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12/41

Mr Ian Holland
Committee Secretary
Community Affairs References Committee
PARLIAMENT HOUSE
CANBERRA ACT 2600

Dear Mr Holland,

Senate Inquiry into Factors Affecting the Supply of Medical Workforce in Rural Areas – Supplementary Information

During the AMA's recent appearance before the Inquiry, members of the Committee requested that the AMA provide further information in relation to:

- existing programs run by the Commonwealth to encourage doctors to work in rural areas;
- costs of locums to cover workforce shortages; and
- the AMA Regional/Rural Workforce Initiatives 2012 Position Statement.

This information is provided below and a copy of the AMA Position Statement "Regional/Rural Workforce Initiatives 2012" is attached.

Existing Commonwealth Programs to encourage doctors to work in rural areas

This section outlines the main programs that the AMA understands are funded or administered by the Commonwealth Government to support doctors to work in regional and rural areas:

1. Multidisciplinary Rural Training Network Programs

1.1. University Departments of Rural Health

Under this program funding is provided to 11 Universities across Australia to:

- Help these universities maintain rural educational infrastructure across the country;
- Promote research into rural and remote health issues;
- Give students of medicine, nursing and other health professions opportunities to practice their clinical skills in a rural setting; and

- Support health professionals currently practicing in rural Australia by providing education and training.

1.2. Rural Clinical Training and Support

The program provides targeted funding to participating Australian medical schools for 3 principal areas:

- Rural student selection;
- Improvement of support systems for students and rural medical educators; and
- Provision of structured rural placements for all Australian medical students.

The targets of the program as outlined on the Department of Health and Ageing website are:

- 25% of Australian medical students do at least one year of their clinical training in rural areas
- 25% of Commonwealth supported medical students are recruited from a rural background; and
- all medical students complete at least 4 weeks of rural training.

1.3. John Flynn Placement Program

Administered by the Australian College of Rural and Remote Medicine (ACCRM), the John Flynn Placement Program (JFPP) places medical students in rural and remote communities to experience life as a doctor in a rural town. Students go to the same communities each year (usually 2 weeks per year for 4 years) and are placed with a medical mentor and a community host.

2. Bonded Medical Places (BMP)

Under the Bonded Medical Places (BMP) Scheme, students accepting a BMP commit to working in a district of workforce shortage area for a period of time, equal to the length of their medical degree, less any credit obtained through the process of "scaling"[1]. 25 per cent of all first year Commonwealth Supported Places (CSP) medical school places are allocated to the BMP Scheme. There are no financial incentives attached to the BMP scheme and students must repay their HECS debt in full.

3. Medical Rural Bonded Scholarship (MRBS)

According to the Department of Health and Ageing website, the Medical Rural Bonded Scholarship (MRBS) Scheme currently provides 100 additional Commonwealth Supported Places (CSP) each year to first year Australian medical students at participating universities across the country.

[1] Scaling is the system where students working in rural areas can fast track return of service obligations based on the Remoteness Area (RA) category they are working in. The more the remote the location, the quicker the "fast track".

Students accepting the MRBS commit to working for six continuous years in a rural or remote area of Australia, less any credit obtained through "scaling", after completing their medical training as a specialist.

The Scholarship is worth over $24,000 a year and is currently tax free and indexed annually.

4. HECS Reimbursement Scheme

The HECS Reimbursement Scheme reimburses a proportion of a medical student's HECS debt for every year they train or work in rural and remote communities.

Under the scheme, doctors can reduce the period for reimbursement of the cost of their medical studies from 5 years to 2 years, depending on the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) location of their training or practice.

Reimbursements are scaled as follows:

ASGC-RA	No. of years to receive full reimbursement
2	5 years
3	4 years
4	3 years
5	2 years

5. Rural Australia Medical Undergraduate Scholarship (RAMUS)

According to the Department of Health and Ageing Website, the RAMUS scheme provides 573 scholarships worth $10,000 a year to medical students (in undergraduate or graduate medical courses) to help with travel and accommodation costs while they are studying for a medical degree. To be eligible, a student must:

- Come from a rural background;
- Show financial need; and
- Be committed to working in rural Australia in the future.

6. Use of overseas trained doctors

International Medical Graduate (IMG) doctors, including overseas trained doctors (OTDs) and foreign graduates of an accredited medical school (FGAMS) working in private practice in Australia are generally subject to the Medicare provider number restrictions contained under section 19AB of the Health Insurance Act 1973 (the Act).

Section 19AB restricts access to Medicare provider numbers, and requires OTDs and FGAMS to work in designated districts of workforce shortage (DWS) in order to access Medicare benefits. The restrictions apply up to 10 years, known as the "10 year

moratorium". This effectively allows the Commonwealth to conscript IMGs to areas of workforce shortage.

The Commonwealth has administered a system of "scaling" which offers time reductions on the 10-year restrictions for doctors who choose to work in more remote areas. (See the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) table below)

ASGC-RA Classification	ASGC-RA1 Major Cities	ASGC-RA2 Inner Regional	ASGC-RA3 Outer Regional	ASGC-RA4 Remote	ASGC-RA5 Very Remote
Period of restriction	10 years	9 years	7 years	6 years	5 years

7. General Practice Rural Incentives Program (GPRIP)

The General Practice Rural Incentives Program (GPRIP) commenced on 1 July 2010. GPRIP was funded in the 2009-10 Budget as part of the Rural Health Workforce Strategy.

The program aims to encourage medical practitioners to: practice in rural and remote communities; and promote careers in rural medicine. It combines 2 previously separate retention incentive programs available to General Practitioners (GPs) and Registrars, and provides a relocation grant.

GPRIP comprises three components:

- GP Component (previously known as the Rural Retention Program-RRP).
- Registrar Component (previously known as the Registrars Rural Incentive Payment Scheme-RRIPS).
- Rural Relocation Incentive Grant (RRIG).

8. National Rural Locum Program

According to the Department of Health and Ageing (DoHA), the Department provides funding to support several health professional groups in rural areas including:

- Nurses, Midwives and Allied Health professionals - through the Nursing and Allied Health Rural Locum Scheme (NAHRLS);
- GP Anaesthetist's - through the GP Anaesthetist Locum Scheme (GPALS);
- GP's - through the Rural GP Locum Program (RGPLP); and
- Specialist and GP Obstetricians - through the Specialist Obstetrician Locum Scheme (SOLS).

9. Rural Locum Education Assistance Program (Rural LEAP)

Rural LEAP provides financial assistance to urban GPs who undertake emergency medicine training and commit to a 4-week (or 20 working days) paid general practice locum placement in a rural location within a 2-year period.

Eligible participants are able to access and obtain a one off-financial incentive to undertake emergency medicine training up to $6,000.

10. Training and Support Programs

The Commonwealth also fund some training programs to support medical practitioners in regional and rural Australia including:

10.1 The Rural Health Continuing Education (RHCE) Sub-Program

This program provides some continuing professional development (CPD) funding to rural and remote health professionals through 2 streams of funding:

- RHCE – Stream 1 provides CPD grants for rural medical specialists (managed by the Committee of Presidents of Medical Colleges); and
- RHCE – Stream 2 provides CPD grants for allied health professionals, nurses, general practitioners and Aboriginal and Torres Strait Islander Health workers in rural areas (managed by the National Rural Health Alliance)

10.2 Remote Vocational Training Scheme

This Scheme delivers structured distance education and supervision (weekly tutorials, twice yearly workshops, remote supervision and individualised training advice) to doctors in some of Australia's remotest locations.

10.3 The Rural Procedural Grants Program

This program provides grant payment to procedural GPs in rural and remote areas to help them attend training and skills maintenance courses. The grants contribute towards course costs, locum relief and travel expenses.

10.4 GP Procedural Training Support Program

According to the Department of Health and Ageing Website, under this program funding of $40,000 (GST exclusive) is made available to 110 GPs to help them study for either:

- The Advanced Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG); or
- A statement of satisfactory completion of Advanced Rural Skills Training in Anaesthesia.

11. Medical Specialist Outreach Assistance Program

The Medical Specialist Outreach Assistance Program (MSOAP) is aimed at improving access to specialist services in rural and remote Australia.

According to the Department of Health and Ageing Website, the Government provides a range of programs, which specifically aim to improve health and medical service delivery by increasing access to medical specialists for people living in rural and remote communities. This is achieved by reducing some of the financial disincentives incurred by medical specialists in providing outreach services. Funds are available for the costs of

travel, meals and accommodation, facility fees, administrative support at the outreach location, lease and transport of equipment, telephone support and up-skilling sessions for resident health professionals.

MSOAP services are prioritised based on community need and endorsed by an advisory forum operating in each state and in the Northern Territory. Services are reviewed annually to ensure they remain a priority for the region in which they are delivered. MSOAP currently provides around 1800 services annually to rural and remote communities across Australia.

Costs of locums to cover workforce shortages

Funding allocated in 2012-13 for these programs is as follows:

Program	Funding (GST excl)
NAHRLS	$8,091,429
GPALS & SOLS	$2,050,000
RGPLP*	$0
Total	$10,141,429

* NOTE: funding for the RGPLP in its current form will cease as of 30 June 2012. Funding for this program will be distributed across Medicare Locals. This funding will be used to meet local priorities and could include locum support.

Incentives paid under each scheme is as follows:

NAHRLS

Type of Support	Subsidy
Locum allowance (maximum of 14 days per annum)	Up to $420 per day
Locum travel	Up to $2,400 per placement

GPALS

Type of Support	Subsidy
Locum subsidy (maximum of 14 days per annum)	$750 per day
Locum travel time	$750 per placement
Locum travel cost	$2000 maximum per placement

SOLS

Type of Support	Subsidy	
	Specialist Obstetrician	***GP Obstetrician***
Locum subsidy (maximum of 14 days per annum)	$1100 per day	$825 per day
Locum travel time	$1100 per placement	$825 per placement

Locum travel cost	$2000 maximum per placement	$2000 maximum per placement

RGPLP

Type of Support	Subsidy
Locum subsidy (maximum of 14 days per annum)	$500 per day
Locum travel time	$500 maximum per placement
Locum travel cost	$2000 maximum per placement

Please note that the AMA does not have access to information on the overall cost of locum programs and we note that state and territory health departments also make extensive use of locums to address rural workforce shortages. In this regard, we are unable to quantify expenditure by the states and territories.

There are a range of programs at state/territory level that are designed to encourage doctors to work in rural areas. The AMA prepared a summary of these in 2007 and a copy of this document is attached. While the information has not been updated since that time, it does provide a picture of the existing range of programs and their fragmented nature.

AMA Regional/Rural Workforce Initiatives 2012 Position Statement

The AMA Federal Council, at its most recent meeting, approved the attached AMA Rural/Regional Workforce Initiatives Position Statement 2012. The position statement builds on earlier AMA work in this area and identifies possible solutions to help attract and retain more doctors to regional and rural areas. To this end, the revised Position Statement highlights five key priority areas for Government policy development that would help attract medical practitioners and students to regional and rural areas. These are:

1. provide a dedicated and quality training pathway with the right skill mix to ensure GPs are adequately trained to work in rural areas;
2. provide a realistic and sustainable work environment with flexibility, including locum relief;
3. provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/relocation and/or tax relief;
4. provide financial incentives including rural loadings to ensure competitive remuneration; and
5. provide a working environment that would allow quality training and supervision.

The Position Statement also highlights the significant ongoing concern at the way in which the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) is being applied to determine the distribution of financial incentives. While we welcome the fact that more areas are eligible for incentives, it is resulting in perverse

outcomes and to that end an independent review of this classification system is urgently required.

The AMA appreciates the opportunity to provide this further information to the Inquiry and would be happy to answer any further questions that Committee may have.

Yours sincerely

Warwick Hough
Senior Manager
General Practice, Legal Services and Workplace Policy Department

22 May 2012

STATE AND TERRITORY RURAL WORKFORCE PROGRAMS & INITIATIVES

AN OVERVIEW

STATE AND TERRITORY RURAL WORKFORCE PROGRAMS & INITIATIVES

AN OVERVIEW

This document provides an overview of programs that aim to improve the recruitment and retention of doctors in rural areas, either directly (e.g. remuneration, relocation grants) or indirectly (e.g. education and training initiatives). The aim is to produce a resource for state/territory AMAs that clearly identified programs that were funded by state and territory governments in each jurisdiction that would then allow the development of a best practice model. This model could be used to influence state/territory government policy on rural recruitment and retention initiatives.

The programs and initiatives have been divided into the main categories of:

1) Remuneration, Grants and Subsidies
2) Leave and Conditions
3) Education and Training
4) Other

There are numerous rural retention and recruitment initiatives delivered by the Rural Workforce Agencies (RWAs) in each state and the Northern Territory. The Commonwealth Government now provides the majority of funding for the RWAs, however State Governments were the original founders of some of the RWAs including WACRRM and NSWRDN.

The Commonwealth provides funding to the RWAs through the Rural and Remote General Practice Program (RRGPP) to deliver a number of program initiatives with the aim of improving the attraction, recruitment and retention of GPs in rural and remote areas.

The RRGPP comprises of:

- The RRGPP Rural Medical Support Forum (RMSF)
- The Rural Medical Family Network (RMFN)
- Relocation, training and remote area grants
- Practice sustainability and crisis grants
- CME/locum grants
- The Rural Locum Relief Program (RLRP)
- Education and training

RWA programs vary across states depending on local need (e.g. education programs are dependent on gap analysis). This overview does not detail all the programs run by RWAs, but rather those that appear to show variances across the states.

RWAs may also receive some funding from their state government. The amount of state government funding received is difficult to ascertain, as is the exact allocation of this money. While some state funding is allocated to specific RWA projects (i.e. Medical Indemnity Subsidy in WA and the Rural Emergency Skills Program in SA), it seems that other state funding is used in conjunction with RRGPP funding.

Rural Workforce Agencies in each State and Northern Territory are:

- General Practice and Primary Health Care Northern Territory (GPPHCNT), Northern Territory
- New South Wales Rural Doctors Network (NSWRDN), New South Wales
- Health Workforce Queensland, Queensland
- Rural Workforce Agency Victoria (RWAV), Victoria
- Rural Doctors Workforce Agency (RDWA), South Australia
- Rural Workforce Support Tasmania, Tasmania
- Western Australian Centre for Rural and Remote Medicine (WACRRM)

Individual rural/regional hospitals have developed their own strategies and offer packages of incentives to recruit and retain doctors and include cars, accommodation, study leave, return airfares, additional leave, assured leave (hospitals arrange a locum), time off in lieu for overtime (instead of loading) as well as family support and spouse employment. Specialist Colleges also have initiatives including locum services, rural training programs and targeted training/practice improvement programs (*Evaluation of Strategies to Support the Rural Specialist Workforce: Summary of Consultancy Commissioned by the Commonwealth*, p 2).

In some states, local governments have also been active in the area of recruitment and retention in an attempt to recruit doctors to live and work in their towns. This has mainly been via a partnership arrangement (ie. with Division of General Practice) to set up the necessary infrastructure and support for services to encourage doctors to take up employment without having to make the considerable investment of setting up a practice. These models have not been included in this overview. Analysis of these types of initiatives have been completed and one such report *'General practice ownership in rural and remote NSW: its impact on recruitment and retention'* can be found at:
http://www.nswrdn.com.au/client_images/6927.pdf

This document should be considered in conjunction with the Australian Medical Association *Rates Guide: Medical Salaries, Sessional Rates, Fee and Conditions: Public Sector.* The rates guide details general rates and conditions across jurisdictions and provides useful comparative information. The purpose of this document is to highlight initiatives specific to rural recruitment and retention.

Please note that the information collated in this overview has mostly sourced from government agency and organisation websites and therefore is not an objective assessment of the program/initiative. The comments section has been provided to incorporate objective assessments where available. The programs and initiatives included in this overview are not necessarily available state or territory wide. They may be specific to particular areas. Where possible this detail has been included.

The matrix on pages 3-5 is provided to assist you locate the information you require and the hyperlinks are provided to help you to easily navigate your way through the document. You can return to the matrix by clicking on the 'back' located at the bottom of each page.

This document is updated at regular intervals. Please forward any information regarding new programs/initiatives or changes to existing ones to the Workplace Policy Department - workplace@ama.com.au

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STATE/TERRITORY	Remuneration,Grants and Subsidies	Leave and Conditions	Education and Training	Other
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QUEENSLAND

1. Remuneration, Grants and Subsidies

New wage classification structure:

Information Source: Mr Rupert Tidmarsh, ASMOFQ, Industrial Report, Industrial Co-ordination Meeting, Sydney – 6and 7 April 2006.

Funding: Queensland Health

The revised wage classification structure provides improved senior registrar rates and in turn will encourage doctors to retrain as specialists, particularly in rural areas. It also provides a career path for advanced skills practice. A credentialing committee will determine a doctor's eligibility for access to the new scale (C2) for rural generalists and other doctors with non-specialist qualifications, and also a new senior level (C3) for this group.

Comments:
The revised wage classification structure provides 2 additional pay points for registrars as well as improved senior registrar rates and in turn will encourage doctors to retrain as specialists, particularly in rural areas. The base salary rate for a staff specialist is raised 3 pay points. Also provides new classifications for staff specialists – Pre-Eminent and Eminent. It also provides a career path for non-specialist senior medical officers with advanced skills practice. A credentialing committee will determine a doctor's eligibility for access to the new scale (C2) for rural generalists and other doctors with non-specialist qualifications as well as progression to the new senior level (C3) for this group.

The new salary structure was an acknowledgement by QH that the solutions to its medical staff recruitment and retention problems are multi factorial and that a simple salary increase on its own would not solve the problem.

Inaccessibility Allowance

Information Source: Mr Rupert Tidmarsh, ASMOFQ, Industrial Report, Industrial Co-ordination Meeting, Sydney – 6and 7 April 2006.

Funding: Queensland Health

The Inaccessibility Allowance recognises the varied needs of medical officers working in such locations and includes assistance for such things as additional personal and family costs associated with everyday living expenses and travel for recreation, schooling of dependents and personal professional development.

The allowance amount varies depending on location (see table below). The allowance is payable as a full monetary incentive or used to fund broadband internet access and/or remote motor vehicle options outlined in agreement with remaining difference paid as an monetary incentive.

Employees must complete the period of service specified for their location as outlined above. All continuous service from 1 September 2005 will be recognised, however pro rata entitlements will not be paid upon cessation of employment in that location. This allowance has now been extended to include Medical Specialists with Rights to Private Practice (MSRPPs) and Medical Officers with Rights to Private Practice (MORPPs) - previously they were ineligible.

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Queensland Health Inaccessibility Category	**Communities (Categorised by criteria of remoteness inaccessibility)**		**Total Inaccessibility Package [1.] (Allowance payable per annum)**
1	Aurukun* Bamaga Doomadgee Gununa (Mornington Island) Hope Vale* Kowanyama*	Lockhart River* Napranum* Palm Island Pormpuraaw* Torres Strait Islands* (other than Thursday Island).	$48,300 ½ paid at completion of each 6 months service without pro rata entitlement
2	Alpha Aramac Augathella Barcaldine Blackall Boulia* Charleville Cherbourg Cunnamulla Dirranbandi Hughenden	Julia Creek Longreach* Normanton Quilpie Richmond Thursday Island Weipa Winton Woorabinda Yarrabah	$41,400 ½ paid at completion of each 6 months service without pro rata entitlement
3	Capella* Cardwell* Clermont Cloncurry Collinsville Cooktown Dysart Injune Middlemount* Mitchell Mount Garnett*	Mount Isa Mungindi Rubyvale* Sapphire* Springsure St George Surat Taroom Tieri* Wandoan*	$34,500 ½ paid at completion of each 6 months service without pro rata entitlement
4	Balgal* Baralaba Blackwater Dimbulah* Eidsvold Giru* Glenden* Herberton	Miles Moranbah Munduberra Ravenshoe* Tara Texas Theodore	$27,600 Paid at completion of each 12 months' service without pro rata entitlement.
5	Agnes Waters* Babinda Biggenden Bowen ChinchillaEmerald Gayndah	Gin Gin Inglewood Jandowae Mareeba Monto MouraRoma	$20,700 paid at completion of each 12 months service without pro rata entitlement
6	Atherton Ayr Biloela Charters Towers Childers Dalby Esk Gatton	Millmerran Mossman Mount Morgan Murgon Proserpine Sarina Stanthorpe Tully	$13,800 paid at completion of each 12 months service without pro rata entitlement

Queensland Health Inaccessibility Category	Communities (Categorised by criteria of remoteness inaccessibility)		Total Inaccessibility Package [1.] (Allowance payable per annum)
	Goondiwindi Ingham Innisfail Kingaroy	Yeppoon	
7	Beaudesert Boonah Gladstone Gympie Kilcoy	Laidley Maleny Oakey Warwick	$6,900 paid at completion of each 12 months service without pro rata entitlement

* No resident position currently

Comments: The Inaccessibility Allowance is focussed on addressing the problem rural and regional hospitals have experienced in recruiting and retaining full time medical officers. This focus drew some criticism as it excluded Medical Superintendents and Medical Officers with Right of Private Practice but that omission was resolved in February 2006 when the Premier announced their inclusion into the Scheme.

Regional Incentive Scheme

Information Source: Mr Rupert Tidmarsh, ASMOFQ, Industrial Report, Industrial Co-ordination Meeting, Sydney – 6and 7 April 2006.

Funding: Queensland Health

The Regional Incentive Scheme comprises of annual funding to regional centres in need of substantially improved recruitment and retention of medical practitioners.

For the strict period 1 September 2005 to 31 August 2008 the scheme will apply to:

- Mackay ($383,211 per full financial year, or pro-rata for a part year);
- Rockhampton ($432,481 per full financial year, or pro-rata for a part year);
- Bundaberg ($284,671 per full financial year, or pro-rata for a part year); and
- Maryborough/Hervey Bay ($399,635 per full financial year, or pro-rata for a part year).

The manner in which the incentive is applied to each regional centre will be in direct response to its most significant needs. These needs will be:

- Determined through a consultative process involving Senior and Resident Medical Officers at each centre and their Unions together with District and Zonal Management; and
- Overseen and monitored by the Medical Interest Based Bargaining Group (MIBB Group).

These benefits must be received personally (unless otherwise approved by the MIBB Group) by the Senior and Resident Medical Staff of each centre in the form of monetary or non-monetary incentives. These must be:

- Based upon evidence or at least operationally self-evident;
- Sensitive to different regional circumstances;
- Applied with greatest utility to the workforce;
- Achieve maximum application of the scheme to the workforce;

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- Efficient;
- Consistent; and
- Supportive of the workforce in the spirit of an incentive scheme.

Comments:

A highly innovative attempt to address the medical officer recruitment and retention problems experienced at particular regional hospitals. Full time medical staff have been granted specific funding where they are to determine how that funding can be best spent to improve the recruitment and retention levels at those hospitals.

Private Practice Allowances – Option A staff specialists

Information Source: Mr Rupert Tidmarsh, ASMOFQ, Industrial Report, Industrial Co-ordination Meeting, Sydney – 6and 7 April 2006.

Funding: Queensland Health

Prior to February 2006, staff specialists who were Option A private practice practitioners received either a 35% or 45% allowance which essentially was metropolitan/non-metropolitan basis. In February 2006, the Premier announced a new arrangement where the allowance is now paid on a broader area basis. The Private Practice allowance is a financial incentive paid to all eligible specialists on the basis that they agree to see private patients in Queensland Health facilities. The allowance is based on a percentage of the base salary and the clinical managers allowance. The percentage increases as the location rurality increases. The difference between Area 1 and Area 4 (see below for categories) varies anywhere from $15668 (bottom scale ED SMO) to $23668 (top scale Spec Director).

Area 1 –	PAH, TPCH, RBWH, QEII, Gold Coast, Sunshine Coast, Redcliffe, Logan, Ipswich, Caboolture Health Service Districts (50%)
Area 2 –	Toowoomba, Cairns, Townsville (55%)
Area 3 –	all areas not included in Areas 1, 2 or 4 (60%)
Area 4 –	Cape York, Mt Isa, and Torres (65%)

Comments:

Though not perfect, the new Private Practice arrangement recognises the difficulties hospitals outside Brisbane, Gold Coast, Sunshine Coast, Cairns, Townsville and Toowoomba have recruiting and retaining staff specialists by providing a monetary incentive..

Medical Manager's allowance

Funding: Queensland Health

The Medical Managers Allowance is an allowance that attempts to provide recognition of the significant and important role of Medical Superintendents have in the management of the hospital. The Allowance is also recognition that to attract quality medical administrators there is a need to financially recognise their significant management abilities.

Comments:

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Medical Indemnity Subsidies

Information Source: http://www.rdaq.com.au/main.asp?NodeID=261

Funding: Queensland Health

Medical Indemnity Subsidies are provided to offset the cost of procedural indemnity cover and remove it as a barrier to rural practice. Queensland Health contributes to the cost of procedural indemnity cover for private rural doctors - up to $4100 negotiated annually.

Comments:

2. Leave and Conditions

Queensland Country Relieving Program

Information Sources: Queensland Health
http://www.health.qld.gov.au/publications/corporate/annual_reports/annualreport2005/docs/sect5.pdf
AMA Submission to 2005 Biennial Review of Provider Number Legislation

Funding: Queensland Health

The Queensland Country Relieving Program is an 'Approved Placement Program' under Section 3GA of the Act. Doctors in their second year after graduation have compulsory rotations into small rural towns to provide locum relief for local doctors needing time-off. This program has been a source of much anxiety for junior doctors who have found themselves thrust into rural practice with little preparation and supervision. The Queensland Country Relieving Program was the only 'Approved Placement Program' that had no accompanying explanation or guidelines at all, unlike the other programs which have guidelines endorsed by the Minister that address supervision, support and working hours.

Comments:
A review of the scheme is progressing to improve the quality of the service for rural doctors and the quality of the experience for relievers. Ensuring the quality of the orientation, supervision and support of relievers is essential to maintain this vital service to rural doctors. The AMA has been pleased that progress has been made and that proper guidelines are nearing completion.

Issue of Medical Board stating that IMGs may be in breach of their registration conditions by participating in rural relieving.

Regional Staff Accommodation Program

Information Source: Queensland Government
http://www.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=47077

Funding: Queensland Health

A $91 million accommodation program to provide 280 extra homes in regional and rural areas – plus improved regional allowances – with the aim of attracting doctors and nurses to work in rural areas.

e.g. Bundaberg – three apartments purchased in July 2006.

Comments:

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3. Education and Training

Queensland Health Rural Scholarship Scheme

Information Source: Queensland Health http://www.health.qld.gov.au/orh/qhrss/default.asp

Funding: Queensland Health

Queensland Health Rural Scholarship Scheme aims to develop rural links of scholarship holders throughout their studies and binds them to work in a rural area upon graduation through a return of service obligation.

Scholarship support consists of:

- a Living allowance of $14,200 per academic year,
- a Tertiary Grant of $5 800,
- an annual travel allowance of $500,
- rural placement kits and newsletters, and
- a mentor program.

A student who accepts the offer of a scholarship completes a contracted service period after graduation (does not include internship). Scholarship holders are required to:

- work in rural communities for a period equal to the period of assistance given following graduation
- complete an annual compulsory two-week rural placement during their studies
- sign a legally binding contract and are liable to repay monies within 14 days if they withdraw from the scheme.

Comments:
Like the Queensland Health Bonded Medical Scholarships (below), it is possible that students might be forced to work in a particular geographic area. The Queensland Health website states that *"All scholarship holders are consulted in the placement process and an attempt is made to introduce an element of choice, however, the Director-General makes the final decision regarding placements."*

Queensland Health Bonded Medical Scholarships

Information Source: Queensland Health media releases and Queensland Health Bonded Medical Scholarships Agreement. Legal Advice prepared by Dr Silvio Demilo, Senior Legal Adviser, AMA.

Funding: Queensland Government

The Queensland Health Bonded Medical Scholarships binds students to work in an 'area of priority service' rural area upon graduation through (return of service obligation). There are 235 Bonded Medical Scholarships at Griffith University being offered over 5 years (commencing 2006).

Queensland Health pays:

- full tuition costs (students do not incur HECS fees) and
- an Educational Support Allowance of $25,000 per annum (taxable) for the 4 years of the MBBS program.

Acceptance of one of these places:

- bonds the students to 6 years service in an 'area of priority service' (does include intern year)
- this can mean a geographical area and/or field of practice
- repayment of the scholarship costs if the agreement is breached.

Comments: *(based on AMA legal advice)*

- The student can be forced to work in any field of medicine and any geographical area.

- No allowance is made for failure. Studies must be completed in minimum time.

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- The student must pass all subjects in each Academic year.
- The student is required to register and work anywhere in Queensland for 6 years.
- The graduate will work where they are told for 6 years, and may be moved at the whim of Queensland Health.
- Uses the word 'may' when seeking the student's agreement in relocating, not 'with' the student's agreement. There are no limits on where or how often a doctor may be required to move.
- The use of the term 'any costs' - leaves the students liable to cover potentially very high costs i.e. the Department is free to employed a team of QC's if it sees fit; the student would be required to pay the costs.

Medical Education Travel and Accommodation Subsidies for GPs

Information Source: http://www.healthworkforce.com.au/Main.asp?NodeID=27668

Funding: Commonwealth through RRGPP

Available to:

- all non-procedural GPs who practice in RRMA 7 to 4 locations who are required to travel more than 100kms to the CPD event
    - GPs residing in RRMA 7-6 locations - a maximum of $400.00 per workshop
    - GPs residing in RRMA 5-4 locations - a maximum of $200.00 per workshop

Not available to:

- locum doctors, GP registrars
- Proceduralist GPs and MSRPPs – as they are eligible for the Strengthening Medicare Initiatives (See: Commonwealth programs: *Training for Rural and Remote Procedural General Practitioners Program*).

Comments:

4. Other

RAPTS project (Recruitment, Assessment, Placement, Training and Support

Information Source: Queensland Health http://www.health.qld.gov.au/medical/support.asp

Funding: Queensland Health

This project the aims to standardise processes and improve support for IMGs. Three work teams have been set up to focus on particular IMG issues.

1. 'Work for us' team – includes coordination of an international recruitment campaign

2. 'Project' team – includes streamlining application/visa processes, developing an orientation manual for IMGs, working with other bodies to work towards a nationally consistent approach to IMG recognition**.**

3. Centre for International Medical Graduates (CIMG) assists IMGs with preparation for AMC exams, promotional activities, including coordination of an international recruitment campaign, assistance to IMGs in preparation for AMC exams.

Comments:

Back

NORTHERN TERRITORY

1. Remuneration, Grants and Subsidies

Attraction Benefit

Information Source: Ms Fiona Stacey, Industrial Officer, AMA NT.

Funding: NT Government

A Rural Medical Officer will be eligible for a package of benefits, developed between the Rural Medical Administrator and the Rural Medical Officer, as an Attraction Benefit.

- Max of $15,000 per annum (including FBT)

Comments:

Retention Payments

Information Source: Ms Fiona Stacey, Industrial Officer, AMA NT.

Funding: NT Government

Retention payments are offered to rural doctors in recognition of working in isolation and the need to retain and develop their medical skills and are paid to Rural Medical Officers who reside and work in Katherine, Tennant Creek, Groote Eylandt, Gove and/or a Remote Community continuously for 12 months.

- $6,146 - payable on the payday on or after their first and second anniversary of employment.
- $12,292 on the anniversary of their third and each subsequent 12-month period of continuous employment.

These payments are separate from all other payments and do not count as salary for any purpose.

Comments:

Relocation Grants

Information Source: http://www.gpphcnt.org.au//www/index.cfm?ItemID=120

Funding: Commonwealth through RRGPP

The Relocation Grant covers:

- actual costs of travel and accommodation in transit for the GP and family
- removal/transport of household goods
- storage for up to a maximum of 24 months may also be paid.

Evidence of obtaining the best price will be needed - this can be achieved by presenting two quotes. The total of the Relocation Grant is subject to negotiation.

Payment will only be made once the starting date of the position has been confirmed and the agreement has been signed. When a GP is recruited from overseas, payment will only be made on costs incurred after arrival in Australia.

Comments:

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Orientation and Training Grants

Information Source: http://www.gpphcnt.org.au//www/index.cfm?ItemID=119

Funding: Commonwealth through RRGPP

The grants are available to all GPs and contract locums relocating to remote areas of the NT or to another remote community within the NT (minimum one year contract). Training covered by the grant is intended to up skill the GP to meet the particular needs of their community.

- capped at $5000 per GP recruitment
    - to cover accommodation, travel, salary subsidy of up to $300 per day and course costs (excluding university fees).

Orientation activities (not exceeding 3 weeks) may include:

- cross cultural awareness training;
- 4WD training;
- an introduction to local and NT health systems;
- specific clinical orientation;
- an introduction to Medicare; and
- cross-cultural awareness training for the GP's partner and family as appropriate.

There appears to be a fairly rigorous application process including a panel assessment and interview.

Comments:

Remote Area Grant

Information Source: General Practice and Primary Health Care Northern Territory (GPPHCNT) http://www.gpphcnt.org.au//www/index.cfm?ItemID=15

Funding: Commonwealth through RRGPP

This grant aims to help establish financial sustainability of GP positions in remote multi-disciplinary teams.

- available to eligible communities and GPs to assist with the recruitment and retention of GPs in very remote and isolated areas
- only to be used for supplementing payment of GP salaries
- approx $40,000

Comments:
Remote Area Grants have been continued in the NT (discontinued in other states) as it is difficult for Aboriginal Health Services to generate the necessary income to offer a competitive salaried position due to longer consultations, chronic disease and travel time. Aboriginal Health Services may also be eligible for a top up grant to allow them to meet the minimum salary requirements to be eligible for the Remote Area Grant.

2. Leave and Conditions

Remote Training Leave

Information Source: Ms Fiona Stacey, Industrial Officer, AMA NT.

Funding: NT Government

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The Remote Training Leave is additional paid leave provided in recognition of working in isolation and the need to retain and develop their medical skills. Available to Rural Medical Officers who reside and work in Katherine, Tennant Creek, Groote Eylandt, Gove and/or a Remote Community.

- on the completion of each 5 years of continuous service, leave is credited - period equivalent to the RMO's ordinary hours of duty during a period of 13 weeks.
- maximum accrual is 26 weeks
- where an RMO proceeds on Remote Training Leave of less than the amount accrued, the RMO will be deemed to have received the full entitlement and shall not be entitled to claim the balance of the leave accrued (this may be varied with discretion of Manager)
- approval of applications is subject to appropriate arrangements being made to provide for service needs and operational requirements (applications made 6 months in adv)
- entitlements are not paid out on resignation.
- annual leave and long service leave may be taken in conjunction with Remote Training Leave.

Comments:

Locum Program

Information Source: General Practice and Primary Health Care Northern Territory (GPPHCNT) http://www.gpphcnt.org.au//www/index.cfm?ItemID=52

Funding: Commonwealth through RRGPP

Assistance through the Locum Program (LP) is available to cover all forms of leave, including recreational, sick and emergency leave and leave to attend CPD activities. Subsidised assistance through the LP is not available to cover positions that are substantively vacant. The priority for the LP is to provide support to incumbent GPs to allow them to take leave. GPPHCNT is responsible for the recruitment, selection and orientation of locum GPs.

Comments:

3. Education and Training

Northern Territory Clinical School (NTCS)

Information Source: Flinders University http://www.ntmed.flinders.edu.au/Quota_Entry/quota_entry.htm

Funding: The Northern Territory Government and Flinders University (S.A.) provide joint funding. Note: this is different to the Rural Clinical School initiative, which is Commonwealth funded.

NTCS is a teaching partnership between Flinders University and Northern Territory clinical service providers. NTCS is based at the Royal Darwin and Alice Springs Hospitals with outreach to diverse general practices and rural or remote communities throughout the Territory.

The NTCS provides students with exposure to rural and remote health and improves access to medical education for local students.

- a quota of 10 places for Northern Territory residents to enter the Graduate Entry Medical Program (GEMP) course with Flinders University.
- NT Quota students complete the first two years of the course in Adelaide and then must return to the Territory for the third and fourth years of their course.
- The NTCS accepts 16 students into its third year course in Darwin each year. The number of places available to non-Territory students is the gap between 16 and the number of quota students.

Comments:

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Rural High School Visits Program

Information Source: General Practice and Primary Health Care Northern Territory (GPPHCNT) http://www.gpphcnt.org.au//www/index.cfm?ItemID=20

Funding: Commonwealth through RRGPP

A small group of medical and allied health students from around Australia are brought together to deliver health career workshops to NT high school students, during a weeklong program. The university students discuss their own experiences as rural students, ways to overcome perceived barriers, and support that they received to move away from home and go to University. The program aims to promote health career opportunities to high school students, to inspire their interest and to address real and perceived barriers to further study such as moving interstate, living independently, and achieving high grades.

Comments:

4. Other

-

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NEW SOUTH WALES

1. Remuneration/Grants/Allowances

Rural Doctors Settlement Package

Sources: NSW Health Policy Directive: http://www.health.nsw.gov.au/policies/pd/2006/PD2006_017.html
Rural Doctors Association (NSW) Inc http://www.rdansw.com.au/about.html
Rural Doctors Association (NSW) Inc. Fees Schedule 2005-2006.

Funding: NSW Health

The Rural Doctors Settlement Package provides increased fee-for-service remuneration (higher MBS rates) to doctors consulting at hospitals listed in the Package. This Package is a result of the 1987 NSW Country Doctors' Dispute providing appropriate fee structure for emergency and after hours work as well as improvements to payment for obstetrics, IV drips etc.

- The package applies to the listed hospitals in all affected Area Health Services (around 60 per cent of all NSW public hospitals).
- These fees are only applicable to Visiting Medical Officer specialists (who have elected to be so remunerated) and general practitioners in hospitals listed in the Settlement Package
- The original Package includes:
    - Increased rates for after-hours attendances
    - Increased emergency attendance fees
    - Increased fees for obstetric services and restoration of IV drip fees.
- All alterations to the original Schedule, including new services, changes to descriptions and base fees are published annually in the RDA Schedule.
- Fees under Package are indexed from 1 August each year according to an agreed formula. Since 1998 the total indexation has been 244.428 per cent.
- In 2002 there was an increase of 10 per cent (in addition to the usual annual indexation).
- Fees not listed in the Schedule can be calculated from the 1987 base rate by multiplying 100% of the 1987 MBS fee by 2.077638 rounded off to nearest ten cents.
- Current MBS and future revisions to the MBS do not apply to GP fee-for-service payments at hospitals listed in the Settlement Package.

Comments:

Rural Doctors Association (NSW): "Rural Doctors Settlement Package sets out the conditions and fees for providing care to emergency and public inpatients. This package has had a major stabilizing influence on rural public hospital services in the state. It is regarded highly by both members and NSW Health, and efforts to ensure its safekeeping are great." (http://www.rdansw.com.au/about.html)
AMA member: The Package has fallen behind lately, as with combined Medicare Plus incentives and the Enhanced Primary Care (EPC) items, it is now possible for rural doctors to gain greater financial rewards from staying behind in their rooms for an hour per day doing EPCs and a few bulk bill visits, rather than endure the uncertainty of the on-call roster.

Regional Incentive Package

Source: Fiona Davies, AMA NSW

VMOs who are working in rural hospitals, which are not covered by the RDA Settlement Package, are now eligible for the Regional Incentive Package. This includes:

- Payment of $10,000 per annum for professional development expenses eg training, seminars, locums, computers, subscriptions etc. VMOs working an onerous roster (less than 1 in 4) will also be entitled to an additional $5,000 per annum professional development payment.
- 10% loading on call backs

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Obstetric and 'Other' Incentive Grants

Information Source: Rural Doctors Association (NSW) Inc. Fees Schedule 2005-2006.

Funding: NSW Health

These grants aim to encourage rural doctors to treat public patients and provide on call services. The grants attempts to compensate for the onerous on call burden solo GP obstetricians face, as the fee-for-service arrangement alone is inadequate. The 'other' refers to GP-Anaesthetists. Grants, favouring those with the most demanding on call, are distributed by each hospital (quarterly)

- Must be a GP with VMO status at a hospital which operates under the RDA Package
- Must be employed for the entire previous quarter as the grants are retrospective
- GP trainees and locums are ineligible
- The amount determined for each hospital is dependent on the number of GP-Anaesthetists and GP-Obstetricians who share the on-call burden when the grant is calculated. The amount received by the hospital is divided evenly amongst eligible doctors. The total amount (2004-2005) for whole of NSW was $2,953,238.

Comments:

Infrastructure grants (2002)

Information source: NSW Health http://www.health.nsw.gov.au/rural/ruralresponse.pdf

Funding: NSW Health

In 2002 NSW Health announced funding for infrastructure grants to assist improve access to educational resources for health practitioners in rural areas. NSW Health provided approximately $1 million in total to the Area Health Services - Far West $110,000; Greater Murray $169,844; Macquarie $170,000; Mid North Coast $170,000; Mid Western $170,000; New England $110,000; Northern Rivers $85,000 and Southern $110,000.

The grants were used to provide library resources, information technology infrastructure including access to CIAP, clinical skills centres/laboratories, refurbishment of study areas, hardware, software and administrative equipment.

Comments:

Employment Entity Grants for Rural General Practitioners (2003)

Information source:
NSW Health http://www.health.nsw.gov.au/news/2003/June/18-06-03gp.htm
NSW Outback Division of General Practice Ltd http://www.outbackdivision.org.au/site/index.cfm

Funding: NSW Health

Employment Entity Grants assist rural doctors establish or expand their practices to help rural towns attract or keep doctors. The Grants were funded by NSW Health in 2003 – a total of $2 million in grants (11 grants). The Grants were intended as 'one-offs' to help support communities where there have been particular difficulties with the GP workforce. Expressions of interest were submitted through rural Area Health Services, NSW Rural Divisions of General Practice, the NSW Rural Doctors Network, the NSW Rural Doctors Association and local government councils.

Example: Hunter Area Health Service received $193, 210 to develop a GP facility at Cessnock Hospital to reduce the need for current and future GPs to invest in practice establishment and running costs.

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Relocation Grants

Information Source: Rural Doctors Network http://www.nswrdn.com.au/client_images/77018.pdf

Funding: Commonwealth through RRGPP (?)

Grants of up to $10,000 are available to eligible GPs relocating to rural communities in need of general practitioner services. The grant includes a $2,000 disruption allowance and the actual costs of furniture removal within Australia to a maximum of $8000. A General Practitioner receiving a relocation grant is required to provide a minimum of two years general practice service to that rural community.
Available to:
- GPs moving to locations GP ARIA 3+ that are 100 kilometres or more from the coast.
- Permanent Resident Overseas Doctors (PROTDs) moving for the first time to locations RRMA 3 - 7.

Comments:

Area of Need Supervisor Grants

Information Source: Rural Doctors Network http://www.nswrdn.com.au/client_images/77021.pdf

Funding: Commonwealth through RRGPP (?)

This grant recognises that eligible PROTDs may initially require a higher level of supervision and support when they commence work in their new position and aims to offset the loss of income by the supervising general practitioner that may occur during this 'settling in' period.

A grant of $1,000 is available to the NSW Medical Board-nominated Supervisor of a conditionally registered Permanent Resident Overseas-Trained Doctor (PROTD) employed through the direct assistance of the NSW Rural Doctors Network (RDN).

Comments:
Some concerns raised about 1) the level of supervision of candidates 2) there needs to be tighter control over supervision 3) focus needs to be on up-skilling to meet Australian standards not accessing a shortcut to independent practice.

Medical Indemnity for Treating of Private Patients in Public Hospitals

Information Source: Mr Sim Mead, Australian Salaried Medical Officers' Federation
http://www.rdansw.com.au/news/Indemnity_Fix_To_Save_Rural_Hosp_Millions.pdf#search=%22rda%20nsw%20indemnity%20fix%22

Funding: NSW Government

From July 1, 2003 the Government allowed level 2-5 Salaried Medical Officers (SMOs) in the eight rural health services the option of having Treasury Managed Fund (TMF) cover for treating private patients in NSW public hospitals at no cost. SMOs are required to sign a Contract of Liability Coverage that requires the doctors to ensure that there is no out of pocket expense for the patient, that they participate in the simplified billing of the health service and in incident reporting/risk management.

In August 2006 it was announced that the TMF would provide indemnity cover for all patients in small NSW rural hospitals. Previously it was uneconomic for many rural GPs and Specialists to take out the indemnity cover necessary to treat private patients in rural hospitals. This meant that the patients were treated as public patients and the cost was shifted back to the hospital.

Comments:

Back

2. Leave and Conditions

Rural Clinician Locum Program

Information source: NSW Health http://www.health.nsw.gov.au/rural/ruralresponse.pdf
http://www.health.nsw.gov.au/rural/taskforce/pdf/spotlightjan04.pdf

Funding: NSW Health

The NSW Government committed to providing $3 million per annum (from 2002) to establish the Rural Clinical Locum Program. The funding was provided to establish the Program to provide locum services, allowing clinicians to undertake professional education leave and other leave. An officer was recruited to tailor locum strategies for medical staff, specialist nurses and allied health workers.

In 2003/04, $300,000 was distributed to each rural Area Health Service and $150,000 to Hunter and Illawarra. Area Health Services were asked to develop proposals for innovative ways to achieve improved locum coverage. A review of past Program expenditure was undertaken to examine the most effective way of using funds under the Program.

Comments:

Rural Doctors Network (RDN) Locum Service

Information Source: NSW Rural Doctors Network http://www.nswrdn.com.au/site/index.cfm?display=34503

Funding: Commonwealth through RRGPP (?)

The NSW Rural Doctors Network (RDN) Locum Service assists rural General Practitioners to take recreational leave and attend Continuing Professional Development activities. The Locum Service provides RDN-employed locum GPs (both casual and full-time) to GPs working in rural and remote areas of NSW. Where possible, priority is given to one to three doctor towns. GP practices enter into a contract with the NSW RDN and are required to pay for the cost of any locum employed by the NSW RDN.

Comments:

Scheduling and Administering Locum Doctors in Rural NSW

Information Source: NSW Rural Doctors Network http://www.nswrdn.com.au/client_images/51739.pdf

Funding: Commonwealth Government, Department of Communications, Information Technology and the Arts (DCITA)

The aim is to streamline the process (using a on-line service) of locum service recruitment, initial orientation, placement (locum booking system) and day-to-day operation of RDN's Locum Service. The website will be developed to display requests for locums from rural GP practices and then match these requests with confirmed bookings from the RDN Locum Service, independent GP Locums and commercial locum agencies.

Comments:
This project was due for completion in February 2006.

Staff accommodation (2002)

Information source: NSW Health http://www.health.nsw.gov.au/rural/ruralresponse.pdf

Funding: NSW Health

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In 2002 NSW Health allocated $4 million to the Rural Accommodation Capital Program to purchase, build or renovate staff accommodation as it was recognised that good accommodation was a significant issue in attracting both permanent and locum staff to rural areas. Staff accommodation was provided or upgraded at 21 sites (Lightning Ridge, Bourke, Corowa, Dubbo, Wellington, Narromine, Gulargambone, Kempsey, Dorrigo, Macksville, Bathurst, Tullamore, Trundle, Emmaville, Glen Innes, Lismore, Moruya, Batemans Bay, Bega, Delegate and Braidwood).

Comments:

3. Education and Training

CPD Vouchers

Information Source: Rural Doctors Network
http://www.nswrdn.com.au/client_images/77020.pdf

Funding: Commonwealth through RRGPP (?)

A Continuing Professional Development (CPD) voucher for $500 (towards travel and accommodation costs) plus full registration fee is available to GPs and their partner/spouse to attend a NSW RDN rural refresher conference. The voucher is available to GPs who are new to rural general practice and apply within six months of their relocation to a rural community. A General Practitioner receiving a CPD grant is required to provide a minimum of one-year general practice service to that rural community.

Comments:

Training Grants - Advanced Paediatric Life Support (APLS) or Emergency Life Support (ELS)

Information Source: http://www.nswrdn.com.au/site/index.cfm?display=1423

Funding: Commonwealth through RRGPP (?)

Training Grants are available to eligible rural GPs who undertake training in Advanced Paediatric Life Support (APLS) or Emergency Life Support (ELS) through an RDN-recognised and accredited trainer.

Available to GPs:
- whose principal practice is in a GP ARIA 3+ location
- who is a Conditionally Registered PROTD providing general practice services in areas categorised as RRMA 3 -7.

$2000 is available for approved PROTDs as well as GPs whose principal practice is located 100 kilometres of more from the NSW coast; or $1000 for GPs whose principal practice is located less than 100 kilometres from the coast.

A General Practitioner receiving a training grant is required to provide a minimum of one years general practice service to their rural community.

Comments:

Medical Student Scholarships (various)

Info source: http://www.ruralstudents.unsw.edu.au/costs3a.html

http://www.nswrdn.com.au/site/index.cfm?display=1490

Funding: various

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- **Bush Bursary Scheme and Country Women's Association Scholarships** ($3000 for 3 weeks). Approximately 11 Bush Bursaries and one CWA scholarship are offered to selected medical students in NSW medical schools who are interested in experiencing rural life and the multidisciplinary nature of rural health practice. Administered by Rural Doctors Network.
- **Cotton Industry Medical Scholarship** ($5,000 per year for 3 years) Available to 4th year MBBS studetn at UNSW and have an interest in and a demonstrated commitment to rural practice and lifestyle. It is desirable that the applicant be from a rural background. Via Rural Health Unit at UNSW or Rural Doctors Network.
- **Dr Senthil Vasan Rural Medical Memorial Scholarship** ($1,000 pa for 1 year) Available to 4th year MBBS student at UNSW. It is desirable that the student's family home is located in a rural area. The Scholarship recipient will be required to spend two weeks of the year in Casino experiencing the activities of a rural medical practice and hospital.
- **Rural Elective Scholarship** ($1,000 pa) Two scholarships offered to final year students undertaking their elective term in a rural general practice in NSW. Via School of Community Medicine, University of New South Wales.
- **Rural Resident Medical Officer Cadetship** (up to $15,000 pa) Funded by the NSW Health Department, 12 cadetships are offered annually for students in the last two years of their medical course. The cadetships are valued at up to $15,000 pa depending on other income received. Recipients are required to work in a rural NSW Base Hospital for a period of two years following graduation. In 2006, the RDN supported 23 student cadets, and a further 22 cadets undertook rural service as Post Graduate Year doctors at regional base hospitals. RDN supports cadets by visits, ensuring they have access to the educational resources they need, and by holding a 'Cadet Weekend.'
- **Rural Undergraduate Placement Program** (accommodation, local flights, up to 80% of cost of interstate flights). Based in the Northern Territory. It is designed to provide educational experience for students interested in Rural and Aboriginal Health. Via Rural Health Unit, Q Health.

General Practice Procedural Training Program

Information source: North Coast GP Training Ltd.
http://www.ncgpt.org.au/uploads/gpptp_general_information_brochure_lu_jan_07.pdf

Funding: NSW Health

Approximately 30 General Practice Procedural Training Posts are provided in the specialty areas of Anaesthetics; Emergency Medicine; Surgery; Obstetrics; and Mental Health. The aim of these posts is to provide the training in procedural disciplines and mental health needed for rural General Practice.

These posts are being targeted towards:
1. Registrars enrolled in vocational General Practice training
2. Rural GPs who wish to acquire new skills or improve existing skills
3. Metropolitan based General Practitioners proposing to take up rural practice
4. Conditionally registered overseas trained doctors currently working in Area of Need

NSW Health fully funds the base salary of the trainees (salary based on award and determined by Area Health Service with NSW Health). The Area Health Service (AHS) employs the trainee and is reimbursed for costs by NSW Health. Posts are supernumery with the allocated funds being quarantined for the GP training post. Additional funding of up to $5,000 per annum per 1.0 FTE trainee is available to support the education, training & supervision of trainees.

Comments:

Rural and regional anaesthetics – training positions

Information source: NSW Health http://www.health.nsw.gov.au/rural/ruralresponse.pdf

Funding: NSW Health

Back

In 2002, the NSW Government announced $3.6 million over three years would be used to increase the number of rural and regional anaesthetic vocational training positions.

The strategy was developed in consultation with the Australian and New Zealand College of Anaesthetics and included:

i) increasing rural participation in training networks
ii) three paediatric anaesthetic training places for rural trainees, seven additional anaesthetic rural vocational training posts, two Anaesthetic Provisional Fellow posts that incorporated paediatric and rural rotations, increasing the number of outer metropolitan vocational training positions

Comments:

Specialty Training Networks

Information source: NSW Institute of Medical Education and Training (IMET)
http://www.mtec.nsw.gov.au/page/specialty_training.html
NSW Health http://www.health.nsw.gov.au/aboutus/pdf/nsw_labor_medical_workforce_plan.pdf

Funding: NSW Health

Training Networks have been established with the aim of training more specialists in rural and regional hospitals.

Basic Physician Training Networks - Since January 2005, basic physician training has occurred in a system of eight networks. Effective July 6 2006, a ninth network has been created. Each network has developed its own training program, including exam preparation and professional development. It is reported that the networks have led to the appointment of 297 trainee physicians, 28 more than 2004.

NSW Government provided $2.8 million in funds for the supervision of Basic Physician Trainees. The funding pays for employment of eight Directors of Physician Training and eight MEOs; training support at each hospital; and a weekly video-conferenced education program. The NSW Government provides $2,000 scholarships for any trainee who completes two full terms a year in a rural hospital.

Basic Surgical Training Networks - In 2006, the basic surgical training network commenced operation. There are six networks. In 2006 the network arrangements apply to only BST1s (PGY3 and above) and BST2s who are aspiring to general surgery and will be expanded to full network recruitment in 2007.

Psychiatry Training Networks – for commencement in 2006 with five networks to replace the previous eight.

General principles:

- Networks group together metropolitan, outer metropolitan, regional and rural hospitals.
- Trainees complete rotations to all hospitals within each network.
- Rural and regional trainee vacancies are filled first, so those hospitals that have difficulty recruiting trainees will be allocated trainees first and the larger city hospitals last.
- Trainees in the network system have access to a statewide video-conferenced lecture series.

Anaesthesia, Radiology, and Emergency Medicine are all currently under review by IMET. IMET has made recommendations regarding the delivery of Cardiology, Paediatrics, General Surgery (SST), Otolaryngology Head and Neck Surgery (SST) training which are currently being considered by the Health Minister.

Comments:

While it has been recognised that the network arrangements are beneficial in ensuring trainee positions are filled in rural areas, there were initial concerns about the quality of training in rural/regional area, including the lack of training infrastructure and the limited access to senior consultants. Also the impact of relocation on the trainee's family has been of concern.

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Advanced Specialist Training Posts (2005-2006)

Information source: NSW Health
http://www.health.nsw.gov.au/aboutus/pdf/nsw_labor_medical_workforce_plan.pdf

Funding: NSW Health

NSW Health has provided funding for additional training posts. These training posts have been funded in 11 locations:

o Ophthalmology and Paediatrics at Broken Hill;
o Orthopaedics at Orange;
o Paediatrics at Bathurst;
o Paediatrics and General Medicine at Lismore;
o Basic Emergency Medicine and General Surgery at Dubbo;
o Pathology at Tamworth;
o General Medicine at Coffs Harbour and Armidale;
o Psychiatry in the Illawarra Area and the Central Coast Area; and
o Radiology at the John Hunter Hospital.

Comments:

General Practice Scholarships Program

Information Source: NSW Rural Doctors Network http://www.nswrdn.com.au/client_images/51739.pdf

Funding: NSW Health

General Practice Scholarships Program funds ten GPs to complete the Alternative Pathway Program to achieve Fellowship of the RACGP. This is funded by NSW Department of Health and was established by Rural Doctors Network in 2002.

As reported by the NSW Rural Doctors Network, at the close of 2004-2005 there were four doctors still enrolled in the scheme. Of the original ten scholarship recipients, four withdrew early in the program and two have subsequently been awarded Fellowship of the Royal Australian College of General Practitioners after sitting the Fellowship examination via the Practice Eligible Route. A further three candidates enrolled to complete the examinations before the end of 2005; one applied for an extension.

Comments:

Rural Health Training Units

Information Source: NSW Health http://www.health.nsw.gov.au/rural/ruralresponse.pdf

Funding: NSW Health

There are eight Rural Health Training Units (RHTUs) across NSW. RHTUs aim to promote recruitment and retention of health professionals in rural and remote NSW including coordination, advocacy and promotion of education and training. In 2002 the total funding was $1.7 million.

Comments:

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Rural Observership Program for PROTDs (2002)

Information Source: NSW Government http://www.eeo.nsw.gov.au/diversity/managing.htm

NSW Rural Doctors Network http://www.nswrdn.com.au/client_images/6193.pdf

Funding: NSW Health

The Rural Observership Program for permanent resident overseas trained doctors (PROTDs) was announced in 2002 to assist in the orientation of overseas trained medical practitioners to the Australian clinical environment. NSW Health provided funding to the NSW Rural Doctors Network to coordinate clinical observership positions for fourteen PROTDs.

Fourteen PROTDs participated in an intensive theory course that was administered by the South Western Sydney Area Health Service Overseas Doctor Training Program, then spent nine weeks observing in a rural hospital and one week observing a rural general practice. Observers were placed in Port Macquarie, Coffs Harbour, Wagga Wagga, Taree, Broken Hill, Nowra and Goulburn (two in each location). Reported results: Six of the 14 participants found employment in hospital or general practice Area of Need positions.

Comments:

4. Other

Partnerships in recruitment (example Nov 2004)

Information Source: NSW Health http://www.health.nsw.gov.au/news/2004/index.html#

Funding: NSW Government, Royal Flying Doctors Service and Sydney University Rural Clinical School.

NSW State Government, Royal Flying Doctors Service and Sydney University Rural Clinical School made co-contributions of $180,000 each (a total of $540,000) to fund the employment of three doctors to work in the Dubbo Base Hospital Emergency Department and be available for RFDS emergency retrievals. These doctors also train medical students from the Rural Clinical Training School in the hospital Emergency Department and on RFDS medical retrieval flights.

Comments:

Back

VICTORIA

1. Remuneration, Grants and Subsidies

Rural Enhancement Package (REP)

Source: Andrew Lewis, AMA VIC

State Government funding is provided to 86 eligible hospitals in an attempt to compensate General Practitioners for after hours public A&E and inpatient on-call work. This is an agreement between the Department of Human Services and AMA VIC.

Each eligible site receives a standard payment of:

- $25,000 per annum regardless of the number of GPs that provide services to the hospital.

Comments: Once the $25,000 has been distributed by the hospital to their GPs, the payment received by an individual GP can calculate to be as low as $4 per hour.

Rural Dermatology Registrar Travel Scheme (2001-2003)

Information Source: Victorian Government
http://www.dpc.vic.gov.au/domino/Web_Notes/MediaRelArc02.nsf/3a3fd087b7891fcc4a25688e00141c97/3788d31633af4c1f4a256a2b0077ec72!OpenDocument&Click

Australasian College of Dermatology http://www.pc.gov.au/study/healthworkforce/subs/sub104.pdf

Funding: Victorian Government

The 2001 Victorian Government budget allocated $17,000 to the Victorian Faculty of the Australasian College of Dermatologists to cover costs for dermatologists to visit rural centres on a rotational basis to provide a monthly consulting service

Extract from ACD submission to the PC:
'Specialists traveling from urban centres to provide outreach services face a duplication of costs as they must both maintain their primary practice and service their outreach destination. Current funding models provide, when available, subsidies for outreach surgeries but do not compensate for primary practice costs incurred in the absence of fee income while the practitioner is away. Policies limiting fees risk making these services uneconomical compared with the primary practice (particularly when down-time for travel and social and personal dislocation are also considered).'

Comments:

Rural General Practitioners Medical Indemnity Insurance Program

Information Source: http://www.health.vic.gov.au/medindemnity/a.htm
http://www.vmia.vic.gov.au/healthcare/documents/FINALNewApplication-RuralGPRenewal2006-2007.pdf

Funding: Victorian Government

Since 1 July 1996, the Victorian Government has provided procedural rural GPs who have admitting rights to designated Victorian Rural Public Hospitals a reduced premium insurance option. This is underwritten by Victorian Managed Insurance Agency (VMIA) and provided on behalf on the Victorian Department of Human Services. This scheme provides cover for care to public and private patients of designated hospitals (excluding private hospitals or private day procedure centres). It also includes cover for all work conducted in private rooms including home visits and emergency work.

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COVER OPTIONS	ANNUAL GROSS EARNINGS FROM SERVICES		
	$75,000 or More	*Less than $75,000*	*Less than $40,000*
1(a) Including Obstetrics, anaesthetic & procedural work.	$7,138.00	$4,829.00	$2,227.00
1(b) Excluding Obstetrics; includes anaesthetic & procedural work.	$5,012.00	$3,545.00	$2,152.00
REGISTRAR – Includes obstetrics, anaesthetic & procedural work.	$1,000.00	$800.00	$500.00

Comments:

2. Leave and Conditions

Rural Locum Subsidy

Information Source: http://www.rwav.com.au/assistanceprogram/locum/locumsubsidy.asp

Funding: Commonwealth Government through RRGPP

The Rural Workforce Agency of Victoria (RWAV) offers a subsidy to rural GP's to assist cover the cost of locum services. The following GPs are eligible to apply for a Locum Subsidy:

- Solo GPs practicing in RRMA categories 5 (Other Rural Area), 6 (Remote Centre) and 7 (Other Remote Area)
- GPs in a group practice in RRMA categories 6 or 7

Rates: Solo practice - RRMA categories 6 or 7: $1,375.00 per 10 sessions
Solo practice - RRMA category 5: $1,100.00 per 10 sessions
Group practice - RRMA categories 6 or 7: $825.00 per 10 sessions

The subsidy is allocated on a sessional basis. GPs may negotiate their own rate of payment with the locum. Locum subsidies will not exceed the remuneration paid to the locum. Locum subsidies are available to subsidise the locum payment only and subsidies are not available to subsidise travel and accommodation for the locum. A GP taking leave from their own practice to operate as a locum for a GP in another town or practice will not be given a subsidy for their principal practice.

Comments:

3. Education and Training

Extended Skills for GPs (Training subsidies and grants)

Source: Victorian Government http://www.health.vic.gov.au/workforce/medical.htm

Funding: Victorian Government

Subsidies are available to health services in areas of workforce shortage to offset the cost of education, training and supervision (posts in other areas with a demonstrable workforce shortage may also be funded - assessed on an individual basis, according to merit and funding availability). This program is administered through RTPs.

Available to GP Registrars in Special Skills posts or Advanced Rural Skills posts. GPs who wish to acquire or maintain a specialized skill, and OTDs working under the Victorian Overseas Trained Doctor Rural Recruitment Scheme (VORRS) or RLRP are also eligible.

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- $12,000 for 12 month full-time posts (or pro-rata) are available to health services that comply with the eligibility criteria.
- $6000 (max) for the development of new posts - where a curriculum for the type of post proposed does not currently exist in Australia.
- $3,000 (max) - where a new post is being developed but an existing curriculum will be adopted.

Health services are expected to make flexible training options available to encourage practicing GPs to participate in the program. This may include making posts available on a part-time basis or facilitating job-share arrangements.

Comments:

Advanced GP Procedural Training Posts

Source: Victorian Government http://www.health.vic.gov.au/workforce/medical.htm

Funding: Victorian Government

Funding is available to subsidise health services for the cost of GP training posts, specifically for the provision of appropriate education, training and supervision provided within a post. Funding is available for posts in an identified area of workforce shortage (RRMA 3-7).

- $100,000 per 12-months is available for posts in anaesthetics, surgery, obstetrics and emergency medicine.
- As part of the $100,000 allocated to each post, a maximum of $10,000 is available for mentoring, accommodation and travel.

RTPs will manage the funding and be responsible for ensuring that the posts meet the specified standards. Funding was originally designed to be for new supernumerary advanced procedural skill posts, however, it has been agreed that 2007 applications may be either to continue to support posts initiated in 2006 or to establish new posts.

Comments:

Basic Physician Training Pilot Consortia Model

Source: http://www.health.vic.gov.au/workforce/train-consort.htm

Funding: Victorian Department of Human Services

The Basic Physician Training Pilot Consortia Model aims to more equitably distribute the medical workforce across the State so that there is adequate supply in areas of workforce shortage. The rationale is that the distribution of basic physicians and basic surgical trainees is one of the greatest areas of concern for outer metro and rural hospitals – they provide a big component of service delivery. Some principle teaching hospitals rotate their trainees to other sites 25% of the time, while others only 10%.

Physician training was targeted first as RACP had experience with this type of model through the network developments in NSW. A State-wide Plan details the priority localities and specialisations and liaison with RACP to enable priority posts to be filled ahead of others. Consortia of Victorian hospitals have been developed with the aim of ensuring equity of distribution of trainees and an adequate range of training experiences (there are five consortia – each consist of at least one level three teaching hospital, trainees are rotated around level 2 and/or level 1 teaching hospitals and/or secondment hospitals).

It was recommended that the model be piloted for two years for BPT, commencing in 2006. Depending on the outcome of the pilot, it may be expanded to other basic and pre-vocational training programs.

Comments:

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Continuing Professional Development for GPs Subsidy Program

Information Source:
RWAV http://www.rwav.com.au/assistanceprogram/professional_development/grants.asp
Victorian Government http://www.dhs.vic.gov.au/pdpd/pdfs/profdevruralgp.pdf

Funding: Victorian Government, Department of Health Services (DHS)

Subsidies are available for procedural training and some non-procedural training as defined by DHS. Administered by RWAV.

- Up to $3,000.00 per financial year for CPD activities

Available to:
- GPs working in rural general practice (RRMA 3 to 7)
- Rural stream registrars undertaking GP terms (RRMA 3 to 7) are also eligible to claim subsidies for CPD activities not funded through their vocational training.

The subsidy covers:
- up to 70 per cent of the registration and course fees for procedural. 50 per cent for non-procedural;
- car travel reimbursement of 49 cents per km;
- cheapest economy airfare via the most direct route;
- accommodation $140 per night;
- childcare up to $60 per day for a maximum of 5 days per year; and
- distance education will be considered as appropriate (i.e to cover education software).

The DHS priority list can be viewed at:
http://www.rwav.com.au/assistanceprogram/professional_development/pdfs/Priority%20Areas%20DHS%20Subsidy%20Program.pdf

Comments:

(Obtained from DHS website) Prior to 2003, the contribution of DHS was set at a maximum of $1993.33 per three years per discipline for each practitioner. A contribution also had to be made by the Hospital. A review of the program in 2002 found that poor uptake by GPs was largely attributed to cumbersome administrative arrangements and the restrictions placed on the topics available for subsidisation. As a result of the review, DHS expanded their list of eligible training topics. The program no longer requires a contribution from the hospital, and the maximum subsidy by DHS has increased to $3,000 per GP per financial year.

Rural Anaesthesia Crisis Resource Management (RACRM) and Rural Emergency Crisis Resource Management (RECRM)

Information source: Victorian Government http://www.health.vic.gov.au/workforce/medical.htm

Funding: Victorian Government, Department Human Services.

These courses provide training for rural doctors and nurses in anaesthesia and emergency medicine. The Victorian Department Human Services has allocated funding of $300,000 over 2 years to support training in Anaesthesia and Emergency Medicine. Courses are delivered by the Southern Health Simulation Centre. It is reported that approximately 200 rural doctors and nurses have been trained to date.

Comments:

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Country Education Program

Information Source: VMPF http://www.vmpf.org.au/country_education.htm

Funding: Victorian Government, Department Human Services.

VMPF is provides medical education to rural practitioners and allied health professionals through the Country Education Program in Victoria. The program is available to General Practitioners, Specialists, HMO's, Nurses and allied health professionals and covers a wide range of topics (determined by a needs analysis in each region). Many meetings are held in the local hospitals during lunch or dinner. Meetings are accredited for CPD/CME points with relevant organisations. VMPF reports that they aims to attract speakers of the highest calibre who are leaders in their field in practice. VMPF offers speakers an honorarium as well as reimbursement of travel expenses and accommodation (if required).

Comments:

4. Other

Rural Workforce Strategy

Information Source: Victorian Government http://www.health.vic.gov.au/workforce/rural.htm

Funding: Victorian Government

The Victorian Government committed $1.5 million per year commencing 2003-04 ($6 million over four years) to attract and retain health professionals in rural and regional Victoria. There are 32 pilot programs funded through this 'Strategy' all at various stages of completion. Projects funded are varied and include:

- education for rural GP Anaesthetists
- support and professional development for Directors of Medical Services across rural health services
- enhancing capacity for rural undergraduate placements
- retention initiatives for OTD psychiatrists
- basic physician training consortia model

Comments:

Victorian Overseas Trained Doctor (OTD) Rural Recruitment Scheme

Information Source: Victorian Government http://www.health.vic.gov.au/workforce/medical.htm

Funding: Victorian Government

The Victorian Overseas Trained Doctor (OTD) Rural Recruitment Scheme aims to attract, assess, place and support overseas trained general practitioners in rural and regional Victoria. This program is run by the Rural Workforce Agency of Victoria on behalf of the Victorian Government. It is claimed that so far 78 doctors have been matched to Scheme locations in RRMA 4 - 7 areas.

Comments:

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SOUTH AUSTRALIA

1. Remuneration, Grants and Subsidies

Rural Health Enhancement Package (RHEP)

Information Source: AMA (SA)

Funding: Government of South Australian

This is an arrangement between the individual doctor and the Chief Executive Officer of a particular country hospital. The RHEP is available to eligible doctors who live and practice in country areas.

The elements of the RHEP are as follows:

- Availability allowance of $ (* see below) for the provision of after-hours and emergency medical treatment to communities where there is not a public hospital, OR
- An on-call allowance of $100 per 24 hour period (max of $36,500) for provision of after hours services at the hospital, and
- Loadings on the standard fees** set out in the South Australian Schedule of Medical Fees for:
    - 20% for anaesthetic services provided by resident anaesthetists;
    - 20% for procedures carried out by resident proceduralists, and
    - 50% loading on the obstetric services as defined by the CMBS item numbers 16500 to 16636 inclusive.

* An on-call period commencing on:

a. Monday to Thursday inclusive is paid at $150.00 per 24 hour period
b. Friday to Sunday inclusive is paid at $200.00 per 24 hour period
c. the day that a public holiday is celebrated is paid at $250.00 per 24 period in lieu of the above rates

** The base payment for all item numbers under the South Australian medical schedule of fees is CMBS plus 7.1%. RHEP is then added on top of this.

Comments:

Rural Doctors' Issues Reference Group

Information Source: http://www.countryhealthsa.sa.gov.au/rural-doctors-group.asp
http://www.countryhealthsa.sa.gov.au/documents/strategies-update.pdf

Funding: Government of South Australian

Rural Doctors' Issues Reference Group undertook a substantial consultation processes in early 2005. This process raised many issues and concerns which have been translated into proposals and strategies, described in "Recognising the past, rewriting the future – a new partnership with rural doctors" - see below.

The reference group is now proceeding to develop an implementation plan. AMA (SA) is represented on this reference group.

Comments:

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Recognising the Past - Rewriting the Future, A new partnership with rural doctors

Information Source: http://www.countryhealthsa.sa.gov.au/documents/Rural_health.pdf

Funding: Department of Health, Government of South Australia

This report outlines the first steps in a program that aims to address the issues facing country South Australia. A commitment of $27.2 million has been made over 4 years (2005-2009). Developed in consultation with AMA (SA), Rural Doctors Workforce Agency, and South Australian Divisions of General Practice, through the Rural Doctors' Issues Reference Group.

The main initiatives outlined in the document include:

- Enhance involvement of doctors in decision-making/policy development
    - Five country doctors (range specialties) to form a chief consultants group as a link to local level doctors and creation of a country medical governance committee (includes chief consultants group)
- Provide rotating specialists from metro to country areas, regional planning to improve service delivery
- Develop links with metro hospitals to deliver education programs to country doctors
- Recognise length of service for resident doctors
- Develop a yearly planner for proceduralists/specialists to allow forward planning (social/clinical activity)
- Possibility of purchasing services from local GP clinics to avoid duplication (i.e. diabetes care, mental health)
- Night telephone call payment*
- Improved locum services*
- CME improvements*
- Four intern positions at regional hospital, specialist registrar positions (increased from four to eight)
- Solo practices
    - After hours work – investigate opportunities for solo-practices to collaborate to cover after-hours
    - Provide business, financial, legal advice to solo practitioners
    - Improve support/orientation to OTDs entering solo practice
- Increase child care allowances for rural doctors, including rural registrars*
- Upskilling program for those returning to rural practice after parental leave
- Spouse grants up to $3000 for education/retraining*
- Relocation grants up to $10,000*
- Employment support for spouses
- Range of OTD specific initiatives – including:
    - $1500 per week for orientation
    - arranging accommodation for orientation
    - paying orienting practices $1000 per week
    - intro to Australian language, HIC, mentor program
- Examine options for co-location of general practices and hospitals.

* more detail provided in following sections

Comments:

Relocation Support Subsidies *

Information Source: http://www.ruraldoc.com.au/grants/relocation.asp

Funding: ?? Commonwealth Government through RRGPP or State through *Recognising the Past – Rewriting the Future.*

The Relocation Support Subsidy reimburses the relocation costs for GPs who take up practice for at least two

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years in rural and remote communities in South Australia that have difficulties in attracting GPs. Subsidies are paid on a cost incurred basis. Eligibility conditions apply.

- $10,000 for an individual GP (full time/part time)
- $15,000 where both partners (e.g. husband and wife) will be practicing in the community
- $3,000 finance and legal support grant to access professional accounting, legal and practice management advice associated with relocating to a new community.

Comments:

Grants for Medical Indemnity

Information Source: Government of South Australia
http://www.countryhealthsa.sa.gov.au/documents/medical-indemnity-letter11-6-04.pdf

Funding: Department of Human Services, Government of S.A

Grants are provided for the reimbursement of the costs of medical indemnity insurance for rural GPs in recognition on the cost of providing SA public health services.

- $1000 per annum

A grant is also available to GP proceduralists and obstetricians to bring their indemnity cover back in line with non-proceduralists, and also for resident specialists – 30% rebate on their premium.

Comments:

The Spouse Employment Assistance Grant *

Information Source: Rural Doctors Workforce Agency http://www.ruraldoc.com.au/grants/spouse.asp

Funding: ?? Commonwealth Government through RRGPP or State through *Recognising the Past – Rewriting the Future.*

To provide spouses/partners of resident GPs and specialists in rural and remote South Australia with the opportunity to undertake training or up skilling for the purposes of gaining employment.

- $3000 (max)

Comments:

Rural Female GP Pre-School Childcare Grant *

Information Source: Rural Doctors Workforce Agency http://www.ruraldoc.com.au/grants/rfgppccg.asp

Funding: ?? Commonwealth Government through RRGPP or State through *Recognising the Past – Rewriting the Future.*

The Rural Female GP Pre-School Childcare Grant is designed to provide a financial incentive to female GPs in rural and remote SA. This grant aims to assist rural female GPs to remain in the medical workforce during their children's pre-school years.

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- Payment is be determined by the number of hours worked per week (excluding after hours & on-call) and the number of pre-school children.

Comments:

On-call allowance *

Information Source: http://www.countryhealthsa.sa.gov.au/documents/Rural_health.pdf

Funding: Department of Health, Government of South Australia

On-call allowance (applies to all doctors eligible to the Rural Enhancement Package)

- Standard rates will increase to $150 for weekdays; $200 per day for weekends; $250 for public holidays; indexed CPI annually.
- All doctors required to be on call will be paid the allowance.

Comments:

2. Leave and Conditions

Improved locum subsidies *

Information Source: http://www.countryhealthsa.sa.gov.au/documents/Rural_health.pdf

Funding: Department of Health, Government of South Australia

- Solo GPs in single practice towns will be granted a seven-week locum allocation
- Weekend locums for solo GPs increased to six weekends per year (up from four) and will now be free of charge (previously $500)
- All other solo GPs and two-doctor practices receive four weeks fully subsidised
- Raise subsidy for practices that arrange their own locum to $2500 (up from $1600)

Comments:

3. Education and Training

General Practice Training Grants

Information Source: Rural Doctors Workforce Agency http://www.ruraldoc.com.au/Education/

Funding: Both Commonwealth & State.

The financial assistance provided by the Rural Doctors Workforce Agency for GPs undertaking the training consists of :

- $10,000 (max)
  - including a salary reimbursement of up to $1500 per week and allowances for travel, accommodation, childcare costs.

A table detailing the grant amounts can be viewed at:
http://www.ruraldoc.com.au/Education/docs/CMEEligiblity05-06.pdf

Comments:

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Continuing Medical Education *

Information Source: http://www.countryhealthsa.sa.gov.au/documents/Rural_health.pdf
Funding: Department of Health, Government of South Australia

- CME allowances increased by 50 percent. Can also be cashed out.
- Priority education areas identified by the medical governance committee
- Annual scholarships for GPs to develop procedural skills (see *General Practice Training Grants*)
- Emergency Medicine Update Course (below)
- Video-conferencing provided to all solo GP practices in single-doctor towns

Comments:

The Emergency Medicine Update Course

Information Source: Rural Doctors Workforce Agency http://www.ruraldoc.com.au/Education/emupdate.asp

Funding: Department of Human Services, Government of S.A

To equip general practitioners who wish to undertake locum work in rural SA with the skills and knowledge to deal with an emergency.

Comments:

South Australian Government-Supported Bonded Places

Information Source: Adelaide University http://www.adelaide.edu.au/news/news9821.html
Flinders University http://som.flinders.edu.au/HTML/COURSES/GEMP/admission_ovr.htm

Funding: Government of South Australia

- 10 new medical places each year (5 at Flinders Uni, 5 at Adelaide Uni) from 2007
- SA Government pays the full cost of tuition
- the student must have lived in South Australia for at least 10 years
- Students sign a contract with the SA Department of Health to work in South Australia in an area of need in either the greater metropolitan area or a rural area after graduation. The placement of graduates at the completion of the course will be negotiated between Department and the graduate apparently with maximum choice given to graduates within designated areas of need. If a student fails a year, the Government support is suspended until they pass a repeat year. During the repeat year, the student would pay full tuition fees.

Comments:
AMA Legal Counsel is currently reviewing the contract.

Medical Student Scholarships

Information Source: RDWA http://www.ruraldoc.com.au/grants/flinders.asp

Funding: ? Commonwealth or State

Available to undergraduate and postgraduate medical students who have an interest in Aboriginal and Torres Strait Islander health.

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For students:

- $1000 which will assist in funding travel, meals and accommodation
    - $300 has been allocated for incidental expenses

For the GP, medical specialists, health service or community:

- a grant may be available in recognition of service partners contribution to assist students in the placement.

Comments:

AMA (SA) Medical Student Elective Grants

Information Source: Carol, AMA (SA)

Funding: AMA (SA)

To encourage student to undertake rural electives by assisting to cover associated costs.

- a grant of $500 is available

Five grants are available each year. Students who are undertaking an elective in a rural/remote area in Australia or overseas are eligible to apply. Students apply in writing to AMA (SA). If required, the relevant university is involved in the selection process.

Comments:

4. Other

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WESTERN AUSTRALIA

1. Remuneration, Grants and Subsidies

WA Country Health Service

Information Source: Mr Steve Gregory, Human Resource Consultant, WA Country Health Service.

Funding: WA State Government

Regional Health Services across WA offer a variety of incentives to recruit and retain staff. The following information was obtained from regional HR Managers. These incentives may vary, dependent on the location, position and difficulty in attracting someone to the position.

These include:

- Relocation expenses and assistance
- Assistance with removals and travel to new location
- Initial assistance with accommodation
- Support with visa and registration process, where required
- Subsidised rental housing, in some cases payment is approx 20% of the market rate
- Eligible to purchase own housing and receive access to subsidised mortgage assistance of up $175 per week for 5 years.
- Home loan subsidy scheme
- Access to a pool vehicle
- Government vehicle scheme
- Salary Packaging arrangements
- Air conditioning reimbursements (October to April incl) for North West locations
- Gratuity payments after 3 years of continuous service to the equivalent of 12 weeks salary, and for each continuous year payment of 4 weeks salary *(as per Agreement, see below).*
- 1 week of 'North West' leave *(as per Agreement, see below).*
- Annual leave travel concession for the employee, spouse/partner and dependant children of return economy air ticket to Perth or other destination (cost still equivalent to Perth) or reimbursement of mileage of the vehicle if driving. The mileage is gauged on the shortest route to Perth from the home town. Travel time also provided when driving.
- Some positions are recognised as training positions for accreditation with College's
- On going training and support for college exams.

Classification Structure

Information Source: Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004, Schedule 5 – North of the 26 degrees South Latitude.

Funding: WA State Government

Applies to practitioners employed in locations north of the 26 degrees South latitude.

- Health Service Medical Practitioner can progress up to level 20 (as opposed to level 15 in metro areas).
- Use of DMO classification from level 15 – 22
- Senior Medical Practitioner can progress up to level 23 (as opposed to level 17 in metro areas)
- Consultants start at level 17 (instead of level 15 in metro areas).

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Gratuity Payments

Information Source: Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004, Schedule 5 – North of the 26 degrees South Latitude.

Funding: WA State Government

This payment applies to practitioners employed in locations north of the 26 degrees South latitude. Payment will be based on the practitioners' substantive base salary at the time of the payment being made.

- After the first three years of continuous service a practitioner shall be paid a lump sum equivalent to 12 weeks salary.
- After each subsequent year of service a practitioner shall be paid a lump sum equivalent to four weeks salary.

A period of service for which a gratuity payment has already been paid shall not be counted towards service for the purposes of this clause. Other gratuity arrangements may be agreed in writing between the Employer and the Association.

Relocation expenses

Information Source: Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004, Schedule 5 – North of the 26 degrees South Latitude.

Funding: WA State Government

Applies to practitioners employed in locations north of the 26 degrees South latitude.

Covers:

- cost of air travel
- freight of personal belongings

Covers practitioner and their immediate family members (if contract is less than 6 months, relocation costs of family members are not covered).

If practitioner is recruited interstate or overseas, the appointee must enter a bond to remain for a fixed period in service in a hospital north of 26 degrees South latitude (not exceeding two years in the case of interstate recruitment and three years in the case of overseas recruitment).

Remote area employment incentive grants

Information Source: WACRRM http://www.wacrrm.uwa.edu.au/etc/subpage.cfm/SID/2/PID/71/SPID/127

Available to assist six remote communities to help attract and retain general practitioner services. GPs practising in those communities may be eligible for grants

- ranges from $20,000 to $40,000 per annum.

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Relocation Grants

Information Source: WACRRM http://www.wacrrm.uwa.edu.au/etc/page.cfm/PID/71/SID/2

To cover the costs of moving GPs from urban to rural and remote areas of Western Australia.

- $20,000 (max)

Medical Indemnity Support

Information Source: AMA (WA) http://www.amawa.com.au/professional/indemnity/index.asp:and WACRRM http://www.wacrrm.uwa.edu.au/etc/page.cfm/SID/4/PID/35

Funding: WA State Government

The AMA (WA) has and lobbied for government funded indemnity for rural doctors. As a result of this lobbying a contract of indemnity is provided for patient claims against country doctors. Specifically, salaried Senior Medical Officers, salaried Consultants and Medical Officers with rights of Private practice employed under both arrangement A and B, and salaried sessional doctors are each indemnified for services provided in country public hospitals to both both private and public patients.

As an adjunct to this, WACRRM administers a WA Department of Health funded reimbursement to:

- resident rural GPs for part of the increased costs of their private obstetrics and procedural indemnity premiums (subsidy freezes the premiums at the 1995/1996 level)
- Specialist obstetricians are also covered (subsidy freezes payments at the 2000 level)

In order to get the WACRRM subsidy, eligible doctors need to have applied for and received the Commonwealth Government's Medical Indemnity subsidy as the WACRRM one is a top-up.

2. Leave and Conditions

Additional annual leave

Information Source: Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004, Schedule 5 – North of the 26 degrees South Latitude.

Funding: WA State Government

Applies to practitioners employed in locations north of the 26 degrees South latitude.

- one week of additional annual leave for each completed year of continuous service.

Comments:

Conference/Study Leave and Funding

Information Source: Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004, Schedule 5 – North of the 26 degrees South Latitude.

Funding: WA State Government

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- Conference leave is a maximum of 2 weeks paid leave during each year of continuous service (as per CHS Agreement, same at metro Agreement).
- Overseas Study Leave is up to a maximum of 5 weeks paid leave after five years of continuous service for overseas training, education and study (as per CHS Agreement, same at metro Agreement).
- Funding for Conference and Overseas Study Leave – equivalent to 10% of Level 17 (pro rata) – *Note: Metro Agreement is 10% of Level 15.*

Under the agreement professional Develeopment and Professional Expense Allowances are payable for al rural doctors.

Rural Locum Service

Information Source: AMA (WA) and WACRRM www.mediventure.com.au

Funding:

The AMA (WA) and WACRRM have a joint recruitment and placement program known as Mediventure. Support provided includes: sponsorship, orientation, accommodation, travel, bonus payments and education.

Comments:

The AMA (WA) recruits overseas trained doctors and local doctors to provide locum relief to rural practice doctors as well as providing long term support to General Practices and hospitals throughout rural Western Australia.

On call and time off in lieu

Information Source: Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004.

Funding: WA State Government

Applies to practitioners employed in locations north of the 26 degrees South latitude.

- Hospital based medical practitioners who are required to participate in an on call roster shall receive an annual allowance (paid on a fortnightly basis) of 30% of the full time equivalent of the medical practitioner's annual base salary.

- Non Hospital based practitioners who are required to be contactable on a regular basis after hours shall receive an annual allowance (paid on a fortnightly basis) of 6% of the full time equivalent of the medical practitioner's annual base salary.

- In lieu of payment for overtime and/or in recognition of the nature and circumstances under which work is performed, a practitioner may by written agreement with the Employer be allowed time off proportional to the payment to which the practitioner is entitled, to be taken at a time convenient to the Employer and Practitioner.

Motor vehicle

Information Source: Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004.

Funding: WA State Government

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Practitioners employed in locations north of the 26 degrees South latitude are provided with a fully maintained motor vehicle for official use. The vehicle is also available for limited private use in (accordance with the conditions laid down by the Director General of Health).

In all other locations covered by the Department of Health Medical Practitioners (Country Health Services) AMA Industrial Agreement 2004 a fully maintained motor vehicle is provided to senior practitioners for official use. The vehicle may also be used for private use – the practitioner must pay 100% of the standard charges for private use set by the Department of Health or Government Agency responsible for establishing the charges.

The hospital may make reasonable use of the motor vehicle during the practitioner's rostered hours.

Motor vehicle allowances increase with rurality:

	CENTS / KM		
	ENGINE DISPLACEMENT		
AREA	1600 cc and under	1600 cc to 2600 cc	Over 2600 cc
Metropolitan Area	48.9	58.9	69.0
South West Land Division	51.0	61.1	71.5
North of 23.5 South Latitude	56.4	67.3	78.7
Rest of State	52.4	62.9	73.7

3. Education and Training

Education Support Grants

Information Source: http://www.wacrrm.uwa.edu.au/etc/page.cfm/PID/71/SID/2

Grants cover the following costs:

- Payment of course fee, travel to attend course (e.g. fuel or airfare); and accommodation. Paid on the basis of costs incurred only.

Available for:

- Obstetrics, Anaesthetics, GP General Surgery (including endoscopy) and Emergency Medicine
- proposed course must meet an area of medical need and be of demonstrable educational value
- Training courses should be of at least 2 weeks duration (with the exception of EMST, APLS and ALSO)
- Course are to be undertaken in WA where possible.
- Salaried doctors may be eligible but will be dealt with on a case by case basis.
- A GP must agree to remain in rural WA for at least two years from the time of training

Where the grant is approved, the GP will be required to provide a level of continuing medical education to her/his peers (where appropriate)

Comments:

Administered by the State Assessment and Support Panel

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4. Other

Colleague of First Contact

Funding:
AMA (WA)

Information Source AMA (WA)

Funding: AMA (WA)

The AMA (WA) established an independent and confidential counselling service for medical called the Collegue of First Contact as a free Doctors' Health Advisory Service in 1988. The Colleague of First Contact now stands alone, with additional funding and resources provided by the AMA (WA). The service is manned by a group of experienced GPs with a psychiatrist 'resource person'. It is a service available to all doctors and medical students with any issues including stress problems, depression, suicidal thoughts, grief and substance abuse.

The Care and Co program

Information Source: WACRRM http://www.wacrrm.uwa.edu.au/etc/page.cfm/PID/29/SID/4

Funding:
Department of Health Western Australia

- Rural Medical Family Support Scheme
- Commonwealth Department of Health and Ageing (RHSET)
- Commonwealth Department of Health and Ageing (RRGPPF)

This program offers rural doctors and their families a GP consultation and a counselling service at no cost.

AMA (WA) Membership

Information Source: AMA (WA) http://www.amawa.com.au/membership/index.asp

AMA (WA) has developed specific support for overseas trained doctors, recruited and sponsored through the AMA (WA). In particular, tailored services include financial and health insurance packages which can be accessed by overseas trained doctors even if they have not secured Australian permanent residency.

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TASMANIA

1. Remuneration, Grants and Subsidies

Relocation Assistance

Information Source: Rural Workforce Support Tasmania http://www.gpatlas.org.au/subsector.php?id=108492

Funding: Commonwealth through RRGPP.

Financial assistance is available to vocationally registered General Practitioners who commit to a specific rural area for a minimum of 2 years.

- one-off grant of $10,000

Available to full-time GPs for the reimbursement of relocation expenses. Part-time GPs receive a pro-rata amount.

Comments:

Financial assistance for GP orientation

Information Source: Rural Workforce Support Tasmania http://www.gpatlas.org.au/subsector.php?id=108566

Funding: Commonwealth through RRGPP.

Tailored orientation programs for doctors relocating to Tasmania. Financial assistance is available to cover loss of income during the orientation program.

- $2,000 (max)

Comments:

2. Leave and Conditions

-

3. Education and Training

Bush Doctors Manual

Information Source: Rural Workforce Support Tasmania http://www.gpatlas.org.au/subsector.php?id=108420

Funding: Commonwealth through RRGPP.

This manual has been developed by Tasmanian rural general practitioners to provide GPs with other doctors' approaches to the management of certain clinical problems with an emphasis on how to cope in a situation where the GP may need to manage a patient without immediate initial help from specialist colleagues. The Manual is provided free to all rural GPs in Tasmania.

Comments:

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Spouse Education and Training Bursary

Information Source: Rural Workforce Support Tasmania http://www.gpatlas.org.au/subsector.php?id=108498

Funding: Commonwealth through the PGPPP (Rural Medical Family Network)

The Tasmanian RMFN offers bursaries to assist rural medical spouses or partners wishing to undertake further education or training. The Bursary is intended to enhance the quality of life and/or career opportunities and to aid in the retention of the medical family in the rural/remote setting.

- $1,000 (max)

Bursaries can be used to cover costs associated with the fees, purchase of textbooks and course materials for the training.

Comments:

Education Subsidies for GPs

Information Source: Rural Workforce Support Tasmania http://www.gpatlas.org.au/subsector.php?id=108490

Funding: Commonwealth through the PGPPP

Assistance is provided to rural GPs to attend the Emergency Life Support (ELS), Advanced Paediatric Life Support (APLS) and Emergency Management of Severe Trauma (EMST) courses.

The subsidy is paid retrospectively and covers

- 75% of the course cost

A CPD subsidy is also be available to assist with travel and accommodation to attend CPD events.

- $275 (two CPD subsidies per GP per year)

Comments:

4. Other

Recruitment practices

Information Source: Mr Rodney Cameron-Tucker, Executive Officer, AMA Tasmania.

The Tasmania Government is currently using locum firms to hire doctors for rural areas and is avoiding the responsibility for recruitment.

There are some Council owned GP practices that seem to work reasonably well as a recruitment tool - doctors do not have the hassle of setting up a practice or the financial burden.

Future Agreements

Information Source: Mr Rodney Cameron-Tucker, Executive Officer, AMA Tasmania.

Negotiations for the new employment agreement will commence in the next 6-12 months. AMA Tasmania will look at 'scaling up' the incentives for rural practice and may use the South Australian initiatives as a model.

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AUSTRALIAN CAPITAL TERRITORY

Eligibility for More Doctors for Outer Metropolitan Areas Scheme

Most of Canberra is now also eligible for the Commonwealth grants under the More Doctors for Outer Metropolitan Areas Scheme (see Appendix A)

ACT Net Health

Information Source: http://www.actdgp.asn.au/downloads/ACT%20Health%20Net.doc

The ACT Health Library has recently developed an on-line information source for GPs and clinicians working in the ACT Public Health. Provides 24-hour access to health information to support evidence-based practice. Resources include: MIMS, Australian Medcine Handbook, Micromedex, E-books (Harrison, Medical Officer Handbook), E-Journals (MJA, Lancet), PubMed, Cochrane Library, and local resources (Health Insite, Australian Doctors).

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APPENDIX A

Commonwealth-funded Programs

Rural and Remote General Practice Program (RRGPP)

Originally called the 'Rural Incentives Program,' the RRGPP started in the early 1990's. Rural Workforce Agencies (RWAs) in each State and the Northern Territory are funded to deliver the RRGPP and provide a range of activities and support services. Activities/services include assisting communities to recruit GPs, finding appropriate placements for doctors who want to relocate to rural Australia, assisting with the costs of relocation, supporting families with fitting into a new communities and helping doctors to access the necessary infrastructure, support and training. Rural Workforce Agencies aim to be the central point of contact for GPs and other health professionals interested in practising in rural and remote areas.

The program comprises:

- the RRGPP Rural Medical Support Forum;
- the Rural Medical Family Network;
- relocation, training and remote area grants;
- Practice sustainability and crisis grants;
- CME/locum grants;
- education and training;
- professional development
- the Rural Retention Program; and
- the Rural Locum Relief Program[#].

[#] *Enables Permanent Resident Overseas Trained Doctors and Australian Graduates who have completed their internship since 1st November 1996 to access Medicare provider numbers to work in general practice in rural areas.*

Rural Workforce Agencies in each state and Northern Territory are:

- General Practice and Primary Health Care Northern Territory (GPPHCNT), Northern Territory
- New South Wales Rural Doctors Network (NSWRDN), New South Wales
- Health Workforce Queensland, Queensland
- Rural Workforce Agency Victoria (RWAV), Victoria
- Rural Doctors Workforce Agency (RDWA), South Australia
- Rural Workforce Support Tasmania, Tasmania
- Western Australian Centre for Rural and Remote Medicine (WACRRM)

Funding is also provided to the Australian Rural and Remote Workforce Agencies Group (ARRWAG), the national coordinating body that provides support for Rural Workforce Agencies (RWAs). ARRWAG has a useful guide on the supports available to current and future GPs in rural and remote Australia available at its website.

Workforce Support for Rural General Practitioners (WSRGP)

The WSRGP program includes support for training, professional development and locum coverage. Funding for the Program is managed by eligible rural Divisions of General Practice. The Australian Government committed $11.2 million over four years from 2004-05. $10.1 million was made available from 2000-01 to 2003-04.

In 2003-04, the key activities that were funded as part of the WSRGP Program were:

- Family support activities (such as orientation of family to area, house and school assistance, social activities, assisting spouses with employment, family camps);

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- General Practitioner support;
- Practice support; and
- Education activities.

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-workforce

More Doctors for Outer Metropolitan Areas Grants

Under one part of the program *More Doctors for Outer Metropolitan Areas*, doctors can apply for a Relocation Incentive Grant of up to $40 000 to establish a new practice, or up to $30 000 to join an existing practice in an area of doctor shortage. This has increased from $30,000 and $20,0000 respectively.

When the program was announced in January 2003, the government was hoping to get 150 doctors to relocate to areas of greatest need over a four-year period. The Government reported that this target was almost reached within the first year. The Government decided to extend the grant scheme. The Department of Health and Ageing reports that it has been working closely with the Divisions of General Practice to enhance the program and make it more flexible and responsive to areas of high need. In addition, the program is also being extended to cover more areas in all state capitals, including some inner suburbs that have a shortage of doctors.

PIP Payment for Rural and Remote Procedural GPs

The PIP payments are set up to acknowledge that GPs in rural and remote areas are required to deliver a range of services such as obstetrics, surgery and anaesthetics and aims to compensate for the limitations of fee-for-service arrangements. Under fee-for-service arrangements, practices that provide numerous consultations receive higher rewards. PIP payments aim to reward aspects of general practice that contribute to quality care.

For a practice to be eligible for the PIP payment it must be located within the target area – Rural, Remote and Metropolitan Area classification (RRMA) 3-7, and have at least one GP that provides one or more of the procedural services described in the definition of a procedural GP. All practices whose main practice location is situated outside capital cities and other major metropolitan areas are paid a rural loading. This varies from 15% to 50% depending on RRMA category (see following).

From November 2006, GPs providing obstetric services who deliver more than 20 babies per year will be eligible for a Procedural Payment of $17,000 per year (previously $10,000).
http://www.medicareaustralia.gov.au/PROVIDERS/incentives_allowances/pip/new_incentives/rural_remote_proc_gp.htm

Rurality

All practices whose main practice location is situated outside capital cities and other major metropolitan areas are paid a rural loading (percentage loading), determined by the RRMA classification. A practice's rural payment is calculated by multiplying the practice's incentive payments by a percentage loading.

RRMA number and category	Rural loading
1. Capital city	0%
2. Other metropolitan centre	0%
3. Large rural centre	15%
4. Small rural centre	20%
5. Other rural area	40%
6. Remote centre	25%
7. Other remote area	50%

http://www.medicareaustralia.gov.au/providers/incentives_allowances/pip/calculating_pip_payments/rurality.htm

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Rural Retention Program

The Rural Retention Program provides financial support to long-serving general practitioners in rural and remote communities that experience significant difficulties in retaining general practitioners.

The major component of the program is the payment of an annual grant (Central Payments System). A Central Payments System administered by Medicare Australia which assesses eligibility based on Medicare Australia's data on doctors' services and locations.

A Flexible Payments System jointly administered by the Australian Government Department of Health and Ageing, Medicare Australia, and the State and Northern Territory-based Rural Workforce Agencies assists long-serving GPs who do not receive an equitable level of payments under the Central Payments System because their services and locations are not adequately taken into account (i.e. where particular services are provided outside Medicare).

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-ruralgp-rurret-index.htm

Comments:

The AMA called on the Commonwealth Government to extend this Program to the specialist workforce and to restore the value of the payments (to accommodate increased living costs and costs of medical practice) and adopt indexation arrangements for future years.

This payment is taxed. Doctors lose 48 cents in the dollar!!! Government gets half the money back. [Feedback from AMAWA member via Mike Prendergast, AMAWA]

Specialist Obstetrician Locum Scheme

In July 2006 the Commonwealth Government recently announced that $500,000 would be provided for a pilot project that will provide locum support for rural specialist obstetricians. RANZCOG, RDAA and ARRWAG are working in conjunction on this pilot. The pilot will run over 15 months and will provide subsidised locum support for 20 rural obstetricians.

The pilot was a recommendation of a scoping study completed by RDAA (in conjunction with RANZCOG and NSW RDN) to investigate the establishment of a subsidised national locum scheme. It recommended that the pilot provide fully subsidised locum support for 14 days per annum for 20 rural specialist obstetricians and investigate the options for a national rural Specialist Obstetrician Locum Scheme (SOLS). It found that a Specialist Obstetrician Locum Scheme (SOLS) would have a positive impact on the rural specialist obstetric workforce by:

- facilitating access to affordable locum services
- relieving administrative and financial difficulties faced by regional and rural hospitals needing quality locums
- utilising the services of experienced obstetricians nearing retirement who would be supported to continue their workforce participation and urban obstetricians who gain the opportunity to experience the challenges and satisfaction of rural practice

Medical Specialist Outreach Assistance Program (MSOAP)

MSOAP aims to encourage more medical specialists to visit rural areas by providing specialists with funding to cover some of the costs associated with delivering outreach. These include travel, accommodation and consulting room hire costs. It also makes payments to visiting specialists who provide up-skilling and/or professional support to local general practitioners, specialists and, in some cases, other health professionals.

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The aims of the MSOAP program are:

- To increase specialist services in areas of identified need;
- To facilitate visiting specialist and local health professional relationships and communication about patient care; and
- To increase and maintain the skills of regional, rural and remote general practitioners and specialists.

Fundholders vary in each state and territory – including Department of Health, RDWA, WACRRM, RWA, Divisions of GP.

http://www.health.gov.au/internet/wcms/publishing.nsf/content/ruralhealth-services-msoap
http://www.wacrrm.uwa.edu.au/etc/page.cfm/PID/32/SID/4

Comments: The AMA has called on the Commonwealth Government to increase the MSOAP funding by 25 per cent in the 2007-2008 Budget. This is because despite extra funding provided in the 2004-2005 Federal Budget, funding has already been exhausted through until 2008.

Rural Medical Infrastructure Fund

The Rural Medical Infrastructure Fund (The Fund) is a three year initiative providing funding to small rural councils to help establish 'walk-in walk-out' community medical facilities, making it easier to recruit or retain general practitioners. The Fund recognises that in some rural areas, the cost of establishing and maintaining suitable a practice impacts on its' viability and is a deterrent for doctors to establish private practices in rural areas. Also, an increasingly mobile workforce means doctors are reluctant to make such a significant and long-term investments.

Some local councils have established community medical clinics that doctors can use for a reasonable charge, but many small councils do not have the resources. The Fund can contribute up to $400,000 (was $200,000 prior to Aug 2006) to the cost of purchasing and fitting-out facilities.

Community-owned clinics established under the Fund offer advantages to doctors seeking short-to-medium term work in rural practice. They can focus on providing clinical services without having to also manage a practice. The local community gains access to a doctor and have the security of knowing that the facilities, staff and medical records will not be affected if one practitioner leaves and another arrives.

http://www.regionalpartnerships.gov.au/rmif.aspx

Comments: Some difficulty has been found in making clinic ownership viable long term. Can be quite an onerous commitment for local government. Also, as GPs 'walk in and walk out' patients do not sense that they receive any continuity of care. Patients may seek care at another town. Patient base of the practice declines and so too does the financial viability. (Julie Barry, AMA (SA) conversation with medical practice staff in rural SA).

The RMIF has not been as successful as hoped, with a significant underspend. However with the increase in the cap to $400,000 may get things moving.

Districts of Workforce Shortage (DWS) and Areas of Need (AON)

There is a strong link between the 'Districts of Workforce Shortage' determined by the Australian Government and the 'Area of Need' or 'Unmet Area of Need' administered by the State and Territory Governments.

The Australian Government defines a District of Workforce Shortage as a geographic area in which the general population need for health care is not met. Population needs for health care will be unmet if a district has significantly less access to medical professional services of the type provided by applicants than the national average.

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The Australian Government controls the distribution of overseas trained doctors through the Medicare Provider Number Legislation. Under section 19AB of the Health Insurance Act 1973, the Government restricts the number of doctors with Medicare Provider Numbers in areas where there is no workforce shortage. Exemptions to Section 19AB can be granted to overseas trained doctors, who are currently not eligible to access Medicare and who agree to work in locations that have been identified as Districts of Workforce Shortage. Working in a determined District of Workforce Shortage allows the doctor to bill Medicare for services they provide.

http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-workforce-otdt-index.htm

Area of Need Program

An Area of Need (AON) is any position/location in which there is a lack of specific medical practitioners or where there are medical positions that remain unfilled even after recruitment efforts have taken place over a period of time. Area of Need applies to both public and private sector positions and most overseas trained doctors are required to work in an Area of Need when they first come to Australia.

Unlike the Districts of Workforce Shortage, which are determined by the Australian Government, Areas of Need are determined by the State and Territory Governments and methods of defining them vary.
http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/work-AON

Rural Clinical Schools Program

In February 2001, the Commonwealth Government committed $117.6 million over 4 years to establish Rural Clinical Schools (RCS) attached to university medical faculties. Although the focus is on medical training, the Rural Clinical Schools create a network that also supports health professionals in the area. There are now 11 Rural Clinical Schools, including the recently announced RCS attached to the ANU.

Rural Transition Program – GP training

As of January 2007, GP Registrars who are in the rural training pathway are able to complete up to six months of their training in a regional centre (RRMA 3) designated as a District of Workforce Shortage. Prior to this, they were required to complete all their training in RRMA 4 – 7 locations. It is anticipated that this will encourage more medical graduates to rural training.

Australian Rural Health Education Network (ARHEN)

The role of ARHEN is to link and support the University Department of Rural Health (UDRH) staff across the country mainly via staff networks. There are 11 UDRHs across Australia – focus on undergraduate, postgraduate and continuing education of health professionals in rural health, also conduct rural health and indigenous health research.

Rural Undergraduate Steering Committee (RUSC)

The Rural Undergraduate Steering Committee (RUSC) Program was developed as part of the Rural Incentives Program in an attempt to increase the number of medical graduates choosing a career in rural and remote practice. The Program is based on the premise that selection of students for medical school from rural locations, increased exposure to rural medicine during the undergraduate course and enhanced support for students and rural educators would lead to more doctors choosing a career in rural medicine.

- At least 25 percent of students enrolled in medical schools are of rural origin (currently RRMA 3-7, with at least five years rural residence (consecutive or cumulative) from commencement of primary school) and
- a minimum of 15 percent are from more isolated communities (RRMA 4-7).

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The selection process is undertaken by staff with a rural background and understanding of rural issues. This target acknowledges geographic and demographic differences between states/territories and that some medical schools may far exceed this target while others may have difficulty achieving this goal.

- A minimum of 8 weeks residential rural placement for every student.

This is to be undertaken throughout the curriculum to maximise training opportunities and breadth of experience, and commence early in the course. A substantial part is in rural general practice and the remainder in rural hospital or community service, with a minimum of 50 percent community experience overall and a minimum of 50 percent community experience in the early placement.
http://som.flinders.edu.au/FUSA/GP-Evidence/rural/frame/RUSC%20program%20guidelines%202002-5.pdf

Rural Australian Medical Undergraduate Scholarships (RAMUS)

Each year 500 undergraduate students with a rural background and limited financial means are provided with a scholarship of $10,000 per annum to help support them to undertake medical training. The scheme encourages a rural medical focus through a rural GP mentoring program for scholars, and scholars participating in university rural health clubs.

http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-budget2004-hbudget-hfact4.htm

Comments: Scholarship payments mean that students receive substantially less Youth Allowance (around 50% less). Students from rural areas often have high accommodation, set up and living expenses as they are required to live away from home to study. These costs may deplete the scholarship completely, and then, as the Youth Allowance is reduced, the student has insufficient funds to live on for the remainder of the year. *Comment made by parent of medical student from rural area attending UNSW.*

John Flynn Scholarship Scheme (JFSS)

$3000 for 4 years, total $12,000, subject to satisfactory progress.

These scholarships have been established to encourage selected medical students to elect to undertake rural or remote clinical placements during vacation periods. The scholarship period is to be for four consecutive years at the same attachment. Students in first, second or third year Medicine are eligible to apply.

Each year there are 150 scholarships awarded with approximately six hundred students in the scheme.
The JFSS is administered by ACRRM.

http://www.ruralstudents.unsw.edu.au/costs3a.html

Medical Rural Bonded Scholarships (MRBS)

Scholars receive $20,000 (indexed annually) each year for the course of their undergraduate medical degree. In return, on completion of their Fellowship (specialist qualification) they commit to working in a rural area for six years. There are 400 students currently in the scheme.

http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-budget2004-hbudget-hfact4.htm

Bonded Medical Places (BMP)

The Federal Government funds 500 bonded medical school places. Students occupying these positions are required to sign a contract to work for six years in a “District of Workforce Shortage”.

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Comments: The AMA opposes unfunded bonding of medical school places. If the Government is intent on more bonded places, then they should satisfy a number of criteria.

- They should be incentive based and entry to medical school should not be conditional upon accepting a bonded position;
- Conditions imposed on participants must be fair and equitable;
- Return of service obligations should not exceed the length of the medical degree;
- All periods of service in workforce shortage areas following entry into vocational training should count towards the return of service obligation.

AMARRG motion:

The AMA Rural Reference Group endorses existing AMA policies that oppose the unfunded bonding of medical schools places as international evidence demonstrates that such policies are ineffective in delivering sustainable medical workforce increases in areas of workforce shortage. The AMARRG strongly believes that participation in schemes that include a return of service obligation should be incentive based.

The AMARRG considers that conditions imposed on participants must be fair and equitable, and the return of service obligation should not exceed the length of the medical degree. All periods of service in workforce shortage areas following graduation from medical school should count towards the return of service obligation.

More information can be found on the federal AMA website:
http://www.ama.com.au/web.nsf/doc/WEEN-5SE5G7

Puggy Hunter Memorial Scholarships

Health Minister Tony Abbott said indigenous students interested in working in the health industry can apply for one of 75 Puggy Hunter Memorial Scholarships commencing in 2007. The scholarships are worth $15,000 a year for each year of study to complete degrees in medicine, nursing, allied health and Aboriginal and Torres Strait health worker courses and health management. The scholarships began in 2002 and are named after Dr Arnold 'Puggy' Hunter in recognition of his commitment and dedication to improving the health of Indigenous Australians.

Prevocational General Practice Placement Program (PGPPP)

The Prevocational General Practice Placements Program expands upon the success of its predecessor program the Rural and Remote Area Placement Program (RRAPP). The PGPPP represents an opportunity for postgraduate year (PGY2-3) doctors to gain exposure to outer metropolitan, rural and remote practice.

The program is nationally administered by Australian College of Rural and Remote Medicine (ACRRM) for rural and remote sites and the Royal Australian College of General Practice (RACGP) for outer metropolitan sites.

PGPPP aims to provide well supervised general practice placements for junior doctors in outer metropolitan, regional, rural and remote areas. PGPP also aims to encourage junior doctors to take up general medicine as a career choice in a rural area through positive and confident experiences.

It is reported that this program provides up to 280 general practice placements per year for junior doctors (equates to 70 full-time doctors). The Australian Government, Department of Health and Ageing, provides the funding.

http://www.rcs.utas.edu.au/PDF/PGPPP%20web%20info.pdf

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The HECS Reimbursement Scheme

This scheme aims to promote careers in rural medicine and increase the number of doctors in rural and regional areas in the longer term. Participants, who undertake training or provide medical services in designated rural and remote areas of Australia, will have one fifth of their HECS medical fees reimbursed for each year of service.

Source: AMWAC Report 'The General Practice Workforce In Australia - Supply and Requirements to 2013.'

General Practice Registrars Rural Incentive Payments Scheme (RRIPS)

The Registrars Rural Incentive Payments Scheme (RRIPS) provides financial incentives for general practice registrars who undertake the majority of their general practice training in Rural, Remote and Metropolitan Areas (RRMA) 4-7 locations. Registrars can receive payments of up to $60,000 over three years of general practice training.

To be eligible for RRIPS, registrars must be formally registered in the Rural Pathway of the Australian General Practice Training Program. Registrars will qualify by completing a period of service in one or more eligible rural and remote locations. However, exceptions may apply for registrars undertaking an Advanced Rural Skills Post, procedural, special skills and mandatory elective training as it is often difficult to undertake this training in RRAM 4-7 locations.

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-rrips

Advanced Specialist Training Posts in Rural Areas (ASTPRA)

Through the Advanced Specialist Training Posts in Rural Areas (ASTPRA) program, the Australian Government allocates $2 million annually to the States and the Northern Territory for about 30-35 accredited advanced specialist training posts in rural and regional areas. State governments also contribute fairly significant funding to this program.

States and the Northern Territory Government propose posts for funding based on State workforce planning priorities and the training targets recommended by the Australian Medical Workforce Advisory Committee.

The program aims to support recruitment and retention of rural medical specialists by providing placement opportunities for trainees wishing to enter rural practice, providing professional support to rural specialists through these placements and increasing the capacity of rural specialist services.

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/workforce-educat-specsup-astpra

Training for Rural and Remote Procedural General Practitioners Program

This Program is part of the 2004 Strengthening Medicine package. This program supports procedural GPs in rural and remote areas (RRMAs 3-7) to attend relevant training that will focus on both skills maintenance and upskilling.

The support is in the form of a grant for the cost of up to two weeks (ten working days) of training including the cost of the required locum relief, to a maximum of $15,000 per GP per annum. This is based on the financial year in which the training is completed.

Emergency Medicine (introduced Feb 06) - a grant for the cost of up to two days training, to a maximum of $3,000 per GP per financial year for GPs practising emergency medicine in rural and remote areas (RRMA 4-7) to attend approved skills maintenance and upskilling activities.

Back

ACRRM, RACGP and Medicare Australia are jointly administering the Program. Under this arrangement ACRRM and RACGP assess the eligibility of GPs and training activities and Medicare Australia makes grant payments to the eligible procedural GPs.

http://www.health.gov.au/internet/wcms/publishing.nsf/content/pcd-programs-trrpgpp
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-trrpgpp

Support Scheme for Rural Specialists (SSRS)

The Support Scheme for Rural Specialists (SSRS) is a program aimed at improving access to Continuing Professional Development (CPD) activities for specialist medical practitioners living and working in regional, rural and remote Australia.

Operation of the Scheme is a major activity of the Committee of Presidents of Medical Colleges and is funded by the Australian Government, Department of Health and Ageing. The SSRS was initiated at the end of 2002 following a report commissioned in December 2001 by the Office of Rural Health of the Australian Department of Health and Ageing.

Research identified a number of disincentives for specialists practising in rural areas including: professional isolation and lack of access to medical education and continuing professional development. The SSRS Program was established to assist with addressing these two issues.

It is reported that in 2003 and 2004, the SSRS supported the implementation of 48 projects covering all specialities. In 2005, 22 projects were been supported and implemented. Examples of some of the projects are:

- Facilitating Audit and Peer Review for Isolated Procedural Specialists
- A regionally based CPD Program for General Surgeons in North Queensland
- Enabling Rural Dermatologists to Access Teaching Hospital Clinical Meetings Via CD-Rom

http://www.ruralspecialist.org.au/about.aspx

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AMA POSITION STATEMENT

Regional/Rural Workforce Initiatives - 2012

February 2012

1. Preamble

The AMA has identified medical workforce shortage as a major health issue. Not only is there a nation-wide shortage of doctors, the overall distribution of doctors is skewed heavily towards the major cities such that regional, rural and remote areas shoulder a disproportionate workforce shortage burden.

Put simply, there is a strong preference amongst much of the current medical workforce to live and work in major cities - with particular preference for the inner suburbs. Given the educational background and the demographics of the current medical workforce - this should come as no surprise. Doctors are no different to any other professional group and evidence throughout the western world shows that attracting young professionals to rural locations is extremely difficult.

Table 1 below is a simple illustration of the current problem with workforce distribution. While it is possible to provide a much more complicated analysis based on other measures, this table provides a useful snapshot of the issue.

Table 1: Employed medical practitioners per 100,000 population: Remoteness Area of main job, States and Territories, 2009[1]

Remoteness Area	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Australia
Major city	343.8	366.1	394.6	422.8	382.6	. .	. .	472.7	372.1
Inner regional	202.6	196.4	188.7	147.5	163.3	457.9	. .	. .	212.1
Outer regional	118.8	106.9	236.6	127.8	193.4	178.3	433.8	. .	188.0
Remote / Very remote	115.2	265.3	161.8	126.1	221.1	101.6	385.8	. .	216.4
Total	308.6	332.7	334.6	353.9	336.7	366.4	442.9	474.2	331.4

It should be noted that the distribution of the medical workforce will always be biased to the major cities and large regional towns because some specialty services can only be supplied there.

In efforts to address these imbalances, the Government has adopted a variety of measures. Evidence suggests that these are starting to have an impact, particularly in the area of increased student enrolments. In 2009, 21% of first-year domestic medical school students came from rural areas, compared to just 12% in 1997.[2, 3] In the medium to long term, this may deliver a much fairer distribution

[1] Australian Institute of Health and Welfare (2011) *Medical Labour Force 2009,* August 2011

[2] Medical Training Review Panel (2010) *Thirteenth Report*, Australian Government, 2010

[3] New Zealand and Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1997), *The Characteristics of Students Entering Australian Medical Schools 1989 to 1997, AMWAC Report 1997*, Sydney

of the medical workforce. However, with long lead times involved in training the medical workforce more needs to be done in the short to medium term to address the current imbalance.

The debate is not just about numbers. It is also about the right skill mix. Rural medicine, especially, requires strong procedural skills - with primary care practitioners representing the backbone of rural health care. With strong trends toward sub-specialisation, and declining numbers of rural GPs who are practising proceduralists the problem facing regional and rural communities is even more acute than the above table would suggest.

Rural doctors are also getting older. The average age of rural doctors in Australia is nearing 55 years, while the average age of remaining rural GP proceduralists – rural GP anaesthetists, rural GP obstetricians and rural GP surgeons – is approaching 60 years[4].

The Commonwealth Government has responded to the general workforce shortage problem by, amongst other things, announcing a number of new medical school places. In 2010, there were 2,264 domestic medical graduates, an increase of 72 per cent from 2005. This is projected to increase to 3,227 domestic graduates by 2015.[5] While this is welcome, there is ongoing concern about the ad hoc nature of some of these announcements, the lack of any co-ordinated plan outlining how the clinical placements of these students will be accommodated in an already stretched public hospital system and whether there will be a sufficient number of quality postgraduate training positions available when these students enter the medical workforce.

The Government is still using a draconian policy of unfunded bonding of medical school places to distribute the medical workforce more equitably. Under this policy, students are bonded to work up to the equivalent length of time as their medical degree in identified workforce shortage areas. Unlike students in other professions such as teaching, medical students who take up bonded positions are offered no incentives and must repay their education fees in full unless they are also eligible for other programs. Given that the pattern of medical school enrolments has shifted dramatically, with a big increase in enrolments of students from rural areas – it is strongly arguable that this policy is highly unnecessary as existing policy settings were having a significant and positive desired effect.

While recent changes have made the Government's bonded medical places (BMP) policy fairer and provided students with more support, it still lacks incentives. It does not address the underlying causes of medical workforce shortages or make the practice of medicine in areas of workforce shortage more attractive. Regular assessment of the efficacy of the Government's various recruitment and retention schemes is important.

The Government has also introduced the HECS Reimbursement Scheme that reimburses HECS debts of medical students if they train or work in rural and remote communities. Under the scheme, doctors can reduce the period for reimbursement of the cost of their medical studies from 5 years to 2 years, depending on the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) location of their training or practice. This is a positive example of an incentive based scheme.

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[4] Source: Rural Doctors Association of Australia.

[5] Medical Training Review Panel (2011) *Fourteen Report of Medical Training Review Panel*, Australian Government, 2011

It should also be noted there are concerns with the new ASGC RA system, introduced in July 2010. These concerns involve anomalies identified with the RA 2 classification. The AMA considered these anomalies would make it more difficult to recruit medical staff to less attractive locations within the same classification. In light of these concerns the AMA pushed for a review of the system. The Government agreed to undertake a review and the report released in September 2011 concludes that the system is working well, however there were some "areas of uncertainty" for towns near classification boundaries and it recommends setting up a tribunal that will assess submissions for changing RA/Health Remoteness Classification (HRC) scores.

2. Opportunities to influence the overall supply and distribution of the medical workforce

The AMA supports emphatically the right of doctors to live and work where they choose and to have the freedom to exercise their clinical judgement. Nevertheless, the profession has a responsibility to ensure that there is equitable community access to a well-trained medical workforce.

There are several points where policy makers can influence both the supply and distribution of medical practitioners. These include:

- medical school intakes and selection practices;
- training curricula and program requirements;
- recruitment and retention initiatives for medical practitioners;
- flexible work arrangements allowing a better balance between work and personal/family commitments;
- development of improved work practices and the provision of appropriate resources to support medical practitioners in the delivery of health care;
- access to services, resources and amenities - community and professional alike; and
- reducing compliance costs involved in delivering healthcare and running a small business.

3. Overseas experience

To date, no country has developed a package of policy initiatives that have been shown to completely address problems in the distribution of the medical workforce. However, there seems to be several emerging lessons:

- the early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enroll in medical schools are the most likely of all initiatives to increase the workforce in these areas;
- proper medical infrastructure, a strong training experience, and access to community and professional resources, and continuing medical education are essential to the provision of a rewarding professional and personal experience;
- the opportunity to maintain and update skills is as important for rural specialists and GP proceduralists as for their city counterparts. Rural specialists and GP proceduralists must have fully funded access to centres of excellence to regularly enhance and broaden their skill base;
- consideration must be given to not only the needs of the medical practitioner, but also their family - particularly with respect to access to employment opportunities, health and education, and social amenities;
- a critical mass of doctors within a region is important in improving the viability of a practice, as well as enhancing professional development;

- appropriate remuneration and incentives are essential to attract and retain medical practitioners;
- bonded students who are treated fairly and provided with appropriate incentives and support can make an invaluable contribution to the development of a sustainable rural workforce. The bonding of students without access to financial and other types of support is counterproductive and can force people to leave the medical workforce or to consider practice in other countries.

4. Why are medical workforce shortages worse in regional and rural areas?

There are a number of fundamental reasons why regional and rural areas are not getting their fair share of the medical workforce. These include:

- inadequate remuneration;
- work intensity;
- red tape;
- lifestyle factors;
- professional isolation;
- poor employment opportunities for other family members, and in particular practitioners partners;
- under-representation of students from regional/rural background (noting that this mix is changing, however, the benefits will take some time to be realised);
- continued withdrawal of services from such areas;
- lack of critical mass of similar doctors;
- hospital closures;
- downgrading of other services;
- limited educational opportunities;
- long hours/rosters; and
- inefficient administration in public hospitals.

5. Solutions

In the 2009/10 Federal Budget the Commonwealth Government introduced an overhaul of rural workforce incentives, backed by additional funding support, to help attract and retain more doctors to regional and rural areas; however, the Government's rural health programs remain under-funded, complex, fragmented and too restrictive. Ideally, incentive payments must be tax-free.

The AMA believes that a combination of policy initiatives can be applied in order to provide regional and rural areas with a more equitable share of the medical workforce. In outlining these policy measures, it is important to recognise that the problem cannot be addressed overnight. Rather, the results will be delivered in an incremental fashion.

Going forward, the AMA has identified five key priority areas for the Government to implement that would help attract medical practitioners and students to regional and rural areas. These are:

1. provide a dedicated and quality training pathway with the right skill mix to ensure GPs are adequately trained to work in rural areas;
2. provide a realistic and sustainable work environment with flexibility, including locum relief;
3. provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/relocation and/or tax relief;

4. provide financial incentives including rural loadings to ensure competitive remuneration; and
5. provide a working environment that would allow quality training and supervision.

It is worthwhile to note that some of these measures are equally relevant to the medical workforce in metropolitan areas, including improved remuneration to general practitioners, better management of hospitals and more flexible training arrangements. Even though some measures are not specific to regional/rural areas, they will still have a positive impact and have been included in this position statement on that basis.

6. Undergraduate education and training initiatives

6.1 Medical schools should have a student mix that reflects the proportion of regional/rural people in the Australian population. Subject to appropriate academic benchmarks, this should be achieved through the establishment of specific enrolment targets, the beneficial weighting of enrolment criteria in favour of regional/rural students or some combination of these. Commonwealth and state/territory Governments should cooperate to ensure that rural secondary school students are aware of the opportunities to enter medical school.

6.2 The Commonwealth should expand access on a means tested basis to existing scholarship programs (e.g. Rural Australia Medical Undergraduate Scholarship Scheme) for students from regional and rural Australia who are accepted for enrolment in medical schools in order to reduce the entry barriers they face to taking up a career in medicine.

6.3 Medical students should be encouraged to take up a career in regional, rural and remote areas by developing and implementing a voluntary return-of-service scheme that offers incentives such as higher education charges relief and scholarship payments linked to remote locality. This scheme should be available to new and existing medical students as well as junior doctors, substantially increasing the pool of potential applicants.

6.4 The AMA supports the use of programs that provide relief from HECS debts to encourage doctors to work in regional and rural areas. Such programs should reduce HECS debts based on each year of service in a regional or rural location.

6.5 The establishment of medical schools or the expansion of medical school places in rural and regional areas must be considered as part of a broader workforce planning process, which takes into account the infrastructure and resource implications for undergraduate, prevocational and vocational training.

6.6 Undergraduate education models should provide medical school students with strong early exposure to regional/rural medicine and, in particular, procedural medicine. This will foster an interest in regional/rural medicine as well as better equip graduates to face the challenges of regional/rural medicine.

6.7 Students should be provided with access to structured mentoring programs to assist them in developing an interest in rural medicine

7. Indigenous health professionals

There is a strong link between the health of Indigenous people in rural communities and their access to culturally appropriate health services. The AMA believes that:

- greater effort should be made to encourage Indigenous people to undertake medical or health professional training, and incentives provided to encourage Indigenous and non-Indigenous doctors and medical trainees to work in rural and remote Indigenous communities;
- Aboriginal Medical Services should be resourced to offer mentoring and training opportunities in rural Indigenous communities to Indigenous and non-Indigenous medical students and vocational trainees; and
- training modules, resource material and ongoing advice should be developed for, and delivered to, all medical schools and rural and remote medical practices on Indigenous health issues, Indigenous-specific health initiatives and culturally appropriate service delivery.

8. Postgraduate Medical Education

8.1 Provided it is consistent with the development of appropriate clinical skills, postgraduate medical training programs should include a regional/rural medical service component, with junior doctors having the ability to pursue more advanced training in regional/rural medicine through their relevant Medical College.

8.2 Trainees should be encouraged to undertake rotations to regional/rural areas as part of their training program. The rotation should be included in the postgraduate medical education/Medical College accreditation processes. Provided it meets the requirements of the training curriculum, trainees may elect to serve longer periods in regional/rural areas. The latter option should be available on a voluntary basis and trainees should not be compelled to serve extended periods in regional/rural areas by using de-facto workforce measures such as rural pathways.

8.3 Medical Colleges face additional challenges and costs in establishing suitable training posts in regional/rural areas. Where appropriate, Medical Colleges should be able to access specific funding to assist in meeting such costs.

8.4 When on rotation, trainees should have access to mentoring programs to assist them in making a smooth transition to the regional/rural medical workforce. These programs should be co-ordinated by the trainee's employer, and where appropriate developed in consultation with the relevant Medical College.

8.5 Trainees are covered by a variety of employment arrangements and undertaking hospital rotations, or applying for employment at a regional/rural hospital in order to satisfy their vocational training requirements often involves the interruption/loss of employment entitlements such as sick leave and annual leave. Innovative arrangements need to be identified that allow for portability of entitlements, which ensures that trainees are not disadvantaged by undertaking regional/rural service.

8.6 Prior to appointment, trainees must be given relevant information regarding any rotations they will be required to undertake during their employment. Reasonable notice should be provided when a doctor will be required to undertake a rotation and consideration of a doctor's personal/family circumstances must be taken into account wherever possible.

8.7 Trainees should be provided with comprehensive assistance when they are required to undertake a rotation that requires them to move away from their usual place of residence. This assistance should be based on the principle that the relocation should be cost neutral to the trainee.

8.8 With increasing opportunities to deliver training in private clinical settings appropriate support for private practices should also be provided.

8.9 The Commonwealth and State/Territory Governments should co-operate in order to set aside specific funding to establish additional training positions in regional/rural areas with appropriate infrastructure and supervision.

8.10 General practice is acknowledged as one of the major planks of regional and rural healthcare. Prevocational training programs such as PGPPP, which provide trainees with greater exposure to general practice are vital for strengthening the general practice workforce.

8.11 To enable sufficient numbers of practices to be recruited to training and supervision roles, measures such as infrastructure support grants are needed to improve infrastructure in general practices, particularly to remodel existing physical space or for the additional space necessary to deliver training effectively.

8.12 In light of the changing expectations and personal circumstances of men and women entering the medical workforce, the growing participation of women in medicine and increasing numbers of post-graduate medical school graduates, Medical Colleges must ensure that access to part time and flexible training arrangements is improved, and that trainees are not unnecessarily penalised when their training is interrupted due to personal or family circumstances.

9. Continuing Medical Education

9.1 Regional/rural practice often requires doctors to treat conditions with less support than would otherwise exist in a metropolitan region. The development of appropriate CME resources and training programs, along with access to locum support is essential to the maintenance of high standards of care.

9.2 Training providers need to expand the suite of distance learning tools to assist doctors in these locations to develop their skills on an ongoing basis, and links to Rural Clinical Schools should be encouraged.

10. Generalism

There has been a decline in generalism in public and private medical practice and an increasing trend towards sub-specialisation. Insufficient numbers of generalists (general specialists) in specialities such as surgery and medicine are practising in urban and rural settings. Generalists have a vital role in the health system, as they are able to manage and treat a wide range of health conditions. The shortage of these professionals is felt acutely in rural and regional areas, and patient access to care in rural areas has decreased in line with the trend to sub-specialisation.

The reasons for the decline in generalism are many and varied, but include lower remuneration for generalists compared to sub-specialists and training models that disadvantage generalism. The decline in generalism in rural and regional areas has been exacerbated by the closure of rural hospitals and procedural units. The high workload of rural generalists and corresponding poor work-life balance also act as disincentives to generalist practice.

The following broad measures should be considered to help arrest the decline in generalism and attract and retain generalists in the medical workforce:

- elevate the status of generalism;
- facilitate greater exposure to generalist practice during undergraduate medical training;
- develop vocational training models that encourage more generalist careers;
- increase state and federal funding for rural generalist positions;
- increase state and federal funding for rural specialist infrastructure; and
- improve the level of remuneration for generalists to encourage generalist practice, including the removal of anomalies in the MBS that reward sub-specialisation over generalism.

11. Remuneration and incentives

11.1 All stakeholders should acknowledge the importance of appropriate remuneration levels, not only for doctors working in private practice but also for doctors working in the hospital sector.

11.2 A simplified structure for Medicare rebates, fully funded and appropriately indexed, should be introduced in order to more properly reflect the nature of primary care delivery, allow GPs to charge an appropriate fee for their services without the fear of leaving patients with high out of pocket costs, and improve incomes for GPs in general so as to attract more doctors into general practice. This will both benefit patients and improve the image of general practice as a career choice.

The Government should support the Rural Rescue Package developed by the AMA and the Rural Doctors Association of Australia. Implementation of the package would help to sustain the regional and rural workforce and ensure that patients in rural communities have improved access to doctors. The package encourages more doctors to work in rural and regional Australia and recognises essential obstetrics, surgical, anaesthetic and emergency skills. This funding would provide a two-tier incentive package, including further enhancements to rural isolation payments and rural procedural and emergency/on-call loading:

- a rural isolation payment to be paid to all rural doctors (including GPs, specialists and registrars) to reflect the isolation associated with rural practice; and
- a rural procedural and emergency/on call loading to better support rural procedural doctors (including procedural specialists) who provide obstetric, surgical, anaesthetic or primary emergency on-call services in rural communities.

11.3 Employers should offer competitive salary packages to doctors in order to attract them to work in regional/rural areas and depending on the location of the employer and workforce need, packages should include:

- accommodation or accommodation assistance;
- fee assistance for the education of the doctor's children;
- return airfares to place of origin;
- home access to broadband internet services – including satellite where appropriate;
- assistance with continuing medical education, including fees, attendance at conferences, additional leave entitlements etc.;
- childcare facilities or access to subsidised assistance;
- assistance with finding suitable employment for other family members; and
- flexible, family friendly working arrangements.

11.4 Incentives to encourage doctors working part time to increase their hours should also be considered, including re-skilling where necessary.

12. Family support

12.1 The decision for a doctor to relocate or practise on a medium to long-term basis in rural areas obviously has a significant impact on their family. Where a partner works or children are at school there may be considerable direct or opportunity cost and loss of amenity from a decision to move to rural practice. Simply paying a medical practitioner more, while helpful, does not address the full dimensions of the problem and ignores significant factors in any individual's decision-making process when considering rural practice.

12.2 There should be adequate compensation, support and access to re-training if required, so that a partner or spouse can remain employed in an acceptable occupation if their partner moves to a remote area. Job seeking assistance should also be offered if required.

12.3 If the family requires assistance to maintain a child in school in a larger town or city centre, there needs to be school fee assistance, given the possible requirement for boarding and other increased services or tuition.

12.4 Where a family is fragmented by a decision for a parent or partner to take up rural practice, there should be funding for at least one return trip home for family members during the doctor's tenure.

13. Hospital work practices and infrastructure

13.1 In 2007, the AMA conducted a survey of rural doctors asking them to rate the importance of various policy issues. Concerns about rural hospitals featured directly in five of the top ten areas identified by rural doctors. The closure and downgrading of rural hospitals is seriously affecting the adequate delivery of health care in rural areas. Such decisions are normally driven by economic considerations, yet they have significant consequences for the local community and the sustainability of the medical workforce.

13.2 Governments must ensure that regional/rural hospitals are properly resourced with adequate infrastructure, information technology support and staffing to ensure that doctors work in an environment that is conducive to delivering:

- quality patient care
- a strong and relevant training experience to junior doctors, with adequate supervision
- an environment to develop their procedural skills
- opportunities for professional development
- safe working hours.

13.3 The efficient use of the skills of the medical workforce is a critical measure to enhance the delivery of healthcare services throughout the country. Doctors should not be burdened with an undue administrative workload that reduces their capacity to deliver clinical services.

13.4 Where appropriate, work practices should be reviewed in consultation with clinicians to ensure that doctors are not undertaking tasks that could be more appropriately handled by nursing or clerical staff.

13.5 Hospitals should support a broad role for Visiting Medical Officers to encourage teamwork, the sharing of information and ideas and skills development for VMOs and salaried doctors alike.

13.6 Hospitals should provide safe workplace facilities and accommodation at an appropriate quality in accordance with the AMA Position Statement – Workplace Facilities and Accommodation for Hospital Doctors. [6]

13.7 Hospitals must value medical staff and provide them with a good working environment. They must consult with doctors on all issues affecting patients and they should ensure that the Director of Medical Services holds appropriate clinical qualifications and is able to provide an effective point of liaison.

14. Community funded facilities

14.1 The Commonwealth Government should establish specific funding grants to allow local governments in regional/rural areas to purchase facilities to support medical practitioners such as housing/practices/equipment, so that practitioners can operate a practice on a walk-in walk out basis. The costs of establishing a practice have been nominated as one of the major disincentives to doctors who might otherwise relocate to an area of workforce shortage.

15. Outreach programs

15.1 Outreach programs to provide funding assistance for specialists visiting rural and remote areas are a valuable means to enhance the delivery of services in these areas. These programs should be adequately funded and based upon the following principles:

- services must be directed to communities where an unmet need is established by the local medical practitioners
- services must be designed to fit in with local healthcare services, and wherever possible they should include up-skilling and other measures to enhance the sustainability of local medical services
- funding must be available to existing outreach services
- there should be strong Medical College involvement in outreach programs in order to encourage greater participation
- service should not be withdrawn without consultation with the local practitioner.

16. Red Tape

16.1 Red tape placed on medical practitioners reduces the time available to consult with patients. It restricts patient access to care, with some estimates suggesting that GPs spend up to nine hours per week complying with red tape obligations. Every hour a GP spends doing paperwork equates to around four patients who are denied access to a GP.

16.2 Reducing red tape and bureaucracy, and providing more opportunities for GPs to spend face-to-face time with patients must be a key priority. It will improve the image of general practice and allow GPs to increase their patient load. The Government should address these issues by implementing the remaining recommendations from the Productivity Commission's 2003 Review of General Practice Administrative and Compliance Costs and from the Regulation Taskforce's 2006 review relating to general practice.

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[6] Australian Medical Association (2006) *Workplace Facilities and Accommodation for Hospital Doctors Position Statement 2006*, available from www.ama.com.au

17. Nurses

17.1 The general practice nurse (GPN) is a model of collaborative care within general practice that is fully supported by the general practice community and this has improved access to care through general practice. In practical terms, this requires the Government to extend practice nurse subsidies under the Practice Incentives Program to all geographic locations and to expand MBS coverage to reflect and support the full range of work undertaken by practice nurses for and on behalf of GPs. Specific loadings for the cost of employing practice nurses in rural areas should continue.

17.2 The AMA does not support a role for independent nurse practitioners, but this does not preclude the capacity for highly skilled nurses, working as part of a collaborative primary care team led by one or more GPs to be supported in the delivery of services to remote areas where access to health care is often very difficult. These nurses should:

- have appropriate clinical experience and training; and
- be supported through the provision of appropriate communication technologies to ensure that treatment can be properly co-ordinated with the supervising GP(s).

18. Rosters

18.1 Doctors in regional/rural areas often face high on-call demands. This is undesirable from both the perspective of patient safety as well as effective service delivery. A core number of doctors need to be on roster to contribute to a sustainable work/life balance. The roster needs to be attractive in order to help recruit and retain doctors.

18.2 Existing competition laws prevent doctors entering into effective rostering arrangements to provide comprehensive medical services to their local community, particularly with respect to after-hours services and covering absences when doctors take leave. Registering business names in a joint venture has been shown to be an effective strategy in some situations.

18.3 The AMA believes that considerable community benefit would flow from allowing doctors to establish viable rostering arrangements, which include reasonable agreement over what fees would be charged. This would encourage doctors to co-operate in order to provide their local community with better access to round the clock healthcare - and address one of the major disincentives to regional/rural practice being a high on-call workload.

18.4 In light of the above, the Australian Competition and Consumer Commission (ACCC) should work with stakeholders to develop a simple notification process along the lines of the collective bargaining notification for small businesses recommended by the Dawson Review of the Trade Practices Act. This would significantly streamline processes and encourage medical practitioners to enter into arrangements that deliver better access to care as well as reduce the excessive hours worked by many medical practitioners in rural areas.

19. Locum Services

19.1 Locum services are also a key element to addressing the problems of high workload and little prospect of relief for rural/regional practice. Lack of time off for professional development, family responsibilities and recreation can be among the most negative aspects of life as a rural doctor. Rural Workforce Agencies and Medical College programs are an important source of

locum doctors and Commonwealth Government funding should continue to support such programs, and where appropriate be increased based on the needs of particular communities.

19.2 The AMA supports existing exemptions allowing junior doctors access to provider numbers for locum services in areas of need/district of workforce shortage, however, the process of accessing provider numbers is lengthy and involves too much red tape - which in turn discourages junior doctors from participating. Initiatives to simplify these processes need to be explored.

19.3 Doctors working in locum services should be able to access VR rebates, and the application and approval process should also be simplified in order to reduce the red tape barrier.

20. International Medical Graduates

International medical graduates (IMGs) form an important part of the medical workforce and regional and rural Australia will rely on the contribution made by IMGs for the delivery of medical services for some years to come. When IMGs arrive in Australia they are often placed in highly challenging work environments with little or no orientation, while access to supervision, professional support, and training can be variable. This is not good for IMGs or their patients. These doctors need more professional and community support to enable them to maximise their contribution to patient care and to encourage them to seek a permanent place in the Australian rural medical workforce. To ensure high standards of patient care in regional and rural areas, and to provide better support for IMGs in their work, the AMA believes that the following measures are necessary[7]:

- the phasing out of the "10-year moratorium" and its replacement with a robust package of incentives and support mechanisms to encourage the increasing numbers of locally trained doctors and appropriately skilled IMGs to voluntarily consider a career in regional and rural Australia;
- consistent and transparent standards of assessment for IMGs across Australia, with the medical colleges having responsibility for assessing overseas qualifications and determining additional training or oversight required;
- introduction of streamlined processes of assessment including recognition of prior learning;
- ensuring that IMGs have access to support mechanisms including mandatory orientation, continuing medical education, bridging courses, assistance with exams, mentoring, community facilities and services;
- ensuring that IMGs have access to working conditions that are equal to comparable Australian trained doctors in like locations;
- streamlining of area of need and district of workforce shortage definitions with a requirement that an objective assessment be undertaken of the reasons for not filling a position with an Australian resident doctor before recruiting an IMGs; and
- change Commonwealth and State legislation to give temporary resident IMGs and their families access to Medicare and public education.

21. Telehealth

21.1 The development of medical and communication technology has the potential to deliver significant benefits to regional/rural medicine. For example, faster broadband would make it

[7] For further detail, refer to the AMA 2004 position statement on overseas trained doctors.

easier for doctors in rural and regional areas to consult with city colleagues when diagnosing and treating patients. It should be noted that improved Internet services will not eliminate the need for more doctors in regional areas and for rural hospitals to be properly funded and staffed – it is a tool for doctors and hospitals to use in patient care. Governments need to work with stakeholders to encourage the innovative use of these technologies and in doing so need to consider:

- policies that promote access to relevant community infrastructure including high speed internet access
- initiatives including funding for community based facilities, or assistance with the purchase of infrastructure
- promotion of collaborative initiatives between clinicians to foster telemedicine
- raising the awareness of available technologies and providing access to training in the use of such technologies.

22. Benefits of regional/rural practice

22.1 Regional and Rural practice is a rewarding experience and does have lifestyle advantages. Stakeholders need to counter the negative perceptions surrounding regional/rural practice by highlighting the more positive aspects. Governments have committed money in the past for campaigns to encourage people to enter particular professions or training programs such as apprenticeships. Consideration should be given to running similar campaigns highlighting the advantages of regional/rural practice.

23. Access to community services

23.1 Governments have consistently withdrawn or rationalised services in regional/rural areas. This only makes it more difficult to attract doctors, and other groups to these areas. Before withdrawing such services, a public interest test should be applied to ensure that communities are not denied reasonable access to services. Consideration should also be given to imposing a moratorium on the withdrawal of Government businesses as a strategy to maintain medical services.

23.2 Governments should provide businesses with access to suitable incentives to relocate to regional/rural areas in order to encourage investment and employment and generate new economic activity, which will support improved local infrastructure and amenities.