Productivity Commission
Health Workforce Study

Submission from the
Rural Workforce Agency Victoria

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Section One: Background

Rural Workforce Agency Victoria

RWAV was established to assist rural Victorian communities gain accessible, equitable and sustainable medical and supporting health services. Formed in 1998 by rural and medical stakeholders, RWAV was established to improve access to general practice services for rural Victorians and overcome the shortage of rural general practitioners (GPs). RWAV services, funded largely by the Australian and Victorian governments, have now broadened to include a range of rural workforce programs primarily working with GPs and medical specialists.

RWAVs workforce programs now focus on:

- *Attracting* medical and supporting health workforce to train and work in rural Victoria
- *Recruiting* appropriately qualified doctors and supporting health workforce. This includes assessment and recruitment of Australian trained and overseas trained doctors and state-wide coordination of a vacancy database and recruitment process in collaboration with Divisions of General Practice.
- *Ongoing workforce support* programs such as locum and family support services
- *Professional development* grants, training programs, coordination and support
- *Rural workforce planning and data collection* including a rural medical workforce database and contribution to the Rural GP National Minimum Dataset.

RWAVs work focuses on Victorian regional, rural and remote communities outside of Melbourne and Geelong, Our work also includes working with all Victorian Aboriginal Community Controlled Health Services and we have provided some limited medical recruitment support for Melbourne and Geelong districts of workforce shortage. In this document, for the sake of ease in reading, we refer to these locations as ‘rural Victoria’.

RWAV works in a collaborative manner with key partners and stakeholders that include rural communities, local governments, Divisions of General Practice, hospitals and health services, medico-political organisations, Australian and Victorian Governments, Universities, Colleges and education and training providers.

Workforce planning is an important component of our work. For more information see attached ‘Planning for 2012’ study and rural electorate profile brochures.

Productivity Commission Health workforce study

The ‘Health Workforce Issues Paper, May 2005’ raises important structural and systemic issues that impact on health workforce planning, distribution, job and role definition, productivity and workforce trends. It identifies the complexity of the environment, the multitude of players, the global, fiscal and regulatory arrangements that impact on the funding and location of health workers.

The Commissions’ issues paper identifies a range of specific issues that relate to rural communities including the challenges of geography, rural health workforce and skills shortages, poorer access and greater costs in health service delivery in many rural and remote communities.

National Health Workforce Strategic Framework

In our view, the National Health Workforce Strategic Framework outlines important key principles for consideration of health workforce reform. These include the principles of:

- National self sufficiency in workforce supply
- Equitable access to health care for all Australians
- Recognising people and communities with greatest need
- Workforce distributed to optimise health outcomes
- A valued and supported workforce in all health locations
- Cohesive action among the health, education, vocational training and regulatory sectors to promote a knowledgeable, skilled, competent health workforce
- Health workforce engaged in lifelong learning
- Complementary realignment of existing roles or creation of new roles and workplace redesign.
- Health workforce policy and planning that is population and consumer focused, linked to broader health planning and informed by the best available evidence.
- Collaborative planning with all stakeholders involving stakeholder commitment to the vision, principles and strategies; a nationally consistent approach; best use of resources to respond to the strategies and a monitoring, evaluation and reporting process.

In this respect, the principles outlined in the national framework provide the context for our comments to the Commission on rural health workforce issues.

In addition, we believe that there are other principles that have been raised through the Commissions discussion paper that are also important to consider. These include:

- Recognition of workforce planning requirements at local, state-wide as well as national level.
- Support of collaborative and team based approaches across professional disciplines in health professional education, training and service delivery.

Section Two: Rural Health Workforce Issues

It is clear that rural, regional and remote communities do not experience the same equity of access to health services that people in our major cities. Within the context of this study, there are some key considerations that pose significant challenges for health workforce and service planning. These include:

National Self –sufficiency in health workforce supply

National trends indicate that the health workforce has significant shortages, not only in rural areas, but also in fringe metropolitan and major metropolitan areas. This will make the task of attracting medical practitioners and other health professionals to rural areas much more challenging. In addition there is a significant trend to a reduction in hours in the medical workforce. As more women enter the workforce (eg 50% of medical students and 65% of GP registrars are women), and the age group of all doctors reduces, and the average hours worked reduces, the downward trend in working hours is set to continue and increase.

Workforce shortages not only exist in general practice, but now also in a range of many medical specialties, including psychiatry, surgery and emergency medicine, particularly in rural areas. Shortages also extend into allied health professions, rural nurses (and midwives) and dentists.

Australia does not currently have self-sufficiency in medical and other health workforce supply.

The Government has responded by increasing medical training places and establishing rural medical school infrastructure to encourage rural students into health careers. In addition, the Australian General Practice Training Program has regionalized and over recent years the number of rural trainees has been increased.

As ‘Districts of Workforce Shortage’ extend into metropolitan areas, RWAV is beginning to see doctors who have been recruited to rural areas, now seeking out urban options placing increasing pressure on rural vacancies.

A substantial proportion of all new entrants to rural General Practice in Victoria are GP registrars and Overseas Trained Doctors. The regionalisation of the Australian GP Training Program has made a significant boost to the rural GP workforce, however some of these OTDs transfer into the AGPTP, which means the data needs to be examined closely before assumptions are made about this.

In rural communities, significant infrastructure has been put in place through Rural Clinical Schools, University Departments of Rural Health and Regional General Practice Training Providers. Such initiatives will have made a major long-term contribution to growing rural medical workforce given the lag times in medical training.

Targeting workforce to areas of need

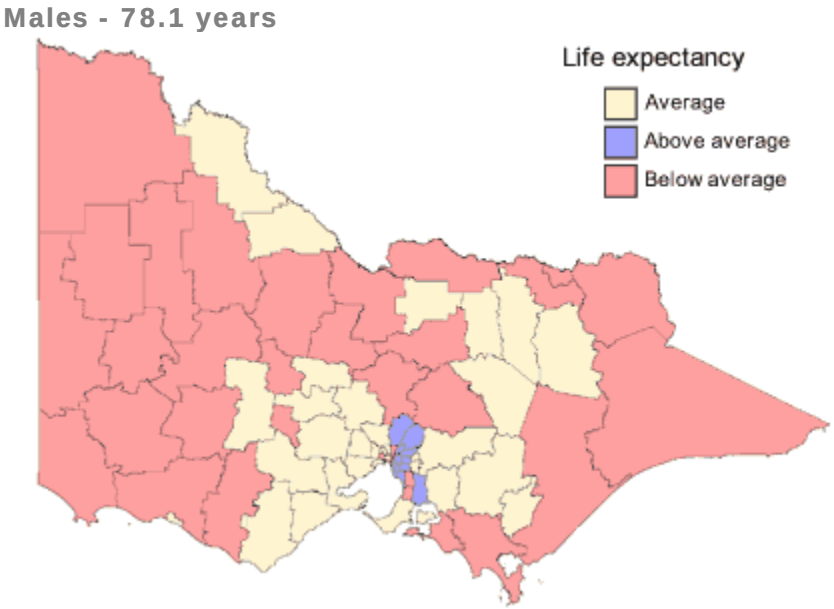
National and Victorian studies [1,2] indicate the poorer health and socio-economic status of rural and remote communities and of Indigenous communities, with proportionally fewer services and health workforce available to them to meet their health needs.

The 2005 AIHW 'Rural Regional and Remote Health: Indicators of Health' study [3] found that health status and socio-economic status indicators were poorer for regional, rural and remote communities across Australia. For example:

- life expectancy was were highest in major cities and lowest in very remote areas, dropping from 78 years to 72 years for males, and from 84 years to 79 years for females
- Burden of disease was greater with regional, rural and remote people likely to have greater injury rates, poorer dental health, higher rates of communicable diseases, disability and reduced activity because of illness
- After-tax incomes for people in regional areas about 80 per cent of those in major cities. For the three indexes of relative socioeconomic disadvantage, economic resources, and education and occupation, outcomes were better in major cities than in regional and remote areas.
- Adults living in regional and remote areas were less likely to have completed secondary school and have tertiary qualifications including TAFE than those from major cities.

The Victorian Department of Human Services Burden of Disease [4] support these findings in rural Victoria. Figure 1 provides the Life expectancy for Males, Figure 2 provides life expectancy for females. A significant proportion of the population of Local Government Areas in rural Victoria have below average life expectancy for both men and women.

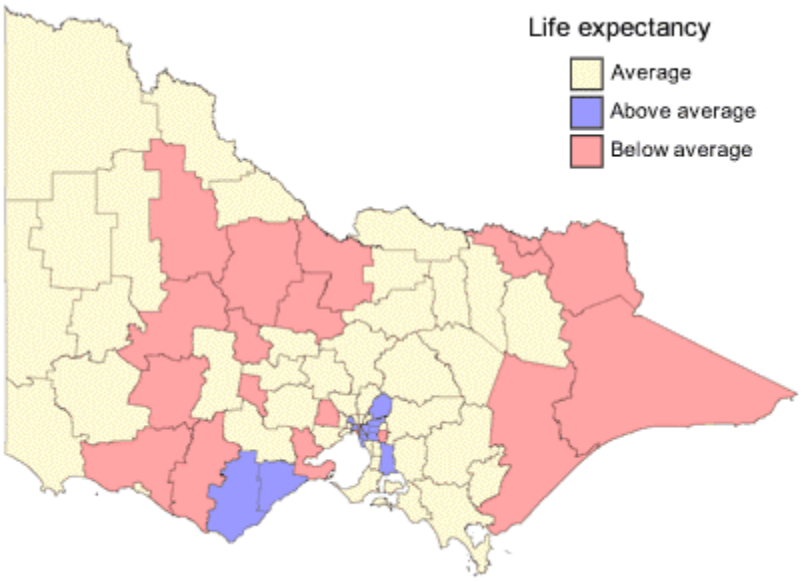
Figure 1: Life expectancy at birth by LGA, Victoria 1999-2003



Source: Victorian Department of Human Services, Burden of Disease website

Figure 2: Life expectancy at birth by LGA, Victoria 1999-2003

Females - 82.7 years



Source: Victorian Department of Human Services, Burden of Disease website

Measures of morbidity also reflect higher burdens of disease across rural Victoria. One such indicator is the Disability Adjusted Life Year (DALY) The DALY is a time-based measure with two components: the years of life lost prematurely when death occurs before expected (YLL) and the years of life lived with disease or injury (YLD) The average DALY range for men is 139.7 and for women 124.4 (DHS,2001).

Figure 3 and 4 are based on rates per 1000 population and compare the overall health status of men and women between Local Government Areas. A high DALY rate indicates poor health status and greater burden of disease. Poorer overall health status is found for a substantial proportion of rural Victoria.

Figure 3: Male DALY range

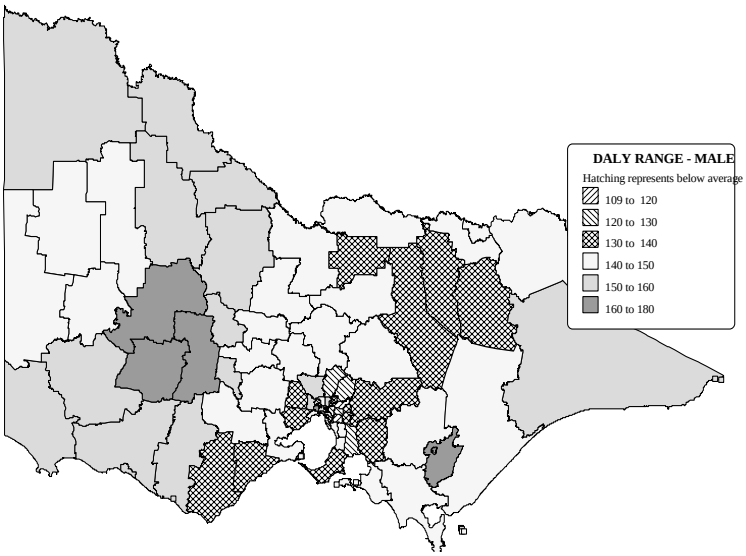
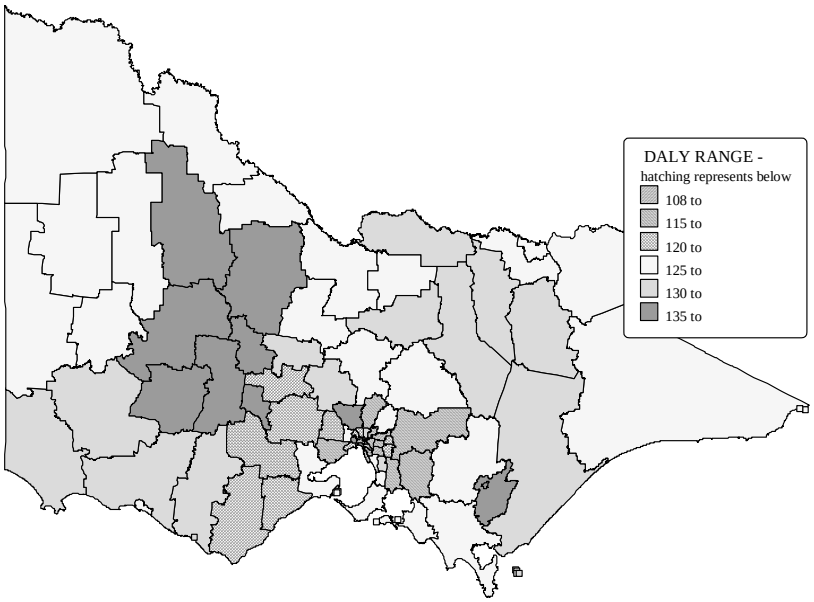


Figure 4: Female DALY range



Meeting health service needs of widely distributed, small and isolated populations

The distribution of the population throughout rural Australia poses the greatest challenges for health service delivery and workforce planning, and Victoria has its own set of problems.

Population

Victoria is a very decentralised State with 1.37 million Victorians living outside of Melbourne [5] and more than 265,000 people living in localities of less than 5000 people [6].

Victoria has a diverse geography of mountains, desert, farming, coastal and fringe urban communities. 13.4 million hectares or nearly 60 per cent of Victoria's land area is used for agricultural activity [7].

Unlike other larger States and Territories, rural Victorians have limited air services to assist them in accessing health services, and are heavily reliant on sealed and unsealed road travel in private vehicles to access services. Major roads tend to radiate to Melbourne, sometimes making the nearest places, not necessarily the quickest places to reach. Victoria's inland cities operate as service hubs for smaller, outlying and isolated towns and communities.

Rural workforce and infrastructure

Small rural communities rely on their GP and nursing workforce for local hospital and primary care services. There are 1147 rural GPs working in Victoria outside of Melbourne and Geelong. One third of all Victorian towns with GPs (60 towns) have only one or two doctors [8]. Regardless of the relative distance to service centres, these communities face very different health service issues than larger population centres or metropolitan areas.

Sustainability of hospital and primary care services is a critical issue in small communities where private practice viability can be marginal or unsustainable.

Loss of services

Rural GPs provide a range of primary medical services, but many also provide procedural services to small rural hospitals. Thirty-six per cent of Victorian GPs provide in-patient and procedural services such as obstetrics, anaesthetics, surgery, trauma and medical emergency services.

Where hospital services are lost for whatever reason, workforce follows. For example, in 1983, there were 129 rural birthing units in Victoria. Since 1983, the rate of closure has averaged at 4 to 5 units a year. In 1997 an inventory found 77 left and by 2005 this has reduced to 47 [9]. The closure of small rural acute health services leads to a loss of procedural doctor and nursing workforce. The loss of procedural GPs has a flow-on effect to the primary care workforce, making it more difficult to retain the general practice services in small communities

In a rural context therefore workforce planning and service planning is very closely linked. The loss of just one doctor can create a workforce and service crisis for a whole community. The loss of a GP obstetricians or midwives, for example, can impact on the provision of obstetric services for patients across a region and will affect the delivery of primary health care and hospital services.

Workforce loss can result in closure of services. The development of new service models or outreach services are required to meet the ongoing health service needs of rural communities. Such models require broad community, health service, government and practitioner involvement to find a solution that guarantees ongoing service delivery.

Rural and remote health workers have often by necessity had to work in a different manner, to work collaboratively, with expanded job roles, or to find new ways to meet old objectives to deliver services to their communities. There are many examples of innovation and reform in the rural health sector; of team based approaches and solutions to overcoming the challenges of distance, service access and workforce issues for rural and remote communities (see RWAV, ‘A snapshot of Sustainable General Practice Models).

Changes in the population demographics of rural communities over time will also have significant impact on service needs.

Regional Centres

A case in point is the growth of Victoria's regional centres. The Productivity Commissions discussion paper reports that "… those living in major regional centres in the south-east of the country often enjoy comparable access to services as those in metropolitan areas".

RWAV disputes this observation. In relation to GP and specialist services in regional Victoria, this is not the case. Bendigo, Shepparton and Albury/Wodonga have significant GP vacancies and are recognised as Districts of Workforce Shortage. As of June 2005, 22 per cent of the 78 GP vacancies in rural Victoria were located in these regional centres and continued GP workforce shortages are predicted for these fast growing centres. These centres are hampered in their recruitment by lack of access to the same incentives and government programs that apply to rural Victoria and some outer metropolitan areas.

Shortages of medical specialist services also exist in rural communities. Under the Medical Specialist Outreach Assistance Program, RWAV has supported the provision of 137 medical specialist outreach services to rural communities with the demand for services substantially exceeding available supply. Fifty per cent of outreach specialists are travelling from Melbourne to provide these services.

Equitable access to health care

Rural people do not have equitable access to healthcare. This is evidenced by the distribution of Medicare benefits (see table 1). The Department Health and Ageing Annual Report 2002-03 found that whilst Medicare benefits per capita have increased for rural and remote Australia between 1998 and 2003, they are significantly lower than metropolitan centres.

Given that Medicare funding is driven by services provided on a fee-for-service basis by medical practitioners, workforce shortages will directly impact on access to services and therefore to Medicare funded services. This inherently limits rural health funding and equitable access to health care. In some locations around the country, Medicare funding has been able to be 'cashed out' to fund services that otherwise would not be able to be provided, where there was not sufficient viability for a private practitioner or where locations are difficult to attract practitioners. Such population based approaches to the funding of under-serviced communities on a broader scale require careful consideration given that rural communities are consistently underserved with associated poor health status.

Table 1 Medicare Benefits Schedule Outlays by regional category per capita, 1998-99 to 2002-03[10]

Region	Total Benefits per Capita, in dollars (2002-03 prices)				
	1998-99	1999-2000	2000-01	2001-02	2002-03
Capital City	425.68	427.50	425.21	437.39	431.98
Other Metro Centre	407.94	409.50	406.87	420.79	417.14
Rural and Remote	319.33	323.16	329.15	345.82	349.87
Australia-wide	**394.03**	**396.47**	**396.58**	**410.22**	**407.71**

1. Non Farm GDP implicit price deflator used for earlier years for meaningful comparison.
2. Population figures as provided by the Australian Bureau of Statistics (ABS) to 30 June 2001.
3. The figures underlying this table are based on cash not accrual numbers in order to preserve the time series.
4. For MBS the numbers are based on claims processed during the year.
5. The allocation to regional category is based on postcode of patient enrolment

Further, currently Governments use geographic indexes such as Rural, Remote, Metropolitan Area Classification (RRMA) or Accessibility Remoteness Index of Australia (ARIA) as a proxy measure of health access. These classification systems are used for a diverse range of purposes including to:

- define whether localities are urban, rural or remote
- determine rural health funding and rural loadings for health programs
- determine eligibility criteria for rural and remote programs. This includes the Australian General Practice Training Program rural stream and locations eligible for the placement of overseas trained doctors. This means for example, the despite being recognised as Districts of Workforce Shortage, Victoria's regional centres cannot recruit overseas trained doctors through the Victoria's 'Five Year Scheme', because regional centres are classified as RRMA 3 and the program only applies to RRMA 4 to 7 locations.

These can be very blunt instruments in targeting health services and in measuring access to health care.

Victoria faces particular problems in the Australian context because of its relative lack of size, and its willingness over time to allow larger sparser states to receive relatively more funding to support rural health services and workforce.

Distance is an important measure to consider when considering the cost of delivering services. However, considering geography is far more complex than measuring distance alone, and neither geography nor distance are sole measures of access to services.

In fact, accessibility has multiple dimensions and can include a range of factors such as time travel to key services, mode of transport, patient mobility, costs, socio-economic factors, language, aboriginality, workforce and service availability and the health conditions including type or urgency of the problem.

It has reached the stage where it is quite clear that the burden of disease carried by rural people in many parts of Victoria is as bad as in some remote areas in Australia. Yet when distance is used as an indicator of access to services Victoria is significantly disadvantaged. For example:

- MSOAP (Medical Specialist Outreach Assistance Program) is funded on a formula that is based on distance measures (ARIA classification). All large regional centres and many smaller rural centres throughout rural Victoria are excluded from accessing specialist outreach services through this program.

- The Flexible Payments System as part of the Rural Retention Program is designed to provide rural doctors with a financial incentive to stay in their rural practice. The first round of FPS funding in 2000 saw Victoria receive three per cent of the $1,046,000. This program is based on ARIA (purely distance).

New tailored measures of access, rurality and health workforce are needed to more effectively target services to areas and communities in need. The Department of Health and Ageing are conducting a review of the RRMA classification. Should the RRMA Review recommend that distance be included in the formula for resource allocation for rural health services and workforce support, then Victorian rural health workforce programs will be further and significantly disadvantaged

RWAV and other peak organisations such as Australian Divisions of General Practice, Australian College of Rural and Remote Medicine, Australian Rural Workforce Agencies Group and the National Rural Health Alliance have been arguing for the development of a flexible national classification system that takes into account the characteristics of individual localities and regions and their access to health services. This should include consideration of:

- Population of localities
- Rurality of location
- Aboriginal populations, given their substantially poorer health status
- Health and well being indicators.
- Workforce Measures.

Ongoing health professional workforce and skills shortages in rural areas

In relation to the health workforce, the AIHW [1] found that:

- Overall, health professionals are less prevalent in regional and especially remote areas. For example, GPs were 0.75–0.85 times as prevalent in regional areas as in major cities, 0.65–0.75 times in remote areas, and 0.7–0.95 times as prevalent in very remote areas.
- Specialists as a whole were substantially less prevalent outside major cities, but there was substantial variation between specialties.
- Enrolled nurses were more prevalent, and registered nurses less prevalent outside major cities.
- The prevalence of pharmacists, podiatrists, physiotherapists and occupational therapists decreased sharply with increasing remoteness.
- With some exceptions, young people from regional and remote areas were less likely or much less likely to commence a health-related degree than young people from major cities.

- It was characteristic of all health workers, broadly, to work longer hours outside major cities, especially in remote areas. On average for example, GPs worked 10 per cent longer in regional areas and 26 per cent longer in very remote areas than those in major cities.

Initiatives that focus on encouraging GPs to work longer hours are unlikely to work in a rural and remote context where GPs are already working long hours and considerable effort is going to support GPs to take leave to reduce their practice, hospital and on-call hours.

In addition to shortages of health professionals, the rural workforce also has specific skills shortages such as the shortage of GP proceduralists (obstetricians, GP anaesthetists and GP surgeons) as well as midwives. Initiatives that support the development of specific skills to meet rural needs need to be considered.

Maintaining the GP proceduralist workforce in rural areas is critical to the hospital workforce and the loss of services has resulted from a range of factors including:

- factors driven by hospital imperatives rather than community need, such as loss of GP, nursing or specialist workforce, financial imperatives or infrastructure or the location of services
- cost of indemnity and fear of litigation
- increasing specialisation and rapid changes in the technology of procedures in medicine
- opportunities for procedural skills training, consolidation, upskilling and maintenance.

Greater flexibility is needed in procedural training. Currently, there are no formalised pathways. In addition, there are problems with obtaining provider numbers if alternative training paths are undertaken, as they are not accredited. Various State Governments have commenced looking at these issues and established a range of initiatives including the funding of additional training posts and information services on training opportunities, but much more is needed to improve the number of procedural doctors in rural communities.

Recruiting and attracting rural health workforce

The Commissions Health Workforce Issues paper proposes that we should be relying more on incentives than compulsion to attract medical practitioners and other health workers outside the major population centres.

Sustained shortages of health professionals testify to the difficulty of attracting and recruiting to rural areas. There are many factors that make rural recruitment more difficult across the health professions. These include:

- Proportionally fewer rural origin students undertaking health professional training, yet rural origin students or practitioners with training experience in rural areas are more likely to return to work in rural communities [11].
- Challenges of meeting the needs of whole families, when attempting to attract practitioners to rural communities mainly opportunities for spouse employment and children's education.
- Migration of young people into metropolitan areas for work and training opportunities, although much has been done to encourage regional training through rural clinical

schools, university departments of rural health and regional training programs and this infrastructure has made a significant impact on general practice in rural areas.
- Limited training and work opportunities in rural communities for some specialties and health professionals, or insufficient workload to attract professionals. In many cases health services have only sufficient work for part-time or sessional workers.
- Overcoming the perception of rural practice as involving isolation, long hours, lack of access to professional development opportunities and support mechanisms;
- The demand for practitioners with advanced skills to work in rural practice.

Over the last decade, there has been a range of measures introduced to redistribute the general practice workforce. Some measures have relied on compulsion, some on incentives and others on considerable investment in workforce support services. In our view, all of these elements, compulsion, incentives and workforce support together work to assist rural and remote workforce recruitment and retention.

Measures that rely on compulsion within general practice have included:
- the ten year moratorium on Medicare provider numbers, which from December 1996, restricted new Medicare provider numbers to only GPs who were willing to work in areas of need, such as rural areas
- Bonded scholarship programs

These measures particularly the ten year moratorium has been a substantial reason for the increase in doctors to rural areas.

There has also been a range of rural incentive and support programs that include:
- Regionalisation of training opportunities such as the General Practice Training Program that allocates rural training places
- Development of Rural Clinical Schools and University Departments of Rural Health
- Workforce support and incentive programs for GPs, medical specialists, nurses and allied health professionals delivered by agencies such as Rural Workforce Agencies and Divisions of General Practice; Such support programs which include locum support, professional development programs and grants and family support are well developed for GPs, but are less developed for medical specialists and allied health professionals.
- Rural retention grants for long-serving rural GPs
- Loosening of restriction to attract overseas trained doctors and health professionals.

As a result, these programs have support the recruitment and retention of doctors and developed substantial infrastructure to assist the workforce. When RWAV first started in 1998, there were 148 GP vacancies (14 per cent vacancy rate) in rural Victoria with many exhausted GPs working extraordinarily long-hours without locum support or relief. Since that time, vacancy rates have halved and the workforce has grown significantly. Support services have been put in place to provide substantial assistance to rural medical practitioners.

Medicare data reflects the effectiveness of rural workforce programs to attract doctors to work in rural communities. Between 2001-02 and 2003-04, there had been increase of 5 per cent in the number of effective full-time (EFT) rural GPs and an 8 per cent increase of EFT rural specialists in Victoria. This compares to a 1.5 per cent decline in the number of EFT GPs and a 5.3 per cent increase in the number of EFT medical specialists in metropolitan Melbourne over the same period [12].

There has however been no formal evaluation of the relative merit of compulsory, incentive or support approaches to the rural workforce and so we do not know with assurance what workforce programs have been most effective. Both approaches have been effective. It is too soon to really assess some of the newer supports.

Rural recruitment is heavily reliant on compulsory schemes that determine rural and remote communities as 'areas of need'. Governments use the moratorium on provider numbers and the systems of identifying eligible 'Districts of Workforce Shortage' or 'Areas of Need' as the means of controlling the distribution of scarce medical resources.

The Commission proposes incentive possibilities as an alternate to compulsory measures including: providing more training opportunities and service delivery infrastructure in rural and remote locations; improving the access of rural practitioners to professional networks; creating career pathways that avoid geographic lock-in and introducing less onerous bonding arrangements.

All of these strategies are desirable with more support needed particularly in the development of infrastructure for the delivery of health services. In the case of General Practice, many initiatives are already in place eg regionalisation of GP training program, Rural Clinical Schools and professional networks of practitioners through Divisions of General Practices, Colleges and Universities. However, it is clear that the greater the exposure to rural practice for medical students and trainees, the more likely rural practice becomes a consideration. As a result, compulsory rural terms or experiences can make a significant impact on students considering their future career, opening up opportunities that they otherwise would never consider.

In our view, the removal of such compulsory measures could have a devastating effect on the already fragile rural workforce and would require careful assessment, planning and substantial evidence of efficacy. In addition, we would expect that substantial *financial* incentives, over and above those provided to medical practitioners in urban areas would be required to provide a real incentive.

The opening up of the 10-year moratorium to metropolitan and outer metropolitan is already causing significant loss of doctors from rural areas. These exemptions should not have been introduced. Instead, substantial incentives to urban doctors to move in to these metro and outer metro locations would be more useful.

In addition, any system of incentives would need to be flexible given that areas of need can change significantly over time as populations grow or decline and service delivery systems, requirements and workforce compositions alter. Rural communities have made inroads to addressing the supply needs of the medical workforce, but significant shortages still exist and workforce supply continues to be under challenge.

The importance of the overseas trained doctors to the rural workforce

Australia's medical workforce is increasingly a culturally diverse workforce. The proportion of medical practitioners born overseas and working in Australia has risen from 40 per cent in 1991 to 44 per cent in 1996 to 47 per cent in 2001 [13]

There has been a rapid increase in the number of Temporary Resident Doctors entering Australia and a continuing supply of doctors arriving as permanent residents settling in Australia. For example, an analysis of 2001 and 2002 Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) migration data on medical practitioners entering and leaving Australia found that overall in those two years, there had been a net loss of 705 Australian doctors overseas with a net gain of 2781 medical practitioners from overseas arriving in Australia, making Australia a net importer of OTD medical migrants. 84 per cent were Temporary Resident Doctors arriving on visas to work in Australia for up to two years (recently extended to four years) and 16 per cent arrived as permanent residents [11]**.**

It is clear that Australia and rural Australia in particular, will continue to rely on overseas trained doctors for the provision of medical services in the foreseeable future. Indeed, overseas trained doctors will always be a component of the medical workforce because each year, new doctors arrive as permanent Australian residents including as spouses of other principal migrant applicants, on family reunion and humanitarian programs.

For those who do not have training equivalent to Australian standards, then these doctors embark on a long process to gain Australian Medical Council or post-graduate qualifications. One pathway for permanent resident overseas trained doctors to work in general practice is through the Rural Locum Relief Program (RLRP). In rural Victoria, three out of four overseas trained doctors placed by RWAV are permanent residents with conditional registration to work in areas of need [8].

Once in Australia, OTDs are seeking to gain post-graduate qualifications. General Practice Education and Training report that overseas trained doctors represented 36.4 per cent of the GP registrars entering the Australian General Practice Training program in 2004, up from 35.1 per cent in 2003 [14]. Whilst these doctors have gained their primary medical degree overseas, more are seeking to gain post-graduate qualifications in Australia.

In Victoria, 30 per cent of the rural GP workforce is overseas trained [8}. Sustained workforce shortages in rural communities and insufficient local supply in the near future mean that despite the desire to rely on an Australian trained workforce, overseas trained doctors are an important component of the rural medical workforce. These doctors require continued support, training and assistance to relocate and work in rural areas and gain their Australian qualifications.

RWAV strongly endorses the commitment to the Code of Practice for International Recruitment Providers not to actively recruit from developing countries and is an ethical recruitment services provider. RWAV operates a web-based and telephone information service for Overseas Trained doctors and receives approx 1000 enquiries per annum from doctors all over the world.

Despite the recruitment campaigns that target developed countries, Australia remains a desirable migration destination for many medical and health workers from developing countries and these doctors continue to arrive as temporary residents or permanent residents under various migration programs. As a result, quality assessment, training and support programs will continue to be required to assist this workforce integrate into the Australian community and the Australian medical workforce.

Lack of nationally consistent approaches between State and National regulatory agencies

The most significant issue affecting the health workforce in rural areas is the fragmented interface of the Federal and State Governments in health financing and health workforce regulatory arrangements.

The Australian Government funds medical services through the Medicare system, pharmaceutical benefits, health services to veterans, health services to Aboriginal and Torres Strait Islander peoples and a range of other national health programs. It also regulates the number of undergraduate medical places and post-graduate general practice and specialist training places. It funds a raft of smaller programs designed to build allied health workforce in smaller rural communities (Regional Health Services Program, Rural Private Access Program, Rural Medical Infrastructure Program), and it funds GP recruitment and rural retention programs.

State/Territory Governments have primary responsibility for the delivery of hospital, mental, dental and community health services and regulating the private health industry. State/Territory Governments also have responsibility for registering health professionals working in that state or territory. Local Governments provide an additional level of health services, including aged care maternal and child health services and local public health infrastructure services.

The medical workforce can be mobile, seeking work opportunities, overseas, inter-state and intra-state. For example, RWAV research conducted by Melbourne and Monash Universities on OTDs working in rural Victoria, found that 66 per cent of OTDs had made at least five major international and national re-locations before moving to their practice in rural Victoria [15].

State registration bodies apply different requirements in the assessment and registration of health professionals. As a result, different recruitment approaches occur across States/Territories.

Medical practitioners working across borders require multiple registration at their own expense. Mutual recognition of medical registration is required across borders.

A single national assessment process of the qualifications of overseas trained doctors is required to ensure that doctors entering Australia with the same qualifications are assessed in the same manner around the country. Currently, Temporary Resident Doctors can by-pass the Australian Medical Council Exams and assessment processes. The Australian Medical Council is to establish a standard off-shore assessment questionnaire next year and this will assist in establishing a benchmark. Various Medical Colleges are also reviewing candidate assessment processes as part of the Strengthening Medicare initiatives.

The assessment of OTDs is becoming a daily issue of public and media debate and there is general support for the concept of assessment of all OTDs.

In Victoria, RWAV administers a comprehensive assessment process on behalf of the Department of Human Services under the auspices of the Medical Practitioners Board of Victoria for the Victorian OTD Rural Recruitment Scheme to assess OTDs eligible under the Five Year Scheme seeking to work in rural general practice. This assessment includes Structured Interviews, Independent Referee checks and for doctors without equivalent post-graduate GP qualifications, Objective Structured Clinical Examinations (OSCEs). Given the different State and Territory requirements, it is feasible for a doctor to fail our assessment processes, but obtain employment in another State or Territory where requirements or assessment processes may be less stringent. A national streamlined and coordinated approach to assessment across the various categories of OTDs including permanent and all categories of temporary residents is to be encouraged.

In a rural context, the delineation of responsibilities of Federal Government or State/Territory governments leads to gaps in services and defensive accusations of cost-shifting that prevent objective sensible solutions to health service delivery at times. Rural GPs work both within the Medicare system but also provide emergency, visiting medical officer and procedural services to patients in rural hospitals funded through the State or private hospital system. GPs see the effects of these splits on a daily basis. For example, the provision of after-hours services in rural communities is subject to complex local arrangements and in many cases left up to the GP to deliver virtually on an honorary basis. This leads to exhaustion for some; refusal to work 7/24 for others, and is frequently the original cause of the many instances of dispute between hospital management and local doctors.

Another example relates to workforce training where the role of the hospital is integral to the development of workforce. In workforce planning terms there can be considerable miss-matches between the number of trainees funded through the Federal Government and trained through universities and the availability of trainee posts within the hospital system, particularly in rural hospitals.

Rigid professional and regulatory boundaries that limit emergence of new health job roles

It is clear that a team-based approach to the delivery of health care is essential, particularly in rural towns. There is considerable potential for addressing skills and workforce shortages through the emergence of new health professional roles and a range of articulated training programs that provide middle level and advanced level training for health professionals across a range of careers.

GPs are embracing a team-based approach. The Practice Nurse initiative and coordinated care items for patients with chronic disease are a good example of effectiveness of a team-based approach. This works particularly well within a practice context, where cases can be managed by the GP and the practice team, patients can be seen by nurses, allied health professionals and the GP where needed.

Funding mechanisms that facilitate a team-based approach to health care are extremely important to the development of new job roles within the health sector as a response to the medical workforce shortages. Making the general practice the hub for the delivery of these services is logical, efficient, and it works very well for rural communities.

A key driver for the uptake of new roles has been the inclusion of these roles within the general practice activities and able to access the Medicare Benefits Schedule. This is one important reason, why the practice nurse initiative has been embraced by the community and doctors whilst the nurse practitioner role has been less so. Indeed nurse practitioner role has been quite fraught at times, where it appears to be building parallel service delivery systems rather than integrated, team-based ones.

Where tiny remote communities exist that have no services other than the local bush nurse, the role of the nurse practitioner is strongly supported. Of course, in these instances, the nurse practitioner needs as much support as possible, albeit from a distance.

There is considerable potential for the development of new middle level medical management positions such as Physician Assistants within the health workforce. Physician Assistant are well established overseas and work under the supervision of doctors. They have some medical training in prescribed areas that are able to be protocol driven.

Such a role may be a good option to explore for overseas-trained doctors who do not have equivalent medical qualifications, whilst they gain training and accreditation. However, much of this training would need to occur within the hospital system and the funding barriers between the Federal and the State would need to be overcome to support such initiatives.

More emphasis is required on competency based training, bridging programs and articulated training options and opportunities for the development of common curriculum across health professions where there is mutual recognition for the qualifications and experience already gained across health professions.

Health profession and population health needs should drive the education and training of the workforce.

Planning across professions, the health and education sectors as to the development of career pathways is essential. This includes further examination of graduate entry programs that have the potential to limit training times and accelerate workforce shortage.

The limitations of workforce support programs that are profession based

Many of the Australian Government rural workforce incentive programs have been made available for specific professions, for example, the Rural and Remote General Practice Program, Rural and Remote Pharmacy Workforce Development program and the Medical Specialists Outreach Assistance Program.

Whilst recognising there are important differences between these programs, there is much commonality in recruitment and retention issues for doctors, nurses and allied health professionals in rural communities that relate to moving to and practicing in a rural and remote community.

There are considerable opportunities to leverage the recruitment, support, training and workforce planning expertise and programs that have been developed in one profession across other professions within a rural context. There would be great advantages to rural communities to extend support currently available such as family support, professional development opportunities, locum support, to a wider range of health professionals.

Whilst health team based training and professional development does occur to a limited extent, there are opportunities to expand existing workforce programs to encompass a range of health professions. In addition, some rationalisation and coordination of the Federal/State funding silos that create barriers to workforce support, could make a very positive contribution..

Development of health industry-wide expertise and data for local and national health workforce and service planning

Workforce information is critical to workforce and health service planning at the local, state and national levels and health workforce planning needs to occur at all of these levels.

National level planning will take account of major workforce inputs and outputs such as trainee intakes, migration, retirement rates on a macro level. However, State and local workforce planning is critical to service planning and delivery. This is particularly accentuated because of the very different health systems operating in each State/Territory.

Rural Workforce Agencies across Australia maintain an extensive database of information on GPs and practices in rural and remote communities, developed in partnership with other agencies such as Divisions of General Practice. All RWAs contribute to a national minimum dataset on rural GPs.

Building this information from the ground up is critical, because workforce requirements are so variable across communities. Local information that identifies which practitioners are working in specific locations enables forward planning and succession planning for individual towns and communities. The Rural Workforce Agencies can identify communities ‘at risk’ or ‘in need’ because we have information that can identify the entrants and exits to the general practice and medical workforce, the locations of medical practitioners, where the solo, ageing or procedural GPs are based and where populations are growing rapidly or declining. Such information is critical for local planning and for the sustainability of services into the future. In small towns relying on one or two doctors, or one or two practices, such information is particularly critical to ongoing services.

Good data is at the heart of good decision-making.

It is clear that across the health professions workforce-planning information is fragmented and for some professionals simply not available. A coordinated system of workforce information across health professions within rural communities and across the specific professions at local, state and national basis would add immeasurably to workforce and service planning.

For example, all Medicare workforce data is based on services provided by Medicare funded practitioners. This data is used by the Federal Government to measure the Australian medical workforce. However, this does not include any work conducted by GPs and medical practitioners that is State funded. As a result, the work of rural GPs in the State hospital systems for example, is excluded from measurement in the national workforce figures. For reasons like this, Rural Workforce Agencies established their workforce data-sets to supplement national data.

Data collection about private practitioners is challenging and at the heart of these issues are questions of privacy and the management of workforce information. Currently, there are multiple agencies and organizations that collect information about health professionals.

In recognising the importance of protecting private and personal information, RWAV would strongly endorse the principles of workforce collaborative planning that enables a greater sharing of information and knowledge for local, state and national workforce planning purposes.

In the end, our view is that local planning must be considered as important as the 'bigger picture' state and national planning to support a more population-centred response.

Section Three: Suggested Initiatives for Reform

Supply of Health Professionals

- Preferential selection for health students who are from, interested and familiar with rural communities

- Expansion of rural-based post graduate training opportunities across the spectrum of health professions.

- Expand rural health education infrastructure in rural and regional communities to train local rural and regional health professionals and actively support the regionalisation of training programs

- Promote multi-disciplinary training opportunities across the health professions at undergraduate, post-graduate, vocational training and continuing professional development to encourage team based training and education. Providing flexible training opportunities and work environments is critical to attract and retain younger doctors and women doctors.

Supply of skills based health professional training

- Examine the potential for the development of mid-level training pathways and roles in areas of skills shortages in partnership with all key stakeholders. Support the trialling of new workforce skills roles including roles such as physicians' assistants.

- Establish rural simulation education centres for procedural training skills for GPs, nursing and other staff that support the provision of obstetrics and gynaecology, surgery, anaesthetics and emergency medicine services.

- Support skills training in rural communities linking hospitals, RWAs and divisions CPD and expand the range of structured training posts.

- Expand the number and capacity of training practices that can support medical education and provide financial assistance to these practices and practice based medical educators and supervisors. In many cases, the provision of additional physical infrastructure such as additional consulting rooms is a considerable barrier to taking students. Investment in training infrastructure and accommodation for additional students and trainees in rural environments is required.

Sustainable rural health services

- Develop flexible rural practice structures and business models to facilitate professional mobility, so that it is easy for health professionals to enter and exit practice. There is very little goodwill in private rural General Practices and younger doctors are reluctant to buy into practices. A range of models need to be developed that includes the facilitation of salaried GP employment, community owned practices, after hours cooperative support arrangements and childcare support particularly after-hours for health professionals that guarantee ongoing services to the community.
- Identify services that are needed in rural communities and fund infrastructure and workforce on a costs incurred basis. Include the consts associated with travel, transport and communication over distance.
- Recruitment, workforce support and education, and incentives funding should be funded on the basis of formulae that take workforce, population, socioeconomic and health status into account.

Incentives and Support programs

- Expand incentive and support programs for rural health professionals. In the rural General Practice workforce, a range of incentive programs are established to recruit and retain GPs to rural and remote areas. These include locum support and subsidies, family support services, relocation assistance, practice orientation and professional development upskilling, support and subsidies as well as scholarship programs to train and work in rural areas. Such incentive programs vary significantly across States and Territories, but have been developed as an essential range of services to rural practices that enhance the attractiveness of rural practice, the skills of the workforce and contribute to the recruitment and retention of GP services. Such services are common to a range of health professionals, but are currently not available or only to varying degrees.

- Provide incentives for health professionals nearing retirement to continue part-time and sessional work, including supporting semi-retired locums working in under-serviced areas including rural areas. This may include incentives such as paid professional registration and insurances costs for locum.

- Simplifying the financial incentives given to students to study general practice and/or to take up rural positions, including examination of other options, such as a reduction of HECS debt in exchange for working in rural general practice.

Overseas Trained Doctors

- Support introduction of standard national assessment processes for all overseas trained doctors to ensure safe practice standards.

- Continue active ethical overseas recruitment programs, recognising the ongoing importance of overseas trained doctors to the rural medical workforce including those doctors arriving as permanent resident Australians.

- Continue to provide structured system of orientation, training and support to Overseas Trained doctors including support for formal structured mentoring and supervision for OTDs in hospital and medical practice posts.

Federal and State Health regulatory arrangements

- Establish a national registration process for health professionals

- Further expansion of Federal and State pooled funding for rural communities to deliver rural health workforce services, so that fragmentation between programs is reduced and local services can be planned, coordinated and supported across Federal and State boundaries.

- Expand Australian training places for health professionals and health skills in short supply and more closely link industry workforce needs with education and training provision.

- Expand existing recruitment programs and develop a coordinated approach for health professionals in short supply including overseas recruitment.

Workforce Planning

- Support a population-based approach to health workforce planning at local, State and national level including planning for workforce and service needs for rural communities or regions.
- Encourage multidisciplinary health workforce planning approaches centred around service requirements eg provision of birthing services or general practice services.
- Build capacity at local level for health workforce planning and recognise the important links with service planning
- Build health workforce data collection and expertise at the local, state and national level that enables sharing of information for workforce planning purposes within the bounds of privacy requirements.
- Build cross-institutional and cross-health professional health workforce policy development and research capability
- Develop classification systems that measure geography, access to health services and workforce supply.

References:

[1] Australian Institute of Health and Welfare. *Rural, Regional and Remote Health: Indicators of Health*. AIHW, Canberra, May 2005.

[2] Victorian Department of Human Services. The Burden of Disease study. DHS, Melbourne. 1999.

3 Australian Institute of Health and Welfare. Rural, Regional and Remote health: Indicators of Health. AIHW Cat. No. PHE-59, Canberra, 2005.

[4] Victorian Department of Human Services. Life Expectancy at Birth 1999-2003. see http://www.health.vic.gov.au/healthstatus/le-99-03.htm#maps

5 Australian Bureau of Statistics. 3235.2.55.001 Population by Age and Sex, Victoria

6 RWAV. Sourced from ABS 2001 Census District data (C Data)

[7] Australian Bureau of Statistics. Agriculture State Profiles: Farms, Land Use. ABS website, At June 2003-03.

8 RWAV data base, 2005.

[9] Moinihan, M. Rural Doctors Association Victoria. Presentation to Statewide Forum, Birthing Services in Rural Victoria, April 2005.

10 Department Health and Ageing, Annual Report 2002-03, Outcome Summary- The year in Review. Cited on website.

11 McDonald J, Bibby L, Carroll S. Recruitment and Retaining General Practitioners in Rural Areas: Improving Outcomes through Evidence-Based Research and Community Capacity Building. Victoria, University of Ballarat, 2002.

12 Derived from data published in Hansaard: Health: General Practitioners question no 124 Question in writing from Harry Jenkins, 7 march 2005

13 Hawthorne, L., Birrell, B., Young, D. Retention of Overseas Trained Doctors in General Practice in Regional Victoria. Melbourne, Rural Workforce Agency Victoria, 2003

14 General Practice Education and Training. Submission to Senate Select Committee on Medicare. Canberra: GPET, 2004.

15 Hawthorne, L., Birrell, B., Young, D. Retention of Overseas Trained Doctors in General Practice in Rural Victoria. Rural Workforce Agency Victoria, 2003.