NSW RURAL DOCTORS NETWORK

Submission to the Productivity Commission Health Workforce Study 2005

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1 August 2005

Health Workforce Study
Productivity Commission
PO Box 80
BELCONNEN ACT 2616

Attention: Mr. Bill Henderson

Submission from the NSW Rural Doctors Network (RDN)

The attached Submission comprises 3 short briefing papers. They identify issues that RDN would like to canvass with you in forthcoming consultations.

The first notes the necessary role of Commonwealth and State governments in providing the training and funding, registration and accreditation framework for the emergence of new forms of medical and health professionals, with 2 supporting attachments.

The second paper provides a brief outline of the current circumstances affecting the rural GP workforce in NSW and the trends that are impacting significantly upon workforce supply and demand. It includes a small break out success story on initiatives in remote North West NSW that have turned around a dire and chronic medical workforce shortage.

The third identifies issues requiring attention and action by Federal and State agencies if the projected increase in medical graduates is to translate into more rural GPs.

Four RDN documents referred to in the submission are available in PDF format from the RDN web site (www.nswrdn.com.au) under Publications. They are:

- "General Practice Workforce Plan for Rural and Remote NSW 2002-2012". July 2003
- "Junior Doctors Working in Rural NSW". Sept. 2004
- "Procedural Medicine in Rural and Remote NSW – The General Practice Workforce", Dunbabin J. (PhD). Sept. 2002
- "Easy Entry, Gracious Exit", M Boucher and M Lynch. Sept. 2003.

RDN has almost 700 NSW rural doctor members and supports over 1600 NSW rural GPs, registrars and their families. They represent some 30% of Australia's rural medical workforce and provide medical services to around 1.6m rural residents including almost 80,000 Aboriginal people. RDN looks forward to being able to meet with you soon.

Dr. Ian Cameron
CEO
NSW Rural Doctors Network
Suite 19, Level 3
133 King Street
NEWCASTLE NSW 2300
Ph: (02) 4929 1811

Rural Workforce – A Changing Environment Needs a Changing Focus

The roles of the people delivering health care has always been changing, but has been highlighted recently with the increase in technology and increasing costs of delivering health care bringing a greater focus on who could be doing what. In particular there have been increasing moves towards:

1. Greater specialisation, both in medicine and nursing
2. Moves for earlier specialisation and shorter specialist training in medicine
3. A vacuum in the generalist role once held by general surgeons and general physicians
4. General Practice moving into that higher level generalist vacuum
5. Middle level clinicians (Clinical Associates, Physicians Assistants etc) as substitute for some of current GP role, especially in community setting
6. Greater use of nurse practitioners as specialists (anaesthetics, specialist units, mental health, sexual assault etc etc), especially in hospital setting.

These changes are already taking place or have been strongly supported. The changes need to be effectively managed so that they help improve access to health care and an integrated workforce. There is a role for each level of Government and for other health organisations.

Australian Government

1. Delegation.
   Currently there is probably not a mechanism within Medicare for delegation of activity from doctor to middle level clinician apart from a few MBS item numbers for practice nurses and allied health practitioners. For there to be an effective **middle level clinician workforce** there needs to be a mechanism for delegation, both activity and in remuneration.

2. Training
   Commonwealth will need to oversee funding arrangements for **specialist training** and for **middle level clinician training**

State Governments

3. There will need to be sufficient places funded for **vocational training for specialist**

4. State Governments can begin immediately on **accreditation and credentialing of nurse practitioners** in an increased range of specialties within the public hospital systems

5. Medical Registration Boards need to begin looking at processes for **registration of non-nurse middle level clinicians**.

Attachments:

1. Middle Level Clinicians – A Role in Rural Australia?, Dr Ian Cameron, 8th National Rural Health Conference, 2005

2. Rural and Remote Health Workforce, Prof Dennis Pashen, Mt Isa UDRH, 2004

Middle Level Clinicians – A Role in Rural Australia?

Dr Ian Cameron, NSW Rural Doctors Network

The last few years have increasingly seen a focus on primary health care teams as the structural foundation of rural health care. While the term 'primary health care' remains largely undefined in an industrial nation, and almost entirely undescribed in rural areas in industrial nations, it has come to be shorthand for health professionals who have first individual patient contact within an ethos that encourages population and preventative health.[i]

While there has been a focus on the 'team', there has been little formal movement about the roles of the team members. Certainly there has been some broadening of professional roles, and some narrowing into areas of interest or specialty area. However the team itself has continued to be composed of members defined by their professional position, rather than the team being constructed by the skills mix required.

In rural areas the 'primary health care team' has been seen as an answer to endemic health workforce shortage. While there appears to be little evidence that this would be so, there is certainly evidence that Government initiatives and the energy of rural health organisations and individuals has been improving at least rural health professional numbers. Maybe it is time to look again at how the required skills mix can best be provided in rural areas, how those skills become part of a team, and to do this from a position of rural success rather than a second best answer to rural workforce shortage.

One of those successes has been the RDN / RARMS experience in remote north west NSW. From 2001 a change in General Practice structure has resulted in

- More doctors
- More personal services
- More population health services
- A decrease in hospital outpatient services
- A decrease in population morbidity as measured by hospital in-patient use
- An increase in community based non-doctor health workers

WHERE TO FROM HERE?

A concrete integrationist approach would focus on better or total integration between health services provided through the GP surgery, the Aboriginal Medical Service and the NSW Health Community Health Centre. While this would be admirable, and would build on the ad hoc integration that is a feature of rural life, on its own it does not address a basic question of what services are needed, and who in rural health is best placed to provide them. The Walgett experience is only one of many which provide a platform to extend beyond the integration of existing professional boundaries to looking at putting together a team that includes the right skill mix. One way to start is to look at Australian and overseas experiences of the non-doctor clinician.

MIDDLE LEVEL – A SHORT REVIEW

There are numerous descriptions of non-doctor clinicians, but in practice they tend to fall into two main groups, Nurse Practitioners and Physicians Assistants. These have been defined in the USA as:

> "A Nurse Practitioner / Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and / or country in which s/he is credentialed to practice"
>
> "Physician assistants are health professionals licensed or, in the case of those employed by the federal government, credentialed, to practice medicine with physician supervision. ….Within the physician / PA relationship, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. The clinical role of physician assistants includes primary and specialist care in medical and surgical practice settings in rural and urban areas"[ii]

Nurse Practitioner

- Builds on basic nursing training
- May be hospital or community based
- May be generalist or specialist
- May be independent practitioners
- Limited prescribing rights
- ? Nursing shortage[iii]
- More, ? better services
- Do not reduce doctor time in community setting[iv]

Practice Nurses

- Nursing training
- Generalist
- Community based
- Role in population and preventative
- Can extend services in community setting

Pysicians Assistants aka Clinical Associates[v]

- Since 1600s
- Increase in USA from 1960s
- In USA over 40,000
- 70% Community based
- Now also in UK and Canada[vi]

- Medical training[vii]
- Regulated by State Medical Board
- Generalists
- Contracted to doctor
- Delegation from doctor

- Paid by doctor
- Doctor substitute
- Limited prescribing rights

Medical Assistants

- Administration with some clinical skills
- Brisbane North Division of General Practice[viii]

Specialist Technicians

- Specialists
- Usually hospital based
- Narrow education
- Non – graduate
- Under-utilised in Australia

WHAT CAN BE DONE?

There needs to be a description, if not a definition of what 'primary health care' is in rural areas in a developed country. This needs to take into account that community based health professionals in rural areas also form the hospital workforce, that health professionals in rural areas also provide secondary and in some cases tertiary care, that "first contact" includes professionals other than doctors and nurses (allied health, Aboriginal health workers, ambulance officers), and that funding models should penalise rather than reward primary care activity which takes place at a secondary or tertiary level.[ix](eg when a specialist surgeon performs procedures that could be done at a primary care level a higher fee is currently paid to the surgeon than if it was done by a GP).

A skills mix approach needs to look at health workers having roles outside the professional delineations that currently exist. In the hospital setting this could include GPs doing middle level anaesthetics, leaving the few specialist anaesthetists free to do the more complicated cases, nurse practitioners doing other anaesthetics. Specialist technicians can replace registered nurses as OT assistants, leaving the RNs free to take on more complex roles. In the community setting there can be a much greater role for nurse practitioners, practice nurses and clinical associates in all aspects of personal, population and preventative health. In many places ambulance officers form an unrecognised first line of community health monitoring, and at the same time can have their advanced training under-utilised.

At the heart of any skills mix system is **delegation**, both skill and financial. In a hospital setting where people are employed under standard awards or agreements the skill delegation is already standard, and largely governed by competency and training. There remains an opportunity for room for movement in who gains what competencies, which health professionals can take on different roles.

In the community setting, and where private practice and fee-for-service from patient are more common, the key is in delegation of activity which continues to attract a fee. For instance in the doctor – clinical associate situation, the clinical associate is employed by, and contracted to, the doctor. The doctor collects fees and pays the

clinical associate, although in most cases the doctor will not see the patient. The doctor has delegated a clinical activity to the associate. In Australia this would require regulatory and legislative change.

WHO CAN DO IT?

Australia has a plethora of rurally based and rurally focussed organisations which could build non – doctor clinician systems. Much of the ground work for practice nurses and nurse practitioners has been laid or is operating. The Nursing Colleges, universities and CRANA all have a continuing role. For physician assistant / clinical associate there are educational curricula in existence that could be further developed by University Departments of Rural Health and Medical Schools. As in the USA it could be expected that State Medical Boards would take responsibility for certification and regulation. Rural Workforce Agencies and Divisions could both have a role in continuing education and in workforce development. Governments would need to be involved in changing regulation and legislation to allow delegation, both financial and skill. Again, there exists a wonderful opportunity for all our organisations to work together in bringing a new pathway in rural health workforce.

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[i] AMA. AMA Discussion Papers. Primary Health Care (January 2001).
[iiii] Hooker RS Nonphysician Clinicians: The US Experience. International Medical Workforce Conference, Oxford, England, September 2003
[iii] Sibbald B Non-Physician Clinicians in the UK. International Medical Workforce Conference, Oxford, England, September 2003
[iv] Laurant MGH et al Primary Care – Impact of nurse practitioners on workload of general practitioners: randomised controlled trial. BMJ, doi:10.1136/bmj.38041.493519.EE (published 6 April 2004)
[v] Hooker RS, Cawley JF Physician Assistants in American Medicine 2nd Ed, Churchill Livingstone, Missouri, 2003
[vi] London VK UK universities to train physician assistants, sBMJ, viewed at http://www.studentbmj.com/back_issues/0304/news/96b.html on 27 January 2005
[vii] US Dept of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, Physician Assistants, viwed at http://www.bls.gov/oco/ocos081.htm on 27 January 2005
[viii] Medical assisting, viewed at http://www.bndgp.com.au/ on 27 January 2005
[ix] The Society of Actuaries in Ireland, The Financing of Primary Health Care, March 2000 viewed at http://www.actuaries-soc.ie/Papers on 1st October 2002

Mt Isa Centre for Rural and Remote Health

Rural and Remote Health Workforce

Background

A number of issues predominate in the rural and remote workforce. The first is the shortage of health professionals, in particular medical practitioners with the skills to adequately care for their communities. Second is the inability to retain the current workforce and attract new graduates to what they perceive as an onerous and high risk occupation. Third is the shortage of Immigrant Medical Graduates putting moral issues aside for the moment. Fourth is the ageing of the rural and remote communities and workforce.

Impending Workforce Issues

International factors will impact severely on the medical workforce in the next five to ten years. The European Union has adopted a resolution that the maximum "safe working hours" for a medical practitioner is 58 hours per week including on call time. This is to be reduced to 48 hours within 5 years. Europe has an estimated workforce shortage of 250,000 doctors currently. The United States and Canada has an additional shortage of 250,000 doctors. Taken together, the ability of first world countries to recruit and compete for the small available workforce, even including those from third world countries will be drastically curtailed. The prospect of working 48 hours per week for a wage of 130,000 Euros in Europe or the UK is not unpleasant to young Australian Graduates or IMGs currently working in Australia.

The impact of the European Union resolution combined with the already burgeoning litigation industry will force governments to change legislation, to adopt new workforce policies and to compete exhaustingly for scant and ever expensive human resources. Current increases in Medical School places in Australia and internationally will take some 15 to 20 years to have any impact.

Opportunities in Innovative Rural and Remote Health Workforce

Recruitment and retention in rural and remote communities are difficult and consistently failing to meet the expectations of the communities. IMGs are often placed in the most perilous and difficult communities where all parties are speaking in their second or third language, often with little knowledge of cultural mores and sensitivities. Young Australian graduates are indentured into those communities by government scholarships and stay rarely for longer than necessary to meet their commitment, or to buy their way out.

To educate a skilled and appropriate practitioner through current medical models takes up to 12 to 13 years from cessation of secondary education. A number of alternative health professionals exist within Australia and internationally that can be time and cost effective, including nurse practitioners and mid-level health practitioners. This latter group has a number of titles including Physicians Assistants (PA) and Primary Health Care Practitioners (PHCP). These practitioners offer the most flexibility in recruitment and service provision, and operate independently including procedurally in many rural and remote as well as disadvantaged communities. There are over 60,000 Physicians Assistants currently operating within the US and Canada in such services. There are many advantages: -

1. Recruits can be from a range of health professions viz. Ambulance Paramedics, Nurse Practitioners, Medical Scientists, Indigenous Primary Health Carers, Population Health Graduates, Veterinarians and International Medical Graduates who fail to pass their AMC examination. Nurse Practitioners on the other hand are recruited from nursing alone and are limited to that occupational stream.
2. Mid level Practitioners such as PAs build upon their previous medical and health backgrounds to complete their training in 2 years full time, with the last 6 months having an intern style role in clinical services. This reduction in education time from recruitment to full service provision is reduced to less than half that of medical practitioners. This includes procedural practice.
3. Mid level Practitioners are administered by the various State Medical Boards and Commonwealth administration structures in a similar manner to medical graduates. They are aligned to particular unique identifiers linked to medical practitioners in the health system such Prescriber Numbers and PBS numbers.
4. Current rural workforce research performed by Qld Ambulance Service has indicated that time spent in rural communities on emergency and paramedical activities is less than 5% of total working time and in some instances <1%. There is enormous potential to develop appropriate

courses for this group which take advantage of a skilled group who can apply their skills in a Primary Health Care setting. In NW Qld current identified needs include primary health care, allied health assistance and support. A number of modules can be created to enhance the more effective and rewarding use of this workforce. The Commonwealth has currently funded and had developed for example, a Graduate Certificate level curriculum for Population Health in Clinical Care which with minor modification could be one such module, distinct in itself or as part of a greater degree e.g. Masters Degree.

Pathways to achieving Mid level Practitioners (MLP)
A number of pathways as outlined above are possible (see Fig 1). A discrete degree course may be set up, or alternatively a range of lesser degrees. These lesser degrees may be appropriate for the style and scope of practice that needs to be delivered by the MLP. This could be via Degrees in Primary Health Care, Rural and Remote Clinical Care, which would contain the primary health care, clinical and procedural components of the curriculum. Large proportions could be delivered in discrete modules, some via distance learning, some essentially via block or facility based mode.

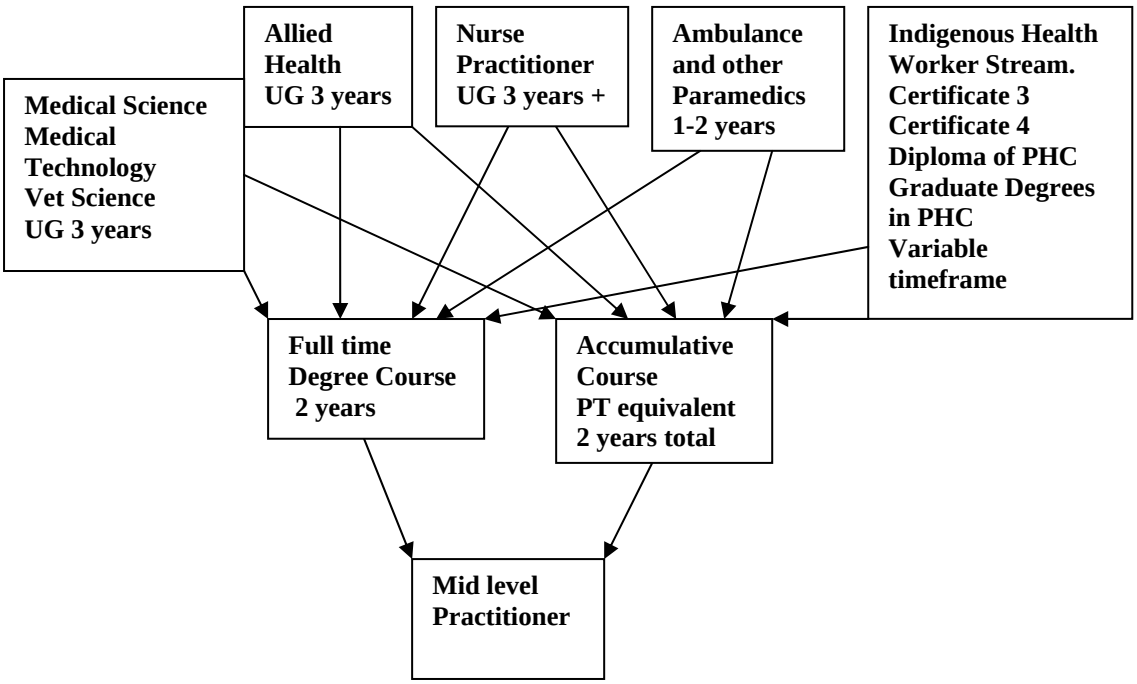

Figure 1. Pathways to Mid Level Practitioner.

Potential Timeframe
A number of curricula already exist internationally which would be appropriate for the target recruit groups. e.g. University of North Dakota bases its curriculum on experienced nurse practitioners, University of New Mexico recruits from medical technologists, medical scientists, paramedics as well as nurse practitioners. These could be purchased into Australia with seconded staff from those Universities within 12 months. A course could commence as a trial in 2005/2006. If this is the case then the first graduates would be in clinical practice by 2008. The modular of Accumulative course would take longer.

Risks and Challenges
A number of recognised barriers would present themselves to the introduction of a new health professional.

1. Industrial Barriers. There are a number of professional organisations that are potential opposition to this program. Overseas the principle opponents have come from the discipline of Nursing. Other groups are the professional and industrial organisations relating to medicine, paramedical and ambulance services. There is ample evidence that these are more easily overcome than that of

nursing. Approval of Nurse Practitioners as a viable and realistic additional workforce solution could be tied to this and assuage some of the conflict. Acceptance of Nurse Practitioners and experienced rural and remote nurses into the program also reduces this process.

2. Legislative Barriers. Legislation will need to be amended at a State and National level for this group to have access to Medicare, PBS. In the United States this has resulted in the PA program being tied to the Medical Board equivalents at State and National levels. This has operated successfully for many years.
3. Political and Community Acceptance Barriers. Acceptance of a new health professional may confront opportunistic political barriers, especially so at time of elections. A marketing strategy would go a large part of the way to reducing this. Using positive examples from overseas, marketing the world shortage of doctors and this as a solution, explaining services that could be better provided to rural and remote and disadvantaged areas from such a service would all need to be part of a broader strategy.

Conclusion

The initiation of newer solutions to the problems of rural and remote health workforce is timely. Emergent issues in international workforce make it an imperative for any government to look at any viable option to solve these shortages. The creation of Mid Level Practitioners in Australia is an appropriate and necessary solution. Trials could commence within 12 months, and such programs could be a part of the workforce solution within 5 years.

Dennis Pashen
Director
Mt Isa Centre for Rural and Remote Health
James Cook University.

The NSW Rural Medical Workforce

In 2003, RDN produced the "General Practice Workforce Plan for Rural and Remote NSW 2002-2012"[1] which estimated rural GP supply and demand to 2012. It predicted that, without new interventions, there would be a likely net increase in GP numbers by 2012 but a larger shortfall than in 2002 (due to population growth and a decline in average weekly clinical hours per GP). That shortfall was expected to be between 275 and 410, compared with a shortfall of around 130 in 2002.

There have been new interventions. Changes to HIC payments in 2004 and 2005 have at least temporarily improved the potential for rural general practice to be more financially viable than it had been. The Commonwealth has also announced increases in places at existing and new medical schools. Projections suggest the number of domestic students graduating in Medicine in NSW and ACT will be restored to 1996 levels by 2007 (476) and will grow further to an annual output of 796 by 2011. There is a lag of at least a further 5 years before such graduates would be fully qualified as rural GPs.

It is not clear what proportion of these graduates will opt for general practice as distinct from other specialties, let alone how many of those that do will then opt for rural or remote general practice. In the meantime, if the increase in numbers is to translate into more rural GPs, it will be essential to ramp up very significantly the capacity for rural hospital and community-based training placements for medical students and registrars. It will be a major challenge to achieve this without placing even more strain on those rural GPs who currently teach undergraduates, early postgraduate and vocational trainees.

A recent evaluation of the NSW Rural Medical Cadetship scheme[2] administered by RDN suggests that cadets assisted through their study and who undertake their early post-graduate years in rural hospital settings, are as likely to pursue specialties other than general practice even when their intention is to work in rural locations. While the prospect of the cadets practising as rural specialists is a welcome development, the result does not support a high level of optimism that, even with bonded scholarships and similar measures, there will necessarily be an early, significant increase in rural GP numbers.

Several significant trends bearing upon the supply of General Practitioners in rural NSW that were canvassed in the 2002 Workforce Plan continue to operate – an **ageing workforce**, a **gender shift** towards more female doctors, a general as well as a generational shift towards **shorter working hours** and a **diminishing number of procedural GPs** (anaesthetics. obstetrics, surgery etc.) who have been the backbone of service provision in rural NSW hospitals.

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[1] "General Practice Workforce Plan for Rural and Remote NSW 2002-2012", NSW Rural Doctors Network, July 2003.

[2] "Junior Doctors Working in Rural NSW", NSW Rural Doctors Network, Sept. 2004 ISBN: 0 – 9581728 – 7 – 0.

The ageing nature of the workforce is illustrated by RDN figures taken at June 30 2005. Of 1527[3] practicing GPs in rural NSW[4], 343 were over 55 years (20.8%) - 295 (86%) males and 48 (14%) females.

The 2002-12 Workforce Plan identified that in 2002, 83.8% of NSW rural male GPs were working full time (> 35 hrs/wk). Overall, male GPs had a self-reported weekly average of 52.7 hours in "direct patient care" (i.e. excluding time taken on teaching, education, business management and divisional work) and 62% of them wanted to work shorter hours. Of the rural female GPs, 45.3% worked full time. Overall, female GPs were reporting a weekly average of 31.2 hours in "direct patient care" - 41% wanted to work shorter hours and 4% wanted to work longer.

In recent years there has been a marked gender shift towards more female GPs with over 60% of GP Registrars now being female. Given that, traditionally, a smaller percentage of female GPs opt for rural practice than do males and, that when they do, a much higher percentage work part-time, these figures pose two additional recruitment challenges in replacing the mostly male retiring doctors that have generally worked long hours.

The first challenge derives from the relative reduction in the male pool of new GPs and the lower inclination of female GPs to take up rural practice. This changes the supply dynamics quite significantly. Rural practices and communities will need to adapt better to the needs of female practitioners if they are to increase the proportion of female GPs drawn to rural practice. RDN has been actively engaged in initiatives to improve the attractiveness of rural practice for women doctors. The second, associated, challenge is that on the 2002 figures 1.68 female GPs (working average female hours) would be required to undertake the same number of clinical hours as an (average) departing male.

Apart from the impact of feminisation upon average workings hours, there is a general trend towards shorter working hours by male GPs, which appears to arise from a number of factors including: older doctors seeking to rebalance their work/personal life mix, and younger male doctors aspiring to work less hours than their predecessors.

The following table provides the current (provisional) figures for the number of GPs arriving and departing the NSW rural workforce in the 12 months to June 30 2005. With 139 arrivals and 145 departures, there was a net loss of 6. While the figure for registrars can fluctuate markedly, it is nevertheless notable that the proportion of female registrars increased from 45% to 57% over the year.

[3] Excludes 116 Registrars on short term assignment
[4] GPs in RRMA 3-7 plus those in RRMA 2 areas of rural Divisions of General Practice.

Table 1
NSW Rural GP Workforce 2004/2005 – Arrivals and Departures by Gender

***Source*: NSW RDN GP Workforce Database as at 29 July 2005**

Includes all practices in RRMAs 3 to 7 and those in RRMA 2 that are in rural Divisions of General Practice.

Number	At 30 Jun 2004	Add Arrivals	Less Departures	At 30 Jun 2005	Net
Male GPs	1091	85	86	1090	-1
Female GPs	442	54	59	437	-5
Total GPs	**1533**	**139**	**145**	**1527**	**-6**
Male Registrars	46	29	25	50	4
Female Registrars	38	47	19	66	28
Total Registrars	**84**	**76**	**44**	**116**	**32**
Total Workforce	**1,617**	**215**	**189**	**1,643**	**26**

Percent	At 30 Jun 2004	Add Arrivals	Less Departures	At 30 Jun 2005
Male GPs	71.17%	61.15%	59.31%	71.38%
Female GPs	28.83%	38.85%	40.69%	28.62%
Male Registrars	54.76%	38.16%	56.82%	43.10%
Female Registrars	45.24%	61.84%	43.18%	56.90%

The number of procedural GPs has, as in rural Australia generally, declined significantly and looks like continuing to decline – with significant potential impact upon the availability of services at rural hospitals. An RDN study in 2002[5] noted that between 1991 and 2001, the number of rural doctors practising obstetrics in NSW dropped from 263 to 166, and those practising anaesthetics dropped from 190 to around 118. In 2001, some 30% of GP surgeons were over 55 years old. There are no signs of a reversal.

There are multiple known barriers to and incentives supporting the recruitment of GPs to rural and remote NSW. The barriers are well known and include perceived lifestyle disadvantages, more limited employment options for spouses and more restricted child education options in many areas, greater medical responsibility and less access to specialist and tertiary medical services. The incentives include financial incentives for relocating to and remaining in rural practice, a diverse range of training and family support assistance by agencies such as RDN and rural Divisions of General Practice, the opportunity to undertake interesting and rewarding medicine, and to become a valued and respected member of the rural community.

A significant barrier to recruitment and retention in remote areas, that is increasingly applying to rural areas as well, has been the effort and investment often seen to be required to find or acquire suitable housing, surgery facilities, skilled practice staff and locally available services (IT, accounting, practice nurse etc.). All other things being equal, communities that can provide these elements, improve their prospects of recruitment and retention. Also the business management of medical practice has become increasingly complex and time consuming. Many young doctors are reluctant

[5] "Procedural Medicine in Rural and Remote NSW – The General Practice Workforce", NSW Rural Doctors Network, Sept. 2002. ISBN: 0-9581728-0-3

(and untrained) to take on this role and see it as adding another burden to the long clinical hours associated with rural practice. A number of older doctors are now looking for ways to eliminate their business management workload – if necessary by seeking employment in a regional or urban centre or, preferably, through new service delivery structures that would allow them to stay in rural practice and maintain their clinical independence.

The Hunter Urban Division of General Practice not long ago surveyed the 75 GPs that had taken up practice in the broader Newcastle area in the previous 3 years. Of these, 69 reportedly had no active role in practice ownership, partnership or business management. They were simply contracted or employed for a certain number of hours per week. Rural communities are competing against the flexibility available in these urban situations.

Over the past 5 years, RDN has been working actively in North West NSW to overcome a chronic shortage of doctors in communities with high levels of disadvantage and poor health standards. New arrangements that provide doctors with housing, surgery, practice management and staff, have tripled GP numbers from 3 to 9 across 4 towns. It has been demonstrated that new approaches can attract doctors to remote, high-cost locations, even when there are scores of vacancies in more comfortable towns. [See boxed story below]

The Productivity Commission Issues Paper[6] suggests: **"Some 'lifestyle' and 'nature of work' considerations that make it hard to attract health professionals to rural and remote areas may be very difficult or even impossible to overcome through changes in policy**". It is often the case that the most challenging areas are also those experiencing greatest disadvantage and poorest health. This suggestion of impossibility runs counter to the 'worst first' philosophy that underpins the "Healthy Horizons" Framework adopted by Federal and State Health Ministers[7] and to the priority given to improving Aboriginal health. The NSW North West success suggests that, while difficult, significant improvement in medical services and health outcomes are not impossible.

Even when a suitable GP may be available and interested in a particular vacancy, RDN cannot recruit into dysfunctional situations or where key infrastructure or other elements are missing – not when there are far less problematic opportunities in urban or other rural locations. The successful experiences of RDN in the North West have led it to taking a stronger role in working with local government, rural Divisions of General Practice, Area Health Services and other stakeholders to help create circumstances that are more likely to appeal to prospective rural GPs and more likely to retain the services of existing long-standing doctors.

The issues and obstacles applying to the recruitment and retention of rural GPs in NSW apply just as much, sometimes more, to nurses and allied health professionals. Health workforce ageing, poor housing, the fragility of adequate staffing levels of skilled

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[6] P.36

[7] "Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians" 1999-2003, and Healthy Horizons: Outlook 2003-2007.
ISBN 07308 56844

nursing personnel in procedural rural hospitals, the unavailability practice nurses in some areas, and the shortage of dental services and virtually every category of allied health (physiotherapy, podiatry, Aboriginal health, psychology, occupational therapy, sexual health etc.) have a severe impact upon rural health services and outcomes. They increase the workload of GPs and diminish the clinical support available.

With some 650 NSW rural GPs providing the Visiting Medical Officer services that are the medical backbone of rural hospital services, high turnover in nursing personnel generally and an uncertain supply of nursing specialists (midwives, theatre nurses etc.) contribute to the burden and stress of rural medical practice. On a more positive note, rural practice often affords greater opportunity for GPs to work more closely with allied and community health personnel on a basis that provides a greater degree of primary health care integration.

"EASY ENTRY, GRACIOUS EXIT" - The North West NSW Experience

A 1999 RDN survey of rural Divisions identified that a cluster of 4 towns in North West NSW (Brewarrina, Walgett, Lightning Ridge and Collarenebri) experienced a dire and chronic doctor shortage. With high Aboriginal populations and a total population seasonally fluctuating between 12-14,000, they experienced the lowest socio-economic indicators in NSW and amongst the worst health outcomes nationally.

RDN met the main regional service agencies and stakeholders, and held meetings with local service providers and stakeholders in individual towns. Multiple obstacles to GP recruitment were identified (poor housing, inadequate surgery space, poor relations between GPs and the area health service, the deterrent of heavy workloads, isolation, woeful telecommunications, high costs, local lack of skills and services, unrealistic community expectations etc.). Local health forums were established that met every 3 months to share information, co-ordinate activity, solve local problems and provide a basis for progressing issues with local, regional, state and federal agencies.

2001 was a low point when there were only 3 resident doctors to provide general practice and VMO services across the 4 towns and hospitals. At times, there were no resident GPs in Lightning Ridge, Brewarrina or Collarenebri. In early 2001, RDN stepped into Brewarrina as an emergency response when the GP left at short notice, employed a medical receptionist and furnished a house so that locums could be placed there in the interim until a new doctor was recruited. It took 20 months and 22 locums before the situation was stabilised by the arrival of two married doctors from NZ.

By mid-2001, Walgett and Lightning Ridge looked set to worsen. With endorsement from the Walgett Shire Health Forum, RDN sponsored establishment of a not-for-profit company, Rural and Remote Medical Services Ltd. (RARMS). RARMS set up a new medical practice in Lightning Ridge when the sole resident GP withdrew from practice due to illness in late 2001, and took over the Walgett medical practice in early 2002. The Department of Health and Ageing provided funding to enable houses to be furnished, computers and equipment to be installed in the surgeries and also to improve facilities in Brewarrina. The RARMS board comprised nominees from RDN, Walgett Aboriginal Medical Service, the Outback Division of General Practice and the Rural Doctors Association (NSW).

Doctors in Bourke established a somewhat similar privately owned company (Australian Outback Medical Services) in 2002 and when medical staffing became settled in Brewarrina, RDN handed over that practice to AOMS under certain conditions such as guaranteed retention of medical records. In Collarenebri, where services had been provided for a long period by a series of locums, a female doctor took up residence in housing and facilities supplied by the hospital.

An account of how RARMS evolved over the following two years can be found in "Easy Entry, Gracious Exit"[8] There are now 5 GPs working in RARMS facilities in Lightning Ridge and Walgett. They conduct their own individual practices, and determine their own fee policies (all have chosen to bulk bill). Funds were obtained to improve housing. RARMS co-ordinates the supply of housing by leasing homes that are rented to the doctors. RARMS personnel provide practice management, medical reception, nursing and IT services. RARMS also manages VMO services at the two hospitals and is agent for the recruitment of VMOs, roster arrangements and billing services – the effect of which is to reduce the stress and time involved in GP/Area Health Service relations. Basically, the GPs can concentrate upon their clinical work.

By 2003, there were 9 GPs resident across the 4 towns compared with 3 only 2 years earlier, including 2 in Brewarrina and 1 in Collarenebri, all working under variations of the "Easy Entry, Gracious Exit" philosophy.

All the doctors working in RARMS facilities have stayed longer than they originally intended. There are enough doctors to share VMO workloads, and it is easier for them to take leave and attend medical education programs. One Walgett GP, after 3 1/2 years, has left for 12 months to undertake anaesthetics training but intends to return – short term arrangements are in place for this year.

Part of the strategy developed was to obtain federal Regional Health Service funding for public health programs – not only because of the high need for them but also because they provided funds and opportunities for prospective doctor recruits to broaden their medical interests and activities. Since 2001, all the practices have expanded and been physically upgraded. Walgett, Lightning Ridge and Brewarrina are accredited. The quality of patient care and the range of medical and health services available from RARMS surgeries have improved markedly.

While the area has suffered significant economic downturn from 4 years of drought, it is estimated **additional externally sourced income of $3m annually** has flowed into the area as a result of the medical and hospital services provided. Some 13 local, skilled jobs have been created. An independent evaluation of RARMS by Deloitte Touche Tohmatsu, commissioned by the Department of Health and Ageing and completed in early 2004, found improved doctor recruitment and retention, a wider range of services being provided, and reduced commitment on other parts of the health system (e.g. a dramatic reduction in RFDS consultations from 777 in 2001-02 to 232 in 2002-03).

RARMS has now reached a point of financial sustainability and is examining options for extending services to other centres in the region. RDN is applying lessons learnt from RARMS in advising other communities struggling to maintain their medical services.

[8] "Easy Entry, Gracious Exit", M Boucher and M Lynch, NSW Rural Doctors Network, Sept. 2003. ISBN 0-9581728-3-8; available at the RDN Website: www.nswrdn.com.au under Publications.

Increase in Medical Graduates 2007-2012

The number of medical graduates in NSW and ACT will increase from **459** in 2005 to **940** in 2012, a more than doubling of the expected early postgraduate medical workforce.[9] This huge increase has major implications for medical workforce training, distribution and roles.

Issues

1. Undergraduate Training
   The increase in undergraduates will place a huge strain on available community based teaching resources. The same GPs who teach undergraduates also teach / supervise early postgraduate and vocational trainees

2. Early Postgraduate
   If the aims of Australian Government bonded scholarships and bonded places in directing doctors to areas of workforce shortage are to be met they will also need to have early postgraduate area of workforce shortage experience. Current indications are that this may not happen.
   - NSW Health is likely to look on the increased number of graduates as an answer to hospital doctor shortages, building a hospital based system on relatively junior, relatively unsupervised doctors.

     NSW Health has indicated that it will not employ or indemnify early postgraduate doctors in community based terms.

     There is a mismatch between Commonwealth expectations that the increase in medical graduates will lead to an increase in doctors in areas of workforce shortage and the NSW Health expectation that it will lead to an increase in hospital based junior doctor workforce.

     NSW Health has funded bonded scholarships for medical students in their last two years of undergraduate training in return for two years of PGY1-3 service since 1993. A recent evaluation of this program has suggested that this has been successful in increasing the number of doctors staying in rural areas, but that especially in the last five years these doctors are undertaking specialist rather than GP training.[10]

     Remembering that return of service on Commonwealth bonded scholarships and places does not begin until after vocational training is completed, there may in future be a welcome increase in rural specialists, but still a shortage in rural GPs. Early postgraduate exposure to community based practice may help to have more young doctors choosing General Practice.

[9] This includes a projected 50 graduates from a New England medical school

[10] Dunbabin, Janet "An Evaluation of the NSW Rural Resident Medical Officer Cadetship Program", NSW Rural Doctors Network Discussion Paper, September 2004

3. Non Articulation of Commonwealth and State Initiatives

Both Commonwealth and State Governments have done much over the last fifteen years to address GP shortages, especially in rural areas. However sometimes the initiatives do not articulate.

An example is in the area of scholarships, with some newer Commonwealth initiatives disadvantaging the already existing NSW Health Cadetships.

Example: Commonwealth HECS Reimbursement Scheme
The HECS Reimbursement Scheme is one of a number of Commonwealth Government initiatives designed to encourage medical students to consider rural practice after graduation. The scheme's guidelines, however, actually discourage some medical students from choosing rural practice. This unintended consequence is the result of a disjunction between Commonwealth and State rural health policies.

Since 1989 the NSW Department of Health has funded the NSW Rural Resident Medical Officer Cadetship Scheme, which has for many years been administered by the NSW Rural Doctors Network (RDN). The Cadetship Scheme provides medical students, who are NSW and ACT residents (including NSW and ACT residents who are studying medicine in another state/territory), with $15,000 per annum in the last two years of their medical degree. In return the cadetship recipients agree to complete two of their first three postgraduate years as Junior Medical Officers in regional hospitals in NSW. The Cadetship Scheme is competitive and applicants are awarded scholarships on the basis of their commitment to practice rurally after graduation. Thus the cadets represent a group of students who are committed to, and passionate about, rural practice. The same group of students is, however, ineligible for the HECS Reimbursement Scheme for the two years of their rural service. This has had a negative impact on the students. They feel that their interest in rural practice has been taken for granted by the Commonwealth and that they may as well go back to the city to practice. Then they would be eligible for the full HECS reimbursement. The students' view is that they "did the right thing and are disadvantaged for it, so why pursue rural practice?" In short, they are disillusioned.

When the HECS Reimbursement Scheme was announced in the 2000/01 federal budget, RDN contacted officers of the (now) Department of Health and Ageing (DoHA) and were advised verbally that the cadets would be eligible for the scheme. The 2001/02 draft guidelines advised "graduates who receive a RMBS (Commonwealth funded Rural Medical Bonded Scholarship) will not be eligible for this scheme during the period in which they are completing their service obligation". Guidelines were silent on other scholarships. Subsequent verbal advice from DoHA was that this exclusion (ie ineligibility) would not apply to RDN cadets. However subsequent guidelines specifically stated "Recipients of any other bonded scholarship will not be eligible for this Scheme for the period in which they are completing their return of service obligation". RDN has

> written to the department and lobbied on several occasions about the cadets being ineligible for the Scheme. RDN has been told that it is "too late…(the scheme) is enshrined in legislation".
>
> Both Commonwealth and NSW governments have done a great deal to encourage and support rural medical practice, and this is surely an unintended consequence of the disjunction between Commonwealth and State policies. Potential applicants for the cadetship have, again this year, as in previous years, advised RDN that they are not applying for cadetships because cadets are ineligible for the two years of their rural service to receive HECS reimbursement. This is particularly serious as a recent review of the cadetship program (Dunbabin 2004) has demonstrated that the cadetship does meet its aim of encouraging young doctors to practice in rural areas.

Both the possibility of a mismatch in outcomes from the increase in medical graduates and the example given around scholarships highlight the need for congruence between initiatives of Commonwealth and State governments.

With the increase in graduates there needs also to be a focus on

- Resources for undergraduate teaching in community GP setting
- Resources for community based practice in PGY 1-4 years, and support for supervisors, teachers

If gaining cohesion across jurisdictional boundaries is difficult, then maybe existing NGOs should be used to overcome these difficulties. For example, Rural Workforce Agencies could be funded to employ and indemnify doctors in the State public hospital system while they undertake community GP placements