rural health workforce
AUSTRALIA

16 September 2014

Committee Secretary
Senate Select Committee on Health
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Dear Secretary

**RE: SENATE SELECT COMMITTEE ON HEALTH INQUIRY**

Rural Health Workforce Australia (RHWA) welcomes the Senate Select Committee on Health's inquiry into health policy, administration and expenditure.

Our organisation is committed to improving health outcomes through making healthcare accessible for Australians living in regional, rural and remote communities.

While there has been progress over the past decade in improving access to healthcare services for those living outside our major cities, much more requires to be done to ensure all Australians have similar levels of access to essential health services.

As such, our attached submission to the Inquiry details four key areas for improvements that represent a priority for us and our Network of Rural Workforce Agencies around Australia.

Should the Committee have any questions or require further information about RHWA's submission, please do not hesitate to contact me. I would also welcome the opportunity to appear before the Committee.

We look forward to the outcomes of this inquiry.

Yours sincerely

**Greg Mundy**
**Chief Executive Officer**

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AUSTRALIA

# Submission to the Senate Select Committee on Health

September 2014

## TABLE OF CONTENTS

## EXECUTIVE SUMMARY AND RECOMMENDATIONS

This document details a submission from Rural Health Workforce Australia (RHWA) to the Senate Select Committee on Health's Inquiry into health policy, administration and expenditure.

In line with the core functions and activities of RHWA and the Rural Workforce Agency Network, this submission addresses the inquiry's terms of reference regarding improvements in the provision of health services, including Indigenous and rural health, and workforce planning.

### Improvements in the provision of Indigenous and rural health services

There is a significant disparity between the provision of health services (and health outcomes) in Australian cities and regional, rural and remote areas, where the demand for health services outstrips supply.

While access to health services in regional, rural and remote Australia is improving, maldistribution and inequity persist. Further, a number of workforce trends and other issues necessitate that more needs to be done.

Recognising that no single health policy or strategy is effective in isolation, this submission details four key priority areas for improvements to the provision of Indigenous and rural health services.

1. *Developing the Australian-trained workforce.*

   There has been a significant increase in the number of medical students at Australian universities in recent years, however only a small proportion of these plan to specialise in general practice and even fewer plan to practise rurally. Unless Australian graduates can be persuaded differently, the growth in medical student placements alone is unlikely to meet rural and remote workforce needs.

   The pipeline from high school student, through university, fellowship and on to rural practice is complex. A holistic approach considering all stages of the decision making process is required to ensure there is a continued rural connection from high school through to fellowship, coupled with adequate training and support to create the rural workforce of the future.

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| **RECOMMENDATION 1** | Continued innovation and refinement of programs and initiatives that provide multiple opportunities for exposure to rural practice and experience of the rural lifestyle along the career pathway to attract and support Australian-trained health professionals who choose to 'go rural' as a career choice. |
| **RECOMMENDATION 2** | A continued commitment and effort from all stakeholders to increasing opportunities and streamlining processes for health professionals to undertake training in regional, rural and remote communities. |
| **RECOMMENDATION 3** | Workforce program funding contracts contain a requirement for the fund-holder to formally liaise with other workforce program fund-holders, including the sharing of de-identified program data where relevant. |
| **RECOMMENDATION 4** | Development of policies to encourage Registrars to remain in regional, rural and remote communities following completion of their training rather than return to major cities. |
| **RECOMMENDATION 5** | Strategies to facilitate increased training opportunities for medical specialists (particularly general physicians) and allied health professionals in regional, rural and remote locations. |

2. *Streamlining and improving administrative processes for overseas-trained doctors.*

To date, much of the growth in GP numbers outside of the major cities has predominantly come from increased numbers of Overseas Trained Doctors (OTDs) who will continue to make a vital contribution to regional, rural and remote health services in the short to medium term.

OTDs are highly valued by their local communities and the RWA Network plays an important role in the attraction, recruitment and support of these doctors. In 2012, a comprehensive report into the registration processes and support for OTDs was undertaken by the House of Representatives Standing Committee on Health and Ageing. This report made 45 recommendations to address significant bureaucratic complexities and inefficiencies and the implementation of these is ongoing.

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| **RECOMMENDATION 6** | That all relevant stakeholders including the Department of Health, the Australian Health Practitioner Regulation Agency, the Medical Board of Australia, the Australian Medical Council, the specialist medical colleges and Rural Workforce Agencies continue to work together to implement the recommendations from the Lost in the Labyrinth Report. |

3. *Reviewing geographic classification systems.*

Different workforce programs and initiatives use different geographic classification systems to determine a health professional's eligibility to receive incentives or work in particular areas. These classification systems can have significant and far-reaching implications on attracting and equitably distributing the health workforce.

Recognising that no system will be perfect, there are a number of well-known issues and anomalies with the current classification systems such as a lack of consistency between the different definitions and a lack of transparency in how they are calculated or derived. Amongst other issues, in some cases this can lead to less than optimal workforce and incentive resource allocation.

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| **RECOMMENDATION 7** | That geographic classification systems used by Commonwealth and State and Territory departments of health to target health work-force programs and incentives be reviewed to ensure that they are transparent, consistent, equitable and target workforce to areas of greater need. |
| **RECOMMENDATION 8** | That any proposed changes to current systems are thoroughly modelled and trialed to assess their impact.. |
| **RECOMMENDATION 9** | That State and Territory jurisdictions develop nationally consistent criteria for the approval of a location as an Area of Need. |
| **RECOMMENDATION 10** | That the requirement for Bonded Medical graduates' return of service obligation to be in a DWS location be reviewed so that the intent of the program is maintained for placements in genuine rural and remote locations. |

4. *Increased focus on the allied health workforce and alternative models of care.*

Maldistribution of healthcare professionals in regional, rural and remote Australia is not limited to GPs. Increasing access to allied health professionals is an important component of improving health outcomes. In many rural and remote communities nursing and/ or allied health professionals represent a viable alternative to a medical model of care.

The Rural Health Professionals Program (RHPP) has proven to be a valuable workforce attraction and support initiative that has recruited 550 nurses and allied health professionals to remote, rural and regional locations since in its inception in 2012.

| RECOMMENDATION 11 | That funding of the Rural Health Professionals Program is renewed to ensure the continued recruitment of nursing and allied health professionals to difficult-to-fill vacancies in regional, rural and remote locations. |
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As with strategies to increase the GP workforce in regional, rural and remote Australia, no single policy or initiative in isolation will be sufficient to meet the challenge, and continual innovation, review and refinement of programs, initiatives and models of care are needed with upfront and ongoing community consultation.

**Workforce planning**

Ongoing health workforce planning is essential to delivering high quality, appropriate and affordable healthcare. With regard to GP data in particular, obtaining accurate and detailed data is a vital component of healthcare needs assessment and planning. The RWA Network collects a comprehensive Minimum Data Set on the GP workforce and has plans to expand the information collected and develop processes to allow the dataset to be collated nationally and tracked over time. The RWA Network has already held detailed discussions with the Australian Institute of Health and Welfare regarding collaboration on this project.

RHWA also acknowledges the valuable contribution to evidence-based planning made by the Medical Schools Outcome Database (MSOD). MSOD is a world-leading project for tracking medical students through medical school and into training. To date, MSOD was funded through Health Workforce Australia and with the dismantling of this agency uncertainty currently exists surrounding the ongoing funding of this project beyond 2014.

| RECOMMENDATION 12 | That key stakeholders including the Department of Health, the Australian Institute of Health and Welfare and the Australian Health Practitioner Regulation Agency continue to work with the RWA Network to develop an expanded primary healthcare Minimum Data Set to enable evidence-based future workforce planning and assessment of program initiatives in regional, rural and remote communities. |
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| **RECOMMENDATION 13** | That the Medical Schools Outcome Database project continue to be funded to ensure its vital role in medical workforce planning and the provision of empirical evidence to inform health workforce policy. |

## 1. RURAL HEALTH WORKFORCE AUSTRALIA

Rural Health Workforce Australia (RHWA) is the national peak body for Australia's network of state and territory Rural Workforce Agencies. The independent, not-for-profit RWA Network is comprised of Rural Health Workforce Australia (RHWA) and the seven State and Territory based Rural Workforce Agencies (RWAs):

- Rural Health Workforce Australia
- NSW Rural Doctors Network
- Rural Workforce Agency Victoria
- Health Workforce Queensland
- Rural Doctors Workforce Agency (South Australia)
- Rural Health West (Western Australia)
- Northern Territory Medicare Local
- Health Recruitment Plus – Tasmania

Our Network is committed to making healthcare more accessible for the people of regional, rural and remote Australia by providing a skilled workforce that meets communities' health care needs. We provide a wide range of services to regional, rural and remote general practices, Aboriginal and Torres Strait Islander health services, dental and primary care services, including:

- attraction, marketing and career advice
- recruitment
- locum support
- training and continuing professional development activities
- ongoing professional and family support services for healthcare professionals
- practice support services
- medical specialist and multidisciplinary outreach health service teams
- community and health service development
- project management
- research and policy advice
- communications and advocacy

The breadth of these services, workforce programs and activities are illustrated in Table 1 overleaf.

**Table 1: Summary of Core Services - Rural Workforce Agency Network**

| Attract | Recruit | Retain | Practices | Educate | Inform | Develop communities |
|---|---|---|---|---|---|---|
| **Australian and International Health Workforce** | | | | | | |
| Doctors | Screening | Locums | Workforce support | Training | Data | Planning |
| Nursing & allied health | Matching | Family support | Business skills | Mentoring | Research | Indigenous health |
| Students | Registration | Incentives | Tele-health | Exam support | Policy | Specialist & health teams |
| Marketing | Orientation | Crisis support | Business support | Conferences | Advocacy | Inter-agency coordination |

Our most recent RWA Network Achievements Fact Sheet highlighting some of our key activities is appended to this submission (Attachment A).

RHWA is also committed to Australia's future health workforce through our management of the National Rural Health Students Network (NRHSN), which has over 9,000 members representing 28 university Rural Health Clubs around Australia.

The NRHSN provides a voice for students who are passionate about improving health outcomes for rural and remote Australians and is unique in being a multidisciplinary rurally-focussed group for students from medical, nursing and allied health courses.

In addition to providing members with networking and professional development opportunities, the NRHSN is actively involved in raising community awareness of rural health issues. For example, each year the NRHSN organises over 200 visits to high schools throughout Australia where young mentors promote and discuss opportunities for a health career in a rural location.

In addition, Rural Workforce Agencies around the country have developed numerous programs and initiatives including scholarships, conferences and rural placement opportunities that aim to encourage high school and undergraduate students to consider a rural healthcare career.

## 2. SENATE SELECT COMMITTEE ON HEALTH

The Senate Select Committee on Health was established by the Senate of the Parliament of Australia on 25 June 2014 to inquire into and report on health policy, administration and expenditure, with particular reference to:

a) the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;

b) the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

c) the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

d) the interaction between elements of the health system, including between aged care and health care;

**e) improvements in the provision of health services, including Indigenous health and rural health;**

f) the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

**g) health workforce planning; and**

h) any related matters.

In line with the core functions and activities of the RWA Network outlined above in the Introduction, this submission focuses on information that informs Terms of Reference (e) and (g). The information presented below is based on the accumulated experience of our Network members of Rural Workforce Agencies, as well as published literature.

Further information can be obtained from the references cited throughout this submission or by contacting the CEO of RHWA, Greg Mundy via email at
or by telephone on 03 9860 4700. Members of RHWA or the RWA Network are available to present at any hearings that the Senate Select Committee may hold.

## 3. BACKGROUND CONTEXT

### Undersupply and Maldistribution of Indigenous and Rural Health Services

Undersupply and maldistribution of health professionals in rural and remote areas is a persistent global problem.[1] As a geographically large and relatively sparsely populated country, Australia is no exception and gaps in access to health services have been evident for many decades.[2]

Poorer access to quality healthcare providers has been cited as one of the primary causes of health inequity and poorer health outcomes.[3] In Australia for example:

- life expectancy is up to 7 years less in rural and remote areas than in cities;[4]
- survival rates of Australians diagnosed with cancer decrease with increased rurality;[5] and
- suicide rates in rural and remote areas are significantly higher than in cities.[6]

A particularly pressing concern is the health of Aboriginal Australians. Substantial inequalities exist between Aboriginal peoples (approximately 70% of whom live outside major cities) and non-Aboriginal Australians, particularly in relation to chronic and communicable diseases, infant health, mental health and life expectancy.

Over the period 1996-2001, there was an estimated difference of approximately 17 years between Aboriginal and non-Aboriginal life expectancy, and hospitalisation for ischaemic heart disease for Aboriginal males was double the rate, and for females four times the rate, than for the general population.[7]

Significant investments have been made to address the issue of shortages and maldistribution of health practitioners in rural and remote areas, including an expansion of medical training places, financial incentives, the establishment of Rural Clinical Schools,

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[1] World Health Organization. 2010. *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.* Geneva: WHO

[2] Duckett, S, Breadon, P & Ginnivan, L. 2013. *Access all areas: new solutions for GP shortages in rural Australia.* Grattan Institute: Melbourne

[3] World Health Organization. 2010. *Op cit.*

[4] Australian Institute of Health and Welfare. 2014. http://www.aihw.gov.au/rural-health-life-expectancy/, accessed 7/4/2014.

[5] Australian Institute of Health and Welfare. 2012. *Australia's health 2012.* Australia's health series no 13 Cat. No. AUS 156. Canberra:AIHW.

[6] Ibid.

[7] Human Rights and Equal Opportunity Commission. 2005. *Social Justice Report 2005*. HREOC: Canberra.

and legislative requirements targeting overseas-trained doctors to communities with under-serviced health needs.

Pleasingly, there is evidence to demonstrate that many of these initiatives are having a positive impact on improving access to health services. For example, one high-level sentinel indicator of access to healthcare services is the number of primary healthcare professionals in an area relative to the population (commonly referred to as 'GP to population ratios').

Medical workforce data collected by the RWA Network[8] demonstrates an increase in the GP workforce significantly in excess of population growth[9] in regional, rural and remote Australia over the past 5 years.

**In 2013 alone, the RWA Network recruited 330 GPs to regional, rural and remote practices (including 21 into Aboriginal Medical Services). More than 12% of these GPs were placed into remote and very remote communities where only 2.3% of the Australian population resides.**

However, while this increase in GP numbers has undoubtedly improved access to GPs for Australians living in regional, rural and remote areas, there a number of workforce trends impacting on the level and type of service provision. These include:

- declining average GP working hours;[10]
- an increasing number of female GPs entering the workforce [11] (who are significantly more likely to work part-time); and
- declining numbers of GPs with 'procedural' skills[12] (such as the ability to deliver babies or undertake minor surgery).

An increase in the number of GPs does not necessarily equate to a commensurate increase in access or service provision as differing working hours, skill-sets and service models must also be considered.

[8] Rural Health Workforce Australia. 2014. *Medical practice in rural and remote Australia: combined Rural Workforce Agencies National Minimum Data Set report as at 30th November 2013*. Melbourne: RHWA

[9] Australian Bureau of Statistics. 2014. *Regional population growth, Australia*. Cat. No. 3218.0. Canberra: ABS

[10] In the 4 years from 2010 to 2013, RWA Network medical workforce data indicates the mean weekly hours worked by regional, rural and remote GPs declined by 1.3 hours. Nationwide, this is the equivalent of around 250 fewer full-time equivalent GPs in regional, rural and remote areas.

[11] Rural Health Workforce Australia. 2014. *Op cit.*

[12] Ibid.

Furthermore, while there have been improvements in access to GPs, the people of outer regional, remote and very remote parts of Australia still experience higher population to GP ratios than Australians living in major cities and inner regional areas.

In 2002, there were 2,024[13] people in remote locations for every 1 full-time working equivalent[14,15] (FWE) GP. Ten years later, this ratio had improved significantly to 1,646 people for every 1 FWE GP. However, this was still substantially more than the population to GP ratios for major cities and inner regional areas, as shown in Table 2 below.

**Table 2: Number of persons per Full-time Working Equivalent GP by Remoteness Area[16] (2002-2012)**

| | RA 1 Major Cities | RA 2 Inner Regional | RA 3 Outer Regional | RA 4/5 Remote/ very remote |
|---|---|---|---|---|
| 2002 | 1,083 | 1,316 | 1,475 | 2,024 |
| 2012 | 1,057 | 1,037 | 1,221 | 1,646 |

Other issues to consider in the context of access to health care services in regional, rural and remote Australia include:

- people in rural and remote areas have relatively higher levels of chronic disease and poorer social determinants of health indicators (eg education, employment, housing) and therefore often require higher levels of health services;

- GPs in rural and remote towns often provide many additional services to their communities as compared with urban GPs such as on-call, hospital emergency and ward rounds and attending accidents;

[13] Australian Bureau of Statistics 2014. *Op cit.*.

[14] FWE is a measure of service provision produced by Medicare taking into account doctors' varying workloads. FWE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period.

[15] Government Department of Health 2012. General Practice Workforce Statistics, http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1, accessed 21/02/2014.

[16] Australian Standard Geographic Classification Remoteness Area (ASGC-RA). ASGC-RA is a geographic classification system that was developed in 2001 by the Australian Bureau of Statistics (ABS), as a statistical geography structure which allows quantitative comparisons between 'city' and 'country' Australia. The RA categories are - RA1: Major Cities of Australia; RA2: Inner Regional Australia; RA3: Outer Regional Australia; RA4: Remote Australia; and RA5: Very Remote Australia.

- the sparse nature of remote regions of Australia means that access measures need to consider both the numbers of healthcare professionals and the geographic distance people live from those professionals and their services; and

- while GPs are at the centre of primary healthcare models for most areas, in remote and very remote locations alternative models of care are sometimes more viable or the only available option (for example, in some communities a Remote Area Nurse may be the sole healthcare professional).

**In Summary, access to healthcare services in regional, rural and remote Australia has improved in recent years.**

**However maldistribution and inequity persists and workforce trends necessitate that continual innovation, improvement and refinement is required to ensure all Australians have similar levels of access to essential healthcare services.**

**It is within this broad context that we detail our priority recommendations for improvements in the provision of Indigenous and rural health services.**

## 4. RESPONSE TO TERMS OF REFERENCE

### e) Improvements in the provision of health services, including Indigenous health and rural health

As noted, a range of factors impact on the delivery of efficient health services to regional, rural and remote communities. Recognising that no single policy or mechanism is effective in isolation, the following details what the RWA Network believes are priority areas for improvements.

At the outset it is highlighted that while some of the recommendations made relate specifically to the medical health workforce, Section 4.4 details the need for an increased focus on the nursing, dental and allied health workforce to improve Indigenous and rural health (refer pages 24-25).

### 4.1 Developing the Australian-trained health workforce

The Australian government has made a significant investment to address the issue of GP shortages and maldistribution through increasing the domestic workforce, with medical student places increasing from 8,689 domestic students in 2006[17] to 14,267 in 2013[18]. However, despite this significant increase in domestic medical graduates, the vast majority will go on to specialise in areas of medicine other than general practice and will do so in major cities. [19]

The latest data from the Medical Schools Outcome Database[20] longitudinal study of students at Australian medical schools highlights that of graduating students:

- 13.3 % list General Practice as their preferred speciality; and
- 4.6% state an intention to have their future medical practice in smaller towns and communities.

[17] Medical Deans Australia and New Zealand. http://www.medicaldeans.org.au/wp-content/uploads/2006-Table-1-Domestic-by-year.pdf, accessed 21/02/2014.

[18] Medical Training Review Panel. 2014. Seventeenth report. Canberra: MTRP.

[19] Duckett S & Breadon P. 2013. *Access all areas: new solutions for GP shortages in rural Australia*. Melbourne: Grattan Institute; p.10.

[20] Kaur B, Carberry A, Hogan N, Roberton D & Beilby J. 2014. The Medical Schools Outcome Database project: Australian medical student characteristics. *BMC Medical Education*; 14:180.

These numbers suggest that unless Australian graduates can be persuaded differently, the growth in medical student placements alone is unlikely to meet current workforce needs. A range of initiatives have been developed to encourage Australian-trained graduates to work in regional, rural and remote areas. These include:

- promoting healthcare careers to rural high school students;
- rural-background admissions quotas or targets for medical schools;
- bonded medical school places with return of service obligations in rural and remote areas; and
- rural exposure experiences for urban students through programs such as the John Flynn Placement Program, the RWA Network Go Rural Program, the development of rural training pathways and extended rural placements for GPs in training.

**CASE STUDY 1**
**Examples of RWA Network initiatives targeting the Australian-trained health workforce**

### Rural High School Visits

**The RWA Network has developed an ongoing program of high school visits to rural areas where young mentors can promote and discuss the opportunities for a health career in a rural location.**

**Every year the National Rural Health Students' Network (NRHSN), auspiced by RHWA, organises over 200 visits to high schools throughout Australia through the University Rural Health Clubs. These visits continue to translate into positive results, illustrated by the uptake of university places in health degrees by rural and remote students.**

### The Go Rural Program

**Go Rural events provide students and junior doctors with meaningful insights into rural life by introducing the culture of smaller communities, opportunities to explore the rural lifestyle and highlighting the value that a doctor can bring to a small town.**

**Supported by a national marketing campaign from RHWA, Go Rural events are delivered locally by the RWA Network. Each agency tailors Go Rural events to suit their jurisdiction such as information sessions, road trips, skills training sessions and network evenings. Many of these events provide an opportunity for hands-on exposure and clinical skills experiences.**

### Workforce Research

**What makes an Australian-trained student or junior doctor from a major city want to go rural?**

**That is the key question that will be answered by a new research project undertaken by RHWA in partnership with the University of Queensland. The study will examine the decision-making process of young people in the medical workforce pipeline, looking at what factors students and junior doctors take into account when deciding where to practise.**

**Researchers will also explore the timing of such decisions and who influences them. The results will be used to inform strategies for engaging with young people at various stages of the workforce pipeline – whether they be a medical student, intern, prevocational doctor or registrar.**

The pipeline from high school student, through fellowship and on to rural practice is complex. The RWA Network believes that a holistic approach to encourage rural medical practice at all stages of the decision making process is required across the spectrum of a practitioners' career - from high school, through the training pathways of university, internship, and post-graduate training, as well as placement and ongoing support. This will ensure there is a continued rural connection from high school through to fellowship, coupled with adequate training and support to create the rural workforce of the future.

**RECOMMENDATION 1** Continued innovation and refinement of programs and initiatives that provide multiple opportunities for exposure to rural practice and experience of the rural lifestyle along the career pathway to attract and support Australian-trained health professionals who choose to 'go rural' as a career choice.

Ensuring adequate training places for our medical students in regional, rural and remote locations is a vital component of the rural pipeline from student to practice. RHWA acknowledges and welcomes recent Government commitments to enhance regional, rural and remote training opportunities for medical students, including:

- significantly increasing the number or rural training places available;
- doubling the practice incentive teaching payments; and
- providing additional funding for at least 175 new general practice teaching infrastructure grants.

Further commitment from all stakeholders is required to ensure continued streamlining of administrative processes and pathways in the rural workforce pipeline. At present there are few formal linkages between the many health workforce programs and stakeholders. This means that some workforce attraction and retention programs (both Commonwealth and jurisdictional) operate in silos. Working collaborations between different program fund-holders generally occurs on an ad-hoc basis through individual organisation negotiation.

RHWA believes that increased efficiencies and better workforce outcomes could be achieved if more formal linkages and data-sharing between relevant stakeholders was required as part of program funding contractual obligations.

| RECOMMENDATION 2 | A continued commitment and effort from all stakeholders to increasing opportunities and streamlining processes for health professionals to undertake training in regional, rural and remote communities. |
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| RECOMMENDATION 3 | Workforce program funding contracts contain a requirement for the fund-holder to formally liaise with other workforce program fund-holders, including the sharing of de-identified program data where relevant. |
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Research highlights that 42% of medical Registrars who train in rural and regional locations remain for at least five years once they have obtained Fellowship (specialist registration).[21] Given that half of the 1,200+ General Practice training places offered each year must be within regional, rural and remote communities, there is scope to further encourage post-Fellowship retention amongst this young workforce through continued support.

| RECOMMENDATION 4 | Development of policies to encourage Registrars to remain in regional, rural and remote communities following completion of their training rather than return to major cities. |
|---|---|

There is also a need to increase training opportunities for Australian-trained allied health professionals (see Section 4.4 following) and medical specialists in regional, rural and remote communities. With respect to the latter, while the outreach service model is the most viable and efficient for smaller communities, there is scope for generalists in larger regional and rural centres.

| RECOMMENDATION 5 | Strategies to facilitate increased training opportunities for medical specialists (particularly general physicians) and allied health professionals in regional, rural and remote locations. |
|---|---|

[21] Bracey A. 2013. Rural registrars stay on five years. *Medical Observer*. http://www.medicalobserver.com.au/news/rural-registrars-stay-on-for-five-years?

## 4.2 Streamlining and improving administrative processes for overseas-trained doctors

As discussed (see pages 14-17), encouraging more Australian-trained health professionals to regional, rural and remote communities is a priority however overseas-trained doctors (OTDs) will continue to make a vital contribution to non-metropolitan health services in the short to medium term. To date, much of the growth in GP numbers outside of the major cities has predominantly come from increased numbers of Overseas Trained Doctors (OTDs), with 42% of the regional, rural and remote GP workforce comprising OTDs in 2012.[22]

OTDs are highly valued by their local communities and the RWA Network plays an important role in the attraction, recruitment and support of these doctors, including ongoing assistance to achieve vocational registration, continuing professional education and family support. In 2012, a comprehensive report into the registration processes and support for OTDs was undertaken by the House of Representatives Standing Committee on Health and Ageing (the 'Lost in the Labyrinth' report).[23]

This report found that OTDs and the agencies working with them faced significant bureaucratic complexities and inefficiencies. A total of 45 recommendations were made to address these issues and RHWA welcomes recent and ongoing reviews by the Australian Medical Council into the Pre-Employment Structured Clinical Interview Guidelines and the Australian Health Minsters' Advisory Council into the National Registration and Accreditation Scheme as evidence of this.

Nevertheless, anecdotal feedback from OTDs and Rural Workforce Agencies highlights that ongoing effort and commitment in this area is required from all stakeholders (see following case studies).

**RECOMMENDATION 6** That all relevant stakeholders including the Department of Health, the Australian Health Practitioner Regulation Agency, the Medical Board of Australia, the Australian Medical Council, the specialist medical colleges and Rural Workforce Agencies continue to work together to implement the recommendations from the Lost in Labyrinth Report (2012).

[22] Australian Government Department of Health 2012. *Op cit.*

[23] Commonwealth of Australia House of Representatives Standing Committee on Health and Ageing. 2012. Lost in the Labyrinth: report on the inquiry into registration processes and support for overseas trained doctors. Commonwealth of Australia: Canberra.

## CASE STUDY 2

### Loss of Medicare Provider Number when residency status changes = impact on communities and practices

**The RWA Network administers the Rural Locum Relief Program (RLRP) which is an approved workforce program under Section 3GA of the *Health Insurance Act 1973*. The RLRP enables overseas-trained doctors (OTDs) with permanent residency or Australian citizenship to undertake work in rural and remote general practice and access a Medicare provider number while working towards post-graduate general practice qualifications.**

**OTDs with a temporary visa are not eligible for the RLRP however they can work in rural and remote general practice under a different workforce program – the Temporary Resident Doctor (TRD) scheme.**

**When an OTD with a temporary visa attains permanent residency or citizenship they are no longer eligible to access a Medicare provider number under the TRD scheme but must apply for the RLRP. Prior to September 2012, when an OTD changed visa status from temporary to permanent, Medicare Australia and the Department of Health allowed a 28 day 'grace period' for the required RLRP administrative process and paperwork. This grace period (removed in September 2012) ensured the OTD could continue working and accessing a Medicare provider number during their transition period until the 3GA placement was approved by a RWA with the associated paperwork sent to Medicare.**

**In the scenario of a solo rural doctor town, the grace period ensured that the GP did not have a gap in access to a provider number, and therefore the community could continue to have access to vital general practice services.**

## CASE STUDY 3

### Two similar GP support programs - Additional Assistance Scheme & OTDNET

**The Additional Assistance Scheme (AAS) provides doctors with financial assistance enabling them to access support for education and up-skilling opportunities to facilitate their work towards gaining Fellowship. The AAS is administered by the RWAs and plays a pivotal role in supporting doctors to achieve Fellowship. It provides them with access to resources, support and education as well as opportunities to meet regularly with their peers.**

**Overseas Trained Doctor National Education and Training (OTDNET) is administered by General Practice Education and Training (GPET, which as announced in the 2014-15 Commonwealth Budget will cease operations on 31 December 2014). The OTDNET program provides OTDs with access to education and training which supports the learning needs of the doctor towards gaining general medical registration and/or Specialist (General Practitioner) Registration, in particular preparing for the relevant Australian Medical Council (AMC) or College exams.**

**The RWA Network is supportive of a coordinated national program to provide Fellowship exam support to OTDs. With the availability of two Fellowships exam support programs (AAS and OTDNET) a challenge is ensuring that eligible doctors are directed to the exam support program that provides best value and support to the doctor while they are preparing for Fellowship.**

## 4.3 Reviewing geographic classification systems

Different workforce programs and initiatives use different geographic classification systems to determine a health professional's eligibility to receive incentives or work in particular areas (this most commonly applies to GPs). The four classification systems of greatest relevance to health workforce programs are summarised in Table 3.

**Table 3: Geographic classifications systems**

| | |
|---|---|
| Rural, Remote and Metropolitan Areas (RRMA) | RRMA was developed in 1994 by the Department of Primary Industries and Energy. Seven categories are included based on Statistical Local Areas (SLA) and allocates each SLA in Australia to a category based primarily on population numbers and an index of remoteness. |
| Districts of Workforce Shortage (DWS) | DWS is determined by the Department of Health using Australian Bureau of Statistics population data and Medicare Australia billing data. A location is deemed to be a DWS if it falls below the national average for the provision of medical services. |
| Australian Standard Geographic Classification-Remoteness Area (ASGC-RA) | Based on ABS data, ASGC-RA determines distance from population centres of various sizes. |
| Area of Need (AoN) | AoN is determined by each State/Territory Health Department using distinct systems, and is applied differently in each jurisdiction. Generally, AoN is applied to individual workplace positions rather than geographic areas and is often granted on a "case by case" basis to a specific hospital or health service. |

These classification systems can have significant and far-reaching implications on attracting and equitably distributing our health workforce. For example:

- the Bonded Medical Places scheme provides additional Commonwealth Supported Places in undergraduate medical schools to students who commit to working in a District of Workforce Shortage for a period of time following qualification from a specialist college;

- the General Practice Rural Incentive Program pays financial incentives to GPs working in regional, rural and remote locations which are scaled according to the ASGC-Remoteness Area and length of time services are provided;

- the Rural Locum Relief Program and Rural Other Medical Practitioners program provide access to a Medicare provider number for eligible GPs while they work towards obtaining Fellowship and operate on the RRMA classification system.

There are a number of well-known issues and anomalies with the current classification systems.[24] These include:

- a lack of consistency between the different definitions;
- a lack of consistency between which system is used to assess eligibility for different workforce programs;
- a lack of transparency in how the different classifications systems are calculated or derived;
- a lack of flexibility in how the classification systems are applied;
- anomalies within classifications (for example, within the ASGC-RA system, cities such as Darwin and Cairns are classified at the same level of remoteness as Broken Hill and Longreach);
- Area of Need classifications vary across jurisdictions; and
- both DWS and AoN locations can be within metropolitan boundaries (albeit usually outer metropolitan).

These issues:

- lead to less than optimal workforce and incentive resource allocation (eg a GP will receive the same level of incentive for choosing to work in Cairns as in Longreach);

- create a significant administrative workload for RWAs and other organisations (particularly when GPs move between locations or are eligible for multiple workforce programs which utilise different classification systems); and

- cause confusion for healthcare professionals.

[24] See for example, National Rural health Alliance. 2013. *Wanted: a uniform system for assessing health workforce shortages and targeting programs to attract health professionals.* NRHA: Canberra.

## CASE STUDY 4
### Bonded Medical Places (BMP) scheme – return of service obligations

**The BMP scheme offers students a Commonwealth supported medical school place for a return of service obligation which commences once the student attains specialist college Fellowship. The scheme's guidelines generally require students to work in a DWS for a period of time equal to the length of their medical degree.**

**Many rural towns are unable to attract BMP scheme graduates however because they are not classified as DWS. For example, Atherton (Qld) and Inverell (NSW) have critical health workforce needs that would benefit from access to BMP placements. However they do not have a DWS classification**

**Further, a bonded graduate who has been working in rural area cannot continue to work in those locations if the area loses its DWS status. Such rural scholars can however move into metropolitan areas of DWS to complete their obligation, when the purpose of the scheme is to grow the local rural and remote medical workforce.**

**RECOMMENDATION 7** That geographic classification systems used by Commonwealth and State and Territory departments of health to target health work-force programs and incentives be reviewed to ensure that they are transparent, consistent, equitable and target workforce to areas of greater need.

**RECOMMENDATION 8** That any proposed changes to current systems are thoroughly modelled and trialed to assess their impact..

**RECOMMENDATION 9** That State and Territory jurisdictions develop nationally consistent criteria for the approval of a location as an Area of Need.

**RECOMMENDATION 10** That the requirement for Bonded Medical graduates' return of service obligation to be in a DWS location be reviewed so that the intent of the program is maintained for placements in genuine rural and remote locations.

## 4.4 Increased focus on the allied health workforce and alternative models of care

Australia-wide there is a chronic shortage of allied health professionals working in rural and remote locations.[25] One study found that Australians in metropolitan areas receive more than double the level of service provision from allied health professionals such as physiotherapists, podiatrists, occupational therapists and social workers as those living outside of urban areas.[26]

This discrepancy becomes more pronounced as the degree of remoteness increases, with the ratio of allied health professionals to population falling from 2.2 per 10,000 in capital cities to between 1.4 and 1.8 in regional areas, 1.2 in remote areas and 0.6 in very remote areas.[27]

The RWA Network believes that increasing access to allied health professionals is an important component of improving regional, rural and remote health outcomes. In addition to providing allied health services, in many communities nursing and/ or allied health professionals represent a viable alternative to a medical model of care.

In 2012, the former Health Workforce Australia (HWA) introduced a new workforce initiative designed to increase the nursing and allied health professional workforce in rural and remote Australia - the Rural Health Professionals Program (RHPP). This program was administered in each state and the Northern Territory by the RWA Network, with each RWA responsible for identifying vacancies within their jurisdiction and providing a fully case managed recruitment service to eligible candidates including retention support for up to two years.

Commencing in January 2012, the program recruited 550 nurses and allied health professionals to remote, rural and regional locations. Funding to recruit new participants ceased at the end of 2013, however RWAs continue case-managing a number of professionals.

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[25] Schoo, A. M., Stagnitti, K. E., Mercer, C., & Dunbar, J. 2005. A conceptual model for recruitment and retention: Allied health workforce enhancement in Western Victoria, Australia. *Rural and Remote Health*, 5: 477.

[26] *Ibid.*

[27] Chisholm, M., Russell, D., & Humphreys, J. 2011. Measuring rural allied health workforce turnover and retention: What are the patterns, determinants and costs? *Australian Journal of Rural Health*, 19: 81-88.

**RECOMMENDATION 11** That funding of the Rural Health Professionals Program is renewed to ensure the continued recruitment of nursing and allied health professionals to difficult-to-fill vacancies in regional, rural and remote locations.

As noted earlier in this submission, in some small communities nursing and allied health professionals may represent the only viable provider of health care services. The RHPP has proven to be a valuable attraction and support initiative. The RWA Network also recognises and welcomes other recent positive initiatives directed towards allied health and multi-disciplinary healthcare including:

- 500 additional nursing and allied health scholarships; and
- changes to medical specialist outreach service program guidelines allowing multidisciplinary healthcare teams.

As with strategies to increase the GP workforce in regional, rural and remote Australia, no single policy or initiative in isolation will be sufficient to meet the challenge. Continual innovation, review and refinement of programs, initiatives and models of care are needed with upfront and ongoing community consultation.

The RWA Network continues to develop and trial alternative models of care to deliver sustainable healthcare services to regional, rural and remote Australia.

**CASE STUDY 5**
**Alternative models of care in regional, rural and remote health**

**Rural and Remote Medical Services (RaRMS) - Established by the NSW Rural Doctors Network, RaRMS is an 'Easy Entrance-Gracious Exit' model or 'walk in walk out' approach, in which a not for profit organisation (RaRMS) administers the surgery for GPs who have their own clinical practice and pay for the administrative services. This model aims to make general practice in difficult to recruit areas more attractive by enabling GPs to work as clinicians without having to be small business owners and managers.**

**Eyre Peninsula - An innovative workforce solution has been developed by the Rural Doctors Workforce Agency of South Australia and Country Health SA for the three communities on the Eyre Peninsula of Kimba, Elliston and Cleve. Two new doctors were recruited to join a resident GP to form a team where all three provide medical services to the three communities each week, giving people choices and certainty. This model addresses the issues of distance, attracting a workforce and medical service sustainability.**

## CASE STUDY 6

### Improving access to dental services in regional, rural and remote Australia

**The Dental Relocation and Infrastructure Scheme (DRISS) is an Australian Government initiative aimed at addressing the maldistribution of dentists in Australia. The scheme provides incentives and infrastructure grants to dentists relocating to more regional, rural and remote locations and is administered by RHWA and the RWA Network.**

**The first DRISS funding round opened in August 2013 and to date two rounds have been completed with the third currently open (September 2014). During the first two funding rounds over 850 enquiries were received from dentists and well over 100 applications were received. Of these, approximately half received a DRISS grant.**

**Today, tens of thousands of Australians in regional, rural and remote communities have access to dental services from DRISS-supported dentists.**

## 5. RESPONSE TO TERMS OF REFERENCE

### g) Health workforce planning

Healthcare is a labour intensive industry with a large proportion of health care expenditure dedicated to the health workforce. Further, the healthcare workforce (particularly doctors) is less flexible than other labour markets due to the long lead time for training (up to 15 years for a medical specialist); licensing and registration requirements and Australia's largely private self-employed model of primary healthcare.[28] Hence, compared with other labour markets, the healthcare workforce can be slow to respond to changes in demand and community needs.

In this context, RHWA strongly believes that ongoing health workforce planning is essential to ensure that all Australians, regardless of where they live, have access to high quality, appropriate and affordable healthcare.

Until recently, Health Workforce Australia (HWA) was responsible for undertaking comprehensive and sophisticated health workforce planning at a national level. In the 2014-15 Federal Budget the Australian Government announced that HWA was to be closed and its functions and programs transferred to the Department of Health. RHWA is confident that high quality, national long-term health workforce planning will continue within the Health Workforce Division of the Department of Health.

With regard to GP data in particular, obtaining accurate and detailed data about GPs working in regional, rural and remote Australia and their total service provision (including non-billable and non-Medicare billable work) is a vital component of evidence-based healthcare needs assessment and planning. For more than a decade, the RWA Network has collected a Minimum Data Set (MDS) on the GP workforce in their respective jurisdictions.

While the Australian Institute of Health and Welfare's Medical Workforce dataset provides an accurate estimate on the *size* of the rural and remote GP workforce (as measured by 'head count'), the RWA Network MDS data provides additional information, particularly in relation to:

[28] National Health Workforce Planning and Research Collaboration 2011. *Alternative approaches to health workforce planning final report.* Health Workforce Australia: Adelaide.

- a breakdown of the hours worked in clinical and specific types of non-clinical work (such as teaching, travelling to other primary care work locations, on-call availability);
- models of service provision (eg resident GP, hospital-based GP, fly-in fly-out);
- procedural skills possessed by the GP which add to the total picture of service provision in a particular location (for example, operative surgical or obstetrics skills); and
- length of stay in current practice.

In the future, the RWA Network plans to expand the information collected through the MDS and develop processes to allow the dataset to be collated nationally and tracked over time. This new and larger dataset will:

- provide a greater understanding of the distribution of the health workforce across different service locations;
- allow longitudinal tracking of individual healthcare professionals in a de-identified way – both over time and across jurisdictions, whilst ensuring privacy principles are complied with at all times; and
- in time, facilitate linkage with other healthcare data sets.

This will represent the most detailed longitudinal data-set on the regional, rural and remote primary healthcare workforce. The RWA Network has already held detailed discussions with the Australian Institute of Health and Welfare regarding collaboration on this project.

**RECOMMENDATION 12** That key stakeholders including the Department of Health, the Australian Institute of Health and Welfare and the Australian Health Practitioner Regulation Agency continue to work with the RWA Network to develop an expanded primary healthcare Minimum Data Set to enable evidence-based future workforce planning and assessment of program initiatives in regional, rural and remote communities.

In discussing health workforce planning, RHWA also acknowledges the valuable contribution to evidence-based planning made by the Medical Schools Outcome Database (MSOD). MSOD is a world-leading project for tracking medical students through medical school and into training. All Australian and New Zealand medical schools are involved in this landmark project which collects critical information such as vocational and practice location intentions, clinical experience, rural background and the length and nature of rural exposure. Since 2005 more than 30,000 questionnaires have been collected.

MSOD data can provide empirical evidence to support policy initiatives such as rural background admissions targets for medical undergraduates and the proportion of Rural Clinical School graduates who go on to practice in rural and remote locations. MSOD can also inform workforce planning through providing data on vocational specialty and practice location intentions.

To date, MSOD has been funded through Health Workforce Australia and with the dismantling of this agency uncertainty currently exists surrounding the ongoing funding of this project beyond 2014.

**RECOMMENDATION 12** That the Medical Schools Outcome Database project continue to be funded to ensure its vital role in medical workforce planning and the provision of empirical evidence to inform health workforce policy.

## ATTACHMENT A: RURAL WORKFORCE AGENCY NETWORK ACHIEVEMENTS FACT SHEET

rhw
rural health workforce
AUSTRALIA

# OUR NETWORK'S ACHIEVEMENTS

Rural Health Workforce Australia (RHWA) is the peak body for the Network of Rural Workforce Agencies (RWAs) in each State and the Northern Territory. Our not-for-profit Network attracts, recruits and supports health professionals for towns and communities across Australia. Our Network is committed to making primary health care more accessible by providing a skilled, sustainable workforce that meets the needs of rural and remote people.

## 2012-13 NATIONAL DATA HIGHLIGHTS

### GP WORKFORCE

- A total of 7,499 GPs were working in a designated rural or remote area (RA 2-5)
- 95% of GPs were remaining for 6 months or more and 84% were employed for longer than 12 months
- Attrition rates for doctors working in their designated RA were also low
- The 2012-13 annual average rate of cessation was 5%

### GP RECRUITMENT

In 2012-13, RWAs managed:

- 9,135 enquiries from doctors
- 1,340 (15%) were assessed as eligible candidates
- 312 commenced in practice – of these 21 commenced in Aboriginal and Torres Strait Islander services
- At 30 June 2013, RWAs were managing 705 vacancies in 421 towns

### LOCUM SERVICES

- In 2012-13, of the 1,232 practitioners who requested locum support, 1,070 or 86% received locum support

### NURSING AND ALLIED HEALTH RECRUITMENT

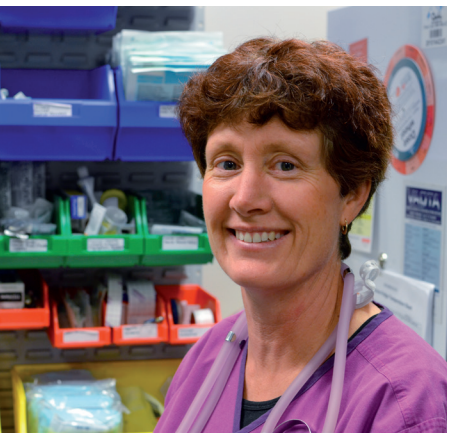
In 2012-13, RWAs managed:

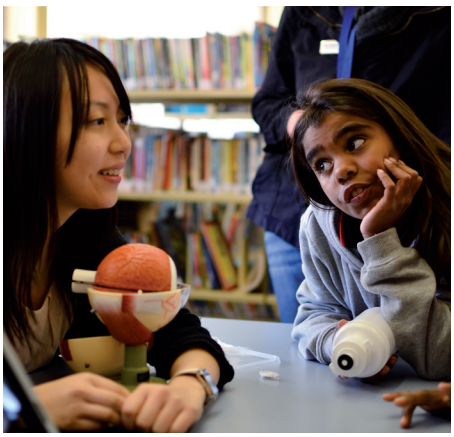
- 2,833 enquiries from nurses and allied health professionals
- 845 were assessed as eligible candidates
- 365 nurses and allied health professionals commenced in practice and were provided with retention packages

### OTHER SUPPORT SERVICES

Across Australia in 2012-13:

- 5,851 GPs were provided with services from RWAs
- 1,995 practices were provided with services from RWAs
- 200 GPs were assessed for Flexible Payments under the GP Retention program
- 911 GPs were provided with professional development grants and subsidies
- 1,820 GP families were provided with family support
- 81 GPs and families were provided with crisis support






### OUTREACH SERVICES

Throughout 2012-13, RWAs in Victoria, New South Wales, Western Australia and South Australia coordinated visiting outreach medical services under a range of Federal outreach and Indigenous chronic disease programs. This included Medical Specialist Outreach Assistance Program (MSOAP), MSOAP – Indigenous Chronic Disease multidisciplinary teams, MSOAP – Maternity Services multidisciplinary teams, Urban Specialist Outreach Assistance Program, Paediatric Surgical Outreach Program and MSOAP – Ophthalmology services.

- In 2012-13 – in New South Wales, Victoria, Western Australia and South Australia – 933 practitioners made 13,764 outreach visits providing 194,226 patient services.

## WORKFORCE PROGRAMS

### RURAL LOCUM RELIEF PROGRAM

- 793 GPs on Rural Locum Relief Program (RLRP) were being supported by RWAs as at 30 June 2013. Since October 2008, a total of 1,143 RLRP doctors have been placed.

### FIVE YEAR SCHEME

- There were 145 doctors on the Five Year Scheme at 30 June 2013

  (A study of Five Year Scheme doctors from four states – New South Wales, Tasmania, Victoria and Western Australia – showed that of the 251 practitioners who completed their service requirements, 57% remained working in rural Australia after the completion of their term)

### ADDITIONAL ASSISTANCE (FELLOWSHIP EXAM SUPPORT)

- From October 2008 to September 2013, 891 doctors received support under the Additional Assistance Scheme

### INTERNATIONAL RECRUITMENT SCHEME

- From October 2008 to June 2013, 405 doctors have been recruited under the International Recruitment Scheme

### RURAL HEALTH STUDENTS

- RHWA supports more than 9,000 rural health students across Australia and 28 university Rural Health Clubs through the National Rural Health Students' Network

*Rural Health Workforce Australia and the Rural Workforce Agencies are funded by the Federal Department of Health.*

## OUR NETWORK

**PEAK BODY**
Rural Health Workforce Australia
www.rhwa.org.au
03 9860 4700

**NSW**
NSW Rural Doctors Network
www.nswrdn.com.au
02 4924 8000

**VIC**
RWAV
www.rwav.com.au
03 9349 7800

**QLD**
Health Workforce Queensland
www.healthworkforce.com.au
07 3105 7800

**SA**
Rural Doctors Workforce Agency
www.ruraldoc.com.au
08 8234 8277

**WA**
Rural Health West
www.ruralhealthwest.com.au
08 6389 4500

**TAS**
Health Recruitment Plus Tasmania
www.healthrecruitmentplus.com.au
03 6334 2355

**NT**
Northern Territory Medicare Local
www.ntml.org.au
08 8982 1000