CHAPTER 8

Workforce and business measures

Introduction

8.1 As discussed in detail in chapter 4, Australia faces considerable medical workforce shortages, both overall and particularly in certain outer-metropolitan, rural and remote areas. Current supply problems are substantially due to earlier government policies partly designed to limit GP numbers which, as noted, included: measures to reduce the number of university and training places; restrictions on the entry of overseas trained doctors; and the introduction of restrictive provider number legislation in the 1996.[1]

8.2 As explained in chapter 5, the government package provides several measures aimed at increasing the supply of the medical workforce to outer metropolitan and rural areas of workforce shortage. This includes funding for 234 additional medical school places each year – amounting to a 16% increase in overall places – with students being required to work for a period of six years in areas of workforce shortage on completion of their training. In addition, 150 extra training places for GP Registrars will be provided each year – a 30% increase – targeted to areas of workforce shortage. These measures will cost $42.1 million and $189.5 million respectively, over four years.

8.3 The package also provides funding for up to 457 full time equivalent nurses to be employed in participating general practices. Practices may also elect to employ allied health professionals instead of nurses, where appropriate. This measure will cost $64.2 million over four years.

8.4 These workforce measures have two rationales. The first is to address the outright, and in some areas critical, shortages of medical services in outer metropolitan, rural and remote areas, as were detailed in preceding chapters. The second issue is to increase the number of general practitioners as a means of leveraging market forces of supply and demand and thereby contain costs. As Mr Davies of the Department of Health and Ageing (DoHA) told the Committee:

> [I]ndirectly, more doctors will mean more competition, which should help restrain fees and out-of-pocket costs to patients.[2]

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1 AMA, Submission 38A, p. 2: see also DOHA, Submission 138, p. 10. See paragraph 4.44 for further detail.

2 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 7

8.5 The current initiatives follow the *More Doctors, Better Services – Rural Health Strategy* announced as part of the 2000-2001 Budget, which included funding for nine new clinical schools in regional areas and three new University Departments of Rural Health, and an additional 100 bonded rural scholarships. Other existing programs include:[3]

- financial incentives for rural general practitioners;
- support for specialists providing rural outreach;
- the Rural Australian Medical Undergraduate Scholarship Scheme (RAMUS);
- the John Flynn Scholarship scheme;
- General Practice Registrars Rural Incentive Payments Scheme (RRIPS); and
- the HECS reimbursement scheme.

8.6 The Medical Rural Bonded (MRB) scholarships attaches to the 100 new medical school places and pays students $20,950 (indexed annually) per year. Students agree to practice in rural areas of Australia for six years upon completion of basic medical and postgraduate training.

8.7 Under the RAMUS program, up to 400 medical students with a rural background[4] receive $10,000 annually, and although not bonded, are required to participate in a rural doctor mentor scheme and undertake rural training activities.[5]

8.8 Under the John Flynn scholarships, medical students commit to a two week placement in the same rural or remote community each year, over four consecutive years of their medical courses. The program has up to 150 new places each year, and covers travel and accommodation with an additional $1000 paid to cover other expenses.[6]

8.9 The Registrars Rural Incentive Payment Scheme (RRIPS) was introduced in the 2000-2001 Budget as part of the Rural Training Pathway, and provides 200 training places for registrars, who receive an incentive payment for every year of their training spent in RRMA[7] 4-7 locations, up to a maximum of $60,000 (on a sliding

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3 DoHA, Submission 138, p 39

4 Which in this case should be distinguished from areas of workforce shortage, which can include metropolitan areas as well.

5 RAMUS information sheet, DoHA website: www.health.gov.au, accessed 23 June 03

6 John Flynn Scholarships information sheet, DoHA website: www.health.gov.au, accessed 23 June 03

7 RRMA stands for Rural, Remote and Metropolitan Area categories. Seven categories are included in this classification – 2 metropolitan, 3 rural and 2 remote zones. The classification is based on Statistical Local Areas (SLA) and allocates each SLA in Australia to a category based primarily on population numbers and an index of remoteness. See http://www.ruraldoc.com.au/

scale according to the percentage of their training time is spent in the designated areas).

8.10 The HECS reimbursement scheme applies to medical graduates and enables participants who undertake training or provide medical services in designated rural and remote areas of Australia to have one-fifth of their HECS fees reimbursed for each year of service.[8] As at September 2003, 80 graduates had applied to the scheme and 63 had received payments.[9]

8.11 These programs appear to have had some success in addressing workforce shortages, although for some of the programs the period of operation is too short to make an informed judgement. According to government figures, the labour supply of GPs in rural areas has increased by 11.4 percent over the last five years, and by 4.7 percent in the past year.[10] While these figures have been questioned,[11] the analysis in chapter 3 certainly supports some degree of improvement, although it may be too early to judge the success of the individual workforce programs discussed above.

Bonded medical places

8.12 The provision for additional medical school places is generally welcomed, although there is the obvious, but inevitable, limitation that it will take ten years before the new university places translate into fully qualified doctors on the ground. However, as Mr Davies noted in relation to GP trainees:

> The fact that they will be working as they train means they will provide an immediate increase in our medical resources in those currently undersupplied areas.[12]

8.13 From the outset it also needs to be recognised that it is unlikely that the additional numbers of doctors created by these measures will fully meet existing needs. As Dr Sprogis observed, no-one has ever successfully achieved a rural and regional work force that is similar to a work force based in a capital city.[13]

8.14 The University of Sydney also noted that these workforce measures fall short of meeting rural needs, even though they complement existing compensatory arrangements:

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8 HECS Reimbursement information sheet, DoHA website: www.health.gov.au, accessed 23 June 03

9 Department of Health and Ageing, Submission 138B, Question 13

10 Department of Health and Ageing, Budget Papers 2003-2004: Continued support for rural and remote doctors.

11 See evidence from the Rural Doctors Association: *Proof Committee Hansard*, Canberra, 28 August 2003, pp. 107 and 109

12 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 7

13 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 12

> … such as the admirable Royal Flying Doctor Service, Aboriginal Medical Services, regional trauma centres, regional obstetric centres and the scaling up of primary care services offered by nurse practitioners do overcome some of these difficulties. However, the disparities in terms of access, quality and timeliness of care remain.[14]

8.15 Nevertheless, it is imperative that steps are taken to equalise numbers to greatest extent possible.

8.16 However, while the additional medical school places received wide support, the tying of these places to bonding provisions has been received far more critically. Critics of the bonded places raised three principle objections relating to:

- equity issues;
- the workability of bonding; and
- the fear that it will create two tiers of medical practitioner.

Equity issues

8.17 Medical students associations around the country expressed strong opposition to the entire concept of bonded places in universities. As well as articulating certain practical concerns, which are dealt with separately below, medical students argued that the bonding system is fundamentally inequitable. According to the Australian Medical Students Association (AMSA):

> Asking students to enter into such strict contracts before they have even begun their studies, and before they have gained some insight into their chosen career is detestable and completely irresponsible. Forcing students to make major judgements about their future in an unknown career is unfair. No student has a complete understanding of what a career in medicine entails before they begin their training. Many of the students who will be tempted into this arrangement could be as young as 17 years old and may not fully comprehend the ramifications of signing the contract. Their situations and plans will change dramatically as they progress through their life and their studies.[15]

8.18 Mr Brown, the National President of AMSA, stressed that the bond is not served until a doctor is fully qualified, which for most doctors takes 10 or 12 years including the time taken to complete undergraduate studies, clinical years as interns, and postgraduate training as registrars. This means that:

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14 Faculty of Medicine University of Sydney, Submission 148, p. 2

15 AMSA, Submission 15, p. 7. The arguments of AMSA are mirrored in the submissions from the state bodies of AMSA: NSW, Submission 160; SA, Submission 207; and WA, Submission 211

> [Y]ou are asking 16- and 17-year-old students to sign a contract which will not affect them for well over a decade, and we think that aspect of the scheme is particularly unfair.[16]

8.19 Professor Marley of the University of Newcastle expressed a similar view:

> The evidence really is that bonding has never been a particularly successful thing anyway, whenever it has been tried. … People do not realise what they are getting themselves into.[17]

8.20 Expressing views supported by the AMA,[18] Mr Brown also pointed to the results of an AMSA survey of 1,000 medical students which found that 98.7 per cent of respondents considered it unfair of the government to require such a decision of medical students, and 96.6 per cent thought that medical students would not have sufficient insight into their career paths to make this decision at such an early stage.[19]

8.21 However, a number of other individuals and organisations indicated support for the general principle of bonding as a solution to the overriding need to resolve the doctor shortages. Dr Moxham told the Committee that:

> People have tried all sorts of ways to get doctors out into small country towns. They have tried giving doctors money. At the end of the day, you have to get people out there. … It is a free choice. These are intelligent people. It is not like they are being forced to do something. They can choose to take the scholarship up, and then they know what the deal is; they know they have to go out to the bush. I think it has some merit. Of all the schemes that have been tried, you have to give this one a shot.[20]

8.22 Ms Anderson told the Committee that the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) also supports bonded scholarships:

> I think it is an indication of our desperation that we will try anything to get doctors out there – and we do not apologise for that.[21]

8.23 In AMSANT's view, increasing the number of medical places, while important, is not of itself enough to rectify current supply and demand problems:

> If these new doctors all end up working where there is an undersupply of GPs then of course it is going to have an impact. But they are all likely to go

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16 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 71

17 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 46: a view also supported by representatives of the AMA, Submission 83, p. 4

18 Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 42

19 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 73

20 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 18

21 Ms Anderson, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 41

> where everyone else goes, which is the north shore of Sydney and the eastern suburbs of Melbourne. Unfortunately, without the second tier – better ways of regulating where doctors set up shop – it will not necessarily have an impact.[22]

8.24 Dr McKenna, from the School of Medicine at the University of Notre Dame, also suggested that bonding is a reflection of an appropriate social obligation owed by those who receive an expensive education:

> I come from a generation where my wife was a bonded school teacher. Life was not easy for a few years but we were in the first generation that got a free tertiary education and there was a social debt that went with that. Perhaps there has been a loss of understanding that there is a responsibility to the providers of this type of expensive education and perhaps attitudes are changing about where people practise and what they do.[23]

8.25 His colleague Professor Carmichael agreed:

> As you have indicated, the medical student societies generally believe that is an unfair approach, but I think that has to be weighed against the requirement to actually ensure that we do have people move to areas of the work force. … I think this is one way of trying to balance up the difficult issue of needing more places – which I think are imperative – and ensuring that at least some of those places will actually end up in the areas of greatest need.[24]

8.26 In supporting the issue of bonded places, Dr Moxham also drew the parallel with scholarships offered by the Australian Defence Force for students to go through medical and dental school under a similar scheme:

> You sign up and you get some advantages, but you know that you have to pay it back at some stage in the future. Those people went into that with their eyes open; they knew exactly what they were doing.[25]

The workability of bonding

8.27 Critics of the bonding arrangements also suggested that it will be ineffective, with many students so desperate to get into university to become a doctor, they will accept a bonded scholarship, but will do so with an attitude of resentment and avoidance. The wider consequence is that it strengthens the perception that working in areas of need, in many cases rural, is an unattractive and onerous obligation to be avoided wherever possible. Dr Mackey suggested that:

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22 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 57

23 Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 22

24 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 62

25 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, pp. 18-19

> [T]he scheme appears to reinforce the image of rural general practice as a sentence rather than an exciting challenge. The package could thus undermine some of the work force initiatives that are out there that the Commonwealth has already started.[26]

8.28 A negative attitude among those fulfilling bonding obligations also has implications for those required to train them. Dr Powell commented on her experience in rural Queensland training doctors under these circumstances:

> I know how difficult it is to have somebody in the area when they do not want to be here. It is very hard work. As soon as they get an opportunity, they go. So you put in a lot of hard work and you know that it is not going to contribute to the long-term solutions for the area or the practitioners who are here.[27]

8.29 Not surprisingly, the doctors who wanted to be there learned a lot while those who resented being there contributed little and were not viewed as 'a good group of doctors to have.'[28] Consequently, the unhappy doctors were unlikely to remain in the area after the period of their bond requirement, while still having absorbed scarce training resources.

8.30 It also evident that the effectiveness of the scheme may be undermined by participants simply avoiding their obligations. This may occur in two ways.

8.31 For some, the bonded places simply offer a path into medical school, after which they have the incentive to pursue qualifications in higher paying specialisations, other than general practice, and buy out of their bonding obligations. On the estimates of the Department, this would amount to a cost of $15,000 per year for each year of default on their bond.[29] This concern was evident in the comments of Dr Mackey of the Rural Doctors' Association, who although not against bonding:

> … feels that, in the way it is set up, there are no incentives to it at all, apart from the incentive of being a medical undergraduate. … The way it is set up, we can easily believe that a large number, if not the majority, will simply pay out their bond. We see it as simply being a fee-paying student, and not much more than that.[30]

8.32 Secondly, bonded doctors may be tempted to take their qualifications overseas. Doctors in North Queensland point out that there is ongoing demand for

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26 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 107

27 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 35

28 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 36

29 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 101

30 Dr Mackey, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 111; see also the AMA's Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 42; Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 32

doctors in Britain, and Europe generally, where they can work under contract with incentive payments and thereby avoid both their bonding and HECS obligations.[31] Mr Grieves, the CEO of Mackay Division of General Practice commented that there is little understanding that doctors are in an international marketplace:

> If you bond the students then all you are doing is encouraging them to go overseas when they finish their training. That is all that is going to happen. … They are not silly people. All they will do is go overseas.[32]

8.33 Newly graduated doctors who go overseas have the opportunity to earn significant amounts free of HECS repayments, making it commensurately easier to buy out their bonding requirements.

8.34 In answering these criticisms, the Department argued that the obligations are not as extreme as many are suggesting. In particular, the bonding applies to 'areas of workforce shortage' which are just as likely to be outer suburban as remote and rural. Furthermore, the scheme will have some degree of flexibility in that graduates will be able to nominate their preferences for particular places and it is not necessary to spend the entire six years in the one place.[33] Professor Carmichael commented that in Tasmania:

> [T]he requirement there is to practise in an area of need – and that could well be in a centre like Launceston which did not happen to have a radiologist or something of that sort – where there is a real requirement in the work force.[34]

8.35 In the view of Dr Tannock and Dr McKenna from Notre Dame University, there is also the increasing likelihood in Western Australia that by the time the new bonded students are being placed in areas of shortage, these areas are most likely to be outer metropolitan areas.[35]

Two tiers of graduates?

8.36 The third major criticism of the scheme is that it will result in lower quality intakes of medical students, creating not only a sub-class of students, but also a sub-class of graduates and the emergence of a two-tiered medical system. It is feared that this lower quality group will then be sent to the areas of workforce shortage. AMSA argued that:

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31 Dr Parker, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 23

32 Mr Grieves, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 36

33 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 100

34 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 60

35 Dr McKenna & Dr Tannock, *Proof Committee Hansard*, Perth, 29 July 2003, p. 23

> Because the scheme is one that lacks incentive and appeal, the Government will be forced to draw its participants from those who have failed to secure a non-bonded position in Medical School. … By targeting vulnerable students who have failed to meet the entrance requirements of a 'normal' position, the Government is shifting the criteria for becoming a doctor away from merit and towards one's level of desperation. This will not result in the best doctors being attracted into this scheme.[36]

8.37 Mr Brown added that the scheme itself contributes to a growing number of reasons why studying medicine is becoming less desirable:

> [F]rom a medical student's point of view, there are more disincentives to studying medicine today than there ever have been. We have an indemnity crisis, we have red tape, we have spiralling HECS costs, we have an increase in postgraduate education costs, we have a restriction on provider numbers and a restriction on college training places, we have increased workloads because of doctor shortages, we have increased demands for family life and a greater lifestyle, we have declining bulk-billing rates, we have decreased public expenditure on medicine and now we are seeing an excessive and, we feel, unnecessary control on medical student places and on students trying to get into medicine.[37]

8.38 However, in the context of the current huge unmet demand for places in medical schools, it is unlikely that the scheme would effectively lower standards. According to Professor Carmichael:

> I think the concern about these students being of lesser merit is a very marginal one when you look at the very large number of capable students we get who just cannot get into the system in any circumstances at the moment.[38]

8.39 This concern should also be considered in the context of a general move away from pure academic standards for selection to medical schools, in order to attract a broader range of people and a more diverse skill set to the medical profession.[39]

Alternatives

8.40 Evidence to the Inquiry canvassed alternatives to the bonded medical school places, which include:

- enhancing and expanding existing workforce measures;

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36 AMSA, Submission 15, p. 8

37 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 72

38 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 62; see also Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 100

39 Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 60; see also Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 24

- commencing the service of the bond period at an earlier stage;
- shortening the bond period; and
- designating the additional medical school places as HECS-free.

8.41 In considering these alternatives, evidence to the Committee supported several underlying propositions. First, measures to address the workforce shortage should provide incentives to participate, and as such, should be voluntary. According to Mr Brown from AMSA:

> The scheme itself paints rural practice in a negative light. By simply having to employ a big stick to enforce this, and to solve the problems, suggests that there is something wrong with rural areas and working in rural areas, and that is obviously not the case – I would like to make that very clear. Rural service does provide many great opportunities for students and doctors but having to enforce such an onerous contract with a big stick and without any incentive paints a really negative picture of that setting.[40]

8.42 Second, past experience has shown that the doctors most likely to remain in rural areas are those that either come from those areas or are trained there. Professor Marley, of the University of Newcastle told the Committee:

> It is very clear that if you have come from a rural background you are much more likely to go back and work there. If you have trained in a rural background, whether you come from metropolitan or rural, you are more likely to stay. If you have got both of those things in place, then you are highly likely to stay.[41]

8.43 Professor Marley's statements are borne out by the findings of a recent AMWAC report, *Career decision making by doctors in vocational training*.[42] Training in rural and secondary hospitals offers additional advantages in medical education, as Dr McKenna explained. Rural hospital experience counteracts the emphasis of tertiary training hospitals on high-technology and high-intervention medicine, which can give medical students a distorted view of what the practice of medicine is actually like:

> That produces two problems: firstly it makes them comfortable only with high-tech interventions and approaches and secondly, it makes them think they are the areas most valued by the community and by other doctors. They do not tend to look outside those areas for their careers very easily. [43]

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40 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 72

41 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 41; see also AMSA, Submission 15, p. 7

42 Australian Medical Workforce Advisory Committee Report, *Career decision making by doctors in vocational training*, May 2002, p. 20

43 Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 29

8.44 The Committee heard anecdotal evidence of opportunities to improve the bonded placements scheme. For example, the University of Queensland receives funding for students to spend their third year at the rural clinical school. This limited opportunity needs to be extended, however:

> If they want to stay for their fourth year – which is optimal because then they will do their first year of internship in a regional hospital, which makes them far more likely to be prepared to consider more rural locations – unfortunately, the funding does not apply to that fourth year. They can be funded for only one year, and at this stage that funding has been determined for the third year. If they stay for the fourth year, our training campus has to bear the cost of that.[44]

8.45 A useful modification of the government proposal could be to enable the bonding period to commence while a doctor is still undergoing postgraduate vocational training, rather than wait until full qualification.[45] This would allow for a less onerous bond obligation but, more importantly, would enhance existing initiatives by creating incentives for students to do part of their training in areas of need – especially in rural areas – thereby increasing the likelihood that they will remain there after qualification. Dr Boffa of AMSANT, explained that working-off the bond period during the vocational training/registrar stage also provides substantial workforce benefits:

> It is difficult enough to get the rural stream filled, so if those bonded scholars choose to go into the rural stream then that should count straightaway because they are a major part of our work force. These registrars do seven clinical sessions a week; they are reasonably competent when they start.[46]

8.46 The Committee notes the concerns of both the Department and the Rural Doctors Association in relation to bonding during training:

> If we were to allow all the bonding to be completed during the training period, those communities would effectively be put into the situation where most of the doctors they would get would be trainee doctors and the mix of qualified and trainee doctors that most other communities expect would not be available to them. It would skew the doctor supply in those areas in that there would be a greater number of trainees.[47]

8.47 The main point of differentiation is the stage of training a doctor has reached. Interns are not yet qualified doctors. As trainees, they require constant supervision,

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44 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 24

45 See for example: Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 112

46 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 60. This idea was supported by Prof Del Mar, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 77

47 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 101

and therefore, do not increase the productivity of a practice. Registrars, although not yet through their postgraduate training, are qualified to see patients independently and require only limited training and supervision, thereby constituting a productive element of the practice workforce.[48] For this reason, it would be viable for bond obligations to be paid off during this later post-graduate registrar period.

8.48 Within the framework of bonded medical school places, another option is to provide some incentive for accepting the bonded places by making them HECS exempt. Mr Brown of AMSA estimated this would amount to around $1.8m in foregone revenue, which is a relatively insignificant amount in the context of overall health spending.[49]

Conclusion

8.49 There is a clear need for additional medical school places and the Committee fully supports the extra 234 positions proposed by the government. In the context of earlier discussions showing that the doctor shortage in Australia reflects in part a maldistribution rather than an outright lack of doctors, it is reasonable to place some bonding requirements on these places. On the evidence presented to the Committee, there also seems little doubt that the additional bonded places will be filled. Mr Wells of the Department of Health and Ageing told the Committee:

> Certainly on the advice we are getting from the medical deans, there should be no trouble filling the places. We have had no advice from the deans other than that they expect to fill all those places and to be able to continue to fill them into the future.[50]

8.50 These views were borne out by academics from the Universities of Notre Dame and Tasmania.[51]

8.51 At the same time, the Committee does see significant practical and equity problems in imposing such significant career choices on students very early in their career. Combined with the absence of any real incentives to join the scheme, the Committee agrees with evidence that suggested that the program's objectives will be highly likely to be undermined by attitudes of resentment and avoidance, reflected in moves overseas, buying out of bonds, or simply poor attitude.

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48 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 112

49 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 80; this idea received support from various commentators. See for example: Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 32; and Dr Glasson, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 42

50 Mr Wells, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 100. Prof Carmichael of the University of Tasmania agreed: *Proof Committee Hansard*, Hobart, 31 July 2003, p. 62

51 Dr McKenna, *Proof Committee Hansard*, Perth, 29 July 2003, p. 26; Professor Carmichael, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 59

8.52 The Committee is also cautious about accepting comparisons with the military bonded scholarships and expecting any sense of social obligation among graduates. In the case of the former, the military pay not only all HECS fees but also a salary, whilst the resulting Return of Service Obligation is calculated as one year in return for each year of training, plus one. In the latter case, a sense of social obligation is less likely in an era of high student contributions.

8.53 It must also be noted that on early indications, the system by which the government will distribute bonded places to various universities appears to be inequitable, with some universities actually *losing* non-bonded HECS places. According to the Department of Health and Ageing, the University of Sydney will offer 27 bonded places in 2004, but will lose 23 standard HECS places over its 2002 enrolment, while Monash University, which enrolled 138 standard places in 2002, will only offer 128 in 2004.[52]

8.54 Overall, in the interests of simplicity and common sense it would seem logical to expand existing measures in preference to commencing an entirely new program. As outlined at the beginning of the chapter, there are a number of programs in place to enhance the medical workforce in areas of shortage. Given the real problems associated with the bonded places, it is surprising that the government now seeks to implement a new and somewhat punitive placements scheme in preference to assessing and, if necessary, refining existing programs.

8.55 For all these reasons, the Committee considers while some degree of bonding is acceptable for public policy reasons, the proposals should be amended to include a greater level of incentives. As AMSA stated:[53]

> I think that with a few subtle changes and a few concessions we will be able to achieve something whereby students will actually want to enter into this scheme, as opposed to it being something which they settle for.[54]

8.56 The Committee is also of the view that the government has still not done enough to recruit students from rural and regional areas. It has been clearly demonstrated that it is students from rural and regional areas that are most likely to return to the bush after they are qualified.

Recommendation 8.1

The Committee supports the proposal for 234 new bonded medical school places, but recommends amending the proposal to enable students to begin working off the bond period during postgraduate vocational training as Registrars.

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52 Department of Health and Ageing, Submission 138B, Question 11. See also *Government 'playing tricks' as medical schools lose out*, Sydney Morning Herald, 8 October 2003, p. 4

53 AMSA, Submission 15, pp. 10-11

54 Mr Brown, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 79

Additional practice nurses

8.57 The proposal to include funding for additional practice nurses, detailed at the beginning of the chapter, received wide support during the Committee's Inquiry. As with other workforce measures, the current proposals need to be considered in the context of an existing program that aims to address the shortage of nurses in general practice.[55]

8.58 This program, announced in the 2001-2002 budget, has three elements. The first provides $86.6 million over four years to general practices to employ more practice nurses. This involves an incentive payment in the order of $8,000 per GP and is available to practices in rural and other areas of workforce pressure. The incentive is paid quarterly in line with the current PIP payment process, with a rural loading applicable to practices in regions categorised under the Rural, Remote and Metropolitan Areas (RRMAs) index, levels 3-7.

8.59 The second allocates $12.5 million over four years to provide training and support to nurses working in general practice, with the immediate priority of enhancing support infrastructure for nurses in general practice, through: developing information resources on nursing in general practice; identification of the training and education needs of nurses; and working with the Divisions of General Practice to increase their capacity to support practice nursing through sharing the knowledge and infrastructure between Divisions.

8.60 The third provides $5.2 million for 400 nursing scholarships per annum, aimed at removing some of the barriers for former nurses living in rural areas to re-entering the workforce. The scholarships provide recipients with financial assistance of up to $3000 and target former nurses in rural and remote areas who wish to return to work in the non-acute health sector.[56]

The role of practice nurses

8.61 It is clear from the evidence received during the Inquiry that practice nurses are both a valued and often underutilised resource for general practice. The Office of Rural Health listed of the roles for practice nurses as including:[57]

- clinical nursing services;
- coordination of patient services;
- management of the clinical environment by assisting the practice to meet relevant standards and legislative requirements;

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55 Practice Nurses – Extending Primary Health Care, Rural Health Website, www.ruralhealth.gov.au/workers/practicenurses.htm

56 The Australian Remote and Rural Scholarship Program

57 Office of Rural Health, website: www.ruralhealth.gov.au accessed 12 September 03

- health promotion and education activities;
- management of human and material resources; and
- management of health through immunisation, recall systems and acute and chronic disease management.

8.62 A practice nurse is thus able to perform a wide range of administrative and clinical tasks that enables the doctor to focus attention on a smaller number of more difficult issues, representing a more efficient allocation of resources. As Ms Mohle, from the Public Hospitals, Health and Medicare Alliance of Queensland told the Committee:

> There is basically very little case management and case coordination that goes on. The practice nurse positions that have been put in place in a number of general practices are beginning to do that. That is an essential issue that needs to be addressed. There needs to be a coordination of care across practice settings and a focus on primary health care rather than on curing people once they get into the acute care system.[58]

8.63 Dr Ruscoe, in putting forward a model for Integrated Primary Care, argued that proper levels of support from practice nurses and nurses with specialist qualifications (such as in population health nurses or educators) is critical to the ability of GPs to provide proper care and to implement chronic care initiatives such as the EPC program.[59]

8.64 Nurses offer other advantages as well, as Professor Wilson explained:

> [F]rom a consumer perspective, particularly in rural areas, where the work force is predominantly male, nurses can offer a balance, particularly for women, who may want to have some sorts of service provided to them by another woman, and nursing is still largely female dominated in that regard.[60]

8.65 While the value of nurses in general practice is not doubted, the Committee received mixed evidence in relation to the numbers needed. Hunter Health in Newcastle told the Committee that in their experience, a ratio of between 1 – 1.3 practice nurses per GP is ideal.[61] Similarly, Mr Walters representing the ADGP explained that:

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58 Ms Mohle, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 13

59 Dr Ruscoe, Submission 153, pp. 10-11. this list could be widened to include specialist nurses such as midwives and theatre nurses: Ms Stratigos, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 25

60 Professor Wilson, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 23

61 Professor McGrath, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 13

> The ratio would depend to a certain extent on the style of practice and on its location. However, utilised correctly, a ratio of one practice nurse to every two or three doctors would seem to be about right.[62]

8.66 In contrast, Dr Moxham, President of the Non-Vocationally Registered GPs, suggested that while nurses are very useful and the rural practices use nurses a lot more than the city areas, he did not think 'the average, middle-of-the-city GP necessarily needs a nurse'.[63]

Scope of the program

8.67 While there is virtually universal support for the proposal to provide additional practice nurses, the view expressed by many witnesses to the Committee was that the government's program does not go far enough. The AMA, among others, would like to see the additional nurses available to all practices, rather than just those participating in GPAS:

> The practice nurses are seen as a great boon. All doctors that have practice nurses believe that it makes them more efficient, they give better service et cetera. Whether it will actually encourage bulk-billing I am not sure, but one way of extending the medical workforce is to assist with practice nurses. We would like to see the government, in the 'A Fairer Medicare' package, incorporate practice nurses right across the board.[64]

8.68 The benefits of practice nurses being more widely available received support from Dr Walters of the ADGP:

> [T]he practice nurse initiative has been very successful. In this time of gross general practitioner shortages, we believe that an extension of that right across the system could help alleviate some of the problems by taking the pressure off general practitioners in the short term whilst measures are taken to increase the number of general practitioners in the community.[65]

8.69 The cost of widening the program in this way is surprisingly modest. According to Mr Davies of the Department of Health, the total gross cost (including existing programs) of providing one practice nurse for every two GPs would be around $320m per year.[66]

8.70 Perhaps the wider problem is the capacity to find additional nurses in the context of an existing national shortage,[67] while ensuring that nurses attracted into

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62 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

63 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 7

64 Dr Bain, *Proof Committee Hansard*, Canberra 21 July 2003, p. 21

65 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 64

66 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 97

67 Professor Hall, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 23

general practice by these policies are not drawn out of the hospital or aged care systems which can ill-afford to lose them. However, according to the evidence of both the Department and Dr Sprogis of the Hunter Division of General Practice, this is not generally a problem, with most nurses being drawn from the pool of those who have left nursing for reasons of family and other pressures. This group finds that general practice offers a very flexible work environment:

> It is not critical to have a nurse on board all the time. If they have to knock off to pick up their kids from school, for example, they knock off at three o'clock and off they go, having done six hours work rather than the full seven or eight – and no nights of course. We have had a bit of a look at the nurses that we have recruited and it appears that we are not pulling them out of the public hospital system; we are pulling them from this other pool – that is, the thousands who are out there that have knocked off nursing.[68]

Conclusion

8.71 In line with most evidence to the Inquiry, the Committee supports the government proposal for additional practice nurses. Wider use of practice nurses has the potential to significantly reduce the burden on GPs, particularly in rural areas where the workloads are high. However, the Committee also strongly supports the view that the nurse initiative should not be limited to those practices that decide to sign on to the government's package.

8.72 The Committee appreciates the government's desire to attach as many inducements as possible to the package to encourage the participation rate. However, the importance of practice nurses to relieving the current workforce shortage, and their key role in achieving the transition of the general practice to a more integrated primary care focus, combine to create a powerful argument to support a more universal scheme, especially in light of the modest cost. It should also be recognised that, on all present indications, very few practices around Australia will actually sign up to the government package, which makes the likely effects of the additional nurses part of the package negligible.

8.73 The Committee also notes the concern of Ms Mohle, of the Queensland Nurses Union. She says that if the federal government does not provide the leadership in recruitment and retention of nurses, the likelihood is that various state government programs will be at cross purposes. Ms Mohle said:

> [T]he state governments in various forms … have all had their own recruitment retention task force or their equivalent processes … There have been some improvements in Queensland because of our local recruitment

68 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 14. See also Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 24

> retention task force, but it is a national problem and, by solving problems in one state, you create problems in another area.[69]

8.74 Accordingly, there is a need for the Commonwealth government to create national policies.

Recommendation 8.2

The Committee recommends that the government expand the existing program for the provision of nurses, allocating assistance on the basis of need rather than limiting it to 'participating practices' in the government's 'A Fairer Medicare' package.

Assistance with IT infrastructure

8.75 The government package includes measures to support general practice to adopt electronic connectivity with the Health Insurance Commission, via HIC Online. Measures include reducing the direct billing payment lag from the HIC to general practices from eight to two days; incentives to providers of GP software to incorporate HIC online links in their software; and, for each practice that opts into the government package, a payment of $750 in metropolitan areas and $1000 in rural and remote areas to assist with equipment and set up costs. These measures are costed at $24.3 million over four years (depending on take up rates).[70]

8.76 Mr Davies from the Department of Health and Ageing also noted that this specific assistance to support the cost of introducing broadband technology in rural regions is intended to work in conjunction with wider government measures to roll out broadband access into remote areas. Mr Davies pointed out that:

> [W]e are not here talking about setting up broadband for health and then going and setting up broadband again for some other government initiative. This is an issue where there is potential for synergy across government initiatives. As I mentioned, we are working with other government departments and government bodies to have an integrated approach to this broad-banding issue.[71]

8.77 Reactions to these proposals were similar to the reactions to proposals for additional practice nurses. Most commentators considered the proposals to be a positive development, but queried whether the proposed level of assistance is adequate relative to the costs involved in getting practices online. Secondly, there was criticism of the limitation of key parts of the proposal to 'participating practices'.

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69 Ms Mohle, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 11

70 Department of Health and Ageing, Fact Sheet 8: Business benefits for general practice

71 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 53

8.78 Evidence by doctors suggested that getting practices properly equipped and operating the HIC online services carries an average cost of $30 000, but can go as high as $70 000.[72] Rural practices face much higher set up costs for IT infrastructure, as Ms Stratigos of Rural Doctors Association explained:

> [W]e are told by rural doctors that they just laugh at $1,000. In fact, we recently saw a quotation for $30,000 for a practice to upgrade itself to broadband. As you are aware, you are not just paying for the technology; you have to pay for the travel and accommodation of the people who are going to do it, and so on. So is there provision for the actual cost of providing broadband and the related technology? If there were not, clearly doctors in rural and remote Australia would be puzzled by the advantage of this offer.[73]

8.79 Dr Kastrissios, a Queensland doctor, told the Committee:

> It is going to be quite interesting to see what happens in the next three years. I can guarantee you that the degree of technical expertise that you have to buy in to maintain a viable, secure private network in your practice has been underestimated by most general practitioners.[74]

Conclusion

8.80 In general, the Committee supports the policy to provide assistance to practices to get access to online services. In the short term it offers important efficiencies for general practice operations and in the longer term represents an important stepping stone to the adoption of higher technology practices, information sharing, electronic patient records and online education.

8.81 For these reasons, the Committee does not agree with the government policy to limit these assistance measures to 'participating practices' – for the same reasons it objects to this policy in relation to the provision of practice nurses, discussed above. The Committee acknowledges Mr Davies' point that 'this is all part of an incentive package to get practices to behave in a particular manner, therefore there is a logic to making it available to those practices who come to the party, as it were.'[75] However, wide-scale national adoption of best practice information technology is in the national interest and should be encouraged for all practices.

8.82 The Committee has not received sufficient detailed evidence to make a final determination of what the appropriate dollar figures for the assistance should be. In general terms, the Committee accepts that the costs associated with getting online are likely to be quite high, but at the same time, the incentives are not designed to meet

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72 Ms Nesbitt, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 43

73 Ms Stratigos, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 52

74 Dr Kastrissios, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 101

75 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 53

the whole of the cost, but rather to make a contribution. This is appropriate given that, notwithstanding its wider significance to best practice health care, information technology is a business cost that must be met by all businesses and one that offers a general practice significant financial dividends through increased efficiencies.[76] As such, there should not be an expectation that the government shoulder the majority of the cost.

8.83 The Committee also agrees with the view put by the ADGP that facilitating access in each area is an ideal role for the Divisions, and recommends that this option be given further consideration and support.[77]

Recommendation 8.3

The Committee recommends that the government provide support to all general practices to assist with the costs of adopting information technology and accessing HealthConnect online. Access to the program should not be limited to 'participating practices' in the government's 'A Fairer Medicare' package.

76 see for example the comments of Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 17

77 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 66