Catholic Health Australia

Senate Community Affairs Committee Inquiry

The factors affecting the supply of health services and medical professionals in rural areas

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Factors affecting the supply of health services and medical professionals in rural areas

Thank you for the opportunity to provide a submission to this important inquiry. CHA comments are limited to the first term of reference (a) of this inquiry, an area where CHA services are able to provide informed comment. CHA's view is that there are a number of factors limiting the supply of health services and medical, nursing, and allied health professionals in rural areas.

It is well known that Australians in rural and regional areas have poorer health status and face particular barriers in gaining access to the same level of health and aged care resources as other Australians. Providers of private health and aged care services in rural and regional areas face specific challenges and costs over and above those faced by providers of similar services in metropolitan areas. Facilities need to be able to provide a wide range of services (and bear the costs of providing those services). Providers in rural centres also face additional costs in relation to training, freight charges, communication and the like, yet their smaller population bases mean that the volume of different types of services demanded is highly variable leading to uncertain revenue flows. The ongoing viability of many rural and regional facilities remains tenuous.

In relation to factors limiting **supply of health services** CHA offer the following observations in relation to rural and regional acute hospitals:

- The viability of regional hospitals is dependent on an adequate workforce and an appropriate funding structure. At present, many regional hospital facilities struggle with shortages and shortcomings in both.

- Grants, such as the National Rural and Remote Health Infrastructure Program, have funded upgrades and expansions to operating theatres, hospital buildings and purchase of necessary equipment. These grants, aimed at enhancing the viability of rural and regional hospitals through funding service planning and capital equipment purchases have been of great benefit to many rural communities and should continue to be supported by Government. However, in terms of long term viability, lump sum capital outlays do not address the problem of a fundamentally flawed funding structure combined with the generally higher operating costs of rural and regional facilities – particularly in relation to freight costs, lack of economies of scale and large and variable casemix.

- The success of the National Rural and Remote Health Infrastructure Program could be replicated by supporting operational programs via similar grants in areas of identified need, as a means of utilising the not-for-profit sector capacity to respond to areas of need.

- If regional private hospitals become unviable, consumers will have nowhere to access use of their private health insurance, and in time medical services generally will diminish in the regional communities. This in turn will bring greater pressure to bear on the public hospital system as those who would have received their health care

through private health insurance turn to the public sector.

- Rural and regional facilities provide a significant proportion of acute health services provided to elderly medical and palliative care patients in rural and regional areas. This area of service need is growing.

- The current aged care place planning and allocation processes need to be made more flexible to allow for more localised responses to immediate need. Due to the often low asset values of houses in many rural and remote areas, the Government's capital funding program needs to be adequate to meet the capital needs of residential aged care services. CHA supports proposals outlined by the Productivity Commission in its 2011 report *Caring for Older Australians* as a method to achieve this outcome.

There are a number of factors **limiting supply of a health workforce** to rural areas.

- For a long period of time there has been significant concern regarding the sustainability of the rural medical workforce. In the past 15 years less than 5% of graduates from Qld and NSW universities have embarked upon rural practice; there is no sign that this percentage is increasing. This has resulted in many areas of rural and remote Australia having little, if any, access to basic health services. To even maintain current rural workforce numbers, the proportion of graduates choosing rural practice should be around 30%.

- There are immediate shortages in specialist medical professionals. Across the CHA network there are reported workforce shortages in the area of Obstetrics and Gynaecology, Generalists, Psychiatrists, Anaesthetists and Gerontologists. There needs to be a critical mass of these specialists present in rural and regional towns in order to ensure viability of hospital services, and to cover periods of leave. The introduction of pathways for rural generalist practice in NSW and Queensland is welcomed.

- More doctors in rural areas are not necessarily the solution to long term workforce issues. Professions such as nurses and paramedics can provide coverage for specific geographic areas, particularly in the area of trauma management. Increased scope of practice for theses professions could provide the basis for the development of networked rural services where supervision is provided by GPs in larger centres.

- Some of these specific roles could be developed for the rural setting –such as:
    - Rural Nurse practitioners
    - Eligible midwives
    - Physician Assistants
    - Indigenous Health workers
    - Paramedics

  These professional could provide cover for GPs, run clinics, act as sole practitioners and also encourage the use of multi skilled professionals (eg nurse provided podiatry services, occupational therapists, physiotherapists) to meet local workforce

shortage, utilising an approach which is competency based.

Nursing workforce

The nursing workforce warrants particular attention in this Inquiry. It is well known that the nursing workforce is an ageing one in rural areas, and is one that will rapidly disappear unless new strategies are put in place to develop a self-sufficient and sustainable nursing workforce.

There is a lack of support provided to undergraduate nursing placements in rural areas, and there is limited support to encourage graduate nurses to rural areas. The distribution of nurses, it can be argued, is relatively even when looked at across the nation, however this masks the severe shortages that are experienced in some rural areas and in some specialty areas.

The medical profession have received a number of incentives to encourage careers in rural areas. For example, there has been a greater rural focus at the medical school and university level. Since 1997 all medical students have been required to undertake 4–6 weeks' rural experience. The University Departments of Rural Health program was established to provide opportunities to undertake clinical attachments and skills development in a rural environment.

In 2001 came the establishment of funding for a national network of 14 rural clinical schools to enable students to undertake medical training in rural environments. The rural clinical schools program stipulates the "25:50" rule whereby 25% of federally supported medical students undertake 50% (minimum 1 year) of their clinical training in rural areas.[1]

The success of the adoption of rural medical clinical schools is becoming apparent. According to the Medical Journal of Australia:

"Evidence is mounting of the positive impact of UDRH and rural clinical schools on the health workforce. For example, academic performance among students studying in rural and urban settings is comparable, and increased interest in rural health careers as a consequence of the rural clinical schools program and UDRH rural health modules are reported. Likewise, increasing numbers of graduates are choosing non-metropolitan teaching hospitals for their intern year."[2]

CHA proposals to the Inquiry

CHA recommends that the Inquiry adopt as its own recommendations actions that include the following:

1) Funding to ensure supply of health services

- Increased funding programs for private rural and regional hospitals which takes into account the higher operating costs.
- Increased flexibility in the allocation of aged care places in rural and regional areas, with

[1] Coping with increasing numbers of medical students in rural clinical schools: options and opportunities
Diann S Eley, Louise Young, David Wilkinson, Alan B Chater and Peter G Baker: MJA 2008; 188 (11): 669-671: http://www.mja.com.au/public/issues/188_11_020608/ele10103_fm.html#0_pgfId-1091844, accessed 9/12/11

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regard to the recommendations of the Productivity Commission's 2011 report, and increased flexibility for consumers in their choice of paying for residential aged care accommodation.

2) Workforce strategies to address sustainability

- A national rural placement scheme for students of health science - replicating that which is currently in place for medical students.
- A HECS reimbursement scheme for health science graduates who practise in rural and remote areas, as a means of increasing numbers willing and able to work in the bush.
- As a means of producing ongoing medical services to rural Australia, the compulsory rotation of medical interns (PGY1 and PGY2), as well as specialists in training, to rural areas in Australia to be considered.
- Evaluation of the effectiveness of the rural bonded scholarship scheme.
- Piloting of new workforce roles to be developed specifically for rural and regional settings.