

Executive summary

Chapter 2: The distribution of medical, nursing and allied health professionals across Australia

The committee considered the distribution of medical, nursing and allied health professionals across the country. Over the last two decades there have been efforts to quantify the adequacy of the health workforce in Australia in order to ensure that policy is evidence-based and accurately reflects community requirements. The task of measuring the adequacy of the medical workforce is complex, requiring more than a national headcount.

The figures available present a picture of contrasts across the health workforce. Although statistics show that GPs and nurses are spread evenly across regions of differing remoteness on a per capita basis, we know access to this workforce is inconsistent. Medical specialist numbers plummet outside the major cities, to levels as low as one-sixth of those in the large capitals. Accessibility, particularly in remote areas, is an issue. Health care needs amongst populations may also vary, and the committee is aware of data showing higher disease burdens and poorer health outcomes in regional and remote areas for some conditions.

The committee accepts the Australian Institute of Health and Welfare's view that the new national registration scheme is producing higher quality data for the numbers and types of medical and health practitioners. However the committee has heard repeatedly that there are data issues limiting the ability to analyse the factors affecting health service delivery in rural areas. The committee thinks that this is a key area of responsibility for the Department of Health and Ageing's Rural and Regional Health Australia.

Recommendation 1

The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, prioritise the collection of robust and meaningful data on rural health as part of the forthcoming review of rural health programs.

Recommendation 2

The committee recommends that Rural and Regional Health Australia, as part of the Department of Health and Ageing, review the current literature from key stakeholders and universities and develop a strategy to address the gaps in research and knowledge affecting rural health service delivery.

Health professionals can face both professional and personal barriers to entering and staying in rural locations. These barriers relate to factors including professional development, income, accommodation, and opportunities for spouses and children. Allied health professionals face additional challenges in delivering services to non-metropolitan populations. This is attributable to current Medicare and other funding arrangements, social barriers, access to appropriate, affordable and secure

accommodation, and is exacerbated by lower remuneration than doctors. More effort needs to be expended in ensuring that appropriate policies are in place to promote the development and retention of multidisciplinary health teams in non-metropolitan areas.

Chapter 3: The nature of the medical profession in rural areas

The committee explored the nature of the health workforce in rural areas, specifically breaking down the types of medical practitioners working in those areas. It then examined the policy proposals of some of the specialist colleges that submitted to the inquiry.

The committee noted a growing trend towards medical specialisms and sub-specialisms. This is having a disproportionate impact on the supply of doctors in rural and regional areas. This is principally due to specialisation causing a reduction in generalist training pathways which has been cited as the area of medical practice most required in rural and regional areas.

The committee concluded that there needs to be a significant increase in rural generalist GPs. The committee is strongly supportive of the efforts of various stakeholders to increase the numbers of rural generalists in the rural medical workforce through the development of rural generalist training pathways.

The committee is strongly supportive of the Queensland Health initiative to develop a program based on local needs. The evidence the committee has received has also endorsed the program as being successful in delivering increased access to healthcare in rural areas. The committee accepts that this program may not be suited to all areas of the country, as each jurisdiction faces distinctive challenges in terms of its dispersal of population and workforce arrangements. Each state and territory Government may wish to explore different pathways to provide increased access to health care tailored to local need.

The model adopted by the Central Australian Aboriginal Congress displays innovation necessitated by need. The emphasis on multidisciplinary teams allows professional development across the health specialties and appears to be successful in combating professional isolation. The collaboration between different education providers to provide health workers and training opportunities has also led to a steady flow of GPs, nurses and Allied Health Workers that appears to be sustainable, and the committee was impressed with the systems put in place by Congress to provide a blueprint for centrally managed healthcare in remote areas.

Recommendation 3

The committee recommends that the Commonwealth place on the agenda of the Council of Australian Governments' Standing Council on Health an item involving consideration of the expansion of rural generalist programs. It further recommends that, as part of that agenda item, the Council consider an evaluation of the Queensland Health Generalist Program and whether it should be rolled out in other jurisdictions.

Recommendation 4

The committee recommends that the Commonwealth government work with education providers and the medical profession to address the issue of the inadequate supply of rural placements for medical interns in their pre-vocational and vocational years.

Chapter 4: Attempts to address the rural medical skills deficit

The committee considered attempts that have been made over recent years to alleviate workforce pressures in rural areas. It looked at the many factors involved in the decision to work in a rural area, and how effective the various government and non-government measures have been in addressing these issues.

The committee is supportive of the efforts of the Commonwealth Government under the Rural Clinical Training and Support scheme. However, the committee does not believe that four weeks structured rural practice training is sufficient time to expose the student to the full gamut of experience available in rural Australia. The committee also heard of a number of instances where the local community had actively welcomed students and ensured that they had a positive feeling of engagement and connectedness with the area. The committee does not think that four weeks is long enough to foster that level of input from the community.

Evidence received by the committee shows a large disparity between the support provided for allied health professionals and that provided for doctors to work in non-metropolitan areas. The committee considers that this situation neither promotes access to quality healthcare in rural areas, nor does it take into account the requirements of team-based patient care.

Most of the existing support mechanisms available for medical specialists should also be available to allied health professionals and nurses. In particular the committee strongly supports the introduction of a HECS reimbursement scheme for nurses and allied health professionals for reasons of equity and incentive.

Recommendation 5

The committee recommends that the HECS Reimbursement Scheme available for doctors be extended to nurses and allied health professionals relocating to rural and remote areas as soon as possible.

Given the extensive range of government programs and measures to address different aspects of rural health, it would be beneficial if there was an office located within DoHA, similar to the Chief Nurse and Midwife, that would provide a strong voice within government on all issues relating to Australia's rural health workforce.

Recommendation 6

The committee recommends that the post of Rural and Regional Allied Health Adviser be established within Rural and Regional Health Australia to coordinate and advise on allied health service provision in rural and regional Australia.

The committee considers the expansion of eHealth and telemedicine to be an opportunity to supplement health care delivery across Australia, with particular

relevance to rural and remote areas. It should not be considered as a replacement for personally delivered primary health. It has the potential to improve training, access to specialist advice and professional development and will be key in future health care delivery. However it will need to be coordinated with current management systems and agencies such as Medicare to ensure that remuneration as appropriate is delivered, and its potential is realised.

In some cases communities lack the population and infrastructure to support specialised practices, and the existing workforce in non-metropolitan areas is frequently overworked. One way to try and overcome this is by broadening the scope of skills and competencies of the existing workforce, particularly through the nurse practitioner model. The committee recognises that any reallocation of professional responsibilities will be contentious, and may encounter strong opposition from some groups. However, the committee did not receive any evidence against equipping the existing workforce to as high a level as possible. Furthermore, it is aware of evaluations showing that professionals and patients have been supportive of such initiatives.

The government is spending a significant amount of money to try and ensure adequate health services in regional Australia. The evidence provided to the committee during the course of this inquiry has highlighted deficiencies in the development and evaluation of these programs. There is an urgent and fundamental need to better understand what programs have been effective and therefore where energy and resources need to be applied.

New programs should include an evaluation strategy that will allow both assessment of the programs' impact and the creation of information needed to compare cost effectiveness with other initiatives. The government should be prepared to redirect funds from less cost effective programs to the more effective ones, but at present it appears difficult to establish which initiatives offer the best value for money for meeting the needs of regional healthcare patients.

The committee acknowledges the excellent work of the House of Representatives Standing Committee on Health and Ageing, in its report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, tabled in March 2012. This committee endorses the recommendations made as part of that inquiry. This committee draws particular attention to the House committee chair's comments that:

it is clear that whilst [International Medical Graduates] IMGs generally have very strong community support, they do not always receive the same level of support from the institutions and agencies that accredit and register them...

[There were] a significant proportion of witnesses describing a system lacking in efficiency and accountability, and importantly, one in which IMGs themselves often had little confidence. Many IMGs also felt that they had been the subject of discrimination, and anti-competitive practices and that this had in some cases adversely affected their success in registering for medical practice in their chosen speciality.

This committee wishes to put on the record its recognition of the work that overseas trained doctors are performing, particularly in regional Australia.

Recommendation 7

This committee endorses the House of Representatives Standing Committee on Health and Ageing's report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors* and recommends that the Commonwealth Government accept and implement the recommendations contained therein.

Chapter 5: Australian Standard Geographical Classification for Remoteness Areas

The Department of Health and Ageing provides incentive payments to doctors based on the geographic area they work in. The greater the relative remoteness of that area, the greater incentive payment they will receive. The committee considered how incentive payments are determined and paid to doctors working outside metropolitan areas. The current scheme (which is presently under revision) is known as the ASGC-RA.

There will never be a perfect model that does not result in some anomalies as a result of the methodology used. However, evidence provided to the committee during its inquiry did not support the use of the ASGC-RA scheme in its current form as the sole determinant of classifying areas for workforce incentive purposes. Even the evidence in general support of the scheme was heavily conditional on it being augmented with further datasets to provide a more accurate representation of workforce conditions across the country. The committee was impressed with the comprehensive nature of the model developed by Professor Humphreys and his colleagues, and the merging of geographical, population and professional and non-professional indicators certainly seems to provide a more accurate picture of the rural workforce.

The committee is supportive of the methodology and data utilised by Professor Humphreys and his colleagues and would like to see this incorporated into a new scheme.

Recommendation 8

The committee recommends that the classification systems currently used for workforce incentives purposes be replaced with a scheme that takes account of regularly updated geographical, population, workforce, professional and social data to classify areas where recruitment and retention incentives are required.

Recommendation 9

The committee recommends that the revised workforce incentive scheme include a comprehensive, public evaluation process.

Chapter 6: The role of universities and medical schools

The committee considered the role of the universities and medical schools in providing educational pathways for the rural health workforce. It discussed the current issues facing the sector and some possible remedies.

The number of medical students in Australia has risen significantly in recent years with domestic student numbers at Australian universities rising to 12 946 in 2010 from 8768 in 2006. It is not possible to say how many students will go on to become doctors in rural areas. However there has been a gradual increase in the number of rural clinical schools across the country and the majority of these are in receipt of government funding through the 'Rural Clinical School' (RCS) program. There is also a scheme, under the Rural Undergraduate Support and Coordination Program, that specifies a target of 25 per cent of Commonwealth Supported medical students who must be from a rural background.

Evidence suggests that while the rural intake target should be met and enforced, it is only one element of a complex problem, and by itself holds no promise of an increase in the rate of graduates practicing in rural areas. However the committee heard evidence that suggests that regional universities are more likely to meet the target and consequently provide more graduates that will practise in rural areas. The committee supports meaningful sanctions for those institutions that do not meet the current target, and although it understands that this is now a mandatory target with funding conditions attached, it would like those sanctions to be in the public arena, and would also like evidence of those sanctions being applied where appropriate. The committee also considers that the definition of a rural student for the purposes of a quota needs to be reviewed.

Recommendation 10

The committee recommends the publication of those cases where universities do not meet the target of 25 per cent of medical students from a rural background, and subsequent publication of information about the sanctions that are applied in those cases.

Recommendation 11

The committee recommends that the commonwealth government explore options to provide incentives to encourage medical students to study at regional universities offering an undergraduate medical course.

Recommendation 12

The committee recommends that the definition of a rural student for the purposes of a quota be reviewed, and that the review should consider strengthening the definition to only include students who have spent four out of six years at secondary school in a rural area; four out of the last six years with their home address in a rural area; or city students showing 'ruralmindedness', defined as an orientation to work in rural and regional areas, and demonstrated by a willingness to be bonded.

The committee was impressed by the success of James Cook University and the model proposed by Charles Sturt University for a new rural medical school. The provision of a full scale medical school based in regional Australia would have a significant impact on the numbers of doctors, nurses, allied health and other essential health professionals that would come from rural areas and would therefore be likely to

remain in those areas after they complete their training. However the committee is also mindful that the current pressing issue is not the student numbers but the capacity in the system to adequately train those students all the way along a pathway from student to health professional who will work in rural areas.

The committee received evidence about affirmative action programs being administered by Queensland Health, James Cook University and Queensland University, which the committee strongly support. The introduction of options for underprivileged young people to enter a career in health and the provision of appropriate support throughout their training is highly commendable. The committee urges other regional and rural institutions and appropriate education providers to examine ways that can increase the opportunities of young people in the health field, with the added benefit of increasing the likelihood of retaining a health workforce if they are sourced locally.

Effective translation of medical students into rural and regional practice requires appropriate support at all stages in the training and placement process. There do not appear to be adequate systems that will support the internships, rotations, or mentoring of the expanding number of medical students. The situation will need to be improved in regional areas if the current drive to expand the number of students is going to translate into actual health professionals working on the ground.

The committee is looking forward to the department's forthcoming review of rural health and would like to see a full exploration of ways in which blockages in the system such as the shortage of rural clinical placements can be addressed.

Recommendation 13

The committee recommends that the Commonwealth, state and territory governments review their incentives for rural GPs with the aim of ensuring that rural GPs who provide training to pre-vocational and vocational students are not financially disadvantaged.

Recommendation 14

The committee recommends the Commonwealth government consider the establishment of a sub-program within the National Rural Locum Program that would provide support for rural GPs to employ locums specifically to enable the GP to deliver training to pre-vocational and vocational medical students in rural areas.

The committee considered the accommodation issues associated with placement programs, rotations and training. It acknowledges that a placement program can only work effectively if students have somewhere to live while undertaking it. The committee notes that existing programs and stakeholders are seeking to address this issue. It is imperative that adequate policies and programs are established to manage the increasing demand.

The specific issue of housing for Aboriginal Health Workers needs to be addressed. The committee is aware of the difficulties this causes in Aboriginal communities, both for staff working in remote communities and for attracting staff to those communities.

The committee urges the Commonwealth government and the state and territory governments to work together to address this need.

Recommendation 15

The committee recommends that a coordinated accommodation strategy for be developed for rural health workers, including Aboriginal Health Workers, in the government's forthcoming review of rural health programs.

Chapter 7: Medicare Locals

The committee examined evidence about the transition to Medicare Locals. Like the majority of submitters to this inquiry, the committee is of the view that the newness of the Medicare Local program makes it impossible to adequately assess its effectiveness at this time.

To be successful the program will require careful and intensive management to ensure that all the key stakeholders are adequately considered and consulted. Greater effort needs to be expended to ensure that the necessary information is available for interested stakeholders. However the committee shares the cautious optimism of the potential for Medicare Locals to fill the gaps between local hospital networks, and GP community care provision.

In the committee's view the needs assessment element of the Medicare Local program is the singularly most important aspect of their work as it will provide the strategic overview that has been missing to date. The timely dissemination of the results of the needs assessments can ensure the constructive input of many of the key stakeholders. The uncertainty over the provision of after-hours service provision is an area that requires evidence based decision making as quickly as possible to dispel the fear and anxiety that has been expressed over the status of existing services. In the medium to long term the regular dissemination of the monitoring and evaluation of the programs nationwide will also ensure that best practice is shared and replicated across the country.

Recommendation 16

The committee recommends that Medicare Locals Needs Assessment Reports are made public and a process of engagement and consultation is undertaken.

Recommendation 17

The committee recommends that where existing after hours services are operating effectively there should be no disruption to their administration or funding.

A range of evidence was put before the committee identifying potential gaps or overlaps between current policies and programs. These can include a mismatch that sometimes occurs between Commonwealth and state or territory health policy and resourcing. The committee is of the view that this particular barrier should be addressed at a national level rather than locally. The Needs Assessment Reports prepared by Medicare Locals will be a valuable resource from which to identify potential inter-jurisdictional issues.

Recommendation 18

The committee recommends that the Department of Health and Ageing prepare a brief for COAG's Standing Council on Health on existing or emerging gaps affecting the delivery of health services to rural and remote communities caused by mis-alignment between Commonwealth and state policy, including options for measures to remediate such gaps. The brief is to be based on engagement with relevant stakeholders, including state and territory governments, Medicare Locals, representatives of peak bodies such as RDAA, SARRAH and NRHA at both national and state level, and to be provided on at least a bi-annual basis.

