House Standing Committee on Employment and Workplace Relations
House of Representatives
Parliament House
Canberra ACT 2600

Submission to the Inquiry into regional skills relocation

To the Committee,

I am making this submission on my own behalf, and am grateful for the opportunity. I am currently employed as a doctor in the public system in Queensland.

I would like to make reference to the shortage of skilled doctors in rural and regional Australia. It is long established that Australia's medical workforce is lacking in these areas. It is long established that "centres of excellence" and tertiary/ quaternary medical facilities are located in metropolitan centres.

My primary concern is the excessive waste of money spent on locum doctors.

Hospitals in each state are frequently forced to employ locums through locum agencies. These agencies are able to pay, for example, $120-180 per hour to a junior doctor. The sudden influx of locum agencies onto the market suggests to me that this is highly lucrative. If lucrative for the companies, I am led to believe that each hospital pays significantly more than the $120-180/per hour to the agency.
This is obscene. I have concerns about the sustainability of a system which is forced to pay such a premium for junior doctors that whom may not be adequately credentialed to work safely in a demanding rural environment.

For comparison, as a 4th year graduate doctor without specialist qualification, I earn $42 per hour. I do, however, have a longer contract with sick leave, recreational leave and superannuation, where locums **may** not.

Anecdotally, my colleagues and I are aware of locums refusing to do night shifts, and even refusing to see patients of a particular urgency in emergency settings. I ask myself: what value is the health system obtaining from this band-aid strategy?

To rectify the undermining of state funding by these agencies includes Locum reform (as recommended by the Garling Report 1.126, page 20).

Suggestion	Notes
Specific legislation governing locum agencies in public hospital system	National legislation (in line with upcoming national registration for medical practitioners). If unable to be legislated against entirely, perhaps capping of hourly payments able to be offered by agencies
Government support into a	Able to offer higher casual rates as per normal industrial relations

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State-based, internally maintained "casual" pool of doctors, credentialed by appropriate governing bodies.	policies, however is not a premium payment. States retain some power over the access to casual doctors, and have intricate knowledge of their capabilities and suitability to a particular job. This service would facilitate the temporary relocation of doctors and their support needs.
Government review of existing rural an regional incentives	A consistent, state- based or national system co-ordinating the scholarships and incentives for rural practitioners. These should not just be housing, or financial, but should be geared toward sustainability e.g. guaranteed backfill for regional practitioners to attend conferences and take holidays, adequate access to administrative staff.

My other major concerns for rural and regional medical workforce are:

- high percentage of international graduates with little to no cultural/social support and cultural awareness training
- training colleges requiring large blocks of time to be spent at tertiary/quaternary facilities
- insufficient medical student exposure to rural health service delivery

My personal experiences have allowed me to form several ideas on how workforce shortages might be addressed.

Suggestion	Potential Outcome
Specialist sit-downs with GP & patient in case managed care	Individually focussed care with "action plan" enabling GPs to better manage patient for longer – with specific and relevant advice on ongoing therapy. Reduce admissions for patients. Builds rapport between medical teams. Patient focussed. Reduce outpatient clinics for specialists. Continuing medical education for GPs.
Specialist fly-in case managed clinics	May be used in regional areas to facilitate above suggestion.
Increase bonded medical scholarship places	Higher proportions of Australian graduates in rural/regional areas.
Restructure bonded medical scholarship places	Example of breakdown: $10, 000 p.a stipend plus $5,000 p.a. rental contribution, for 3 years bonded service.
Pre-purchased government places for medical students in rural health conferences	Increased exposure to rural health service delivery requirements.
Increased direct financial support to rural medical schools	e.g. able to fund free or heavily subsidised rent to students taking rural placements.

Thank you for your time and this opportunity.

Return address for correspondence:

Dr Sara Creedy

Sincerely,

Dr S.Creedy

19. March 2010 .