Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2010-11, 20 October 2010

Question: E10-326

OUTCOME 6: Rural Health

Topic: RURAL HEALTH

Written Question on Notice

Senator Fierravanti-Wells, asked:

a) What was the rationale behind the move from the older Rural, Remote and Metropolitan Areas (RRMA) classification to the Australian Standard Geographical Classification (ASGC).
b) What locations that have been reclassified now receive a lower level of funding than under previous classification system?
c) What has been the general response to the implementation of the ASGC and revised rural health program arrangements from 1 July 2010?
d) What specific concerns have been raised about these new arrangements and from what locations in Australia?
e) What is the overall impact of these changes on program expenditure and on the amount claimed to date (compared with the same time last year) since the changes were introduced?
f) What refinements, if any, is the department modelling or considering?
g) How is the department intending to evaluate the new arrangements?

Answer:

a) The new Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system better reflects community need and supports better targeting of funding, than the previous RRMA system.

b) Due to 'grandfathering' arrangements no doctors will receive lower levels of funding than under the previous classification. If such arrangements were not in place then eleven locations out of 2042[1] would have received lower levels of funding. These are shown in the *table below.

Town Name	**State**
Baralaba	QLD
Bluff	QLD
Dingo	QLD
Duaringa	QLD
Dysart	QLD
Glenden	QLD
Hay	NSW
Kambalda West	WA

[1] Locality in ASGC-RA 2-5 and with a population of greater than 100.

Lake Cargelligo	NSW
Theodore	QLD
Cherbourg	QLD

c) From 1 July 2010, almost 500 communities around Australia became eligible for rural incentive payments and more than 2,400 rural doctors for the first time became eligible for grant payments to remain in rural and remote areas through the *Rural Health Workforce Strategy* (RHWS)

Research commissioned by the Department in May 2010 found that many doctors reacted positively to the increased payments offered under the RHWS.

Scaling incentives that underpin the RHWS (including scaling of the 10 year moratorium for overseas trained doctors) were viewed positively by respondents who felt that the incentives, in conjunction with other elements of the Strategy, could result in more doctors considering rural and remote areas. Greater levels of reimbursement of HECS debts incurred for medical studies were well accepted by medical students and younger high school students.

The Strategy's locum programs were supported widely by respondents.

d) Some stakeholders have expressed concerns around the application of the one ASGC-RA classification. In some rural areas that contain large well serviced areas as well as smaller towns nearby. It is too early to determine whether these concerns will affect doctor numbers. The Department is closely monitoring outcomes.

e) The General Practice Rural Incentives Program (GPRIP) commenced 1 July 2010 with the first payments made in November 2010. Details of program expenditure, the amount claimed to date (compared with the same time last year) since the changes were introduced is not available at this time.

f) The Government is closely monitoring the impact of the changes in conjunction with independent academic experts and Rural Health Workforce Australia (RHWA), before considering if any refinements are necessary.

g) For the RHWS as a whole broad, national statistical indicators will be established to look at the impacts of the distribution of the medical workforce and medical workforce shortages in rural and remote areas. Independent advice will also be provided by RHWA and academic experts.