Questions on Notice to Charles Sturt University.

We are pleased to have the opportunity to respond to the questions on notice from Senator McKenzie. We thank you and the Senators for the opportunity to discuss in some detail evidence regarding the effectiveness of existing policies to redress the maldistribution of Australia trained medical practitioners in rural and regional areas. We anticipate that your report will emphasise, as have other recent government enquiries, that further reform is required in the administration and focus of rural medical education and workforce programs to address the chronically low rate at which Australian medical graduates relocate to rural and remote practice, with a particular focus on 'train *from* the bush, retain *in* the bush' programs.

For us the major imperatives can be summarised: -

(1) Australia needs to commit to training rural Australians with a demonstrated predisposition to rural practice to address the chronically low rates at which Australian trained medical graduates voluntarily locate to rural practice. Our dependence on overseas trained doctors is fraught with problems, both ethical and practical. International competition, and growing concerns in developing countries about the drain of medical practitioners from their own health systems, is almost certain to see a reduction in the ongoing availability of doctors from developing countries with health care needs far greater than our own. Please note the disturbing development in Victoria where the government, in an effort to protect the income available from full fee paying international students, will give them preference when it comes to allocation of internship places ahead of Australian medical students in Victorian hospitals (http://www.theage.com.au/national/education/job-fears-for-500-medical-graduates-20120619-20m83.html

(2) Rural Australians need and deserve to be cared for by doctors who want to pursue their careers in a rural or remote setting and have been trained at a regional university with a rural specific curriculum. Such a curriculum

should provide students with early training in a number of procedural techniques providing skills urgently needed in rural settings.

(3) To achieve these goals national and international evidence tells us that we must increase the number of students entering medical school who have a demonstrated predisposition to rural practice. The current definition for designation as a "rural" student is totally inadequate, as future intentions on practice location are not assessed. We draw your attention to similar sentiments published last week by the Rural Medical Students Association. (www.nrhsn.org.au/NRHSN_Priorities_Paper).

(4) To better use the work force available to rural Australians "team medicine" (Integrated Primary Care) must be fostered with the unique skills available from different health professionals being available, in a patient focused manner, in the one practice. This less doctor centric approach is essential for the development of health maintenance strategies as we discussed in detail with the committee.

(5) To change the health professional "silo" mentality that dominates in our current system universities need to introduce curricula based on inter-professional learning. "Team learning to prepare for team practice". Universities training the next generation of health professionals should be encouraged and supported to establish model integrated primary care clinics to treat while they teach this new model of care.

The Inquiry has raised a number of very important issues for the future sustainability of rural health services. In our view, some of the questions the Committee will need to address are:

(1) Is it appropriate that students with little connection to rural communities are allowed to occupy medical student places targeted to 'rural origin students'?

(2) Should Rural Clinical Schools be required to enrol students as a condition of funding that are committed to a rural career?

(3) Should medical schools be required to reserve at least 35% of total medical student places (domestic and international) for students from a rural area with a demonstrated predisposition to rural practice to reflect the proportion of rural people in the general population?

(4) Should medical student places reserved for rural students be reallocated away from medical schools that fail to meet minimum enrolment targets?

(5) *Should international full fee student enrolments be reduced to allow for an expansion of domestic places for rural students, and to avoid the possibility of misleading international medical students about the availability of medical training in Australia?*

(6) *Should there be an expansion of medical training funding to support growth in capacity to meet demand?*

(7) *Should the government negotiate with the medical schools and colleges to increase the use of non-hospital settings in the delivering of medical training to expand capacity?*

The answers to Senator McKenzie's questions are appended.

We look forward to your most important report and thank you for the opportunity to contribute. For your interest and records we have forwarded a copy of our application to the Prime Minister for a rural based medical school to serve the communities of western NSW.

Your Sincerely

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Professor, University of New South Wales

Executive Consultant, Charles Sturt University

QUESTIONS ON NOTICE FROM SENATOR McKENZIE.

(1) What influence does your organisation (CSU) have on health policy?

Charles Sturt University's mission is to meet the needs and aspirations of rural and regional Australians living in western NSW and northern Victoria. The University offers one of the most comprehensive suites of professional health and human services programs of any University in the country including dentistry, oral health therapy, pharmacy, pathology, medical imaging, medical science, paramedics, physiotherapy, occupational therapy, exercise physiology, speech pathology, audiology, nursing, midwifery, psychology, mental health nursing, social work, social welfare, counselling, podiatry, and nutrition and dietetics.

Charles Sturt University also offers a 3-year pre-medical clinical sciences degree to prepare rural students for entry to medical programs offered in major cities. It offers a range of postgraduate and graduate entry programs in specialist areas to support rural health practitioners to re-skill and up-skill to support retention in the rural workforce. As well the university provides continuing professional development opportunities using its extensive network of regionally located campuses. It offers an Indigenous mental health program that has been successfully rolled out in western NSW and Western Australia, and our health academics work with academics in disciplines such as teacher education and early childhood to share expertise in nutrition, dietetics, psychology and health to improve long-term health outcomes for rural and Indigenous communities.

The University's Centre for Inland Health is engaged in the practical application of health research to improve the lives of rural communities ranging from community resilience, and heart health to diabetes and asthma management. Our agricultural and environmental scientists are engaged in research and scholarship that addresses social and environmental factors that support and sustain healthy communities.

More than 70 per cent of the University's on-campus health and human services students come from rural and regional areas, and more than 80 per cent of these move back into rural and regional areas for employment after graduation. This is

consistent with a recent national study by the Australian Centre for Educational Research in Melbourne that found that 65.7% of students that attended a regional university were in employment in a rural or regional area 5 years after graduation.

Charles Sturt University's policy goals, encapsulated in our *Inland Health Strategy*, has been to grow the range of health courses delivered locally in rural communities in areas of regional labour market shortage to increase opportunities for talented rural Australians to study locally, thereby significantly increasing the supply of health and other professionals into rural practice. Recognising the need for more innovative models on practice to support our communities, the University has committed to renew its curriculum to support inter-professional health education and practice. Our research is focussed on key challenges for rural and Indigenous communities in prevention, early intervention and chronic care.

Staff of the University are active contributors to public policy discussions through membership of a variety of rural health, community and workforce related bodies. Staff are active in a range of public policy forums including the National Rural Health Alliance (a CSU academic was the former Chair of the Alliance), Services to Australian Rural and Remote Allied Health (SARRAH), Engagement Australia and the Institute for Rural Clinical Services and Teaching. The University has appointed Australia's first Professor of Rural Pharmacy in 2005 to advance research and policy in this field.

The University has been engaged in advancing public health policy proposals to government over many years, including the University's successful policy proposal to expand opportunities for rural students to study dentistry and oral health therapy in rural areas, and its more recent engagement in public policy discussions around the effectiveness of rural and remote medical education and workforce strategies. It has recently prepared detailed and evidence based submissions to Health Workforce Australia's review of existing Health Workforce strategies, the NSW Government's review of health workforce and the submission to this Senate inquiry.

However, the University remains concerned about the extent to which the views and experiences of people who actually live and work in rural communities are prioritised in the development of rural and regional health and workforce policy. For example, Country Women's Association branches across the country have a more practical and local understanding of the challenges and opportunities of their communities than almost any other organisation in Australia. Local government, and regional organisations of councils, are also an essential source of local advice, particularly in providing 'on the ground' feedback about the effectiveness of policies in their local areas. Regional universities are the largest suppliers of health professionals to rural communities, and are engaged in research that is directly relevant to the health service and workforce needs of their surrounding rural communities. They offer a perspective informed by a long track record of success in delivering practical and workable solutions to rural health and workforce challenges within their communities, and should be more actively engaged by government in public policy development.

It is also important to recognise that with more than one billion dollars spent on rural health and workforce programs, rural health policy is increasingly becoming an industry in its own right. *In this context, there is a danger that without appropriate segmentation between those involved in the delivery of programs and subsequent program evaluation, reliable, indeed critical outcome data may be compromised.* Government needs to ensure that it has mechanisms to properly account for the relevant interests of participants in public policy consultations and development to ensure the needs of rural and regional communities remain the paramount consideration.

(2) Was your organisation involved in Medicare Locals consultation?

While individual staff attended information sessions on the development of Medicare Locals, CSU has not been formally consulted at an organisational level on the development of these bodies. The University expressed concern in its formal submission to the Committee about the geographic boundaries of Medicare Locals in its regions, and the practical capacity of these bodies to achieve consistent outcomes across each region in terms of primary health care and workforce development.

CSU is the largest provider of health science and human services degrees to rural and regional NSW and northern Victoria and has a substantial amount of practical 'coal-face' experience in addressing rural and regional health and workforce issues. There are therefore important opportunities for engagement between the University and Medicare Locals in designing and implementing strategies to address the long-term primary health care needs of our communities.

(3) Is there any research into how much is spent on incentives for regionally based medical practitioners?

The University is not aware of any consolidated or reliable reports on public expenditure on rural health and workforce programs that would enable effective evaluation of programs and public accountability to rural communities with respect to performance and expenditure. Information on the goals, performance and funding of rural health and workforce programs is highly fragmented and difficult to access in a consistent form for researchers, let alone by member of rural communities who wish to independently assess whether programs are achieving articulated goals.

The University is aware that in 2012 the Minister for Regional Australia, Regional Development and Local Government published a Statement on Portfolio Expenditures in Regional Australia (the Regional Statement) alongside the Federal Budget. The 2012-13 Statement outlines Government budget commitments to health expenditure in rural and regional areas (http://www.budget.gov.au/2012-13/content/ministerial_statements/rural_and_regional/html/rural_and_regional-11.htm). Table 6 of the document shows that "total expenditure (grants, subsidies and personal benefits) for the Health and Ageing portfolio is estimated to be over $50.0 billion in 2012–13, with over $14.0 billion in expenditure allocated in regional areas".

However, the document only provides a partial disclosure of information on funding for different rural health and workforce programs. For example, while the Statement details anticipated expenditures against some programs (e.g., it states that the General Practice Rural Incentive Program will receive $34 million in 2012-

13), other programs (in some cases with substantially larger budgets) are described without any detailed information about funding allocations.

Similarly, information about funding for the Rural Health Multidisciplinary Training Program (RHMT) (this combines the pre-existing Rural Clinical School program and Rural Undergraduate Support and Coordination program) is not separately identified in the Budget Portfolio Statement or Regional Statement. To find out information about this program, a reader would need to search the web site of the Department of Health and Ageing to access the Program Guidelines. The Guidelines show that the government will spend $385 million over the forward estimates on this program.

A major challenge for all parties interested in achieving genuine improvements in rural health and workforce outcomes is the complexity of accessing reliable, independent and granular public data on program objectives, funding and evaluation. The University has recommended in its submission that the government allocate responsibility for data collection and performance reporting on rural health and workforce programs to an independent authority.

The complexity of accessing data has increased in recent years as the Department has aggregated smaller funded programs into larger initiatives. We understand that the aim of this was to give the Department greater flexibility to allocate funds between programs as required. Flexibility is an important element of addressing rural health workforce needs. However, within a large program there may be five sub-programs that are highly successful in achieving program goals, and five that are ineffective. Without granular data and regular progress reporting on each program, including the relative cost of each program, it is difficult for members of the public to independently assess the performance of each program and the relative value of each investment.

Professor John Humphries, Chair of the Centre of Research Excellence in Rural and Remote Primary Health Care, made a similar point to the Senate Committee hearing in Albury-Wodonga on 5 June 2012 (Transcript page 21-22):

> We have battled desperately with this issue of trying to get good evaluation data. We had the nonsensical situation where, in one of the

> projects that we were doing which was funded through the Department of Health and Ageing, we had to use part of the money to go through freedom of information to get a document that the department had—the results of an evaluation it had conducted—as part of the building blocks. That is the nonsensical kind of secrecy that goes on in terms of they way consultancies are done.
>
> I think it is fundamentally important that once we have identified the nature of the lever that we are trying to pull and allocated some money to pull that harder, we ought then as a matter of obligation see how well it is working in achieving the desired outcome. I think that is a real issue. (p21-22)

While the Department of Health and /or Treasury could no doubt supply the Senate enquiry with the total expenditure involved in these programs, it is critical that this information is routinely available for public scrutiny on an ongoing basis. As it is there is little data to suggest that any initiatives have significantly improved the flow of Australian trained doctors to rural and remote communities. The cost effectiveness of the incentive programs needs urgent analysis. The money in the program may be much more useful funding any number of the initiatives canvassed herein.