President: Dr Mike Moynihan

Vice-President: Dr Sue Harrison. Treasurer: Dr Mark Zagorski
Member Reps. Graham Slaney, Nola Maxfield, David Campbell, Shaker Issa,
John Griffiths, Peter Radford
EO Kathy Panozzo
execassist@rdav.com.au A.C.N 096 669 680 A.B.N 83 096 669 680 www.rdav.com.au

Rural Doctors
Caring for the Country

Brief Submission to the Senate Inquiry 6.1.12
Factors affecting supply of health services and medical professionals in rural areas.

Overview

Advanced rural medical services in Victoria continue to retract. About 90 rural maternity and theatre units have closed in the past 25 years. There has been very little replenishment of rural medical workforce. The average age of Victorian rural doctors with procedural ability in anaesthetics and obstetrics is well over 55.

Despite a large and now slightly chaotic array of incentives, the overall balance of Governmental initiatives in the medical sector has conspired to make it progressively more difficult for rural doctors to practice and have created disincentive to select a rural career. The separate responsibilities of State and Commonwealth for Hospitals and General Practice have resulted in unrelated approaches and a lack of commitment on both sides to genuinely effective initiatives. Only in Queensland has a rural generalist pathway been properly instituted and hence fully subscribed.

What is rural? *A distinction is very much required between rural proper, requiring advanced medical services, and non-rural proper, requiring only standard general practice. Both sectors might have problems with workforce supply but have substantially different requirements in the type of general practice required. Consideration of this reality remains largely absent from policy and planning.*

The concept of '*rural*' has been constantly broadened to accommodate politics of the middle ground. Not only did Prime Minister Rudd refer to Fringe Metropolitan as 'rural' but '*Area of Need*' and '*District of workforce shortage*' are now virtually synonymous with 'rural', further metastasising into after hours clinics in some inner metropolitan '*areas of consideration*'. The Rural, Remote and Metropolitan Area (RRMA) classification metamorphosed into the Australian Standard Geographical Classification (ASGC) after some years of uncertainty, meaning that Victoria is now 2/3 'inner regional' and 1/3 'outer regional', with few remote locations. The word '*rural*' now tends to be used substantially as a descriptive and convenience concept.

Basically '*inner regional*' extends Australia-wide in a 100 Km radius around centres large enough to accommodate a tertiary hospital with full rosters in the main specialties. This encourages perception that 100 Km is a safe distance to travel. It is not. A British study showed that every 10 Km travelled by ambulance adds 1% to mortality. http://emj.bmj.com/cgi/content/abstract/24/9/665.*. Basically risk increases significantly beyond ½ hour travel and becomes quite significant at 1 hour. It also becomes very expensive for community and government and adds to the complexity and length of treatment at the retrieval destination. (Adult Retrieval Victoria aspires to give advice whilst the retrieval team is being prepared, to mentor management while it is on route, and if possible not to have to retrieve once there.)

Various parameters are used to construct the ASGC including accessibility and numbers of doctors, but they mostly do not have any great bearing on medical reality. The foremost questions should be: if this patient has to be transported, will it improve prognosis or not, can effective management be instituted here, and if effective can the patient be retained here? If the volume of such work reaches a threshold then it makes economic and social sense to establish and maintain hospitals to provide such care. In the context of already established hospitals in a changing environment, it would be logical to select which of them them should be targeted for maintenance and to decide how should this be achieved. This would need a different set of criteria to the AGSC.

Where there are such hospitals, justified by the volume of complex cases, it is invariably the case that services overall in their vicinity are less comprehensive, with doctors and allied health staff called upon to do correspondingly more to optimise patient care. As the burden of chronic disease steadily increases it becomes less and less feasible to transfer all problems to major hospitals. Far too much is transferred in any case. What is needed is good community care, primary care triage of acute illness by experienced doctors, and effective casualty management.

There are many examples in Victoria of 'inner regional' of hospital towns requiring advanced GP services, and consequently workforce promotion. These include, going through the regions, Heyfield, Sale, Yarram, Wonthaggi, Leongatha, Korumburra, Warragul, Kilmore, Seymour, Yea, Alexandra, Mansfield, Bright, Mt Beauty, Benalla, Yarrawonga, Cobram, Nathalia, Kyabram, Echuca, Bacchus Marsh, Ararat, Stawell, Terang, Timboon, Camperdown, and Colac. Most of them have active theatre, obstetrics and GP proceduralists at this time.

The size of the workforce is not large. In Victoria in 2010 (PHCRIS) there were 4047 Metropolitan GPs (including Fringe metropolitan), and 1574 rural and regional GPs of whom perhaps 630 are in non-regional towns (RWAV estimate) but possibly as few as 400 of whom (figures not available) might nowadays be accredited Visiting Hospital Medical Officers, with a further small number in isolated towns without hospitals.

Rather than rely on obscure and easily manipulated geographical classifications, the States and Commonwealth need to reach agreement on where generalist advanced care is required and how to realise it in close cooperation. The simple metropolitan GP-Specialist algorithm does not work for rural.

What do rural towns need? They need all the standard offerings of General Practice together with a protective umbrella for proper diagnosis and at least initial

management of acute conditions, as well as hospital services appropriate to their size and isolation. That might imply obstetric services, an active operating theatre, XRay and CT facilities, together with resident or visiting surgical services proportional to local need. Rural 'Generalists' need therefore a wide range of skills, and subspecialist capability (especially obstetrics and anaesthetics) on top of competence in chronic and acute medicine. In this day and age GP anaesthetists need to be able to insert intra-arterial and central venous pressure lines, and obstetricians to perform Caesarean section.

This is not the viewpoint of many planners, bureaucrats and members of the medical profession. It is regrettably held by these that rural doctors need no more than mainstream GP skills and that all serious morbidity can be transported. Prof Stephen Leeder (University of Sydney): "Rural Hospitals are as out-dated as the corner-shop". It is envisaged that helicopters should be working round the clock bringing patients in. Such magical thinking takes no account of availability, expense and the effect of weather, so often dictating road transport in Victoria. Neither does it recognise the ability of doctors (who after all in Australia are recruited from the topmost high school graduates), to achieve advanced competence in a wide range of skills.

The scale of morbidity in rural populations is entirely underestimated and increasing rapidly. There is an obesity epidemic. Diabetes, at 4% and heading towards 7.5% in the future, is at the tip of an iceberg of associated conditions of heart, vascular, kidney, brain and eye, together with increasing cancer rates and pneumonias, not to mention growing rates of musculoskeletal, orthopaedic and psychiatric conditions. In rural towns too, drug usage is ubiquitous, causing serious psychiatric morbidity and hepatitis C. Problems of perception are sometimes compounded by planning overestimates of population. Thus while the populations of Swan Hill, Echuca and Bairnsdale are estimated at 45 thousand, they include many that go to other hospitals, so that the population effectively generating current morbidity load is more like 20-25 thousand for each of these towns. What additionally is not recognised by planners is the problem of early undifferentiated disease, within which minor considerably outweighs major, requiring training, experience and ability to manage effectively and avoid unnecessary hospitalisation and transfer.

The scale of morbidity in rural Australia is consistently underestimated and ignored. It is also simply not feasible to transport every sick person 100 Km, to which must be added large numbers of seemingly sick.

Acute illness in rural Victoria. Australia has been extraordinarily lucky with its rural medical workforce. Perhaps it was the idealism of the 60s and 70s, but for whatever reason a large cohort of doctors self-selected themselves for rural, and were prepared undergo training on the job, or go overseas for experience, to put in the long hours, become part of their communities, not go on holidays when maternity cases were due, be on call for prolonged lengths of time, be poorly paid, accept at times a denigrating attitude towards rural, tolerate bruising negotiations over pay, and even pay for the privilege of seeing casualties in their local hospital (this persisted into the mid 90s).

The majority of Victorian rural hospitals still do not have officially designated casualty or emergency departments. State administrations say that it is part of General Practice and hence a Federal responsibility, and insist on rural GPs billing patients

directly until they are admitted. Until very recently Medicare remunerated only one doctor per casualty no matter how many were involved, and not uncommonly the fee was 'appropriated' by the referral destination.)

The substantial role of rural doctors in dealing with rural casualty and acute illness is explored in our 2009 Emergency services position paper posted on www.rdav.com.au.

Administrations have been loath to commit themselves to addressing the problem of rural casualty. In particular there is no commitment to holiday traffic, which is enormous on the East and South coasts and the ski fields. Failure to recognise rural casualty is an impost on the rural populace.

History of the rural doctor shortage. In 1985 virtually every small Victorian town of size had a hospital with obstetrics and an operating theatre. Rural Victoria had some of the best obstetric statistics worldwide (Prof Roger Pepperell in annual VBNA reports). Rural generalists trained themselves, many by going overseas for experience, and had a thirst for a wide range of advanced medical activity allied to enjoyment of fresh air, surf and snow.

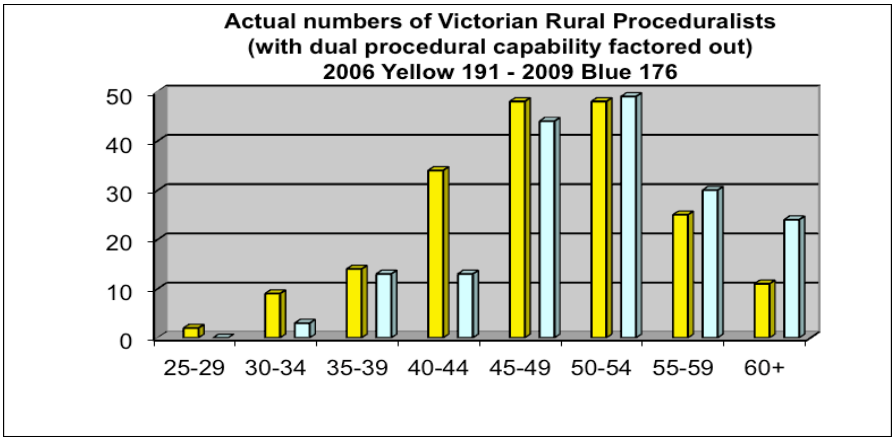
Already however the burgeoning of medical specialties was inducing a profession-wide attitude that medical conditions with serious potential should carte-blanche be sequestered into the specialties and that GPs should relinquish care of these conditions and become 'referralists'. This was to largely wipe out GP obstetrics in regional towns and metropolitan zones. In NSW 1983 it caused the closure of perhaps a majority of rural maternity units on the grounds of 'smallness'. In Victoria luckily the Health Commission, as one of its last acts, systematically studied rural maternity in 1983 and found, counter-intuitively, that the smaller the unit the safer it got, with no limit. Judith Lumley later confirmed this in her studies, which resulted in a State policy of not actively closing small units, which later occurred instead by attrition.

By the 90s it was obvious that the trend to smaller working hours and feminisation of the workforce was going to produce a nationwide shortage of doctors. (Governments ignored this, 1996 insisted there was an oversupply, did not increase medical school output, and held back GP training numbers.) Rural doctors started agitating early on, but with little result. Our studies have shown that from 1990 there was virtually no new recruitment of doctors with procedural capability in obstetrics and anaesthetics to rural, despite the development of regional training programs. The graph below shows that pre-1990 cohorts are progressively phasing out. The bulk of graduating specialist general practitioners from the regional programs have progressed to metropolitan areas after benefitting from the teaching and experience of rural practice.

Although there has been extensive recruitment of doctors trained overseas, few of them have arrived with the general and procedural skills necessary for rural areas. Most seek to move on to cities once they have necessary credentials. Some who stay do acquire such skills, just as Australian rural doctors originally did, but few are ever able to supply the anaesthetic and obstetric skills so necessary for the well-being of rural towns. (Those trained in South Africa are notable exceptions.)

Much greater use of evidence based medicine needs to be made use of in planning rural services. The recent Victorian rural and regional health plan with accompanying dataset is welcome as a sign that Government, at least in this instance

might be thinking of the rational achievement of population health. The newly established Health Workforce Australia is of interest but in view of past mistakes made there does need to be adequate academic input.



Training.

Prof. Max Kamien in the 1980s talked of the "City or the Bush". Rural doctors were not held in high regard at that time and even today the attitude has persisted in teaching hospitals. This is probably more of a cultural attitude, because many teaching specialists have enjoyed the benefit of rural experience. However, medical students are not given a good impression of rural medicine and this tends to be reinforced in the hospital clinical years. The ideal of moving education out of cities was therefore very attractive in terms of getting doctors into rural. Additionally it was hoped that with affirmative rural selection, rural undergraduate medical schools, rural hospital residencies and rurally-based GP training with advanced skills acquisition, allied to various scholarship and inducement schemes, rural doctors might start to appear.

Genesis of rural doctor action. Rural Doctors Associations were formed from 1987 onwards (NSW) and identified the need for formal Australian training. Many rural doctors worked through the RACGP and formed a 'Faculty of Rural Medicine' to develop response to the particular exigencies of rural patient care. Advanced curricula were designed with Federal Rural Health Support Education and Training RHSET funding. A dichotomy however developed between ruralists, who increasingly felt that there should be a rural fellowship, and principally metropolitan-based doctors who not only feared a division in GP ranks but also resisted the idea of more highly trained rural doctors. As rural doctors became more active in the RACGP the case for a rural fellowship was increasingly supported, and under the presidency of Col Owen, a rural doctor, matters came to a head in 1996, when the issue was defeated on the RACGP council by one vote. This resulted in the defection of 2,000 doctors and the creation of a rural college, the Australian College of Rural and Remote Medicine ACRRM, (despite the best efforts of Federal Minister Wooldridge). Within the RACGP the name 'Faculty of Rural Medicine' was abolished and changed to the 'Rural Faculty' and a long lasting commitment made to diploma rather than fellowship training for rural.

GP training. It was also recognised that GP training based within the RACGP was not fully functional and not generating rural doctors despite having a rural

program. The 1997 Ministerial review of GP training resulted in the creation of GPET (now AGPT) in 2000. (http://www.agpt.com.au/GPETtheCompany/AboutGPET/ - not published on the web.) Rural doctors were heavily involved in the creation and operation of regional training consortia and remain so. GP registrars go out to rural practices for periods of 6-12 months but are deliberately limited in the number of patients they are allowed to see, so provide a ½ to 2/3 FTE addition to practices. Rural GPs for their part undertake ongoing training as educators and commit to the close supervision and mentoring of rural GP registrars.

Lack of medical school output has unfortunately meant that regional programs have had to rely on overseas graduates with Australian residence to fill these programs, often commuting from Cities for their training. Very few indeed of these have remained in rural.

With medical school output now risen from 1200 to 2200, and 2900 in the year 2014, it is very important that there be effective settings for training of specifically rural GPs, especially 'Rural Generalists', (see below), taking example from Queensland.

Rural Undergraduate Medical Schools. Preparation for rurally-based training had been occurring since the late 1980s with the creation of rural Special Education Resource Units (SERU) such as the Centre for Rural Health (CRU) in Moe (now Traralgon) under Roger Strasser and the Cunningham Centre in Toowoomba under Denis Lennox. These centres generated prodigious amounts of research and energy. The CRU was transformed into the School for Rural health in 1992. In 1994 a rural medical campus was established by Flinders Medical School in the SA Riverland under Paul Worley and by 1996 it was evident that the students were topping their years. All this did not go unnoticed. Rural doctors had been found to be 'natural teachers' and here was an opportunity to give medical students experience they were increasingly not getting in the teaching hospitals. Under the Howard administration rural clinical schools were established throughout Australia and now, in Victoria form a comprehensive mosaic throughout the State, with mainstream rural practices providing comprehensive education to students, registrars and doctors trained overseas.

All this is imperilled by the decline through ageing and lack of replacement the trained rural medical workforce.

Rural Medicine. The debate meanwhile about 'rural medicine' continued unabated with the antagonists disputing its existence as an entity. This formed the principle reason for the rejection, despite a huge volume of literature emphasising the contrary, by the Australian Medical Council in 2005 of the category, and for the time being denial (http://www.amc.org.au/index.php/ar/rms/policies/reports) of the ACRRM to have its fellowship training recognised. Federal Health Minister Abbott declined to intervene.

However the 2005 Bundaberg crisis had begun to shape events. In Queensland it had a cataclysmic effect on Health services and out of this emerged a realisation, at least in Queensland, that there really had to be Australian standards of training for this extensively rural State. Without waiting for the AMC, a commitment was made to utilise the ACRRM, usefully based in Brisbane, as the agent for that training.

In due course in 2006, Queensland insisted through COAG that rural medicine be recognised, and that the AMC be required to progress the approval of the Fellowship of the ACRRM. Moves were announced by the AMC on 27.7.06 but were to take a regrettably long time until late 2011 for full approval, exercising a brake on progress. In the meantime States moved to approve the FACRRM as a portal for full registration. One side-effect of the COAG approval was almost immediate declaration by the RACGP that the Diploma of Rural Health as an addition to the FRACGP would continue unchanged as the 'Fellowship of Advanced Rural General Practice' FARGP, though without a formal curriculum adaptation or approval process through the AMC as yet.

The Bundaberg crisis has not had much effect outside Queensland, certainly not on Federal Policies. It did in any case involve not a general practitioner but a surgeon, with much greater scope for misadventure. There have been other instances, but as Birrell points out (The Aftermath of Dr Death) these have not affected policy.

The debate about rural medicine as a separate discipline has been resolved. *It has taken 20 years, during which time a generation of rural doctors has been lost. We now need to move into an era in which the manner and scale of its implementation is the issue.*

Rural Generalist training.

There has been some argument about what to call rural doctors who specialise in providing services appropriate to isolation. In Canada they are termed 'Rural Physicians'. In Australia they have been designated Rural Generalists to avoid specialist connotation, and because use of the word Physician is reserved for specialists other than surgeons, as opposed to 'Internist' in North America. The specialist argument has been superseded because of registration, by the newly formed Australian Health Practitioners registration Agency AHPRA, of all GPs with Fellowships as specialists, and also the Queensland decision to create a specialist industrial arrangement for generalists.

In committing Queensland to the training and deployment of Rural Generalists, it was considered that to seduce medical graduates from specialist to rural generalist pathways it is essential 1. To give public recognition of the value of this occupation, something that hadn't been done before. 2. To give clear and defined recognition to the process end-point. 3. To substantially support appropriate training pathways.

The Fellowship of ACRRM is the principal recognised qualification in Queensland. The FARGP is accepted if relevant supervised and referenced experience has been obtained, though it still lacks significant acute medicine content. A specialist pathway and appropriate remuneration scales has been created. A great deal of energy has gone into advertisement in medical schools, and the creation of formal and informal networks to support generalists in training and to combat negative perceptions and inputs. The result has been a program oversubscribed by Australian Graduates, which is very promising indeed. It is to be noted that rural generalists are viewed in Queensland as having potential to operate in a wide spectrum of locations including remote and rural, as well as in larger hospitals as practising subspecialties. They are also working in the Antarctic Survey.

In various States the Generalist ideal is catching on. Both South Australia and NSW seem to be committing themselves. In Victoria the current Liberal administration made an election commitment to rural generalist training and this will commence in 2012 as a rather small pilot program, hopefully to be expanded. It will take 5 years to get them into practice, so more rural services will unfortunately be lost.

The role of the Federal Government is obscure because States hold responsibility for hospitals. Additionally, Federal administrations have had a disengaged attitude to rural medical exigencies and, except for some politically motivated inducements to rural doctors, have not looked beyond the needs for rural GP as part of Medicare general practice. DoHA commissioned the NOVA report in the Queensland program in 2010 (not published on line) which found in favour of Rural Generalists Australia-wide. Perhaps something will come from the growing role of the COAG Council of Health Ministers.

A National standard is required for the training, status and remuneration of rural generalists, combined with a rational approach to the operation and distribution of rural hospitals, utilising a new approach to assessment of geographical needs and based on medical rather than social exigency.

Standards of Training and workforce development. There is a strong and regrettable public perception that General Practice is comprised of minor matters, responses to patient requests, and consequent referral to appropriate specialists. Views alter according to the latest publicised coroner's case, but the public does tend to opt for immediate access to a doctor rather than looking at the long-term perspective. Medical registration confirms possession of a basic medical degree and safety in an observed year of hospital practice. It does not imply training as a general practitioner.

Realisation of the serious nature of many GP presentations, the need for effective complex chronic care and shared care arrangements with specialists led to the creation of GP colleges in the 1950s and development of postgraduate GP training first in the UK and then in Australia. With the inauguration of Medicare the argument grew for encouraging training, and higher levels of rebates for trained GPs were implemented by Minister Neil Blewett in 1986-7. Prior to this standards were not high in GP. Subsequently, vocational training has hugely lifted them.

Low intakes for GP training, combined with the difficulty of attaining fellowship outside training programs, led to shortages of GPs in non-metropolitan areas. (Metropolitan zones have excellent ratios of patients to fully trained and registered specialist GPs). The need for advanced capability in rural made rural GPs reluctant to recruit overseas doctors without such capability. Initially doctors with capability were available, especially from South Africa, where doctors from all over the world as well as South African nationals received encouragement and training. Ironically, because of lack of policy about rural hospitals, many doctors with skills appropriate to rural found it harder to gain entry to rural Australia because they did not have General Practice qualifications. Pressure grew to make it easier for Overseas Doctors to enter. Despite many submissions to the contrary made to the current Parliamentary Inquiry, this has in fact already happened, in quite a major way.

Doctors with approved qualifications in GP have been able to enter Australia for some years and continue to do so through the 'competent authority pathway' (1200 in

2010). Doctors with full registration (AMC parts 1 and 2) are able to enter supervised GP relatively easily. In 2008 it was decided to make the primary qualification for entry from overseas to be the first part, (knowledge test) of the Australian Medical Council examination, which could be taken overseas, and to give these doctors 'limited registration'. The result was a deluge of applicants, ('08 3112, '09 2610 and '10 2263, with pass rates around 60%), who became eligible for section 457 visas as skilled migrants if they could find employers willing to sponsor them.

Programs were started for 'A1' medicare rebates to be extended to regional towns and fringe metropolitan areas and lately for other inner metropolitan areas of need. These also allowed 'Other Medical Practitioners' OMPs with a pass in the AMC second part but no GP qualifications, mostly from overseas, to work in designated areas in the OMP range of programs – After Hours AHOMPS, MedicarePlus MOMPS, Outer Metropolitan OMOMPS, and Rural ROMPS – and be rewarded with full vocational rebates (and not to be identified as anything but GPs). Whereas the original 2008 specification was that such doctors should be enrolled into fellowship pathways, this requirement is not found in the current Medicare Schedule. (See www.health.gov.au/...nsf/.../R**OMP**sProgramGuidelines-Jan2011.pdf.

Now consider the National numbers. There were 24,211 doctors accessing General Practice Medicare rebates in 2010 (PHCRIS), and we assume that this did not include registrars in training. This amounted to 19,729 Full Time Equivalent GPs; (the FTE GP working week is 45 hours). There were 9191 Overseas doctors in GP (Birrell) who can be assumed to be full time workers, This equals 47% total GP FTE. 6576 of these were working in 'Areas of Need' (Birrell). At 31.1.11 there were 2731 Overseas doctors with Limited Registration working in these areas (AHPRA), which can be reckoned to be increasing by at least 1000 per annum. There were 3693 with limited registration working in hospitals, who stand to be progressively displaced from hospitals by the 'Tsunami' of Australian graduates commencing this January 2012. There were also 2159 unemployed overseas doctors resident in Australia in the 2006 census, which may have doubled by now.

Potentially then, even without further 457 Visa influx utilising the Limited Registration facility, a further 5-10,000 doctors could be added to the GP workforce, if they were allowed to do so, (and it would be a political headache if they were not), dwarfing current and future output from Australian GP training, and which the forthcoming 'Tsunami' of Australian trained graduates will meet head on.

It has to be realised that for some years now, doctors without Fellowship have been allowed to work in General Practice only under strict supervision and with proviso that they are working towards Fellowship acquisition. Under College Guidelines, Registered Fellows are allowed to closely supervise only two Australian graduates in training for GP, and this is closely policed. It wasn't until June 2011 that the AHPRA issued their own less strict supervision guidelines for limited registration doctors in GP, and it transpires that they have essentially acquired responsibility for a major training program somewhat larger than the Australian General Practice Training AGPT program. They have since acknowledged to the Parliamentary Inquiry that they do not have resources to police this program and are basically relying on self-reporting by employers, creating potential conflict of interest. Their guidelines allow supervision of 4 doctors by one supervisor, with extensive use of telephone supervision as opposed to the 1 in 2 physically present required by AGPT programs, with no system for accrediting teachers Limited Registration OTDs general are being

utilised much less by mainstream practices with accredited teachers because they prefer doctors with full registration and the hospital experience (including paediatrics) hitherto mandated for fellowship acquisition by Australian Graduates. There is growing concern about this situation, which threatens to create a 2 tier division in GP, as explained below.

Evidence is to hand that corporates are starting to take advantage of the arrangements. There are reports of rural corporate activity from all the major States. This is nothing new in regional towns and outer metropolitan, but has especial significance in rural proper. For Victoria, utilising http://humanservicesdirectory.vic.gov.au/ and AHPRA published registration and supervision details, a picture emerges of corporate clinics operating not always with Registered Fellows, with substantially telephone supervised limited registration doctors, without adherence to the AHPRA supervision standard, and not providing hospital services except in very small locations.

This has significance for the rural sector for several reasons. The viability of Visiting Medical Officer rural medicine depends on a combination of 80-90% general practice and 10-20% hospital practice. (In the Queensland model of Hospital Medical Officer with 'right of General Practice', salaries are guaranteed). Rural Corporate GP clinics therefore undermine the VMO workforce. They also undermine training processes by decreasing patient flow for students and registrars, and whilst registrars are required to declare their status as in-training, limited and general registration doctors in GP do not, giving the public a perception that they are fully trained.

If the present situation continues it can be foreseen that AGSC Inner Regional areas will progressively be taken over by corporates, making it difficult or impossible to operate standard rural medicine. Since Fellowship pass-rates for overseas doctors run at under 50% (Birrell) there will be a substantial long-term workforce not trained to fellowship standards unless repatriation is insisted upon when Fellowships are not obtained in the specified period, which to date has hardly happened, and which Birrell describes as a 'powder keg situation'. Moreover oversupply of numbers, even though less trained, will make if difficult for future graduates, especially the current 4,000 rural bonded scholars.

State uptake of Limited Registration doctors into Area of Need GP at 31.1.11 was Queensland 1172, NSW 172, Victoria 227, South Australia 143, Tasmania 119, West Australia 646, Northern Territory 102 and ACT 12. (Total 2731). Source: AHPRA newsletter May 2011 http://www.medicalboard.gov.au/News.aspx. The 3.12.11 Newsletter states that there are "6221 medical practitioners with limited registration, most international graduates (IMGs) registered to practice in areas of need." As this figure is similar to the total 6161 LRs registered from both hospital and GP at 31.1.11 it may represent the January 2011 figures. On the other hand the total number of AHPRA medical registrants had risen from 86326 to 88293, a jump of 1967. The number of 10 year moratorium doctors in rural and regional in 2010 was 6576, nearly triple that of 2004.

It has been observed that Australia saves itself the cost of medical training by importing doctors, perhaps $300,000 each, although every imported doctor can cost that much in extra Medicare fees the first year. In terms of training, advanced Australian scientific medicine is lost but the cost to the donor countries is far far higher, $billions to sub-Saharan Africa. http://scienceblog.com/49681/doctor-migration-costs-sub-saharan-africa-billions/. Australia did in fact commit unofficially

itself to not recruiting from less developed countries at the World Rural Health Conference in 2002 in the 'Melbourne Manifesto', which can be downloaded from www.rudasa.org.za/download/melbourne_manifesto.pdf.

One neglected aspect affecting rural workforce dynamics has been the unbridled expansion of the specialties, sucking graduates away from the generalist workforce. The total number of specialist practitioners was given on 31.1.11 as 49,636. This includes registered GP Fellows. The number on 3.12.11 is rounded at 51,000 and may reflect improved data collection by AHPRA in 2011. The total number of doctors in General practice was 24,211 excluding GP registrars. Assuming arbritarily 8,000 limited and General Registrants without specialist GP fellowship, this reduces specialist GPs to 16,211, implying a non-GP specialist complement of about 35, 000, which is top-heavy in practical and financial terms. There is no agreement on the ratio of GPs to specialists, but as Birrell points out the ratio of 'GPs' (doctors in General Practice) to population is falling towards 1/1000 from the original benchmark of 1/1500 (although the ratio of registered specialist GPs to population might be more valid for the achievement of good population health). Might it be time however to consider measures to cap the specialist as well as generalist workforce? The excess of specialists is part of the rural problem. The need for specialists also is partly generated by a deskilled GP workforce.

Within the rural combined community and hospital GP sector, the shortage is more of appropriately trained doctors than doctors per se. Necessary clinical competence will not be found through wholesale importation of overseas doctors. Substantial overseas recruitment is developing an oversupply of doctors in regional towns, with overseas doctors sequestered in clinics without experienced specialist registered GPs to train them as GPs, reducing their potential to make much needed contribution to population health. The situation threatens teaching processes through a dilution of the trained workforce in non-metropolitan zones.

The role of Medicare Locals and Primary Care processes. Whilst DoHA has been focussing almost solely on the role of Medicare Locals in engineering after-hours services, it is hoped that there is some intent towards real health reform to prevent a deterioration in population health from burgeoning complex chronic disease including metabolic, musculoskeletal and mental health. This will require very well trained GPs working closely with allied health teams to help drive protocol driven management.

Medicare Locals are being developed out of divisions of General Practice. They are primarily therefore a Commonwealth initiative. There was an attempt to add Victorian State community health care processes and organisations to them. In Victoria, rural community services are by and large operated by Health Services together with Hospitals. The State did not take kindly to the proposed arrangement to relinquish them, to divide services, and to hand over quite large Metropolitan Primary Care Services. It remains to be seen therefore, with both State and Federal components of Medicare Locals in Victoria, how the Governance will operate. These organisations need to be politically accountable.

Divisions of General Practice in Victoria mostly include regional as well as smaller rural towns. Under Federal direction this has tended to render them sometimes opaque to the needs of rural medicine and the requirements of doctors responsible for both primary and secondary care. This has also been true of the Rural Workforce Agency

and the Divisions coordinating body, who together coordinated the '2009 RWAV Divisions Report' http://www.rwav.com.au/resources/publications.aspx about rural workforce. This paper made only most fleeting reference (P57) to the hospital and acute medical role of rural doctors. Additionally there has been in Victoria little and at times no policy of selective recruitment of overseas doctors with procedural capability to appropriate locations, and no mechanisms developed for embedding them, or overcome the many obstacles to their commencement and continuation of practice. (Unfortunately this wave of medical immigration is largely complete and very many have ended up in metropolitan penumbra as a result of such neglect).

The Victorian Government has just released a Rural and Regional Health Plan together with a data-set http://www.health.vic.gov.au/healthplan2022/. It is mindful of the ageing population and chronic disease explosion, the growing tendency of health care to centralise and put extra strain on metropolitan systems, and the need for generalists. As discussed above, the State is not well placed in terms of trained General Practitioners to implement the necessary population health care in this sector, as opposed to Inner Metropolitan regions where GPs are for the most part fully trained as specialist GPs.

There is concern that Medicare Locals will further impede, accelerate decline of, and be refractory to the specific needs of rural combined community and hospital medicine. Robust governance arrangements and strong representation from the rural sector will be needed together with adequate and effective clinical input. The primary role of Medicare Locals should be oriented towards population health and not convenience and after-hours medicine. State and Federal Governments need to combine in overview of their activities. UK Health Trusts have required regular constitutional overhauls.

Industrial conditions have been traditionally very poor for rural doctors.

Rural practice is complex and expensive. It involves maintaining a central practice while providing services to the hospital, visiting branch surgeries, and providing outlying community care in the home. This was clearly established by the 2003 Federally funded and academically conducted Viable Models Study (http://www.rdaa.com.au/policies-submissions/papers), and more recently by the rural component of the 'Medicine in Australia, balancing Employment and Life' (MABEL) study 3.6.11.rural section (See eg http://www.publish.csiro.au/?paper=PY11063). Good rural practitioners provide longer complex consultations routinely and deal with the whole patient.

By the mid-80s pay conditions were bad enough to generate a strike in NSW against the pay for their work as visiting medical officers (VMOs) to their local hospitals. The resultant Industrial court hearing produced the 'Rural Doctors Settlement package' http://www.health.nsw.gov.au/policies/pd/2011/PD2011_056.html, which remains in place, annually indexed to this day.

Following NSW the AMA in Victoria immediately took a case to the then existent Health Remuneration Tribunal; this was primarily for specialists but Generalists had a modest increase and the package lasted until 1994, when Jeff Kennett quite inappropriately decided to introduce competition into rural hospital medical services. Rural doctors were made to negotiate individually with their hospitals under ACCC

rules for the 'privilege' of providing services. How short-sighted this was is demonstrated by the growing sshortage of experienced doctors. The RACGP subsequently successfully, as part of its own licence to negotiate medicare rebates with the HIC, persuaded the ACCC to let legally constituted medical groups individually negotiate collectively on behalf of their members and employees. This has not taken away the bruising effect of such negotiations, their interference with mutual trust and clinical governance, and the position of the hospital to gather information from other hospitals and to play off medical practices against each other. It is not uncommon for agreements to go a year beyond their expiry. Rural medicine, so meagrely provided for, does not need such situations. The current stance of the Victorian Government is that Health Services have statutory independence and that a State-wide award is no longer applicable in Victoria.

South Australia had a change of heart in 2006 and introduced an annually indexed package. (www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article). Queensland as already mentioned has a strong salary structure for Hospital Generalists with rights of private practice, but also has GP Visiting Medical Officers who have to negotiate like Victoria but in a more complex fashion. Tasmania has an annually negotiated award which is not strongly remunerative, but there is very little left of rural medicine in that State, due to previous savage State Government cuts, which could be an ominous precursor for Victoria.

This all goes to show how heterogenous State remuneration for generalist hospital work has been over the years and how unreliable the industrial ambience is for doctors with any thought or aspiration to work in rural areas. Only in NSW has there been consistency and predictability, and that most regrettably the product of the only rural medical industrial action on record. The most effective rural doctors are those who stay there for life, who invest in the practice infrastructure, assist the hospital with governance on the increasingly rare occasions that they are allowed to do so, set up and run the rural medical school hubs, provide registrar and IMG teaching, develop the corporate knowledge to pass on to doctors following and bring up their families in the community. These doctors have to send any of their children with academic potential away to school. This costs up to $25,000 a year per child (after tax).

On call payment is another vexed issue. NSW has an indexed rate of currently $7-80 per hour in-hours, and $11-50 after hours. This can be compared to the initial $26 for rural GP locums in the Commonwealth round the clock after hours program, and immensely higher rates for specialists. In Victoria the 'Rural Enhancement Package' started with rates of $4.50 an hour and was open to scrutiny until it became incorporated into hospital budgets and a matter of largesse for hospitals in their private negotiations with medical practices.

In terms of community health, if the Federal Administration wants good advanced rural practice then it has to recognise that it will have to pay for it. Now that it is paying 100% of the Medicare rebate and additional inducements to bulk bill, it sees its options as limited. The RDAA has advocated Rural Consultation Item Numbers http://www.rdaa.com.au/policies-submissions/papers) consistent with the Viable Models Study of 2003. These take into account the extra expense of ethical rural practice with its need for nursing staff and advanced diagnostic capability. This would be available only to registered rural specialist GPs. An alternative would be a rural Medicare loading, more palatable but still basically 'hiding rural medicine away'.

The Queensland view and experience is that only proper recognition, training and industrial reward will solve the rural doctor problem. Engineering this from the Federal Centre would be difficult but could be feasible if made through commitment by the Council of Australian Health Ministers.

Inducement schemes and the 10 year moratorium. A comprehensive account of the many inducements will not be attempted. RDAs oppose the concepts of bonded scholarship and 10 year moratorium because they are a form of constraint and are likely to produce resentment and consequent poor practice if expectations are not realised.

Even though some inducements, like rural retention grants of up to $20,000 per annum in remote, might seem generous to the uninitiated, they are not especially significant when matched against total salaries. It is necessary to be a little frank about medical salaries. Specialists can expect to total over $1/2m, with much less overhead than the GP. GP Corporates like Prime expect their Doctors to see 45 patients a day, which on present bulk-billing rates 5/7/50 equates to a gross of $450,000 a year, which can be exceeded easily using extended primary care item numbers. That is why they offer $1/2m inducements to work with them for 5 years, even to limited registration OTDs on occasion. Neither is 45 patients a day excessive for experienced metropolitan and regional doctors with good patient flow who expect to see a minimum of 5 patients an hour throughout the day in their 45 hour FTE working week.

Such (taxable) inducements have made some rural doctors feel 'wanted' but should be seen for what they really are, a way of foxing people out of seeking genuinely competitive remuneration for their work in the hospitals and communities of isolated towns together with arduous on call and sleep-deprived after-hours work.

The system of inducements, scholarships and bonded schemes needs complete review and a hard look at what it really takes to build long term rural medical workforce.

Medical Indemnity. Possibly nothing did more damage to rural Medicine than a series of high profile rural Indemnity cases in the 1980s, well publicised in Australian Doctor Weekly and Medical Observer, that illustrated the vulnerability of rural doctors to unexpected happenings and to the evidence of hostile metropolitan specialist-trained witnesses. Undergraduates and newly qualified doctors began to ask themselves who would be foolish enough to expose themselves to such risk. It seemed to confirm the myth that becoming a specialist confers safety from being sued (it doesn't at all).

Since then there has been indemnity reform and the development of health complaints mechanisms that defuse many cases, not to mention a huge improvement in the standards of practise of properly trained rural generalists. The fear of being sued however should not be underestimated as a deterrent to rural practice. Rural doctors live in a goldfish bowl and occasionally have to put up with 'a bit' from the town. IMGs in our experience have sometimes been given a very hard time by local newspapers and should more often take recourse through the Victorian Civil and Administrative Tribunal as have one or two.

In 1996, with absurdly rising cost of indemnity and the poor recompense for performing obstetrics, Victorian rural doctors came to the conclusion that they might have to withdraw from this activity. As a result the Victorian Managed Insurance Scheme set up the Rural GP Program, which has, in continued consultation with RDAV, maintained a comprehensive and as far as possible legally water-tight package for all doctors practising in rural Victoria who hold visiting rights in a rural hospital. Rural Doctors need such coverage and it is hoped that in other States similar cover is provided.

Medical indemnity reforms have so dampened down negligence cases that medical indemnity is cheap, and subject to such competition between Medical Defence Organisations that peppercorn indemnity is now being provided to registrars and possibly even limited registration overseas doctors as well.

Medical Indemnity for rural doctors probably does not need major attention at this time.

Concluding observation. How can the Federal Government act? There is an enormous amount of literature about the problems of supplying rural medical services but few of them have fed into policy. Rural Health is a bit of a political football, used to satisfy public attention but not solve problems, and relying on folkloric attitudes to rural. The divide in Federal and State responsibilities has allowed both parties to duck and weave, leaving issues unaddressed. Federal Rural Health Policy could beneficially be directed through the Council of Health Ministers who could make a start by being honest about the definition of rural, produce a charter of responsibilities and then construct the means to address them through formal agreements. This would be in line with such concepts as 'rural obligation' and 'rural proofing'.

Rural Health policy needs insulation from broader health policy, because decisions that favour metropolitan often conversely disadvantage rural.

Such policy would need to be communicated to all responsible organisations with responsibility associated with recruitment and placement of rural doctors, including the AHPRA and its State Medical Boards, Rural Workforce Agencies and Medicare Locals, so that they can support by their own structure and activities the aims of Government towards rural medicine.

With proper policy, Australia could also start to move away from dependence on Overseas doctors and thus cease or at least ameliorate the unacceptable and not altogether solid advantage it derives by enticing graduates from impoverished less-developed countries.

A coordinated policy between States and Commonwealth is required if socially just, effective and stable provision of rural medical services is to be established for the long-term future.

RDAV

This organisation has for 20 years supported rural doctors providing advanced community and hospital medical services wherever needed in rural Victoria. It is a constituent of the RDAA. It has been involved in numerous rural initiatives. There is

much material on the website, including a number of submissions. RDAV wishes to present an independent perspective in submissions of this nature.

The author Dr Mike Moynihan is a UK trained International Medical Graduate who has been in 10 years solo and 16 years group rural Australian practice following 10 years hospital and administrative medicine in Papua New Guinea. He is current chair of the RDAV. He is available to give information to the committee, particularly after the Parliamentary rural breakfast on 29s.2.12.

References

AHPRA newsletters http://www.medicalboard.gov.au/News.aspx.

2005 AMC assessment of Rural and Remote Medicine as a Medical Speciality http://www.amc.org.au/index.php/ar/rms/policies/reports.

Birrell: Australia's new health crisis: too many Doctors: CPUR Sept 2011. http://arts.monash.edu.au/cpur/staff/bbirrell.php#publications

Birrell and Schwartz. The Aftermath of Dr Death: has anything changed elecpress.monash.edu.au. Examines the Bundaberg and similar instances.

Distance effect on Mortality; *Emergency Medicine Journal* 2007;**24**:665-668 http://emj.bmj.com/cgi/content/abstract/24/9/665. A British study showing that every 10 Km travelled by ambulance adds 1% to mortality.

1997 Federal Ministerial review of GP training (available in print but see eg http://www.agpt.com.au/GPETtheCompany/AboutGPET/)

GPET/AGPT genesis http://www.agpt.com.au/GPETtheCompany/AboutGPET/)

MABEL Medicine in Australia, balancing Employment and Life' study 3.6.11. rural section (See eg http://www.publish.csiro.au/?paper=PY11063).

Migration of doctor costs to less developed countries. http://scienceblog.com/49681/doctor-migration-costs-sub-saharan-africa-billions/.

Melbourne Manifesto www.rudasa.org.za/download/**melbourne_manifesto**.pdf

NOVA Public Policy. Review of the Queensand Rural Generalust Pathway (RGP model) to examine whether there is the potential to expand the model Nationally 2010

NSW 'Rural Doctors Settlement package' http://www.health.nsw.gov.au/policies/pd/2011/PD2011_056.html,

2008 OMP www.health.gov.au/...nsf/.../R**OMP**sProgramGuidelines-Jan2011.pdf*)*,

PHCRIS http://www.phcris.org.au/products/asd/keycharacteristic/index.php

RDAA. Viable Models Study (http://www.rdaa.com.au/policies-submissions/papers),

2009 RDAV survey of (Victorian) Rural Proceduralists. www.rdav.com.au.

2009 RDAV Emergency services position paper www.rdav.com.au.

2009 RWAV Divisions Report' http://www.rwav.com.au/resources/publications.aspx

2006 South Australian industrial award "Recognising the past, Rewriting the future" www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article...

Victoria, DoH http://humanservicesdirectory.vic.gov.au/

Victorian Rural and Regional Health Plan and data set. http://www.health.vic.gov.au/healthplan2022/.

Acronyms and abbreviations.

ACCC Australian Consumer and Competition Commission
ACRRM Austrian College of Rural and Remote Medicine
AGPT (GPET) Australian General Practice Training
AHPRA Australian Health Practitioner Regulation Agency
ASGC Australian Standard Geographical Classification
AMA Australian Medical Association
AMC Australian Medical Council
COAG Council of Australian Governments
CRU Centre for Rural Health
CT Computerised tomography
DoH Department of Health (Victoria)
DoHA Department of Health and Ageing (Federal)
FARGP Fellow of Australian Rural General Practice
FRACRRM Fellow of the Australian College of Rural and Remote Medicine
FRACGP Fellow of the Australian College of General Practitioners
IMG International Medical Graduate
GP General Practice, General Practitiioner
OMP Other Medical Practitioner
OTD Overseas Trained Doctor
RACGP Australian College of General Practitioners
RDAA Rural Doctors Association of Australia
RDAV Rural Doctors Association of Victoria
RHSET Rural Health Support education and Training
RWAV Rural Workforce Agency of Victoria
SERU Support Education Resource Unit
VBNA Victorian Bush Nursing Agency
VMO Visiting (Hospital) Medical Officer