Health Workforce
Queensland

GPO Box 2523

Brisbane Qld. 4001

Submission to Senate Community Affairs Committee on factors affecting the supply of health services and medical professionals in rural areas

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Introduction

Health Workforce Queensland is a rural workforce agency, established in 1998 and funded by the Australian Government Department of Health and Ageing. Our purpose is:

- To facilitate the recruitment, retention and quality of general medical practitioners and primary health care teams in rural and remote Queensland communities.

Our primary objectives are:

- To increase the number of GP services and increase access to GP services in rural and remote Queensland
- Retain GPs in rural and remote Queensland
- Support up skilling of GPs and other supporting health professionals in rural and remote Queensland
- Develop sustainable models for general practice in rural and remote Queensland
- Establish benchmark workforce data and research to inform and direct policy.

Health Workforce Queensland has extensive knowledge and experience in the recruitment and retention of general practitioners to rural and remote locations and would like to take this opportunity to provide comments and observations in relation to Senate Committees terms of reference.

Factors limiting the supply of health services and medical, nursing and allied health professional to small regional communities as compared with major regional and metropolitan centres

The factors limiting the supply of medical practitioners and other health professionals in smaller rural and regional communities have been extensively documented over the years and are well summarized by Lousie Bibby in her Balance of Retention diagram in McDonald et al. 2002 'Recruiting and Retaining General Practitioners in Rural Areas. Evidence Based Review: Final Report [1]. Professional factors that negatively impact on recruitment and retention in smaller communities include:

- Heavy workload with excessive after hours and on call requirements.
- Lack of locum relief.
- Professional isolation (including lack of peers, specialist support, geographical distance from peers and professional events).
- Difficulty in accessing Continuing Profession Development activities.
- Low remuneration especially for after hours and on call work.

Family and personal factors include:

- Lack of quality schooling.
- Spouse/partner unhappiness – lack of opportunities for spouses (employment and other areas).
- Isolation from family, friends and cultural opportunities.

Community factors include:

- Lack of facilities – including schools, hospitals and medical technology, housing, social and cultural facilities.
- Loss of privacy and anonymity.
- Conflict with other health professions in the community.

An additional factor that has become increasingly prevalent in mining and resource based communities is the high costs of housing and rental accommodation in many of these areas. These costs make it increasingly difficult to attract new or replacement health professionals.

The effect of the introduction of Medicare Local on the provision of medical services in rural areas

We believe that it is too early to assess the effect of Medicare Locals on the provision of medical services in rural areas as many have not yet commenced. Our major concern would be that the MLOs will not be adequately resourced and funded to develop local solutions based on identified needs.

MLOs are designed to operate on a regional basis to identify needs and provide primary health care solutions within Government policy priorities to match these regional needs. The ability of these newly established organisations to enhance medical services within rural areas is uncertain as the stated objectives for MLOs is broader than medical services so we are concerned that attention will drawn away from medical services to broader primary health care services.

There are opportunities for greater collaboration between MLOs and Rural Workforce Agencies (RWA) to assist in the improvement of medical and primary health care services by leveraging the RWA's expertise in workforce recruitment and retention, workforce development and health service planning.

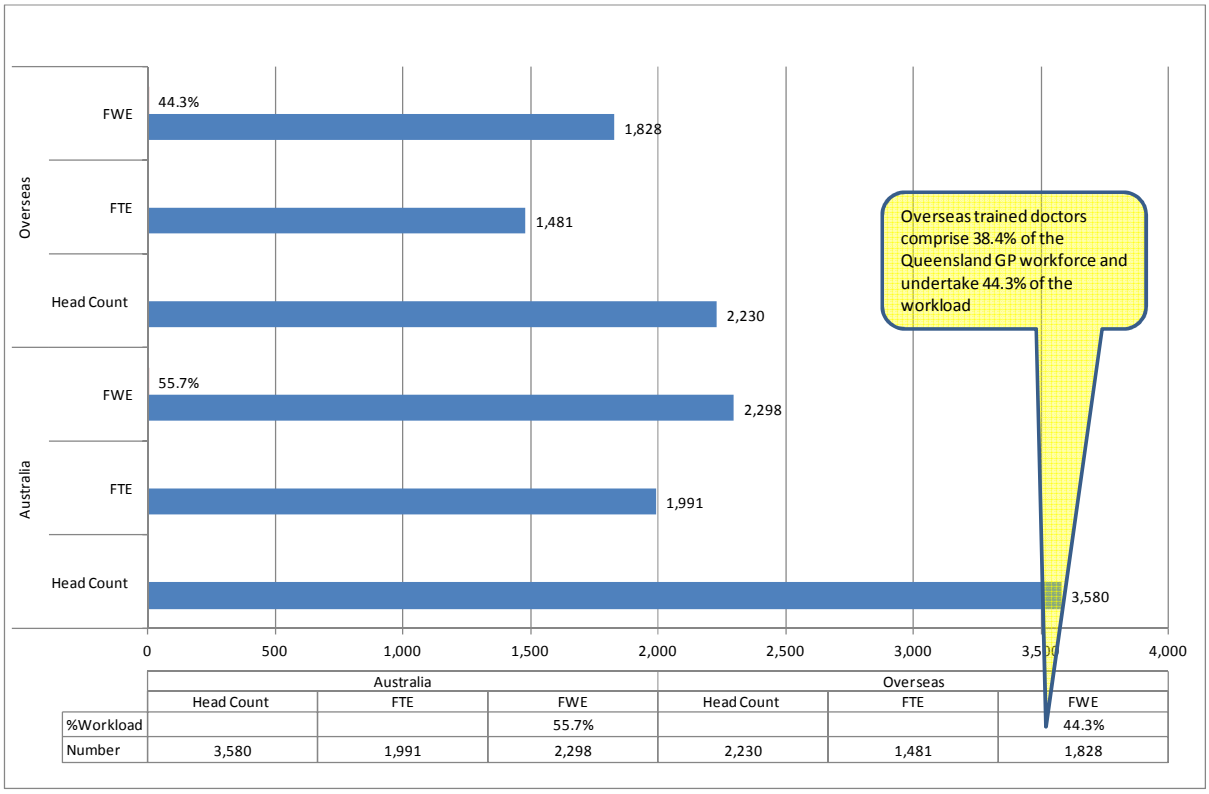
Current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities.

A 2006 review of the Rural Retention Program concluded that RRP as it currently operates contributes to the retention of rural and remote GPs with the program's key impact being on GP morale [2]. It also notes that the RRP is more critical in more remote locations where the financial support provided by the program is critical to the continuation of many practices. The report also suggests that withdrawal of the RRP would have a significant impact on morale among all rural and regional practitioners.

While we tend to agree with these conclusions, the replacement of GPARIA (upon which the retention payments were based) by ASGC-RA has produced anomalies in that smaller communities such a Charters Towers, Malanda, Biloela are classified the same as large provincial cities such as Townsville and Cairns that have populations over 150,000.
This makes it more difficult to recruit and retain doctors in smaller communities as they can receive identical incentives in large cities. Similarly, we have smaller locations such as Dalby, Oakey, Kingaroy having to compete with Toowoomba (population over 100,000) to recruit and retain doctors.

While we understand that the objective of the General Practice Rural Incentive program is to increase the number of rural medical practitioners, GP and Specialists through the provision of incentive grants, we note that overseas trained doctors are not eligible for relocation grants available through the Rural Relocation Incentive Grant (RRIG). As overseas trained doctors are generally required to work in a District of Workforce Shortage, we would suggest that the criteria that excludes them from the RRIG indirectly discriminates against overseas trained doctors compared to their Australian counterparts. Recent GP workforce statistics produced by the Medicare Financing and Analysis Branch (DoHA) [3] indicate that overseas trained doctors comprise 38.4% of Queensland general practice workforce and undertake 44.3% of the workload (see Figure 1).

Figure 1: Workload - Australian trained and Overseas trained (Queensland)



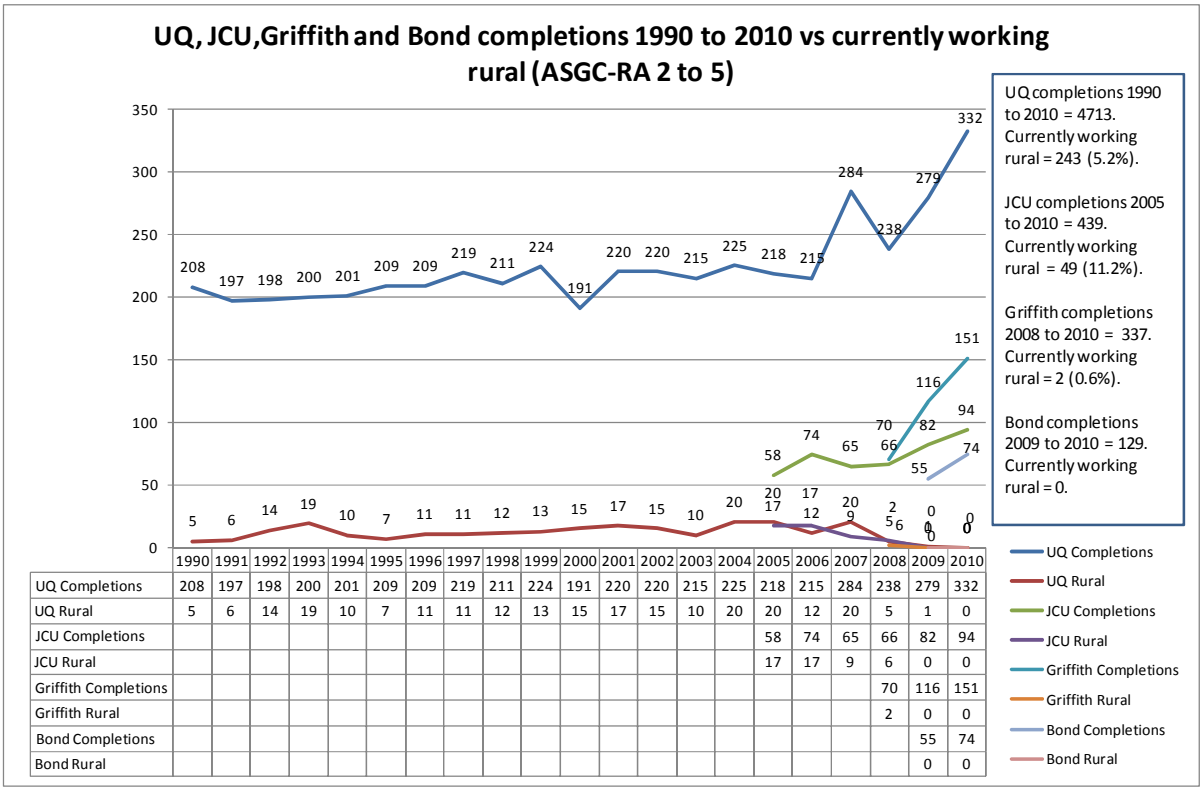
	Australia			Overseas		
	Head Count	FTE	FWE	Head Count	FTE	FWE
%Workload			55.7%			44.3%
Number	3,580	1,991	2,298	2,230	1,481	1,828

In rural and remote areas in Queensland, the percentage of overseas trained doctors is even higher with data maintained by Health Workforce Queensland indicating that as at 30th November 2011, overseas trained doctors comprised 48.4% of the rural and remote general practice workforce [5].

While it is possible that return of service obligations under the Bonded Medical Places (BMP) and Medical Rural Bonded Scholarship (MRBS) schemes will, over time lead to an increase in Australian trained medical graduates working in rural and remote locations, evidence to date is not encouraging. Health Workforce Queensland has been actively tracking the number of Queensland trained doctors who are currently working in rural and remote locations [5]. Data indicates that of the 5,618 graduates from the University of Queensland, James Cook, Griffith and Bond Universities between 1990 and 2010 only 294 (5.2%) are currently working in ASGC 2 to 5 locations. Figure 2 displays the number of Queensland medical graduates by year from 1990 to 2010 and the number currently working in ASGC 2 to 5 locations as at November 2011.

In summary, it would appear that polices based on compulsion such as provider number legislation or return of service obligations are and/or will be more effective in increasing the number of GPs working in rural and remote locations compared with current relocation incentives.

Figure 2: Number of Queensland medical graduates currently working in rural and remote locations as at November 2011 for years 1990 to 2010

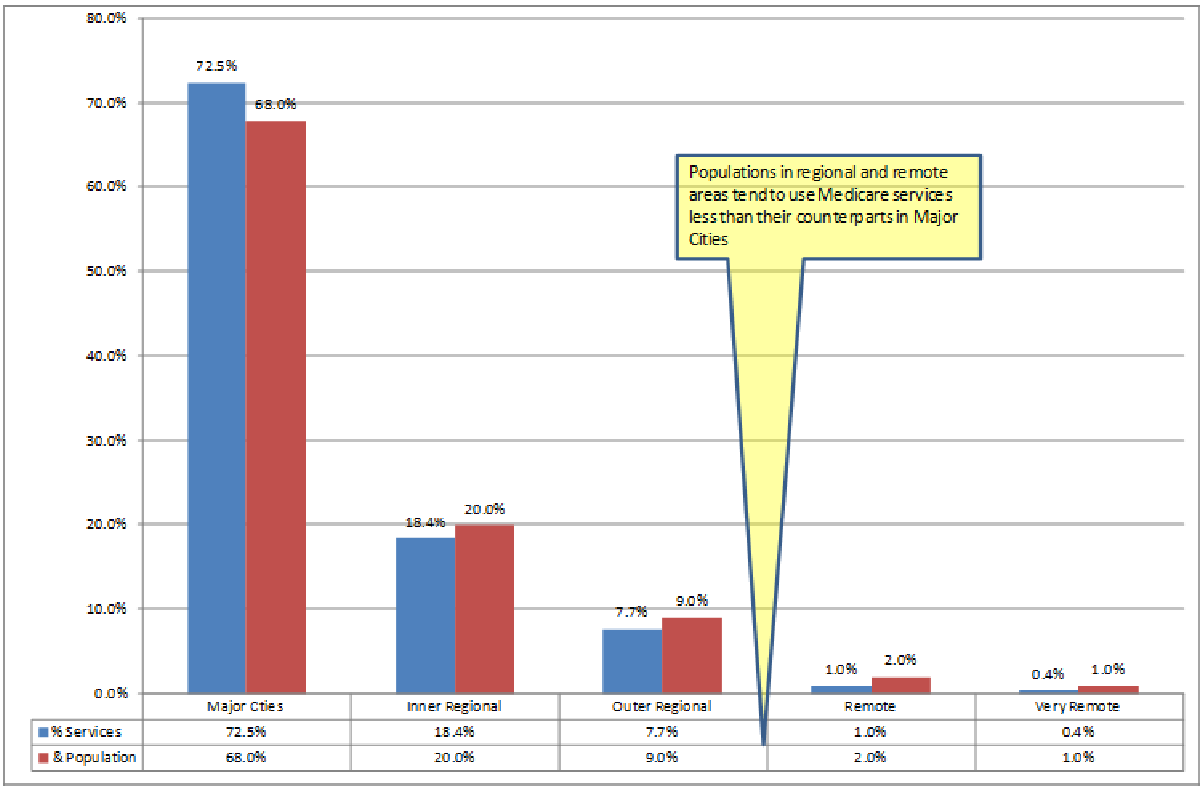


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
UQ Completions	208	197	198	200	201	209	209	219	211	224	191	220	220	215	225	218	215	284	238	279	332
UQ Rural	5	6	14	19	10	7	11	11	12	13	15	17	15	10	20	20	12	20	5	1	0
JCU Completions																58	74	65	66	82	94
JCU Rural																17	17	9	6	0	0
Griffith Completions																			70	116	151
Griffith Rural																			2	0	0
Bond Completions																				55	74
Bond Rural																				0	0

Maldistribution

Maldistribution of the general practice workforce continues to impact on access to medical services in rural, regional and remote communities. General Practice services data as compiled by Medicare Financing and Analysis Branch indicate that populations in rural, regional and remote areas tend to use Medicare services less compared with populations in Major Cities [3, 6].

Figure 3: Percentage of services provided by ASGC-RA and population percentage by ASGC-RA (National) [3, 6]



ASCG-RA classification system

The major problem that Health Workforce Queensland has with ARIA/ASGC is that it gives a large weighting to physical road distance from a capital city and relatively small weighting to population size.

As GISCA itself acknowledges; it is a purely geographic measure of remoteness, which excludes any consideration of socio-economic status, rurality and populations size factors (other than the use of natural breaks in the population distribution of Urban Centres to define the service centre categories)[4].

This means that doctors working in large regional cities receive the same or higher incentives compared to doctors working in small rural locations. Given the higher level of facilities and options available in larger cities, it makes the recruitment and retention of doctors in smaller towns more difficult and challenging.

We believe that the current ASGC-RA classification system penalizes smaller towns and communities and makes it more difficult for these communities to attract and retain health professionals. We do not believe that the ASGC-RA classification system can be made more equitable with minor adjustments and that a new system that takes into account level of services available, rurality and population size is required.

An additional anomaly with ASGC-RA is the way it uses distance from a state capital as one of its major weightings. For example, we have Bendigo (population approx 104,195) and 152

kilometres from Melbourne having the same ASGG-RA 2 rating as Mackay (population approx 118,842) and 968 kilometres from Brisbane. Similarly, we have Swan Hill approximately 338 kilometres from Melbourne having the same ASGC-RA 3 rating as Sarina approximately 932 kilometres from Brisbane.

Other related issues

An additional area of concern is the closure of maternity services in rural and remote communities. Since 1995, over 40 maternity units have been closed in Queensland and centralized in larger provincial and urban cities. These closures have led to additional costs for rural and remote families who have to relocate to access birthing services. It has also led to a steady decline in the number of GPs providing procedural services such as obstetrics, anesthetics and surgery. Figure 4 displays the location of maternity services closed since 1995.

Summary

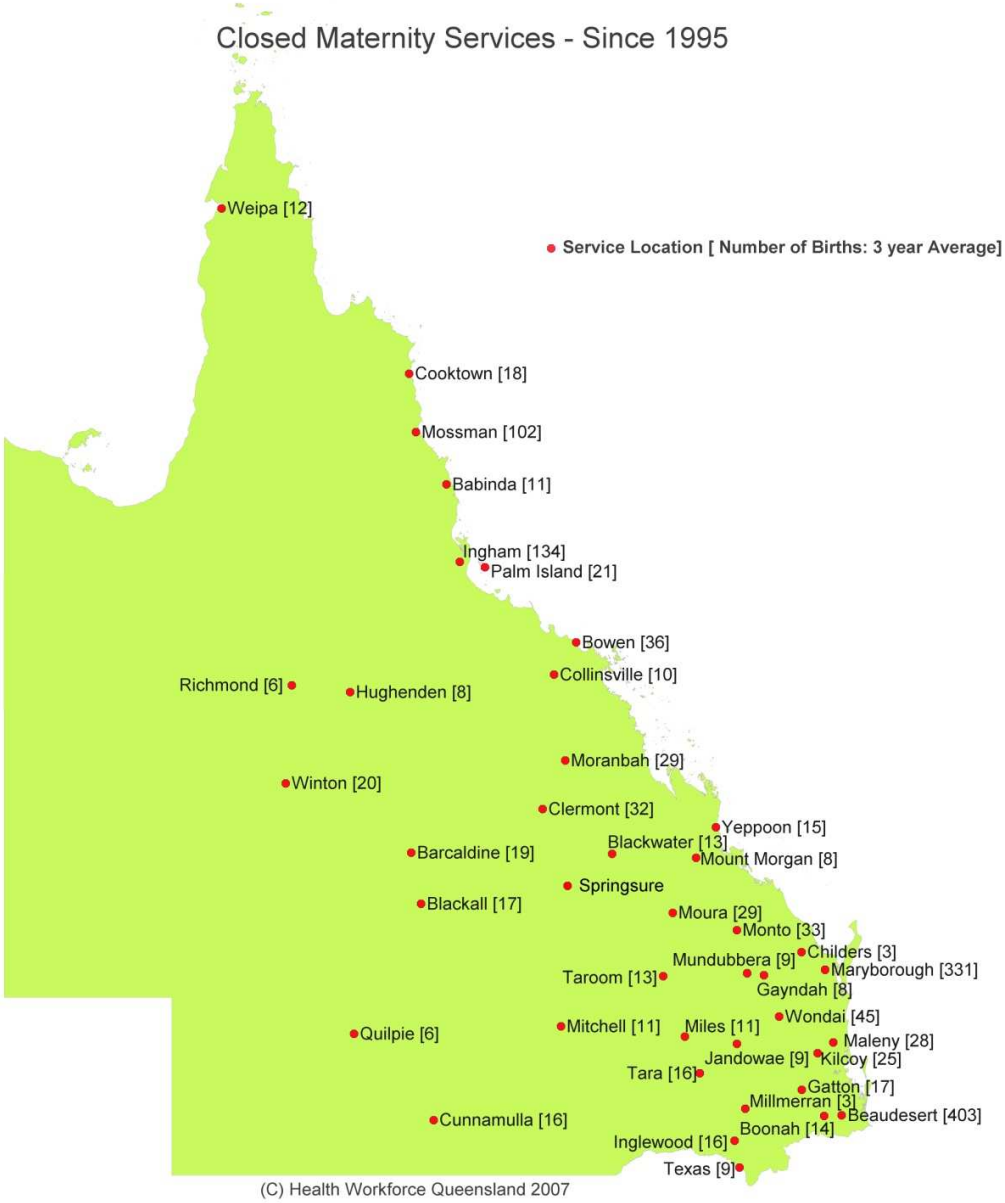
The factors affecting the supply and distribution of health professionals are well known. We do not believe that current relocation incentives will be effective in increasing the supply and distribution and note that many of the current incentives are not available to nursing and allied health professionals.

It would appear that polices based on compulsion such as provider number legislation or return of service obligations are and/or will be more effective in increasing the number of GPs working in rural and remote locations.

We believe that the current ASGC-RA classification system penalizes smaller towns and communities and makes it more difficult for these communities to attract and retain health professionals. The fact that many smaller communities have the same classification as large provincial cities makes it more difficult to recruit and retain doctors as they can receive identical incentives' in large cities. We do not believe that the ASGC-RA classification system can be made more equitable with minor adjustments and that a new system that takes into account level of services available, rurality and population size is required.

The increasing centralization of health services to major provincial cities makes it more difficult and expensive for smaller communities to access basic health services and to attract health professionals.

Figure 4: Closed Maternity Service since 1995



References

1. McDonald J, Bibby L, Carroll S. Recruiting and Retaining General Practitioners in Rural Areas: Improving Outcomes through Evidence-Based Research and Community Capacity-Building - Final Report. Ballarat, Victoria: Centre for Health Research and Practice, University of Ballarat; 2002.

2. Gibson P, Hales J. Review of the Rural Retention Program. Adelaide: Health Outcomes International; 2006.

3. Medicare Financing and Analysis Branch. General Practice Workforce Statistics. AGDOHA; 2011. Available: http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

4. GISCA (u.d.) About ARIA+ (Accessibility/Remoteness Index of Australia). Available http://gisca.adelaide.edu.au/projects/category/about_aria.html

5. Health Workforce Queensland. Medical Practice in rural and remote Queensland: Minimum Data Set (MDS) Report as at 30th November 2011. Brisbane: HWQ; 2011

6. Australian Institute of Health and Welfare. Remoteness classifications. AIHW; 2008

Appendix 1: The Balance of Retention