Chapter 6

Other matters

Workforce reforms

6.1 Reforms in relation to the medical workforce were considered largely inadequate and unable to address the central problems of attracting and retaining GPs in primary care and medical professionals in rural and remote areas. Concerns were raised about the nurses working in general practice initiative duplicating services and leading to financial losses for larger practices in rural communities.

Medical workforce

6.2 The Commonwealth is providing $487 million in funding over four years to create more training places for GPs and funds to pay 975 junior doctors to experience a year in general practice. However, this extra funding was not seen as being enough to address the medical workforce problems in primary care. Professor John Dwyer, for example, commented that only 13 per cent of senior medical students in Australia have the intention to train as a GP. He argued that more was needed to make primary care a career choice:

> Without making a career in primary care seem more attractive, these dollars are unlikely to have the desired effect. Our young doctors are trained to deliver in multi-disciplinary teams in hospitals and will only be attracted to a life in primary care when they believe that, in doing so, they will be appropriately remunerated and experience the job satisfaction associated with really helping their patients.[1]

6.3 The Australian Medical Association (AMA) also put to the committee that it was less confident that the states would match the Commonwealth's commitment to increase the number of training positions in public hospitals and that:

> Unless States lift their overall contribution, it is likely that a shortage of quality training positions will occur or that the overall quality of the training in public hospitals will diminish.
>
> In implementing the IGA, it is essential that States be held to account for delivering the required number of high quality training places.[2]

6.4 In relation to the funding for new GP training and pre-vocational places, the Rural Doctors Association of Australia (RDAA) stated that whilst it welcomed the funding, it took the view that this initiative was merely a first step and that the

---

1 John Dwyer, 'Health plan needs a few dollars more', *Australian Financial Review*, 11 May 2010.

2 Australian Medical Association, *Submission 10*, p. 11.

introduction of 'realistic measures to actually entice these and other doctors to move to the bush once they have graduated' was the next step which had been 'largely ignored'.[3]

6.5 In relation to the extra locum support in the package, the RDAA commented that 'there is so little there…the bottom line is we need more workforce out there. Locums are not going to do the job. If we get the workforce out there we can then provide them with the locum support to have time off'.[4]

6.6 The RDAA expressed its disappointment that 'the most significant health reforms of recent times do not involve the much-needed Rural Rescue Package' proposed jointly by the RDAA and the AMA. The package is designed to entice more doctors to the bush and better support rural practices. The RDAA went on to remind the committee of the realities of medical practice in the bush:

> At least 1800 doctors are needed immediately in rural and remote Australia to ensure even basic medical coverage in the bush. The influx of overseas trained doctors is the only reason that medical workforce numbers in rural areas are not in complete free fall. Close to 50% of rural doctors are overseas trained and in many areas 100% of services are being provided by overseas trained doctors, well above the national average of 25%.[5]

Nursing workforce

6.7 Whilst increased funding for practice nurses for GPs was welcomed, the Royal District Nursing Service (RDNS) voiced concern that the proposal may in fact lead to duplication of services. The RDNS noted that the funding will be used to employ practice nurses to provide care outside the GP clinic. However, 'across Australia there are nurses and other health professionals employed through other programs who already provide care in settings such as the home – RDNS and our interstate counterparts are examples'. The RNDS continued:

> With new funding provided through Medicare there is a risk of duplication as GPs seek to set up systems and structures which duplicate those already in existence. Surely it would be more cost efficient to allow existing providers (even though they do not have a provider number) to be able to access this funding and provide this service).[6]

6.8 The ACMHN commented that the $523 million to support nurses in the area of general practice and aged care was 'woefully inadequate' for a profession with over 250,000 members.[7] It also noted its disappointment that the Mental Health Nurse

---

3 Rural Doctors Association of Australia, *Submission 22*, p. 1.

4 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 67.

5 Rural Doctors Association of Australia, *Submission 22*, p. 2.

6 Royal District Nursing Service, *Submission 11*, p. 3.

7 Australian College of Mental Health Nurses, *Submission 23*, p. 2.

Incentive Program's provision of $13 million only 'returns the program funding to around 35% of the original commitment' and that it requires additional investment to support the uptake of the program by mental health nurses, GPs and psychiatrists.[8]

6.9 Mr Steve Sant, RDAA, stated that there were significant concerns around the nurses working in general practice initiative (the Practice Nurse Incentive Program (PNIP)). Modelling undertaken by the RDAA indicated that practices in larger rural towns which have come together as a single practice for efficiency reasons would lose money under the initiative:

> These are practices that are larger practices in rural Australia, probably in centres of close to 20,000 or 30,000 people. They are large practices of more than five doctors, often as large as 20 or 30 doctors. Because of the caps on the way that program has been set up, and because those practices have very well utilised practice nurses and using the practice nurse items, they potentially could lose up to $100,000.[9]

6.10 The RDAA noted that whilst there was a guarantee against financial loss within the initiative, it was limited to three years. The RDAA concluded that the initiative would be 'unlikely to encourage those practices to continue to use nurses to the same extent in the longer term' and thereby, reduce access of their local community to care.[10] It has taken the matter up with the Government 'but we are yet to hear any real outcome'.

6.11 Mr Sant concluded:

> We have yet to see whether [the reforms] will have any effect on the health of rural Australians. We certainly believe that without those specific rural incentives, and specific rural supports, we will not see the health of rural Australians in any way being improved, nor will we see the workforce, those 5,400 nurses, the 1,800 doctors, moving back into rural Australia where they are really needed.[11]

6.12 In response to these concerns, Ms Huxtable of the Department of Health and Ageing stated that it was not the intention of the measure to 'go backwards in any way' and that rather, it was to provide a 'more sustainable foundation for practice nurses' whilst providing medical practices with flexibility in terms of 'how they can use practice nurses'.[12]

---

8 Australian College of Mental Health Nurses, *Submission 23*, p. 2.

9 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 65.

10 Rural Doctors Association of Australia, *Submission 22*, p. 6.

11 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 66.

12 Ms R Huxtable, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 32.

Electronic health records

6.13 Concerns were raised by involved stakeholders regarding the funding of the proposed electronic health records system otherwise known as e-health. Issues including the security of the information that will be kept on the records, who will be able to access information and whether the records will become a means to achieve 'function creep' through the use of such information for other purposes have been raised.[13]

6.14 The National E-health Strategy prepared by Deloitte estimated that the development of a national system would cost around $1.5 billion over five years or $2.6 billion over ten years.[14] Questions have been raised, therefore, about what the pledged Commonwealth funding can achieve.

6.15 University of Sydney surgery professor Mohamed Khadra argued that with more than 100 different computer platforms used by doctors and other medical professionals, it was impossible for the budget allocation to cover the costs of integrating all those systems.[15]

6.16 SARRAH emphasised that access to electronic health records and other key strategies should not be limited to those 'soon-to-be Nationally Registered Professionals, as this would limit access to services critical to improved health outcomes and health reforms'.[16]

Health care in rural and remote areas

6.17 The RACGP noted that the NHHRC recommendation 65 for a patient travel and accommodation assistance scheme which takes account of out-of-pocket costs of patients and their families and facilitates timely treatment and care in the achievement of delivering health outcomes to remote and rural communities has not been realised. Of this it stated:

> The College believes that the Government should adopt the NHHRC's recommendation and introduce a nationally consistent patient travel scheme, which will provide much needed access to medical services for

---

13 Adam Cresswell, Experts warn over medical records plan, *The Australian*, 13 May 2010, http://www.theaustralian.com.au/in-depth/budget/experts-warn-over-medical-records-plan/story-e6frgd66-1225865740097 (accessed 10.6.10).

14 Deloitte, *National E-Health Strategy*, 30 September 2008, p.90, http://www.health.gov.au/internet/main/publishing.nsf/Content/604CF066BE48789DCA25751D000C15C7/$File/National%20eHealth%20Strategy%20final.pdf (accessed 25.5.10).

15 Fran Foo, Expert slams meagre e-health funding, *The Australian*, 12 May 2010, http://www.theaustralian.com.au/in-depth/budget/expert-slams-meagre-e-health-funding/story-e6frgd66-1225865353736 (accessed 10.6.10).

16 Services for Australian Rural and Remote Allied Health, *Submission 6*, p. 6.

patients in rural and remote communities, and contribute to the Government's Closing the Gap Campaign.[17]

Medicines associated with health care

6.18 The Society for Hospital Pharmacists of Australia (SHPA) emphasised that there was an 'absence of any consideration for the use of medicines associated with almost all health care' which implied that the 'continuation of the plethora of medicines funding systems looks set to continue'.[18] The SHPA stated:

> A plethora of arrangements now underpins hospital medicines funding, some of which include cost-shifting opportunities between government funders. Reforms should improve transparency and efficiency of care, as well as providing information about the safe and cost-effective use of medicines in all health care settings. This will strengthen future local and national evidence based decision making, including the anticipation of changes in the use of medicines and future funding needs.[19]

17 Royal Australian College of General Practitioners, *Submission 15*, p. 4.

18 The Society for Hospital Pharmacists of Australia, *Submission 9*, p. 3.

19 The Society for Hospital Pharmacists of Australia, *Submission 9*, p. 3.