



**Australian
General Practice
Network**

*Delivering local health solutions
through general practice*

**Australian General Practice Network
submission to the Senate
Standing Committee on
Community Affairs**

***The factors affecting the supply of
health services and medical
professionals in rural areas***

January 2012

Australian General Practice Network

PO Box 4308

MANUKA ACT 2603

Telephone: 02 6228 0800

Facsimile: 02 6228 0899

www.agpn.com.au



The Australian General Practice Network (AGPN) currently represents a network of 106 general practice networks (GPNs) as well as eight state based entities. AGPN and its members are collectively known as the Network. More than ninety per cent of general practitioners (GPs) and an increasing number of Practice Nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support.

AGPN is currently in transition, providing the foundation for the establishment of the new national network of Medicare Locals (MLs). MLs are regionally-based primary health care organisations responsible for supporting greater coordination of primary health care services regionally, identifying and addressing local service gaps, driving quality improvement in primary health care and helping to deliver on the goals of the Primary Health Care Strategy including prevention and better self-management of chronic disease.

Following approval by the Government in late 2011 to form the new Medicare Local National Body (MLNB), AGPN will commence transition to the new entity in early 2012. A key role for the MLNB will be to provide leadership to support MLs in driving change management at a regional level in order to drive high quality performance through Medicare Locals.

Australian General Practice Network
PO Box 4308
MANUKA ACT 2603
AUSTRALIA

Telephone: +61 2 6228 0800
Facsimile: +61 2 6228 0899
Email: agpnreception@agpn.com.au
Web: www.agpn.com.au

AGPN acknowledges funding from the Australian Government under the Divisions of General Practice Program.

Contents

Executive Summary 4

About The Australian General Practice Network 4

Factors Affecting The Supply And Distribution Of Health Services And Medical Professionals In Rural Areas 6

 TERM OF REFERENCE (A): FACTORS LIMITING THE SUPPLY OF HEALTH SERVICES AND MEDICAL, NURSING AND ALLIED HEALTH PROFESSIONALS TO SMALL REGIONAL COMMUNITIES AS COMPARED WITH MAJOR REGIONAL AND METROPOLITAN CENTRES..... 6

 TERM OF REFERENCE (B): THE EFFECT OF THE INTRODUCTION OF MEDICARE LOCALS ON THE PROVISION OF MEDICAL SERVICES IN RURAL AREAS..... 7

 TERM OF REFERENCE (C): CURRENT INCENTIVE PROGRAMS FOR RECRUITMENT AND RETENTION OF DOCTORS AND DENTISTS, PARTICULARLY IN SMALLER RURAL COMMUNITIES.11

Executive Summary

The Australian General Practice Network (AGPN) welcomes the opportunity to provide a submission to the Senate Standing Committee on Community Affairs on the factors affecting the supply of health services and medical professionals in rural areas.

AGPN and the Network have traditionally had a broad role in supporting and assisting the primary health care workforce. The transition of GPNs to form the ML network will see a consolidation of this role. As larger entities, MLs will have greater capacity to improve health outcomes at a regional level. Over time, it is expected that they will assume responsibility for managing demand, engaging primary care providers, enabling integration of services, developing more accessible services in the community and primary health care settings, and enabling greater scrutiny and assurance of the quality and performance of primary health care services.

MLs will operate as regional health care planners, coordinators and commissioners to better identify community primary health care needs and address service gaps in their communities. MLs will be charged with the responsibility to undertake their own service design and development which may incorporate new models of care in response to the particular needs of the region against the background of the workforce supply. This strengthened capacity will enable improved coordination and collaboration in identifying local health workforce needs and the ability to coordinate at a regional level, to address health workforce gaps.

About the Australian General Practice Network

AGPN is the national organisation representing 106 general practice networks (GPNs) and eight state-based organisations (SBOs). AGPN and its members are collectively known as the Network. AGPN coordinates and disseminates general practice and other primary health care programs through the Network, including those with a focus on:

- Chronic disease management
- National primary mental health care initiatives
- Indigenous health: Close the Gap (CTG)
- Immunisation
- eHealth and information management
- Prevention and lifestyle modification
- Nursing in general practice (NiGP)
- Rural palliative care
- Quality use of medicines

Many of these programs have a workforce element, which in cases such as NiGP, CTG and mental health can be significant. GPNs are therefore familiar with issues of workforce across Australia generally as well as how they affect rural regions specifically – some of these and other workforce programs that GPNs manage have been set up to address workforce and access issues with a particular focus on rural areas.

GPNs represent the community-based infrastructure which enables general practice to provide services to patients in the community and in their homes. GPNs:

- deliver local health solutions through general practice to ensure all Australians have access to high quality primary health care
- increasingly deliver services directly to patients – particularly through allied health and nursing
- are in tune with their local communities. They understand their communities’ health needs and socio-demographics as well as how these two interact - which makes them a solid foundation for strengthening Australia’s primary health care system
- are involved in a range of activities including
 - health promotion
 - early intervention and prevention strategies
 - health service development and delivery
 - medical education
 - workforce development and support
 - eHealth and other strategies to connect care.

The Network is unmatched in its locally based support services which penetrate the vast array of communities across Australia – it is the only national, state and regional/local infrastructure of its type.

The Network is currently in transition, providing the foundation for the establishment of the new national network of Medicare Locals (MLs.) MLs are regionally-based primary health care organisations, responsible for:

- supporting greater coordination of primary health care services across their region
- identifying and addressing local service gaps and areas of need
- driving quality improvement in primary health care.

The Government has announced that initial focal areas for MLs will include after hours services, mental health care and care for older Australians. All of these, especially after hours and mental health, have significant workforce elements. Although national in focus, the workforce elements of these initiatives will undoubtedly pose greater challenges in rural areas.

The first and second of three tranches of MLs have been established, with the full national network of 62 MLs expected to be operational by 1 July 2012.

The Commonwealth Government has made clear its intention that AGPN will evolve to become the national body for the network of MLs (known as the Medicare Local National Body – MLNB) during 2012. The MLNB will provide leadership to support MLs in driving change management at a regional level and driving high quality performance through MLs.

Factors affecting the supply and distribution of health services and medical professionals in rural areas

Term of Reference (a): Factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres

Workforce shortages across the primary health care sector limit timely access to comprehensive primary health care for many Australians. Workforce shortages and access issues are often particularly acute in smaller regional and rural communities. Factors affecting the ability of smaller regional and rural communities to attract a suitable health workforce generally cover issues associated with both the professional experience, workload and opportunity provided in these areas, as well as with the personal/family issues associated with relocating to and/or living in a smaller regional or rural community. Many of these factors are already well established and well documented. In summary however they include:

- lack of peer support and opportunities to work as part of a comprehensive primary health care team, commonly associated with regional workforce shortages across the primary health care sector.
- lack of other supporting health infrastructure, including rural hospitals, specialists and other primary health care professionals/practices, as well as other diagnostic and allied health services. This in turn results in barriers to the provision of timely and comprehensive quality care for patients.
- heightened demand on services: for example, many rural GPs are often required to be on-call around the clock with little respite, increasing the risk of fatigue and burn-out. This situation can be exacerbated by lack of access to locum services. There can also be heightened demand on GP teaching requirements in rural areas. Rural GPs need to take on medical student and junior doctor teaching obligations in order to train future generations of GPs and provide good exposure to rural practice, however this competes with an already high patient load and other demands of rural practice (such as after hours care).
- limited professional development opportunities. This can be linked to limited access to clinical supervisors/mentors, to where/how education is provided (which is often in large urban centres) as well as limited access to locums to support off-site professional development.
- Legitimate concerns about setting up and investing in a viable business in a new, untested area. This is of critical relevance to those professions primarily run as private businesses, such as general practice and a number of private allied health professional practices.
- high re-location costs, as well as a lack of incentives, particularly for allied health professionals, to make relocation financially viable.
- limited or sub-optimal business, employment and educational opportunities for spouses and offspring who relocate with the health professional

- limited availability of affordable and suitable accommodation
- perceived lack of recreational activities, including artistic and cultural activities
- issues in integrating with the community, a factor that can be of particular relevance to International Medical Graduates and their families as well as more general issues of privacy in small rural communities.
- Reliable access to broadband internet and other technology

For allied health professionals in particular, additional factors include that:

- salaries offered in metropolitan and regional centres are often higher than in rural areas
- there is limited capacity to link in to clinical leadership and expertise in specified fields (eg mental health)
- allied health providers are rarely offered incentives to relocate to rural or remote areas, compared to those offered to nursing and medical staff
- there are more limited promotional and career advancement opportunities in rural areas compared with urban or regional centres.

Term of Reference (b): The effect of the introduction of Medicare Locals on the provision of medical services in rural areas

The main initial areas in which the introduction of MLs can beneficially impact on the provision of medical, and other health, services in rural areas are:

- a) By building on the previous work of GPNs in facilitating and supporting medical and health workforce, including initiatives specific to rural and regional areas
- b) Through MLs' new and expanded roles in population health planning and service development according to local need
- c) Through acting as a broker and coordinator for medical and other health clinical placements
- d) Through specific workforce and/or rural related ML programs

Further detail on these areas is provided below:

a. Building on the previous work of GPNs' in workforce support/supply

The national network of Medicare Local primary health care organisations (MLs) is being established to strengthen primary health care systems and drive improvement in access to, and quality of, primary health care, by working at a regional level to identify, link, coordinate and develop services to fill priority gaps in primary health care services and address identified local need.

General Practice Networks - that provide the foundational infrastructure from which MLs are being established - have traditionally provided locally tailored approaches to support workforce development and address key workforce recruitment and retention issues, such as those outlined above. This has included:

- facilitating access to relevant continuing professional development opportunities for general practitioners, primary health care nurses and allied health

professionals, including access to multidisciplinary education and development opportunities

- facilitating the establishment of local professional networks for both medical and allied health professionals. These networks would include profession-specific and inter-professional networks, to provide peer support, collaborative learning opportunities and help address professional isolation. They could also include regionally delivered professional development opportunities
- supporting and orienting health professionals new to the area, particularly International Medical Graduates (IMGs), to integrate into the community and understand and navigate the Australian health system
- brokering access to health services through the coordination of flexible funds, such as currently occurs through the Rural Primary Health Services program
- providing practice support, including to recognise and take advantage opportunities to enhance the viability of the business and most effectively utilise clinical staff as part of the practice team
- supporting practices and health services to design systems of care that enhance workflow and quality of care, thereby facilitating better patient access, such as has occurred through the Australian Primary Care Collaboratives program
- supporting practices to identify and plan to address the health needs of their practice population in a cost effective manner, as for example has occurred in GPNs that have supported practices to use the Practice Health Atlas tool
- brokering access to allied health professionals for residents in residential aged care facilities, as has occurred through the Aged Care Access Initiative – allied health component
- supporting health services with succession planning to help ensure services are not left without key health team members for lengthy periods of time when a professional resigns
- supporting health services to recruit health professionals and supporting health professionals to secure a suitable placement within the region. GPNs, in partnership with others, such as Rural Workforce Agencies (RWAs) have used a variety of approaches to this matter in rural areas including:
 - orientation support, especially for IMGs, to increase the likelihood of retention of IMGs in a rural location
 - case management¹ and mentoring of IMGs to assist them in passing their RACGP fellowship exams or the equivalent, so increasing the quality of care provided to patients and increasing the likelihood of retaining the

¹ Network examples include those provided by WestVic GPN (to become the Grampians Medicare Local in July 2012) which has built considerable expertise over the past 15 years in recruiting international Medical Graduates (IMGs). Further details about this approach can be provided by AGPN upon request.

recruited IMG. Such case management recruitment and retention support services could also be extended to other health professionals.

- working in partnership with local councils and/or other agencies to set up general practice facilities and so enable an “easy entry, gracious exit” approach to rural practice for GPs which limits their business risk in moving to a new area.
- facilitating service integration to ensure care provided to patients is well coordinated and makes best possible use of limited professional personnel
- supporting the development and effective utilisation of new and emerging health professional disciplines, such as the growth, development and effective utilisation of the practice nurse workforce.

Continuing to undertake such work will be important for MLs servicing regional communities to meet their strategic objectives. To meet these objectives they will also need to expand the target of such activities from primarily focused on general practice, to focused more generally on primary care services. However, MLs will only be able to effectively continue and extend such activities if they are provided with sufficient resources to do so.

b. MLs’ new and expanded roles in population health planning and service development according to local need

The establishment of MLs also provides the opportunity for a broader scope of initiatives to enhance access to medical services in regional and rural areas. Over time, it is expected that MLs will come to operate as regional health care planners, coordinators and commissioners, identifying community primary health care needs and developing locally relevant solutions to address service gaps and drive better service access for their communities. This will include through:

- integrating and coordinating local services to most effectively utilise available services and workforces by driving re-orientation of care around multidisciplinary teams and better matching service provision to local need. The effectiveness of the ML network in these roles will be enhanced if it is supported by research and development activities to develop and pilot models of integrated care. This is likely to be most effectively and efficiently coordinated at the national level, by, or in partnership with, the MLNB.
- developing and implementing locally tailored solutions to address identified service gaps, local workforce development needs and health service access issues. To realise these opportunities MLs must be:
 - sufficiently resourced and enabled adequate flexibility in how resources are deployed within the region to meet local needs; MLs are likely to be most effective in enhancing access to primary care services when they are given broad scope in how they utilise funding to provide locally-relevant workforce solutions.
 - provided access to appropriate supporting infrastructure and resources, for example, comprehensive workforce data to support effective workforce

planning and the assessment of recruitment and retention initiatives, and access to online national education and training initiatives linked to professional accreditation.

c. MLs ability to act as a broker and coordinator for medical and other health clinical placements

Workforce planning and clinical training placements are integrally related. Ensuring a strong relationship between adequate (in quality and number) clinical training placements and workforce planning for subsequent service design and delivery is critical. GPNs have previously played a key role in working with local practices and other agencies such as Regional Training Providers (RTPs) and universities to coordinate clinical placements in general practice – predominantly for medical placements but also for nursing and allied health placements in some instances. MLs are well placed to further strengthen this coordination and brokerage role for clinical placements (including, potentially as part of Health Workforce Australia’s (HWA’s) proposed Integrated Regional Clinical Training Networks) for example by:

- Identifying practices that have capacity to take on placements to maximise clinical training opportunities
- Liaising with practices, universities and RTPs for better coordination of placements
- Operating hub and spoke models of supervision whereby supervision requirements can be shared between rural practices and urban centres to lessen the load on busy rural practices and ensure that supervision and practice requirements are more balanced
- Increasing the number of practices/GPs willing to supervise placements by building capacity and confidence in GPs to become supervisors. (Currently only about 25% of practices in Australia are involved in clinical supervision². Time, costs, lack of GP confidence in their teaching skills and lack of coordination between practices and educational institutions are often cited as key barriers to GPs/practices taking this on)

By linking this clinical placement coordination and brokerage role with their population health and service design role - as well as through MLs’ requirement to link and work closely with key stakeholders such as universities, RTPs, their community - MLs are ideally placed to help put in place workforce planning approaches that will help address current and future gaps in health service delivery. Many such gaps are most notable in rural and remote areas.

d. Specific workforce and/or rural related ML programs

Various programs that MLs will be charged with will include a significant workforce focus. Initial programs include the ML component of the Government’s new After Hours

²Based on figures from Victoria as reported in Burgell Consulting, *Medical Student Clinical Placements in Victorian General Practices. Concluded Final Report February 2008*. Deakin University, Monash University and University of Melbourne; Melbourne: February 2008. Figures from Medicare Australia Practice Incentive Payment (PIP) data reflect similar trends nationally.

initiative, MLs' role in supporting uptake of the new Practice Nurse Incentive Payment (PNIP), potential and proposed work in Mental Health and Aged Care, as well as ongoing work in programs such as Closing the Gap (CTG). While these are national initiatives, the nature of MLs' new roles in developing and designing services according to regional need mean that approaches to these initiatives will be tailored according to local circumstances. This will include taking into account specific challenges and conditions associated with rural areas.

MLs are also well placed, and expected to, enhance access to primary health care services in all areas of Australia, including rural areas, by:

- supporting the roll-out and uptake across the primary health care workforce of eHealth and telehealth solutions to support greater coordination across services and facilitate better access to health professionals
- implementing locally relevant approaches to address national priority areas relevant to health care access: The ML network provides the infrastructure to deliver locally tailored responses to national priority areas across the country. Notably, the Commonwealth has clearly defined an early role for MLs in enhancing the coordination of access to local face-to-face after-hours primary care services through effective needs assessment and workforce planning. The Commonwealth has also flagged, through the 2010-11 federal budget announcements, an early role for MLs in facilitating enhanced access for aged care recipients to primary health care services through locally relevant responses to access issues.

Term of reference (c): Current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities.

NB, this TOR includes issues relating to: the role, structure and effectiveness of incentive programs; the appropriateness of the delivery model and; the application of the Australian Standard Geographical Classification – Remoteness Area classification scheme

There are various items and processes that could be referred to as "incentives" in relation to rural medical workforce, including, for example, national incentives such as rural loadings in the MBS items and Practice Incentives Payments (PIP) Program, rural-related grants such as relocation grants, as well as features such as District of Workforce Shortage (DWS) and Area of Need (AON) designations. There are also certain jurisdictional grants and incentives such as funding available through the IMG Recruitment Support Packages in Victoria for hospitals to recoup the cost of attracting a GP to provide VMO services.

Network feedback to AGPN suggests that these measures go some way in assisting with recruitment and retention of medical staff in rural areas. For example, the DWS measure can assist in getting IMGs to rural locations (although of note, IMGs affected by 19AB regulations are often not eligible for certain incentive funding); rural loadings can help offset some of the additional costs of working in a rural location, which can help ease the financial burden on a practice and so assist with retention. However, as a number of barriers to recruiting and retaining medical and other health workforce in rural areas is

not financial, such incentives, while they play an important role, are only a partially effective (See also box 1 below for more specific Network feedback on these matters).

Box 1: Issues regarding incentives

- *Funding is available through the Victorian Department of Health under the International Medical Graduates Recruitment Support Packages for hospitals to recoup cost of attracting a GP to provide VMO services. As this is specifically hospital based and not GP based, can only be refunded once a doctor commences, and as funds are capped and there is no guarantee of payment [back to primary care] ... we are not aware [locally, however] of any hospital accessing these funds.*
- *Rural Relocation Incentive Grants do not appear to be attracting doctors out from metropolitan to Rural [areas]. IMGs are the main candidates who take up rural positions and IMGs affected by 19AB are not eligible for this funding.*
- *Funding for Fellowship support programs well received by IMGs and is vital to the support and retention of IMGs working towards Fellowship. Currently Temporary Resident Doctors are not eligible for the Rural Workforce Agency, Victoria (RWAV) IMG Fellowship Assistant funding. IMG Fellowship support funding should be available for all doctors especially temporary resident doctors as, due to the costs of getting into the Australian system, they are the least likely to afford the cost involved in preparing for this expensive exam*

Rather, AGPN's experience is that other mechanisms, in addition to incentives, are required to assist in recruitment and retention. Such mechanisms include:

- support for doctors in rural areas to help address social and professional isolation, such as providing links with their peers through access to ongoing professional development, professional networks and mentoring
- support and assistance in finding accommodation, schooling and employment for doctors' spouses and family
- integration and orientation support for doctors, especially IMGs, around Australian culture, the Australian health system and their specific community
- Providing low risk opportunities for doctors to try out rural practice for example through easy entry, gracious exit approaches
- Providing access to specialist and allied health professional support through a variety of models of care. Such models include those run through GPNs – and which could be built on by MLs - such as Access To Allied Psychological Services (ATAPS) program, the Rural Primary Health Services (RPHS) Program (formally More Allied Health Services [MAHS]) and the Medical Specialist Outreach Assistance Program (MSOAP) as well as and/or telehealth approaches to care provision.

Thus, while incentive programs play an important role in supporting recruitment and retention of primary health care professionals in rural and remote areas, AGPN believes that these should operate alongside, and be complemented by, ML and other initiatives to support local workforce development such as those mentioned above.

AGPN also believes that incentives will be most effective in attracting health professionals to where they are most needed if they are formulated not solely on the basis of geography, but also give due consideration to population health status and needs, distance to services, other supporting infrastructure/other health resources, specific regional and local issues and current workforce supply.

In this vein, feedback to AGPN indicates that the current Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system, based solely on geography, provides too blunt an instrument to most appropriately support workforce distribution to meet access needs (See also box 2 below).

Under this [ASGC-RA] classification system, many towns and regions are classified together as RA2 regardless of significant differences in population size, proximity to regional centres and access of the population to health services. This results in GPs in small rural communities and larger regional centres being offered the same incentives payments, despite the very different environment and working conditions, including the demands for 'on call' and after hours services from GPs in smaller rural communities that may not be required in larger regional centres.

Box 2: Issues with ASGC-RA classification

- *Small rural communities such as Ararat, Stawell and Maryborough who fall just inside the Inner Regional region are competing with larger centres such as Ballarat and Bendigo to attract GPs when the incentives payments are the same under the ASGC – RA index. Yet GPs in larger centres do not have the [same] demands of on call and after hours experienced by their rural colleagues who are providing these services in addition to visiting medical officer services to acute and aged care patients. [This leads to an inequity in the incentives which is counterproductive to their intended use]*
- *If the aim was to get GPs out into rural areas then the ASGC – RA index especially in Victoria with such a small remote area does not appear to be working and it [mainly] benefits the larger centres.*
- *The number of IMGs wanting to work in Australia has declined and the increasingly complex and expensive process to recruit appropriately trained IMGs to rural areas is further affecting the flow of what has been a reliable source of doctors to rural communities. The ASGC_RA classification scheme is further impacting on our potential pool of doctors for rural general practice.*

A preferable incentive indexation system would distinguish between larger regional townships and small regional towns, and overlay geographical and population size data with data that considers health status, health service access and current health workforce availability.

Further, AGPN believes there is a need to extend incentives to support access to comprehensive primary health care teams, rather than focusing incentive programs solely on medical and nursing workforces. As noted above, extending incentive programs to allied health professionals is likely to support better access to the type of comprehensive, multidisciplinary care that is increasingly required by patients to address the growing burden of chronic disease.