health

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

A Victorian Government Submission to the Australian Senate Community Affairs References Committee

December 2011

State Government Victoria

Department of Health

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Contents

Executive summary

In May 2011, The Victorian Government released the *Victorian Health Priorities Framework 2012-2022* (the Framework) which provides the blueprint for the planning and development priories for the Victorian healthcare system for the coming decade. The Framework provides the foundation for the development of the *Rural and Regional Health Plan*, which was published on 16 December 2011.

The *Rural and Regional Health Plan* provides greater certainty to rural and regional Victorians about what they can reasonably expect from their local health services and the broader health service system. The Plan recognises that the rural and regional Victorian population is growing, as is the prevalence of chronic disease and health care utilisation. Planning for health service provision needs to be responsive to this change and there is an expectation that the nature of service delivery must continue to evolve.

The rural and regional health services in Victoria play an integral role in supporting rural and regional Victorians to be as healthy as they can be. This role includes delivering a range of services from health promotion and primary health through to providing acute inpatient services, mental health and drug services, aged care services and end of life care.

Rural and regional health services and the staff and volunteers that work within them have strong relationships with the local communities in which they are located. They contribute to the economic viability of many rural and regional towns and help build the social fabric of the local community.

The Victorian Government has embarked on a significant program of work designed to support and build rural and regional health services and workforce. This submission recommends a number of actions for the Commonwealth Government that would assist.

The Commonwealth Government should:

- play a leading role in building closer collaboration with other funders, health care providers and health professionals to trial alternative ways of funding care that are better aligned to agreed patient pathways
- accelerate the implementation of the Health Workforce Australia Innovation and Reform Framework
- play a stronger role in supporting transition into non-public settings as part of enhanced recruitment and retention into rural Victorian health services
- continue to work with the Victorian Government in the development of a joint Primary Health Care Plan
- consider developing and funding hub and spoke models for primary care, in which a lead GP clinic or community health centre would auspice, support and coordinate training for medical students, interns, prevocational and vocational learners within a range of primary health settings
- encourage Rural Clinical Schools in Victoria to broaden their scope of delivery to provide for greater opportunities for nursing and allied health students to train and gain experience in rural and regional areas
- strengthen the District of Workforce Shortage system by establishing a formal communication mechanism and tool for State and Commonwealth Government representatives to resolve issues as they arise

This submission is derived from the *Rural and Regional Health Plan* and its supporting technical paper. Additional information has been provided in response to the specific Terms of Reference of the Inquiry.

The Victorian rural and regional healthcare system

The rural and regional health care system includes a diverse range of public, private and not-for-profit services and is broadly organised into three levels.

Regional health services are located in Victoria's larger regional centres. Within these centres both state funded and private health providers deliver hospital and community based care across a range of service types. These health services are essential health care hubs with the critical mass to support and effectively use expensive technology, specialist workforces and a comprehensive range of diagnostic support services.

Sub-regional health services are located in predominantly middle and outer rural areas. In general they provide a range of services including surgical, emergency, sub-acute, maternity and diagnostic support. These health services provide the bridge between the range of low-complexity services provided by the smaller local rural health services and the larger regional health services.

Local health services are located across rural Victoria and provide a range of services, including residential aged care, primary health care and limited specialist and acute health care. Services are offered in local hospitals, both public and private, bush nursing centres (BNCs), registered community health centres, private medical and allied health services and residential aged care services. Local health services vary considerably in size and the range of services they offer. Each plays an important role in ensuring communities can access timely, appropriate care close to home.

The independent **State Based Organisations** also play an important role in our system. In recent years, General Practice Victoria, as an independent body, has proved invaluable in working with Victorian Divisions of General Practice and the Victorian Government on key strategic, operational and emergency management issues. The need for this coordinating role has if anything increased, not diminished, given the roll out of new Medicare Locals and the commitment to develop a joint GP and Primary Health Care Plan.

The Rural Workforce Agency of Victoria provides a comprehensive range of supports and programs in rural and regional Victoria covering outreach services, workforce planning, rural doctor recruitment and support for Indigenous health services.

Rural and regional public health services operate under a system of devolved governance, ensuring local oversight of health service planning and provision. Local governance enables a close connection between health services and their local communities, ensuring accountability for and responsiveness to the unique health care needs of local populations. Healthcare providers in rural and regional Victoria delineate the types of services that they provide, based on service demand and availability of the resources needed to offer the service.

Flexible funding arrangements are essential for the smaller state-funded local health services, including BNCs and community health services, allowing local health services to adapt services to respond to local community needs and service planning priorities.

The Victorian Government's primary responsibility in health is to support the health and well being of all Victorians. It works to achieve this aim by leading and managing the health care delivery system and works in partnership with the Commonwealth Government and private providers to meet the health care needs of local communities.

Rural and regional health services and the staff and volunteers that work within them have strong relationships with their local communities. They contribute to the economic viability and many rural and regional towns and help build the social fabric of the local community.

Responses to specific issues raised by the Inquiry

(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

There are not enough services when and where they are needed

Population growth and ageing has resulted in service demand exceeding capacity in some locations and parts of the health system. Additionally, services are not necessarily located where they are needed. Matching service locations and infrastructure to a shifting population is a complex planning process. New infrastructure investments often require long lead times and may lag behind rapid population changes. As populations change, services must also change to better meet the needs of the community. Creating a flexible capacity in the system is also important to meet seasonal service demand changes as people move between rural and regional locations for work and recreation.

The ageing of the population in rural and regional Victoria will increase the demand for health services. Older people with reduced functional ability and cognitive impairment will increase the demand for community based support services and residential aged care.

The importance of strong and effective links between general practice and other types of health services is most critical in smaller regional communities. General practitioners are integral to the operation of local health services by providing after-hours and urgent care, obstetric care and support for residential aged care. Across Victoria access to general practice services varies considerably.

Rural and regional demand for specialist services is increasing and medical specialist distribution is uneven. The distribution primarily reflects the location of hospitals and health services where these specialists work. Significant overall differences can be seen between rural and metropolitan areas in the distribution of the specialist medical workforce. Attraction and retention of clinical staff with the necessary skills to rural and regional areas is difficult, although this is less true for rural areas perceived to have a high level of amenity, access to high quality schooling and relatively close proximity to a large population centre.

Better integration across services, public and private, can address some of these challenges. The Victorian Integrated Cancer Services that support service integration and coordination across five regional areas is a good example of this at work. A synopsis of the initiative is included in the appendices.

The Commonwealth Government should play a role in building closer collaboration with other funders, health care providers and health professionals to trial alternative ways of funding care that are better aligned to agreed patient pathways. For example, people with diabetes receive care across the continuum, with services often being funded from separate State, Commonwealth, private, not-for-profit and non-government funding sources. Accessing multiple funding streams can create unnecessary barriers to care which could be resolved through alternative funding mechanisms such as a jointly funded package of care. Alternative models need to be further explored and replicated across the system where demonstrated to be clinically-and-cost effective.

The current workforce is not working to its full capacity or scope of practice

The Health and Hospitals Reform Commission estimated that the share of healthcare expenditure as a proportion of GDP will increase from 9.6 percent in 2002 to 12.3 percent in 2032. As labour costs represent over 70 percent of total Victorian public health outlays, effective use of the workforce is not just a workforce supply and service model necessity but also a sustainability, productivity and efficiency imperative[1].

Although workforce supply pressures have acted to accelerate reform in some areas of practice, for example in extended skills development for general practitioners, uptake of extended or advanced roles for nursing and allied health staff in rural and regional Victoria is still underdeveloped. The rural and regional palliative care and oncology Nurse Practitioner models currently being supported by the Department of Health are specifically structured to improve access for rural regions/subregions to specialist palliative care and oncology services, largely through outreach or hub and spoke models. This approach addresses the dual disadvantage of rural communities, namely that they do not have ready access to training to develop the specialist workforce in situ and face reduced access to those specialist clinical services. If successful this Nurse Practitioner model could address other areas where communities are currently under serviced with respect to access to specialty services.

In most areas of the health workforce, assistant roles have been developed to enable highly trained health professionals to focus on using their full range of skills. Use of allied health assistant roles in Victoria has been growing over the past four years and is proving successful in rural and regional Victoria in releasing skilled allied health clinicians to focus on more complex interventions. Expansion of these types of roles into new areas may help to provide a more flexible workforce that can be scaled up quickly due to shorter training times and lower barriers to entry.

Assistant roles provide an entry point into the healthcare workforce that can support young people or those returning to the labour market to enter a health career for the first time. Greater use of assistants may also improve retention of skilled health professionals in rural and regional areas, who are then able to deliver services that more closely align with their level of competence.

Innovation and reform in rural and regional Victoria is being supported by the Department of Health through a range of funded initiatives. Health Workforce Australia (HWA) has also recently released its national Health Workforce Innovation and Reform Framework that focuses on supporting extended scope of practice and developing an assistant workforce. HWA will also develop a specific rural and remote workforce strategy for Australia.

Driving workforce change requires sustained effort at local level and effective clinical leadership. Within condition-specific pathways such as cancer, stroke or diabetes, clinical networks can play an effective role in driving change. Health service clinical leaders within a single organisation also require upskilling in workforce planning and change management to identify and deliver workforce change that enables best use of the medical workforce alongside consideration of new roles for nursing, allied health and assistant workforces.

The Victorian Government welcomes Health Workforce Australia's innovation and reform program to support extended scope of practice and the development of assistant level roles in public and private health services. This program should also fund local initiatives that support clinical leaders in rural and regional areas to deliver workforce change. Accelerating the implementation of new roles or embedding extended scope of practice can be enhanced by Medicare and PBS systems. Funding arrangements should make it more financially viable for health services to employ practitioners with advanced levels of skills to deliver services and for customers to access PBS-subsidised prescriptions from nursing or allied health practitioners with the requisite competencies in prescribing

[1] Australian Institute of Health and Welfare 2008, Projection of Australian healthcare expenditure by disease, 2003 to 2033.

Workforce recruitment and retention is challenging

Retention and turnover remain critical issues for rural and regional health services, in particular for allied health groups. According to Victorian State Services Authority data, from 2008 to 2010 turnover for allied health professions rose from 17 percent to 18 percent in regional health services, from 13 percent to 22 percent in sub-regional health services and from 14 percent to 19 percent in local health services. This increase in turnover cannot be attributed to employment models.

Retention of nurses is much stronger than for other clinical groups in rural and regional areas, with turnover rates decreasing over the period 2008-2010 from 9 percent to 6 percent in regional health services, from 12 percent to 10 percent in rural health services and from 14 percent to 9 percent in local health services.

In addition to difficulties encountered in recruiting and retaining skilled staff in rural and remote areas, changes in the market for health services have resulted in increasing difficulties recruiting and retaining sufficient numbers of staff into certain areas of care (such as palliative care and geriatric medicine) and/or in public health services (particularly in areas such as psychiatry, dentistry and pharmacy). Issues such as remuneration parity, nature of client base, professional supports, indemnity issues and capacity for private practice have all been cited as factors contributing to this geographical maldistribution.

Research demonstrates the link between training in a rural and regional area and remaining in those areas to work. Victorian research also demonstrates that graduates entering a structured early graduate program are more likely to remain in employment than those that don't. Additional supervision and mentoring provided through expanded early graduate programs could assist in retaining first-time clinicians in rural and regional areas.

Enabling successful transition to practice and ongoing support for clinicians in rural and regional Victoria is a priority for the Victorian Government. For medical, nursing and allied health staff, a successful first year in practice following graduation can have a lasting positive effect on retention. The Victorian Government already supports early graduate positions in a number of public health services in rural and regional Victoria. Delivering sufficient opportunities however requires a partnership to funding that also allows for private, not for profit and aged care partners to build additional capacity for these programs in rural and regional Victoria. The Commonwealth Government could play a stronger role in supporting transition into non-public settings as part of enhanced recruitment and retention into rural Victorian health services.

(b) The effect of the introduction of Medical Locals on the provision of medical services in rural areas.

Primary health care is central to all Victorians throughout the course of their lives. Most people will see a general practitioner (GP) at least once a year; many require other primary health care services (such as allied health services, community nursing and dental care) to deal with a range of physical, developmental, social and emotional issues and to maintain their health. Some will need active management of their chronic and complex conditions. Regardless of how much a person needs primary health care, all people benefit from a cohesive, high-functioning primary health system. Integrated health promotion and prevention programs support the health of communities and strengthen the social fabric.

The Victorian Primary Care Partnership Strategy supports the state-wide operation of 30 local alliances of service providers. These work in partnership to improve the coordination of services to clients, plan and deliver integrated approaches to health promotion and develop integrated approaches to the management of chronic disease. With only modest funding, the key resource is the collaboration between providers. PCPs have been improving the coordination and integration between state-funded health and human services and with general practice.

General Practice Victoria are a critical partner in this strategy and the Victorian Government is concerned that the process undertaken by the Commonwealth Government to establish new governance arrangements for Medicare Locals does not take appropriate account of their role. The new National Body will address the important functions that need to be continued at the jurisdictional level. It is vital that the National Body be required to ensure there are adequate mechanisms in place within jurisdictions to ensure meaningful, timely and coordinated engagement with the State government, as the public health system managers, on primary health care issues. Ensuring adequate engagement within the state network of Medicare Locals and between the network and the State government will be paramount if the primary care reforms agreed by our governments in the National Health Reform Agreement are to receive the support they require.

Medicare Locals are required to be independent legal entities established as public companies limited by guarantee – incorporated under the *Commonwealth Corporations Act 2001*. It is intended that Medicare Locals will provide the mechanism to support a number of Commonwealth Government primary health care programs, including those currently funded through the Divisions of General Practice Network.

Medicare Locals are expected to work closely with Health Services, health professionals and the Victorian community. They will also have a role in planning and supporting after hours face-to-face GP services to reduce the strain on public hospitals. The Victorian Government supports ongoing delivery of existing critical functions of the Victorian Primary Care Partnerships to improve health outcomes for Victorians.

Divisions of General Practice will need to be maintained whilst their current functions are transferred into Medicare Locals. It is expected that the Medicare Local is unlikely to maintain the full functions of the division of general practice as the Medicare Locals will be required to have a broader primary health care focus.

There will be 17 Medicare Locals operational in Victoria from 1 July 2012. The first four became operational on 1 July 2011:

- Inner East Melbourne Medicare Local (existing Melbourne East GP Network);
- Barwon Medicare Local (existing GP Association of Geelong);
- Inner North West Medicare Local (existing Melbourne GP Network and Progressive Primary Health Ltd); and
- Northern Melbourne Medicare Local (existing North East Valley Division of GPs and Northern Melbourne Division of GPs).

As Medicare Locals have not yet been fully introduced in Victoria it is premature to offer a comprehensive commentary on their effect on the provision of medical services in rural areas. However, the first area that is

likely to be affected is the provision of after-hours face-to-face GP services. The Commonwealth Government is funding Medicare Locals to be responsible for the contracting of GP face-to-face after-hours services. At the same time, the Commonwealth is withdrawing incentives and grants for general practices and divisions of general practice to provide after-hours services. This may result in withdrawal of GPs from provision of after-hours services and a risk that there is a resulting increase in emergency department primary care type presentations.

The Victorian Government will work with the Commonwealth Government to develop a joint Primary Health Care Plan which will set key directions for a future collaborative approach to integrated and more effective primary health care service delivery. This will provide a coordination mechanism and directional statement for working effectively with Medicare Locals to integrate care provided by general practice and other primary health care providers, both public and private, across the continuum.

The Commonwealth should continue to fund a state based organisation, independent of the proposed national organisation, with similar functions as the existing state based organisations funded under the Divisions of General Practice program. The organisation must also evolve to reflect the broader role played by Medicare Locals. The proposed national coordinating body would not be in a position to act responsively to across all jurisdictions and has the potential to add a layer of bureaucracy and confusion regarding the Commonwealth's role in setting appropriate policy and funding context.

(c) Current incentive programs for recruitment and retention of doctors and dentists' particularly in smaller rural communities including:

(i) their role, structure and effectiveness,

(ii) the appropriateness of the delivery model, and

(iii) whether the application of the current Australian Standard Geographical Classification-Remoteness Area (ASGCRA) classification scheme ensure appropriate distribution of funds and delivers intended outcomes.

Typically, practicing in the rural setting provides greater opportunities for clinicians to perform a variety of tasks within their scope of practice, operate in different service delivery models, establish local and regional networks, work across sectors to support patient management and decision making, and build closer community relationships, as well as developing their management and administration skills.

Education, support and training of rural health professionals is vital and robust partnerships between health services, universities and the vocational education and training providers are needed to ensure rural clinicians and health workers receive training which supports their needs. For example, the Murray to the Mountains initiative seeks to increase the number and capability of rural doctors by providing a comprehensive training program for year one and two medical graduates and specialist trainees, and by building a culture of continuing professional and skills development for practising rural doctors, nurses and allied health practitioners. Details of this program are included in the appendices.

General practitioners are fundamental in ensuring early diagnosis and ongoing management of care for many rural people. The Victorian Government has committed to establish a program for specialist rural general practitioners in recognition of the particularly important role general practitioners play across rural and regional health services. They not only provide primary health care services but support the provision of acute and subacute services within local health services, requiring specific skills and expertise unique to rural practice.

Supporting primary health-based teaching models

While teaching for medical students has been significantly strengthened in larger rural and regional public health 'hubs and spokes', more progress needs to be made to develop teaching networks and infrastructure in primary health. Alongside its support for the Prevocational General Practice Placements Program (PGPPP) and GP training networks, the Commonwealth Government could consider developing and funding similar hub and spoke models for primary care, in which a lead GP clinic or community health centre would auspice, support and coordinate training for medical students, interns, prevocational and vocational learners within a range of primary health settings in their geographic area.

The Victorian *Rural and Regional Health Plan* sets out a number of actions that will be taken in the short to medium term in order to address rural workforce challenges. These include inter alia:

- Implement the Victorian Government's commitment to:
    - support continuing medical education;
    - establish a program for specialist rural general practitioners;
    - create a rural relocation fund; and
    - fund a rural scholarships program.
- Support dental clinicians (dental therapists, oral health therapists, dental prosthetists and dentists) to relocate from metropolitan locations to rural and regional communities
- Develop collaborative approaches that support health services deliver the necessary professional education, training and support in partnership with others to reduce unnecessary duplication of effort
- Identify opportunities to address workforce gaps and make better use of existing workforce capability and capacity across the public, private and not for profit sectors
- Facilitate mechanisms that support more appropriate distribution of workforce to match the needs of rural and regional communities including, for example: advocating for the distribution of MBS provider numbers to be matched to areas of need and workforce shortage
- Build on innovative workforce recruitment and retention and training, education and professional development strategies including:
    - consolidating the Clinical Placement Networks. This will better enable coordination, planning and facilitation of quality entry-to-practice clinical training activity across sectors (public and non-government health providers and higher education and training providers within a natural community of interest);
    - the sharing of workforces across regional and sub regional health services, and supporting joint appointments and accredited training positions; and
    - building on the potential of the Rural Clinical School model and expanding rural clinical placements and professional support.

With respect to current incentive programs for the recruitment and retention of rural doctors and dentists the approach taken has concentrated on supporting local, sub regional and regional health services to meet their workforce needs. A description of current and planned incentive programs for doctors and dentists is included as an appendix to this submission.

Specialist rural general practitioners

The Victorian GP – Rural Generalist program aims to increase recruitment and retention of medical practitioners in rural Victoria. The Victorian GP – Rural Generalist training pathway offers students of rural clinical schools rural postgraduate opportunities in general practice and advanced skills/specialised training. This is intended to give medical students a supported and cohesive pathway to a rural career.

To focus implementation, the GP – Rural Generalist training pathway will initially target support for maternity services. In addition to obstetrics, this may include procedural training in anaesthetics and surgery.

Rural Clinical Schools

The Victorian Government strongly supports the Rural Clinical School (RCS) model, which has delivered additional training places for rural and regional students and now provides the basis for a significant expansion of the domestically-trained medical workforce to service rural and regional communities. RCSs have forged strong partnerships with a number of rural and regional health services in Victoria which has also supported additional clinical placement opportunities in public and private settings. Rural and regional health services would benefit from a broader range of training pathways being delivered under the auspice of the RCS model.

The inclusion of additional allied health opportunities in particular, in shortage areas such as radiography, would also strengthen interprofessional learning in these locations. Exposure to stronger interprofessional teams is often cited as one of the potential attractions of training and working in a rural and regional location, in which smaller teams often work more flexibly and across traditional boundaries when compared to larger metropolitan centres.

The Commonwealth and State governments should encourage Rural Clinical Schools in Victoria to broaden their scope of delivery to provide for greater opportunities for nursing and allied health students to train and gain experience in rural and regional Victoria, particularly in geographic areas experiencing persistent workforce shortages, such as the Gippsland region. Rural Clinical Schools should also be encouraged to work more closely with health services to support changing workforce mix, including the development of advanced roles or technical skills within a strong interprofessional framework.

ASGCRA

The Victorian population distribution is quite unlike other that of other states and territories. With a number of large regional cities such as Bendigo, Ballarat and Geelong many health services are run as hub and spoke models from a regional centre. The larger regional centres employ specialist health professionals that offer outreach and visiting services to sub-regional and local health services. Doctors employed in this way may not be able to access support programs where ASGCRA is used to determine thier eligibility.

(d) Any other matters?

The Commonwealth's District of Workforce Shortage (DWS) process is a barrier to the timely recruitment of international medical graduates.

Section 19AB of the Commonwealth's *Health Insurance Act 1973* applies to international medical graduates and foreign graduates of an accredited medical school who gained their first medical registration on or after 1 January 1997. Section 19AB of the Act restricts their access to Medicare benefits and requires them to work in a 'district of workforce shortage' (DWS) for a minimum period of ten years from the date of their first medical registration.

A DWS is defined as a geographic area in which the general population need for health care services are not met, which are generally rural and remote areas. Population needs are seen to be unmet where a community has significantly less access to medical professional services, of the type provided by the applicant, than the national average. However, the Commonwealth delegate may consider a range of factors in the assessment process. All applications for section 19AB exemptions are assessed by the Commonwealth Department of Health and Ageing on individual merit (that is on a case by case basis).

State/territory Area of Need (AoN) process.

Section 67(5) of the Victorian *Health Practitioner Regulation National Law Act 2009* states that 'A responsible Minister may decide there is an area of need for health services in the participating jurisdiction, or part of the jurisdiction, if the Minister considers there are insufficient health practitioners practising in the particular health profession in the jurisdiction or the part of the jurisdiction to provide the service at a level that meets the needs of people living in the jurisdiction or the part of the jurisdiction.'

The AoN criteria and process vary between states, but the outcome of an Area of Need endorsement relates to the type of registration an international medical graduate may apply for. AoN is a limited form of registration valid for a period of four years, and indicates an international medical graduate who is temporarily permitted to practice in a specialist role against a particular job description, but required to up-skill to meet Australian specialist standards. The doctor is permitted four years to achieve Fellowship of an Australian specialist college in order to maintain registration.

The current AoN policy in Victoria aims to assist employers in their attempts to recruit suitably skilled doctors. Therefore there is no specific list of AoN positions or locations, as this varies due to cause of the recruitment difficulties faced by individual communities. AoN endorsements are awarded in Victoria on satisfactory evidence that employers have been unable to recruit a suitable candidate from within the existing Australian medical workforce.

Within Victoria the AoN status is often dependant upon the DWS status. This is especially relevant to general practice, where without a Medicare Provider number an IMG will be unable to access any form of Medicare rebate for professional services. In this instance an AoN will only be issued if there is a DWS or preliminary assessment of such.

How DWS and AoN policy affects local and sub regional health services

There are a number of effects of DWS and AoN policies on recruitment to small rural health services. These include:

- delays in processing applications for registration and employment of international medical graduates;
- difficulties gaining approval for a Medicare provider number in small rural locations where the larger regional area is already well subscribed with medical practitioners;
- problems with sustainability of existing practices where a doctor leaves but cannot be replaced, as another doctor has already been granted a DWS in another practice;

- limited consideration of public health service workforce needs, and the wider skill base needed, when a private practice seeks to recruit an international medical graduate – for example after hours, urgent care and visiting service needs; and
- can act as a disincentive to recruitment, particularly from Competent Authority countries, given the requirement for international medical graduates to work for up to 10 years in a DWS.

The 10 year moratorium and restriction on practice are seen as unpopular by many as they do not apply to Australian trained doctors. The Victorian Government's position has been to support an incentives-based approach to build the rural workforce, rather than an enforced restriction on practice. On the positive side, the 10 year moratorium has supported small towns to recruit doctors who would not otherwise choose to work there.

The DWS system could be improved by a more detailed dialogue between the Commonwealth and State governments on areas that may require further analysis of the nature of the specific shortage. The DWS system should be more evidence-based and transparent, with the Commonwealth sharing its methodology and data with states and territories and allowing jurisdictions to contribute to DWS determinations to ensure they are responsive to local workforce needs and circumstances.

A recent example in relation to anaesthetics provision in the Bendigo area shows that, when DWS analysis is applied too narrowly to one local government area, the DWS process may overlook service patterns (e.g. hub and spoke models of service) that see specialists sharing their time between a hub hospital and outlying areas, with the effect of a narrow DWS ruling being that both hub and spoke areas remain under serviced. Similar problems have been raised in Geelong causing ongoing problems in recruiting specialist doctors.

As system manager with the responsibilities outline in the National Healthcare Reform Agreement - the Victorian Government is best placed to determine workforce need.

Both the Commonwealth Government DWS and Victorian Government AoN seek to influence the distribution of doctors by controlling where international medical graduates can work.

- DWS operates by offering the doctor a provider numbers on specified terms and conditions tied to a location of workforce shortage.
- AoN operates by limiting the category of registration the doctor is eligible for and by tying registration to a location and job.

Both are seen as effective workforce measures.

From time to time the administrative requirements of the two systems cause confusion and delay recruitment.

The Commonwealth Government should recognise Victoria's role as the health system manager and should make DWS determinations on the basis of advice from the State's regarding Area of Need determination.

Appendix One Current Victorian Government incentive programs for the recruitment and retention of rural doctors

Program	Role	Structure	Effectiveness	Appropriateness of the delivery model
Rural Relocation Grants	To encourage and assist doctors from metropolitan areas to relocate to rural Victoria.	Grants of up to $25,000 are available to rural health services for relocation packages to attract doctors. Funds may be used to cover relocation costs, travel and accommodation as well as assist with education fees for children or provide spouse employment support.	This program began in October 2011 as a new program and as such its effectiveness can not yet be determined.	The program is administered centrally and has been designed to minimise the administrative burden of application and accountability reporting requirements. Candidate specific funding ensures the total investment is explicitly linked to meeting the program goals.
Rural dental practitioners relocation support initiative	The initiative will support clinicians and their families who incur high costs in relocating and establishing a practice in rural and regional areas.	Funding is provided for four years to help dental clinicians (dental therapists, oral health therapists, dental prosthetists and dentists) relocate from metropolitan locations to rural and regional communities.	This program is currently being developed.	It is envisaged that the program will be administered centrally by Dental Health Services Victoria.
IMG Recruitment Support Packages (formerly known as IMG Incentive Packages)	To support health services recruit an internationally trained doctor where an Australian graduate is not available. Rural health services are prioritised for this funding due to the difficulty in attracting doctors to rural areas and because of the disproportionate burden of recruitment costs borne by local and sub-regional health services.	Packages of up to $35,000 are available to health services to assist in the recruitment of internationally trained doctors. Packages may be claimed to cover expenses related to relocation, recruitment and start-up.	This is considered to be an effective program. In 2010-11 health services packages were funded to recruit 111 internationally trained doctors. Of the 111 packages, 32 were for rural specialists; of these 31 are still working in rural Victoria. 48 packages were for rural junior doctors of which 29 are still employed by a rural health service.	The program is administered centrally and has been designed to minimise the administrative burden of application and accountability reporting requirements. Candidate specific funding ensures the total investment is explicitly linked to meeting the program goals.

Program	Role	Structure	Effectiveness	Appropriateness of the delivery model
Rural Continuing Medical Education (CME) grants	To offset the costs of medical education for doctors working in rural and regional Victoria and encourage trainee doctors to complete rural placements.	Specific grants are awarded to rural doctors to update their knowledge and skills in metropolitan locations. Registered medical practitioners have access to up to $2,000 per annum and doctors in training who complete a minimum of 13 weeks in a rural placement are eligible for up to $3,000 per annum.	This program began in October 2011; as a new program its effectiveness can not yet be determined.	The program is administered centrally and has been designed to minimise the administrative burden of application and accountability reporting requirements. Candidate specific funding ensures the total investment is explicitly linked to meeting the program goals.
Victorian General Practitioner (GP) – Rural Generalist program	To increase recruitment and retention of medical practitioners in rural Victoria, this program will provide a dedicated training pathway for GP rural generalists to practice in Obstetrics, Anaesthetics, Emergency Medicine and Surgery. The program is currently under development.	The training program will be delivered by regional partnerships comprised of the organisations involved in local medical training and employment.	As the program is currently under development its effectiveness can not yet be determined.	This program is aligned to existing appropriate training structures and related programs. Implementation is being supported by an advisory committee of key stakeholders.
Rural Medical Scholarship Scheme	To assist rural and regional health services attract, employ and retain early medical graduates, assist students overcome financial barriers to studying medicine at university and support career pathways to rural medical practice. From 2012-13 the program will be linked to the Victorian General Practitioner – Rural Generalist Program.	Scholarships of $20,000 are available to medical students undertaking their final year of medical studies in 2012. Students should spend a minimum of 3 months in a rural or regional clinical training site in Victoria during the course of the year and demonstrate a commitment to rural or regional practice in the future.	This is a new program and no scholarships have been awarded to date. As such the effectiveness of the program can not yet be determined.	The program will be administered centrally and has been designed to minimise the administrative burden of application and accountability reporting requirements. Candidate specific funding ensures the total investment is explicitly linked to meeting the program goals.

Program	Role	Structure	Effectiveness	Appropriateness of the delivery model
Strengthening Medical Specialist Training (SMST)	To assist health services increase the number of specialist training places in key specialties considered to be in shortage.	An incentive payment is made to health services to aid in meeting the additional costs associated with specialist medical training. Rural posts are funded at $70,000 per post per annum and rural health services may apply for funding to support training posts in any specialty based on their own workforce requirements.	Since the commencement of the program in 2008, 262 specialist training posts have been supported in rural Victoria. The program is consistently oversubscribed. A program evaluation is currently underway.	The program is administered centrally and has been designed to minimise the administrative burden of application and accountability reporting requirements. Candidate specific funding ensures the total investment is explicitly linked to meeting the program goals.
Advanced procedural training for GPs	To increase the number of GPs with procedural skills in rural Victoria. The program assists to retain rural GPs and address specialist workforce shortages in rural areas.	Funding of $100,000 per full-time post is available for GPs and GP Registrars to undertake 12 months of Advanced procedural training in a health service in Obstetrics, Anaesthetics, Emergency Medicine and Surgery. Funding enables health services to provide this training through the creation of supernumerary posts.	Demand for this program is growing and will rise from 19 training posts in 2011 to 26 in 2012.	The program is administered by the three rural Victorian GP Regional Training Providers. The program has been designed to minimise the administrative burden of application and accountability reporting requirements. Candidate specific funding ensures the total investment is explicitly linked to meeting the program goals.
Rural Workforce Agency Victoria (RWAV)	The Victorian Government has funded RWAV since 2001 for various programs aimed at supporting the recruitment, training, support and retention of rural doctors.	RWAV is funded by the Victorian Government through a Service Agreement. The agency is also funded by the Commonwealth Department of Health and Ageing.	In 2010-11, 118 doctors were recruited and commenced into permanent positions against a target of 110. RWAV has also been able to respond promptly to emergency medical situations such as sourcing additional GP locums during the bush fire crisis.	Commissioning RWAV activities through a service agreement has proven effective in relation to responsiveness and accountability. RWAV also has a network across Victoria to support delivery of local solutions.

Program	Role	Structure	Effectiveness	Appropriateness of the delivery model
Rural Medical Family Network	To provide support to rural doctors and their families through the provision of information, mentoring programs, development of networks between doctors' partners and training bursaries.	RMFN is funded through a Service Agreement.	Lack of spousal and family support has been identified in research as a key determinant in doctors' decisions to leave rural areas. RMFN provides a service specifically to address this aim. Services offered are in line with expressed needs.	Though RMFN services are flexible, the organisation reports some trouble in getting access to doctors' families and encouraging them to take advantage of its services. The Department of Health is working with RMFN to explore options to extend its services to other rural health professionals.
Developing Organisational Capacity (DOC) program	To support rural health services to address training, supervision and other related issues affecting their medical workforce.	An annual call for submissions is made and DOC applications are accepted by the closing date and then throughout the year, subject to funds availability.	An external evaluation is presently underway. The evaluation is suggesting that the program is well regarded and anecdotally has supported health services to grow, train and retain their junior medical workforce.	The flexibility of the DOC project money allows local and sub regional health services to respond to the unique medical workforce issues faced in rural Victoria.

Appendix Two Integrated Cancer Services

Providing condition specific regionalised integrated health care

Integrated Cancer Services (ICS) support improvements in the integration and coordination of cancer services within specified geographic areas. There are three metropolitan ICS, five regional ICS and one state-wide paediatric ICS.

The primary task of the ICS is to improve the delivery of cancer services through the development of clear and formal communication processes, referral patterns and relationships between services to meet the needs of people with cancer. ICS members include; general practitioners, community-based service providers, public hospitals, private hospitals and supportive care services.

ICS have had a focus on:

- shifting cancer service planning from the needs of the health service to the needs of the population and patients;
- shifting from clinical treatment based on local practice and interpretation of clinical practice guidelines to formal multidisciplinary, evidence based approaches to care;
- supporting health services to work together in more formalised ways to deliver cancer services; and
- changing the approach to treatment and care planning from the basis of local service availability to patient needs along the tumour stream care pathways.

Regionalised patient care management

Cancer treatment often involves treatment across a number of different specialties and modalities. Larger metropolitan and regional hospitals may be able to provide all of these however medium and smaller hospitals generally cannot. This can result in people receiving fragmented cancer treatment. By coming together from across multiple services, including between private and public services, to establish formal patient care arrangements cancer care for patients has improved.

Overall the survival rates have improved across both metropolitan and rural Victoria. There is still a difference in the 5-year survival rate between rural and metropolitan cancer patients although the variability between the groups is decreasing.

Appendix Three Murray to the Mountains (M2M) sub-regional partnership

The Murray to the Mountains (M2M) health services comprises Cobram District Health, Numurkah District Health Service and Yarrawonga District Health Service in Moira Shire and Alpine Health (Bright and Mount Beauty campuses) in Alpine Shire. The overall aim of M2M is to increase the number and capability of rural doctors by providing a comprehensive training program for Postgraduate Year 1 (PGY1) interns and Postgraduate Year 2 (PGY2) medical graduates and vocational trainees, and continuing professional development for practising rural doctors, nurses and allied health professionals to assist them in updating current skills or obtaining additional skills.

In 2009, the (then) Victorian Department of Human Services (DHS) proposed the establishment of rural Medical Workforce Partnerships. The M2M partners considered that, in the first instance, a partnership at a subregional level would be more sustainable than one that endeavoured to operate at a regional level from the outset. In time, established subregional partnerships could come together to form partnerships at a regional level.

Intern Training

M2M developed a model for intern training, the innovative features of which include:

- five interns residing in or close to Moira or Alpine Shire, rotating to major centres in north-eastern Victoria for their core medical, surgical and emergency medicine terms. That is, this model departs from the traditional approach which sees interns based in major metropolitan or regional hospitals and 'rotating out' for terms in rural settings; and
- 20-week rotations with interns based in general practices and working with the GPs and visiting specialists at the local health service. Interns would experience the broad role of rural general practice and the continuum of care provided, encompassing the episodic care of patients in general practice as well as the management of hospital inpatients and residents in aged care facilities. This is considered the most appropriate structure for a rurally-based training program.

The five positions were accredited by the Postgraduate Medical Council of Victoria (PMCV) to take interns from 2012. There were 213 applications for the five M2M positions.

Clinical Educational Activities

M2M has funding to conduct a number of clinical/educational programs, in keeping with its stated aim. These include the following.

Geriatric Program: A consultant geriatrician or advanced geriatric registrar from Western Health will visit the three Moira Shire health services (initially) on a six-weekly cycle, providing consultant geriatric services to public sector residential aged care facilities, including case conferences and clinical reviews, and formal as well as informal teaching. The visits will be supplemented by fortnightly videoconferences.

Radiology/Radiography Training: This program will foster competency in using the diagnostic imaging facilities, which are now all digitalised across M2M, and the interpretation of diagnostic images such that, in each of the M2M health services, there is a substantial number of doctors licensed in the use of radiology equipment, and credentialled and privileged in its use.

Skills Workshops: Four skills workshops, each with approximately 20 participants, and suitable for medical students and PGY1 and PGY2 medical graduates, are to be run per year, in association with the University of Melbourne Skills Laboratory at Goulburn Valley Health.

IMG Grand Rounds: Grand Rounds provide IMGs with the opportunity to present interesting cases. The Grand Rounds format allows IMGs to act as presenters and discussants, and to form part of an audience which, in the case of most presentations, involves a broad spectrum of health professionals and audiences of up to 40 people.

Parallel Consulting: Parallel consulting is widely employed as an integral component of supervised general practice and medical student teaching but there appear to be no accepted guidelines for its implementation. The aim of this project is to undertake a literature review and develop a set of guidelines that are applicable across M2M and may also be applicable across Victoria. (It is important within an arrangement such as M2M to ensure that all the teaching sites work to the same set of guidelines.) The integrated care clinic at Cobram District Health offers an opportunity to test the guidelines in a clinic specifically designed to facilitate parallel consulting.

Paediatric Telehealth: Paediatricians from the Royal Children's Hospital will conduct five one-hour clinical teaching videoconference involving GPs and medical graduates from general practices in the five M2M towns, plus medical students, nursing staff and allied health professionals.