Chapter 3

The nature of the medical profession in rural areas

Medical Specialisms

3.1 The committee has received evidence that the growing trend towards medical specialisms and sub-specialisms has 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[1] as the area of medical practice most required in rural and regional areas.

3.2 Professor Richard Murray, Dean of the Medical School at James Cook University, and President of the Australian College of Rural and Remote Medicine (ACRRM) described this trend:

> I have watched the tide go out in the rural remote workforce. Once upon a time we would be able to look for a doctor with qualifications in public health and obstetrics et cetera to hold together services in the remote Kimberley, for instance, and I just watched all of that disappear over a period of a decade. So it felt like a shortage to me.
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> In fact, through that period and to now, we have continued to grow our medical workforce above population growth. We have more doctors than at any point in history...and we do very well compared to the other comparable countries. So, arguably, the greater problem is not so much absolute numbers; it is both geographic maldistribution and discipline maldistribution, in particular too many subspecialties—subspecialists in the cities—and too much of what we call multiple professional care.[2]

3.3 The reasons for the general increase of specialisation and subspecialisation are varied and range from the higher remuneration and greater career opportunities, to doctors "feeling comfortable within a domain of practice"[3]. The committee also heard from the Australian Medical Association (AMA) that the Medicare Benefit Schedule (MBS) contributes to the culture of rewarding specialisation over generalism:

> ...there is a consensus that the MBS generally speaking rewards subspecialty, [...] particularly in the procedural areas ... the thinking doctors, such as the generalist physicians, generally speaking are not looked after as well. [4]

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1 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

2 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, James Cook University, *Committee Hansard*, 23 April 2012, p. 3.

3 Dr Paul Mara, Rural Doctors Association of Australia, *Committee Hansard*, 11 May 2012, p.17.

4 Mr Warwick Hough, Australian Medical Association, *Committee Hansard*, 11 May 2012, p. 63.

3.4 The AMA go on to suggest that this is achieved through higher rebates for particular MBS item numbers, and there are consequences for attracting new recruits into general medicine:

> There certainly does need to be a review of those particular areas to try and restore some of the balance. So, ultimately, if you have got young graduates looking at careers in these areas they will see that if they want to go into generalism financially they will not suffer as a result compared to some of the other specialties.[5]

3.5 The MBS outlines the difference in rebates for initial services from a GP and a general physician. An initial attendance by a general physician for a single course of treatment commands a fee of $148.10, while a typical attendance at consulting rooms for a GP commands a fee of $35.60.[6] While there are many other factors such as length of training, these basic figures illustrate the challenge of attracting students into general practice, even without bringing the rural and regional dimension into the equation. Comparisons between generalists and sub-specialists that would support the AMA's assertions are difficult on a purely fees basis because the MBS provides fees for specific activities rather than paying for who provides the service.

3.6 The numbers of GPs in Australia also support the suggestion that it is difficult to attract doctors into general practice. The most recent figures from the Australian Institute of Health and Welfare's (AIHW) Medical Workforce Survey in 2010 state that out of the 81 639 registered medical practitioners in Australia only 35.3 per cent of these were general practitioners compared to 36.1 per cent who were specialists.[7]

3.7 The figures in the Survey also provide valuable data about the distribution of the workforce. The number of full time equivalent[8] medical practitioners across the country ranges from 400 per 100 000 population in Major Cities, to 185 per 100 000 in Outer Regional Areas, but if we look at general practitioners only then the variation is 105 to 103 respectively.[9]

3.8 These figures provide a picture of the workforce that shows the numbers of general practitioners across areas defined by the Australian Standard Geographical Classification-Remoteness Area (ASGC-RA) classification system are consistent, but

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5 Mr Warwick Hough, Australian Medical Association, *Committee Hansard*, 11 May 2012, p. 63.

6 Medicare Benefits Schedule Book, 1 July 2012, pp 94, 98.

7 AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. vi.

8 Full time equivalent is defined as: the number of employed medical practitioners in a particular category multiplied by the average hours worked by employed medical practitioners in the category divided by the standard working week hours. In this report, 40 hours is assumed to be a standard working week and equivalent to one FTE. (AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. 48).

9 AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. vi.

proportionally they represent a much smaller percentage of medical practitioners in Major cities than they do across Inner Regional, Outer Regional and Remote areas.[10]

3.9 The figures point to a conclusion that the rural and regional populations are not served poorly in relation to GPs, rather it is that patients cannot access the services provided by specialists without travelling across significant distances at great cost to the patient and the health system. The submission from the Australian Institute of Health and Welfare supports this conclusion stating:

> The number of clinical specialists decreased with increasing remoteness (142 FTE per 100,000 for *Major cities*; 24 FTE per 100,000 for *Remote/Very remote* areas).[11]

Medical Specialist Colleges

3.10 In order to be registered as a Medical Specialist in Australia you have to be assessed by an Australian Medical Council accredited specialist college as being eligible for fellowship of that college, although actual fellowship is not a requirement.[12] This arrangement gives the specialist colleges a key role in shaping the nature of the medical workforce in Australia.

Royal Australian College of General Practitioners

3.11 General Practice itself is classified a specialism by the Australian Medical Council and the Royal Australian College of General Practitioners (RACGP) is the primary specialist college representing GPs. The RACGP also has a National Rural Faculty (NRF) with over 7600 members including more than 4,400 GPs living and working in regional, rural and remote Australia.[13] The faculty's stated policy focus is to develop strategies that will produce rural GPs with procedural and advanced skills to meet the demands of rural medicine. They also emphasise the need for flexible policies and strategies to be developed through local needs-based assessments.[14]

3.12 Aside from the issue around procedural training discussed in the following section the RACGP's submission and evidence to the committee reflected the complex and localised nature of the problems that exist in the delivery of rural health. They propose the enhancement and expansion of current programs that have made an impact such as:

- expanded university placements and Medical Rural Bonded Scholarships;[15]

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10 AIHW, *Medical Workforce 2010*, AIHW, Canberra, 2012, p. 24.

11 Australian Institute of Health and Welfare, *Submission 110*, p. 3.

12 Medical Board of Australia, *Specialist Registration*, available at: http://www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx (accessed 17 July 2012).

13 The Royal Australian College of General Practitioners, National Rural Faculty, *Submission 41*, p. 2.

14 *Submission 41*, p. 3.

15 *Submission 41*, p. 10.

- an emphasis on rurally orientated general practice at undergraduate as well as postgraduate level;[16]
- initiatives that increase training capacity by attracting new GP supervisors; [17]
- adequate remuneration for GPs for teaching roles;[18]
- an increase from 25% rural origin students for the Commonwealth Supported Places in medical schools to 33%;[19] and
- decreasing student debt for those locked into rural pathways. [20]

Royal Australian College of Physicians

3.13 The Royal Australian College of Physicians (RACP) is the college representing General Physicians. General Physicians or Consultant Physicians are often the first point of referral by a GP seeking expert medical advice.[21] While having a different perspective than the RACGP, the RACP's position is consistent with the RACGP's focus on training that will address:

> ...the impediments for the supply of sustainable health care delivery in rural and remote communities: [that is] maldistribution of specialists in rural areas and chronic disease management.[22]

3.14 The RACP contends that growth in the number of physicians, particularly those that are dual-trained in one or more specialisms, could lead to significant cost savings and other benefits in rural communities:

> Facilitating the growth of accessible medical specialist services in small communities could lead to reduced hospital admissions, improved quality of life for patients through reduced interactions with the healthcare system and the development of system-wide savings over time. One of these savings could be the reduced cost of patient transfers and travel to metropolitan settings.[23]

3.15 The RACP specifically propose a model of dual-trained physicians who will have "core training in general medicine and further training in an additional specialty."[24] This would result in physicians with:

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16 *Submission 41*, p. 10.

17 *Submission 41*, p. 4.

18 *Submission 41*, p. 10.

19 *Submission 41*, p. 11.

20 *Submission 41*, p. 12.

21 Royal College of Physicians, *What is a Physician/Paediatrician?*, http://www.racp.edu.au/index.cfm?objectid=D7FAA1D5-09B4-E1FD-5DE5E361F1A9C56E (accessed 21 July 2012).

22 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

23 Royal Australian College of Physicians, *Committee Hansard*, 11 May 2012, p. 54.

24 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

> ...expertise in the diagnosis and management of acute, undifferentiated illnesses and complex, chronic and multisystem disorders in adult patients. Additional training in a specialty such as endocrinology, oncology or respiratory medicine, will increase the level of expertise of the general physician. For example, a general physician with an additional specialty in endocrinology would be able to manage complex acute complex diabetes cases in a population with a high rate of diabetes. [25]

3.16 The current training program to become a physician takes upwards of six years, with the last three years involving advanced training in one (or more) of 30 possible specialities. The RACP proposal is that this three-year segment include the undertaking of two advanced training programs that would be assessed simultaneously.[26]

3.17 According to the RACP the success of its proposal is contingent on a number of factors:

> There is anecdotal evidence to suggest that trainees are interested and keen to participate in dual training with generalism as the core specialty, within a rural area. This is provided there is the capacity to train physicians within the rural facility and there is a clear career pathway and program to follow. Increasing the capacity of rural clinical schools and training facilities as centres of excellence and linked to universities will support this proposal.
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> There is also evidence that basing General Medicine physician training in rural areas, or longer-term rural placements, attracts the trainee to the area. They are more likely to stay in the areas as a physician, providing the community with a sustainable and secure workforce.[27]

3.18 The 'dual-training' model proposed is similar to one that is has been running in New Zealand for over ten years. However the employment conditions for a physician in New Zealand are different, as the provision of services in local regional communities is included in their contract. This is unlike the Australian model where the physician decides if they want to provide services in a particular area or not.[28]

3.19 The RACP used an example of a cancer patient with co-morbidities that require a coordinated approach to care as an illustration of the benefits that a general physician can provide:

> We have a rural and regional oncology service in Albury-Wodonga. We have their specialist come down one day a week to Wangaratta. We have delivery of regional treatment in Wangaratta. I supervise the oncology on day to day. These patients have multisystem disease. They do not just have cancer; they have diabetes and heart disease. That is where I come in. The oncologist tells us what they are going to have and supervises that. But as

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25 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 2.

26 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 7.

27 Royal Australian College of Physicians, answer to question on notice, 11 May 2012, p. 8.

28 Royal College of Physicians, *Committee Hansard*, 11 May 2012, p. 55.

> soon as they end up with pneumonia or their diabetes is out of control or their heart disease has been right, they end up being coordinated.[29]

3.20 Professor Koczwara, President of the Clinical Oncology Society of Australia (COSA) also stated that cancer patients need access to a number of medical services, not just oncological:

> ...cancer care is multidisciplinary—very rarely do we deliver care by one professional. You often need surgery, chemotherapy, radiotherapy, allied health care staff, supportive care not to mention prevention and so on.[30]

3.21 The representatives from the RACP expanded on the service they operate out of Wangaratta. The have six general physicians who have undertaken to visit up to 100 kilometres from Wangaratta at least one day a week. This service is carried out under the Medical Specialty Outreach Access Program (MSOAP).[31] However as much as they endorse this model it is dependent on the specialists involved, and there is no coordinated approach to manage the integration of specialist services into ambulatory and primary care. According to the RACP this is in part because one setting, the local hospital networks, is with the states, while the Medicare Locals are the Commonwealth's coordinating tool for the delivery of services.[32]

Australian College of Rural and Remote Medicine

3.22 The Australian College of Rural and Remote Medicine (ACRRM) is the specialist college specifically engaged with the issues contained in the committee's terms of reference. The College is an accredited medical college for the specialty of general practice,[33] however rural medicine itself is not a recognised medical speciality so the ACRRM is not the only college with a rural dimension. It has however played a key role in the development of Rural Generalist Pathways.

Rural Generalists pathways

3.23 There is a recognition that services once delivered by rural and regional GPs such as obstetrics or anaesthetics are now largely delivered by specialists in large regional towns or in major cities. Dr Mara from the Rural Doctors Association of Australia (RDAA) considered this trend to be unsustainable:

> ...we have lost the concept of generalism in medicine as being a vital thing...We simply cannot afford to have an ever-increasing superspecialisation, because it is going to cost the government and it is going to cost the taxpayer too much. At the end of the day, we have to start

29 Royal College of Physicians, *Committee Hansard,* 11 May 2012, p. 55.

30 Professor Bogda Koczwara, President, Clinical Oncological Society of Australia, *Committee Hansard,* 11 May 2012, p. 46.

31 Royal College of Physicians, *Committee Hansard,* 11 May 2012, p. 55.

32 Royal College of Physicians, *Committee Hansard,* 11 May 2012, p. 55.

33 Australian College of Rural and Remote Medicine, *Submission 125,* p. 2.

> putting some investment into people who can do basic things very, very well in a comprehensive sense.[34]

3.24 Professor Murray from James Cook University and the ACRRM agreed that the focus should be on producing more generalist practitioners to address the maldistribution of doctors across the country, and recent actions in the form of rural generalist pathways are already proving successful:

> The big challenge for us in the regions now is to build the training pipeline into all of the medical specialties, with an emphasis on generalism. I will close perhaps on the rural generalist point. It is hard to explain how much of an impact this model has had locally. I have been around the rural and remote space for a long time. It was a very depressed space. Doctors' meetings would be full of woe and stories of gloom. I have watched that turn around, in particular in this area, as there is an obvious prospect of generational renewal and as people are coming through. What was once a shrinking healthcare facility now has a buzz and a life to it where people have taken on new and expanded roles within a teaching-intense healthcare service that in fact helps to underpin and secure their future. There has been a profound impact already.[35]

3.25 Doctors Meagher and Douch, who practice in Young, suggested that there is a lack of "training in procedural skills"[36] for GPs working in rural areas and there are barriers for GPs wanting to access that training:

> The first one might be a traditional barrier. A lot of the procedural training appears to have been an add-on to training GPs. If you take my own case, I was a little unusual in that I did my anaesthetics training before going out into rural GP practice, so I arrived skilled and trained to perform an anaesthetic. The usual routine in the past was to make that procedural training occurred at the end of your time. It meant that you were getting GP trainees moving out to the country who had no procedural skills. They were more or less committing to a line of work and a pathway of development, with family circumstances et cetera. To pick up and leave all that to go back and do procedural training was difficult.[37]

3.26 They believed that barriers could be overcome in the long term through generalist pathways:

> We see a light on the hill with the ideas being pushed about generalist pathway training—training people in a more fulsome sense for practice in the country. That would incorporate, I would expect, some form of procedural training rather than having it as an add-on. That may be a hope

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34 Dr Paul Mara, Rural Doctors Association of Australia, *Committee Hansard*, 11 May 2012, p.17.

35 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, James Cook University, *Committee Hansard*, 23 April 2012, p. 4.

36 Dr Meagher, Young District Medical Centre, *Committee Hansard*¸ 11 May 2012, p. 33.

37 Dr Douch, Young District Medical Centre, *Committee Hansard*¸11 May 2012, p. 33.

> for the future but, as Dr Meagher pointed out, that will be a long-term solution rather than a short-term solution.[38]

3.27 The rural generalist pathway that Professor Murray referred to is the initiative taken by Queensland Health in 2002. Queensland Health explained the development of the pathway through a paper it delivered at the committee's hearing on 10 July:

> The Rural Generalist Pathway concept was developed in 2002 through a consortium of Queensland Health, the Australian College of Rural and Remote Medicine (ACRRM), General Practice Education and Training, Remote Vocational Training Scheme and the Royal Australian College of General Practitioners (RACGP). The concept responded to the data analysis of rural medical officer attraction and retention, which indicated longitudinal decline of rural medical services with increasing dependency on international medical graduates.[39]

3.28 Dr Denis Lennox, Executive Director of the Office of Rural and Remote Health at Queensland Health, described the pathway in detail:

> We have developed a joined up, principle based pathway from secondary education at high school through medical training to postgraduate establishment in practice and registration, and then to vocational training in Australian general practice training, along with other elements that we require for the credentials in rural generalist medicine in Queensland, and that particularly relates to advanced specialised disciplines. We have eight approved advanced specialised disciplines covering areas of obstetrics, anaesthetics, emergency medicine, Indigenous health, adult internal medicine, paediatrics and mental health. These are all disciplines in which these doctors practice in rural settings that would otherwise be the prerogative of specialised practitioners in those disciplines.[40]

3.29 The Queensland Health submission defined a Rural Generalist as:

> ...a rural medical practitioner who is credentialed to serve in hospital or community-based primary medical practice as well as hospital-based secondary medical practice in at least one specialised medical discipline (commonly, but not limited to obstetrics, anaesthetics and surgery) without supervision by a specialist medical practitioner in the relevant disciplines. The practitioner may also be credentialed to serve in hospital and community-based public health practice – particularly in remote and indigenous communities.[41]

3.30 The first rural trainees have now exited the program, and have been awarded fellowship of the ACCRM in 2012.[42]

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38 Dr Douch, Young District Medical Centre, *Committee Hansard*¸11 May 2012, p. 33.

39 Queensland Health, *Submission 126*, p. 1.

40 Dr Denis Lennox, Executive Director, Office of Rural and Remote Health at Queensland Health, *Committee Hansard*, 10 July 2012, p. 1.

41 Queensland Health, *Submission 126*, p. 1.

42 *Submission 126*, p. 1.

3.31 The committee found that there is significant support for the pathway from a number of submitters. Rural Health Workforce Australia reported that:

> Our advice is that it works in Queensland and that it is being rolled out. What we need is pathways to rural practice. If that is one of the pathways then we would welcome it. We need to look at all the pathways that are available for domestic and overseas doctors.[43]

3.32 The Royal Australian College of Nursing also endorsed the Queensland Health model suggesting that it could provide opportunities for advanced nursing practice in rural areas as well:

> [The] whole idea of valuing being a generalist—we do not do that...Well, they do in Queensland now. And I think that the Rural Generalist Pathway that they have established in Queensland is actually a very good model. It probably could provide some sort of pathway for nursing to go down as well, but of course that would require external funding because it is outside of state government remit.[44]

3.33 However the model has not attracted consistent support across the professions. Despite being one of the founding partners of the Queensland Health program the RACGP now say that:

> State-based medical workforce initiatives (e.g. Queensland Health Rural Generalist Program) are working as deterrents to the recruitment and retention of rural general practitioners...with perceived success in Queensland due to lucrative salaries which cannot be matched by private practice. It should also be noted that the term 'rural generalist' represents a state jurisdictional term and is not a recognised specialty by the Australian Medical Council.[45]

3.34 In their submission they state that their opposition to the measures taken in Queensland through the Rural Generalist Program are due to the lack of evaluation[46] and the emphasis on secondary or hospital based skills rather that the enhancement of the GP's skills in the community. The RACGP would rather see a broad suite of measures designed to "expand the availability and flexibility of procedural training"[47] and offer the NSW Rural Generalist Training Program as a good example.

3.35 When appearing at the committee's hearing in Albury the RACGP expanded on the comments made in their submission:

> The feedback we have from some of our members in Queensland is that private general practice cannot compete with the amounts of money through the industrial award that Queensland health offers to attract private GPs. So

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43 Ms Margie Mahon, Rural Health Workforce Australia, *Proof Committee Hansard*, 5 June 2012, p. 27.

44 Dr Mills, Royal Australian College of Nursing, *Committee Hansard*¸11 May 2012, p. 41.

45 Royal Australian College of General Practitioners, *Submission 41*, pp. 5, 8.

46 *Submission 41*, p. 5.

47 *Submission 41*, p. 9.

> if as a fourth- or a fifth-year you can get $300,000 working for Queensland health in a Queensland health facility, private general practice cannot compete with that.[48]

3.36 Dr Kirkpatrick, the Chair of the National Rural Faculty of the RACGP provided the example of the situation in Dalby to illustrate the RACGP's point:

> At Dalby we have a 20-bed hospital. There are four doctors employed by Queensland health at the hospital. They work purely in the hospital. We have three medical practices in town. I work in one of the major ones there. We have eight full-time-equivalent GPs. We work as VMOs to the hospital, but we are not employed by Queensland health. If the doctors are not at the hospital then the private GPs would be picking up the patients. The patients would get a Medicare rebate and then pay us, whereas the doctors at the hospital are paid by Queensland Health to see the patients that present at the hospital.[49]

3.37 The committee is aware of the pressures involved in running a small medical practice in a rural or regional area. The doctors from the Young District Medical Centre described the margins they work on as a private practice:

> We have a minimum of 55 per cent running costs before the individual doctors look at their own indemnity, their own running costs, equipment, superannuation and all of those things so it is only just a viable proposition. If we are not here working full time then it is not a viable proposition.[50]

3.38 They then described a typical scenario which impacts heavily on their ability to staff the practice on a full time basis while also providing public hospital emergency services:

> The demands of the hospital for the four of us doing that work is not only aligned to the time that we are on call for emergency or for obstetrics or for anaesthetics when we may get calls but also when we need to do rounds in the morning to follow-up patients. We can be up there for two to three hours in the morning. We receive numerous phone calls during the day about patients who are in-patients, which disrupts the services here, and then we receive emergency calls during the day to assist Caesareans or emergency airways or anything during that time.[51]

3.39 When asked about the views of the RACGP, the ACCRM defended the program on the results it has achieved to date:

> I do not really want to comment on another college's approach or what they have said but I can only talk about what we have seen and the fact that the rural generalist program and generalist medicine is now very much on the

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48 Dr Kirkpatrick, Royal Australian College of General Practitioners, *Committee Hansard*, 5 June 2012, p. 39.

49 Dr Kirkpatrick, Royal Australian College of General Practitioners, *Committee Hansard*, 5 June 2012, p. 39.

50 Dr Meagher, Young District Medical Centre, *Committee Hansard*¸11 May 2012, p. 32.

51 Dr Meagher, Young District Medical Centre, *Committee Hansard*¸11 May 2012, p. 32.

> agenda within other states. We have a successful model now that addresses what the real workforce needs are within rural and remote communities. Hence, we would like to see that extended into general specialists within it. Those are the skills that are missing out of the area, too, so we have a challenge with that. The strength of it is that it is local training. As I said in my opening, it is about a totally different approach to workforce, wherein there is benefit to the community and the doctor providing the services out there.[52]

3.40 Dr Lennox from Queensland Health also countered the perspective of the RACGP saying that it had "resulted in an increased number of medical graduates applying to be trained through Australian General Practice Training to general practice."[53] Dr Lennox also posed the question of whether the program, and its success in meeting its objectives, could be replicated nationally:

> My response is overwhelmingly, yes, indeed it could. The need is common with variations upon the theme in each jurisdiction. The innovation we have embarked upon has been principle based; it is based upon evidence; it is based upon joining up policy and strategy, and existing operations. It is evidence based, it is systematic, it is principled and it can be extrapolated to other jurisdictions, and adjusted according to local need. Providing that happens, providing that it occurs in a principled way, I would argue very strongly that, yes, the transformation could be nationalised.[54]

Indigenous Health

3.41 The issue of attracting health practitioners, GPs, and specialists to Indigenous communities was discussed in the committee's hearing in Alice Springs and Darwin. The nature of Indigenous health care in rural areas is often unique in its scope, the type of issues that health workers deal with, and the management and delivery of health services. The committee heard evidence from the Central Australian Aboriginal Congress who outlined their innovative approach to attract health practitioners:

> We went from having three FTE GPs and about eight unfilled positions in 1995 to having 13 FTE GPs and no unfilled positions in the last, say, four years. The median length of stay is more than seven years and the average is more than nine years. What made the difference? Remuneration back in the mid-nineties was terrible, so we had to get more funding. That came both through greater grants, the Primary Health Care Access Program was very important, and access to the MBS, which happened in 2006. That meant we had more funding so we could offer more money. We also needed better working conditions. We had to get rid of the after-hours on

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52 Ms Wyatt, Australian College of Rural and Remote Medicine, *Committee Hansard*, 5 June 2012, p. 11.

53 Dr Denis Lennox, Executive Director, Office of Rural and Remote Health at Queensland Health, *Committee Hansard*, 10 July 2012, p. 2.

54 Dr Denis Lennox, Executive Director, Office of Rural and Remote Health at Queensland Health, *Committee Hansard*, 10 July 2012, p. 1.

> call service because we were the only ones offering that service. We hung onto that for a long time. We got rid of it in about 2005. That has further improved workforce retention.[55]

3.42 Dr Boffa from Congress also emphasise the importance in having good governance and multidisciplinary teams to make the positions more sustainable:

> We have effective multidisciplinary teams, so our doctors are working in an organisation that has good clinical governance processes. We have psychologists, social workers and alcohol treatment programs. Our doctors do not feel like they are on their own; they feel like they can refer to other services, they can make a difference and they can see how they are going in terms of outcomes. They get that feedback.
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> That has all helped, but I think Michael Wooldridge's 1999 overseas trained doctors scheme was critical. Without that we would not have a complete workforce. The GPs…from those countries have all now got their fellowships. They came under the five-year scheme and got their fellowships, but most stayed after that. We have only lost a couple at the five-year point. Most have stayed. [56]

3.43 The importance of collaboration between key stakeholders is another theme that came out of the evidence in Alice Springs. Congress discussed the Northern Territory General Practice Education (NTGPE) which is a training provider of general medical education in the Northern Territory. NTGPE was established in 2002 by:

> …a consortium of partners including Flinders University, Charles Darwin University, GP Divisions of the NT, Aboriginal Medical Services Alliance NT, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. It is funded by the Federal Government to provide postgraduate training in general practice, vocational placements for prevocational doctors and to provide specialised community based primary care placements to students from medical schools in all Australian states and also overseas.[57]

Committee View

Queensland Health Rural Generalist Program

3.44 The committee is of the view that the purpose of a rural health workforce is to provide access to quality health care for communities in rural areas and that this goal is best advanced through a significant increase of rural generalist GPs. The committee is strongly supportive of the efforts of the ACCRM, the AMA and the other colleges to increase the numbers of rural generalists in the rural medical workforce through the

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55 Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 20 February 2012, p. 2.

56 Dr John Boffa, *Committee Hansard*, 20 February 2012, p. 2.

57 Northern Territory General Practice, *About Us*, http://ntgpe.org/index.php/about-us/, (accessed 13 August 2012).

development of rural generalist training pathways. The Queensland Health Rural Generalist Program and the NSW Rural Generalist Program are two such pathways.

3.45 The NSW program endorsed by the RACGP has very similar objectives to the Queensland program, with an emphasis on providing practitioners in rural settings who provide:

> ...primary care to a rural community whilst being credentialed at the local health service to provide procedural / advanced skills on their chosen speciality (obstetrics and gynaecology and/or anaesthetics).[58]

3.46 While the committee did not receive specific evidence on the NSW model, one of the differences between the two programs is that the NSW program is aimed at up-skilling GPs in private practice to provide the services required in a rural setting, for example, providing "care in a rural community and advanced procedural services at a rural hospital";[59] whereas the Queensland Health program provides salaried doctors to "serve in hospital or community-based primary medical practice as well as hospital-based secondary medical practice"[60].

3.47 On evidence received, both in written submissions and orally, the committee is not convinced by the argument from the RACGP that the Queensland program is a long term deterrent to the retention and recruitment of rural general practitioners. The program is now training an additional 50 new graduates per year and is committed and funded to do so over the next five years.

3.48 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.

3.49 The committee accepts that this program may not be suited to all areas of the country, and each state and territory Government may wish to explore different pathways to provide increased access to health care tailored to local need. However it does not consider this to be sufficient grounds to reject innovative programs such as the Queensland model.

3.50 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

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58 Health Education and Training Institute Rural Directorate, *NSW Rural Generalist Training Program factsheet.* P. 1 of 2, available at: http://www.ruralheti.health.nsw.gov.au/__documents/initiatives/rural-generalist-training-program/rural-generalist-information-fact-sheet.pdf (accessed 17 July 2012).

59 Health Education and Training Institute Rural Directorate, *NSW Rural Generalist Training Program factsheet.* P. 1 of 2, available at: http://www.ruralheti.health.nsw.gov.au/__documents/initiatives/rural-generalist-training-program/rural-generalist-information-fact-sheet.pdf (accessed 17 July 2012).

60 Queensland Health, *Submission 126*, p. 1.

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. As discussed in Chapter Two there are difficulties in the supply of Aboriginal Health Workers that need to be managed, but the committee was impressed with the systems put in place by Congress to provide a blueprint for centrally managed healthcare in remote areas.

Increasing the number of Specialists in rural areas

3.51 The committee welcomed the evidence from the RACP and COSA as it illustrated the complex nature of health care delivery in rural areas. The changing pattern of chronic disease management requires more than GPs to provide care to rural and regional populations and the description of the Wangaratta model of physicians' outreach provided a template for the type of care the committee would like to see delivered across rural and regional Australia. The committee also took an interest in discussion about whether medical practitioners could be contracted to provide care in these areas.

Recommendation 3

3.52 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

3.53 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.