programs was introduced in July 2011 to increase the rural medical workforce by enlisting Australian medical schools to deliver rural medical training, to recruit rural medical students, promote and encourage rural medical careers and increase opportunities for Aboriginal and Torres Strait Islander students.

The project also seeks to have a more immediate impact on the rural medical workforce by encouraging health professionals to take up rural academic positions, often through joint funding arrangements with local area health services.

Under the RCTS, 25% of Australian medical students must undertake a minimum one year placement in an ASGC-RA 2-5 location; 25% of Commonwealth Supported medical students must be from a rural background and all Commonwealth Supported medical students must undertake at least four weeks of structured rural placement.

The general practice training programs, the Australian General Practice Training Program (AGPTP) and the Prevocational General Practice Placements Program (PGPPP) allocate a minimum requirement of 50% of placements in ASGC-RA 2-5 locations with the aim of encouraging these trainee GPs to take up rural positions after obtaining Fellowship. Recent improvements in the program will result in the following increase:

- AGPT registrars will increase from 675 (in 2009) to 1,200 from 2014 onwards; and
- Junior doctors placed on the PGPPPP have increased from 380 in 2010 to 975 placements from 2012 onwards.

The Remote Vocational Training Scheme (RVTS) supports 22 doctors each year practising in some of Australia's remotest and / or isolated locations. The Scheme delivers structured distance education and supervision to doctors while they continue to provide general practice medical services to their communities.

Health Reform Initiatives and Strategic Policy Development for the future rural workforce

Under the National Health Reform Agreement (NHRA) the introduction of Activity Based Funding (ABF) and a national efficient price for hospital services will help to drive efficiency and reduce waste. However, the NHRA recognises that small rural hospitals may not be viable under ABF, and may be better covered under block funding arrangements.

The NHRA also provides for the Commonwealth contribution to teaching and training to be provided as block funding.

In 2012-13, the amount of Commonwealth funding for hospital services to patients in public hospitals better funded through block grants will be agreed between the Commonwealth Health Minister and each State Health Minister to ensure that, where it is possible to do so, Commonwealth funding is provided on an ABF basis. Discussions with states and territories are currently underway. It is expected that most small hospitals in rural areas will be funded on a block funding basis.

More information is available at www.yourhealth.gov.au

Local Hospital Networks

Responsibility for public hospital management across Australia is being devolved to Local Hospital Networks (LHNs), giving local communities and clinicians a greater say in how their hospitals are run. LHNs are being formed as single or small groups of public hospitals with a geographic or functional connection in each state and territory. LHNs will be large enough to operate efficiently and to provide a reasonable range of hospital services, and small enough to enable the LHNs to be effectively managed to deliver high-quality services.

LHNs are being established in line with nationally agreed characteristics, and in close consultation with the Commonwealth Government. In regional Australia, a flexible approach will be adopted to determine the regional, rural and remote LHN structure that best meets the needs of these communities and best takes into account the challenges of managing multiple small hospitals.

Each LHN will have a professional Governing Council and Chief Executive Officer, responsible for delivering services, meeting performance standards and improving local patient outcomes. They will maintain effective communication with relevant local stakeholders, including clinicians and the community. The overall makeup of LHN Governing Councils will be determined taking into account the need to ensure local community knowledge and understanding.

National Health Reform and the introduction of Medical Locals

Through National Health Reform the Australian Government is working with all state and territory governments to improve access to care, drive improved efficiency, increase public information to enable comparison of health service performance and ensure more transparent funding of public hospitals based on services delivered and the efficient cost of delivering those services.

Through the National Health Reform Agreement, signed by all states and territories and the Commonwealth in August 2011, it has been agreed that the Commonwealth Government will:

- Take lead responsibility for the system management, funding and policy development of GP and primary health care;
- Establish Medicare Locals to promote coordinated GP and primary health care service delivery; and
- Promote equitable and timely access to GP and primary health care services.

The Australian Government has announced the implementation of Medicare Locals to improve the coordination and integration of primary health care in local communities, develop strategies with local service providers to address service gaps, and make it easier for patients to navigate their local health care system.

Medicare Locals will work with general practitioners, primary health care providers, Local Hospital Networks, Aboriginal and Torres Strait Islander health service providers, aged care providers and communities to ensure that patients receive the right care in the right place at the right time.

Given the local focus of Medicare Locals, Medicare Locals in rural and remote areas are likely to develop solutions and promote activities that are particular to the needs of rural communities.

In devising appropriate governance arrangements for Medicare Locals, Local Hospital Networks and Lead Clinician Groups in rural areas, consideration will need to be given to making the best use of available clinicians, health and aged care service managers, business managers and community advocates.

More information is available at www.yourhealth.gov.au

National Strategic Framework for Rural and Remote Health

The Commonwealth, states and the Northern Territory governments worked collaboratively to develop a new National Strategic Framework for Rural and Remote Health, which identifies practical strategies to address key priorities of access, sustainable service delivery, health workforce, service planning and policy development, and governance, transparency and accountability.

The National Strategic Framework for Rural and Remote Health (the Framework) has been a collaborative priority project of the Australian Health Ministers Advisory Council Rural Health Standing Committee (RHSC) and was endorsed by Health Ministers on 11 November 2011.

The Framework is an overarching policy statement that identifies nationally agreed rural health priorities and directions to guide policy development and planning at the national, state and local levels over the next five years. The Framework will be publicly available in 2012.

The Framework contains strategic directions on providing rural and remote Australia with an appropriate, skilled and well supported workforce. The objectives aim to build a sustainable workforce through improving recruitment, retention, training and professional development.

More information is available at
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/nhra-brief-qa-abf

Rural and Regional Health Australia (RRHA)

RRHA was established within the Department from 1 July 2011 to provide advice to the public about needs, policies and service delivery in health and aged care in rural and regional Australia.

RRHA provides a central entry point for information about Commonwealth health and ageing programs for people living in rural, regional and remote Australia.

There are three methods of contact for rural, regional and remote health consumers and providers:

- www.ruralhealthaustralia.gov.au;
- our call centre 1800 899 538 (toll free); and
- our email query service infoRRHA@ruralhealthaustralia.gov.au

The website and the call centre have information on around 100 programs from across the Department that have a rural, regional and remote focus.

A list of targeted rural health programs on the RRHA web page is at **Attachment D.**

Health Workforce Australia

Health Workforce Australia (HWA) has been established as part of the 2008 COAG reform initiatives. HWA plays a key role in providing national workforce planning information and advice, as well as funding national workforce innovation and reform initiatives. A range of work being undertaken by HWA will help inform and support better rural and remote health workforce supply and enable improved understanding of the dynamics and levers for impacting on the distribution of Australia's health workforce.

HWA's work plan is published on the HWA website at www.hwa.gov.au with regular updates on progress of implementation of programs. HWA has four key work groups which each provide some contribution towards addressing issues of workforce supply in rural Australia:

- Information, Analysis and Planning
- Workforce Innovation and Reform
- Clinical Training Reform
- International Health Professionals

The Information, Analysis and Planning key program of relevance is the National Training Plan for Doctors, Nurses and Midwives. This plan will provide national workforce modelling of aggregate supply and demand for doctors, nurses and midwives and is currently being finalised. The purpose of the plan is to quantify the current health workforce and examine the impacts of possible future trends on key workforce characteristics. The plan includes consideration of distributional issues for the health workforce. This Plan and the further work being undertaken on additional professionals in 2012 will help inform the understanding of workforce supply issues across Australia and the impact of different policy outcomes in regard to workforce supply and demand.

Under the Workforce Innovation and Reform program HWA has developed a National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 which has been endorsed by the Australian Health Ministers' Conference. This Framework has been designed to provide an overarching, national platform that will guide future health workforce policy and planning in Australia. As part of the implementation of that Framework, HWA will fund the implementation of innovative workforce models that focus on extended scopes of practice for health professionals, development of assistant workforce models and establishment of new and emerging workforce models. Another key piece of work currently underway is the development of a National Rural and Remote Health Workforce Strategy. HWA has been extensively consulting across rural and regional Australia to inform the development of this strategy, which will support the National Strategic Framework for Rural and Remote Health which was approved by Health Ministers on 11 Nov 2011.

This strategy and accompanying implementation plan will seek to address workforce issues in rural and remote areas. HWA will fund a national implementation program to support national adoption of innovative rural workforce initiatives. Through its Innovation and Reform work program HWA is also investing in the development of Rural Medical Generalist Training Pathways and Rural Allied Health Generalists. HWA will draw on rural allied health generalist models previously trialed in New Zealand, the Northern Territory and South Australia to support rural allied health practitioners to extend their scope of practice to include other speciality areas within a collaborative inter professional team environment.

Through the Clinical Training and Reform investments HWA is:

- Supporting growth in clinical training places and as part of that program there is a focus on improving access to clinical training for rural students and increased training opportunities in rural settings
- Expanding training capacity by investing in the use of simulated learning technologies for use, where appropriate, within health professional curriculum
- Improving the management and coordination of clinical training placements across training providers, the public, private, non-government and education

sector through the establishment of Integrated Regional Clinical Training Networks
- Supporting and recognising the role of clinical supervisors through the delivery of a Clinical Supervision Support Program

HWA through its International Health Professionals program will also be supporting increased supply and retention of nursing and allied health professionals into rural Australia through the funding of a Rural Health Professionals Program. Funding under this program will target nursing and allied health professionals to work in rural primary health care settings. This program will directly contribute to improved supply of the health workforce in rural Australia and overtime will provide valuable information on the evidence base for retention in rural areas.

HWA has a broad work program and rural workforce issues are a key focus. HWA's work plan will provide a contribution towards addressing rural health workforce supply issues across Australia and over time will be able to provide authoritative planning and knowledge base to inform policy decision making in this space.

Increasing capacity in access to health services

Commonwealth funding is provided to a range of rural stakeholders with the aim of increasing access to health services in regional, rural and remote Australia.

Rural Health Workforce Australia

Rural Health Workforce Australia (RHWA), and Rural Workforce Agencies (RWAs) play a vital role in supporting and delivering rural health programs for and with the Commonwealth.

RWAs, located in each state and the Northern Territory are funded by the Commonwealth to provide a range of activities and support to improve the recruitment and retention of GPs to rural and remote areas (ASGC-RA 2-5). This includes helping communities to recruit GPs, finding appropriate placements for doctors who want to relocate to rural Australia, assisting with the costs of relocation, supporting families with fitting into a new community and helping doctors access the necessary infrastructure, support and training.

Core business activities for the RWAs are specifically targeted at recruiting and retaining GPs in regional, rural and remote Australia. This includes promoting rural and remote general practice to Australian and international markets, administration of several rural workforce programs, ensuring that international and Australian medical graduates receive appropriate job orientation, training and education support and a special focus across all of these activities on Aboriginal and Torres Strait Islander health care services.

Funding is provided to RHWA, the national peak body, to provide support for RWAs. This includes national advocacy and representation, effective coordination and administration, and management of national data relating to rural workforce activities. RHWA also contributes to Australian Government rural and remote health program and policy development.

More information is available at http://www.rhwa.org.au/site/index.cfm

National Rural and Remote Health Stakeholder Support Scheme

Following the review of Commonwealth funded rural health programs, the Government agreed to establish a *National Rural and Remote Health Stakeholder Support Scheme* (NRRHSSS), effective from 1 July 2010.

This initiative provides a consistent approach to the funding provided to six peak rural and remote health stakeholder organisations to assist in supporting their core secretariat functions and to enable their contribution to develop better policy and programs to address rural and remote health issues.

The organisations funded through the NRRHSSS are:

- National Rural Health Alliance;
- Services for Australian Rural and Remote Allied Health;
- Rural Doctors Association of Australia;
- Health Consumers of Rural and Remote Australia;
- Council of Remote Area Nurses of Australia; and
- National Rural Health Students Network.

Funding

The NRRHSSS has been allocated $3,913,242 (GST exc) in 2011-12.

Organisational Breakdown

- **National Rural Health Alliance (NRHA)**
  Under the current funding agreement, the NRHA is funded to operate a Secretariat to facilitate a range of information management and coordination functions to resource and inform governments, key stakeholders and Australians living in rural areas, on rural health issues.

- **Rural Doctors Association of Australia (RDAA)**
  Under the current funding agreement, the RDAA undertakes a range of activities to support medical practitioners working in rural and remote communities, with a particular focus on:
  - ensuring that the interests and perspectives of medical practitioners, either practising or intending to practise in rural and remote communities, are represented;
  - communicating government policies to its members; and
  - presenting to the Australian Government, analysis and research on existing policies and input to the development of future policies.

- **Health Consumers of Rural and Remote Australia (HCRRA)**
  Under the current funding agreement, HCRRA is funded to provide:
  - informed feedback to the Australian Government, from both established networks and new networks, which may develop in relation to particular community issues;
  - a network for the dissemination of information to rural and remote consumers;
  - access to a committee able to participate in informed debate about the issues in rural and remote Australia; and
  - ensure the particular needs of people from rural, remote and isolated areas are considered in planning, implementing and evaluating health services.

- **Services for Rural and Remote Allied Health (SARRAH)**
  Under the current funding agreement, SARRAH is funded to operate a national secretariat to support and provide assistance to rural and remote allied health professionals and provide advice to the Australian Government on issues affecting rural and remote allied health professionals to support decision-making.

- **Council of Remote Area Nurses Australia (CRANA)**
  Under the funding agreement, the Australian Government is funding CRANA's corporate services, the First Line Emergency Care Program and the Health Research / Education Officer. This funding allows CRANA to support the remote area health workforce through training and contribute to the development and delivery of safe, high quality primary care to remote Australia.

- **National Rural Health Students Network (NRHSN)**
  Under the current funding agreement, the NRHSN is funded to assist in increasing the number of health professionals choosing to practice in rural and remote areas of Australia and represent university Rural Health Clubs across Australia.

Summary

The Department will continue to monitor and evaluate current policy levers designed to achieve an optimal workforce distribution. While improvement is evident and reflected in the current data, it is recognised that further work is necessary to meet the current and future needs of Australians living regional, rural and remote areas.