Submission No 47

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

Organisation: AMA NSW

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The Australian Medical Association of New South Wales (''AMA (NSW)'') provides its submission to NSW Parliament regarding the Inquiry into the implementation of Portfolio Committee No. 2 recommendations specifically relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

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The Australian Medical Association of NSW ''AMA (NSW)'' is grateful for the opportunity to make a submission to the Legislative Assembly inquiry, chaired by Dr Joe McGirr.

AMA (NSW) is a medico-political organisation that represents more than 8,000 doctors-in-training, career medical officers, staff specialists, visiting medical officers, specialists, and general practitioners in private practice. Doctors working in remote, rural and regional areas are highly trained and care deeply about their patients and improving the system of care available to them.

AMA (NSW) acknowledges the distinct challenges facing remote, rural and regional healthcare workers, as well as the flow-on effects to health outcomes, patient experiences, wait-times and quality of care for people who live in rural, regional and remote NSW. AMA (NSW) emphasises that improvements in workplace culture, funding, and workforce supply would play a significant role in reducing the disadvantages in accessibility and health outcomes experienced by non-metropolitan individuals enumerated in the Legislative Council's Portfolio Committee No. 2 Report findings.

AMA (NSW)'s submission regarding the implementation of the recommendations of Portfolio Committee No. 2 has been prepared with the input of our members who have experience working in rural, regional and remote facilities. The input covers a range of experiences from the perspective of doctors in training to senior practitioners. We believe their feedback and observations are invaluable on such a topic.

Please note at the end of our submission AMA (NSW) has included two additional reports, both stemming from the Regional Specialist Forum AMA (NSW) held in Wagga Wagga NSW in 2013 that may be of interest to the Committee.

AMA (NSW) believes that residents in remote, rural and regional (RRR) areas deserve the best possible services in terms of the full suite of specialists available in acceptable reach from their home. Those who live outside our metropolitan areas remain outliers who must contend with sub-standard care.

It has been seventeen months since the release of recommendations made in the Portfolio Committee No.2. In this period AMA (NSW) recognises that while there have been some improvements, many of the recommendations are yet to have resulted in significant change.

It is the view of AMA (NSW) that government initiatives designed to reinvent and expand initiatives designed to attract and more importantly to retain doctors to RRR areas are lacking.

Medical Workforce

As noted in the Committee's report, attracting and retaining doctors and other health professionals to live and work in rural and regional areas is the key issue for regional health services. The Inquiry unfortunately perpetuated a negative public perception of RRR health as poorly resourced and associated with poor outcomes. This narrative was not a fair reflection on those working in rural and regional NSW and may have served to further discourage doctors from moving to RRR communities. While COVID was also a likely factor, the timing of the inquiry also coincided with a notable reduction in applications for the regional general practice training pathway.

Recognising this, it is critical that the NSW Parliament ensures a continued focus on medical workforce and the attraction and retention of doctors in regional areas.

While AMA (NSW) has not undertaken detailed research regarding attitudes and expectations of doctors with regard to their work, in providing assistance to doctors with enquiries regarding their working arrangements, we are seeing a significant change in expectations.

AMA (NSW) held a forum regarding the regional specialist workforce a decade ago. The recommendations of the forum were not implemented but remain sound, if not even more critical.

In surveys conducted by AMA (NSW) over time, doctors working in regional areas reported being on call more frequently than metropolitan colleagues and being required to be called in more frequently. With many training programs continuing to rotate junior registrars to regional areas and to ensure trainees are not working unsafe hours, this adds to the burden of regional consultants. While this was once an accepted part of regional and rural practice, understandably, there is less desire to undertake such working arrangements. As such, Local Health Districts must be accountable for not only maintaining the current medical staffing levels but planning to increase the medical workforce where required.

As an example, AMA (NSW) recently assisted the anaesthetists of Tamworth who have been seeking to negotiate terms and conditions that they felt may assist in attracting doctors to live and work in Tamworth. Like in many regional areas, the majority of the department is aged over 50 years old. Despite members of the department actively seeking to encourage new consultants to come to the hospital. Through a mediation under the VMO Determination, agreement was reached to trial different contractual arrangements, including a one in twelve roster. While the negotiation was significantly limited by the wages policy and the constraints of the VMO Determination (and will be

less effective due to these factors), the situation in Tamworth is indicative of the need for RRR health services to be more flexible in their arrangements to attract doctors.

Similarly, AMA (NSW) is currently assisting a surgical department at a major regional hospital. The department had previously had 8 members but now has 6. The LHD is refusing to advertise for additional positions or to provide locum cover. This is even though there is no additional cost associated with appointing additional Visiting Medical Officers (VMOs) to a Department. VMOs are contactors who are paid if they work. The work available to be undertaken by the VMOs is the same irrespective of the number of Visiting Medical Officers – they do not bring with them an additional burden of disease or injury. Instead, the only possible reason for limiting the number of VMOs in a department is a desire to reduce or hide the unmet burden of disease, also known as *the hidden waiting list*.

AMA (NSW) has also been assisting doctors working in oncology in the regions. Oncology is a critical service for regional and rural communities. While not all services will be able to be provided in RRR areas, it should be a stated objective of our health system to aim to provide as much oncology care as possible as close to people's homes. However, our experience is of oncologists seeking to work in the public hospital system or seeking to expand their services into communities and being unable to do so.

Anecdotal evidence from our members suggests that complex bureaucracy and a lack of support navigating it, is a continuing issue for VMO retention in remote, rural and regional areas. VMOs feel unsupported, and, in some cases, feel that barriers are imposed in areas such as submitting billings and gaining access to their Professional Support Payments ("PSP"). AMA (NSW) strongly believes small gestures can go a long way here, such as LHDs providing billing support and not pushing back on PSP to the point where it renders the program ineffective in retaining the regional workforce.

AMA (NSW) therefore recommends that a full review of the current workforce be undertaken with LHDS required to provide advice regarding the demographics of the current workforce and feedback from doctors working in the hospital regarding intentions for work, preferred on call models and gaps in the roster.

AMA (NSW) also calls on the Parliamentary Inquiry to direct the Ministry of Health to urgently and genuinely engage with AMA (NSW) regarding a review of the Visiting Medical Officer Determination. AMA (NSW) wrote to the Ministry regarding a review of the Determination in November 2022, and has met and written further, and is yet to receive a definitive response to our position.

AMA (NSW) has also been concerned by recent media coverage conflating the work of VMOs and locums. We note that locums remain an important part of the service delivery model in RRR areas. However, it has been damaging and inappropriate to confuse the roles. Visiting Medical Officers are a critical workforce in rural and regional NSW, and they ensure that regional centres are able to develop both public and private based health services. Their role should be promoted and supported rather than vilified. Without VMOs, RRR areas will be left with a significant void.

Aside from specialist workforce, there is a dire shortage of GPs in RRR areas. Despite the recommendations, primary healthcare access has continued to deteriorate in remote and rural areas, with 72 GPs moving from rural and remote areas to larger regional cities in the second half of 2022 alone. AMA (NSW) recognises that the responsibility for improving GP numbers rests with the Commonwealth Government, however, we also believe that the NSW Government has the

opportunity to make a positive contribution to encouraging doctors in training to pursue general practice in rural and regional areas.

On 14 September 2023, Federal AMA released the AMA plan for improving access to rural general practice, detailing solutions to the current issues of retention and supply of GPs in RRR areas. While there is much focus on medical students experiencing rural and regional practice, the anecdotal advice is that this exposure is too early in their life and career to be meaningful. Instead, NSW Health should be focusing on ensuring that doctors in training, including interns, are encouraged and supported to work in regional areas. This could be directly measured by assessing the number of final year medical students to select regional hospitals as their first preference. This could be measured and reported on as a KPI.

AMA (NSW) acknowledges that the Ministry has implemented recommendation 14 to address the disparity in regional and rurally based doctors in training being able to access financial and accommodation support (noting the current industrial arrangements provide financial and accommodation support to metropolitan doctors moving to regional areas but not regionally based doctors moving to metropolitan areas.) However, this recommendation does not extend to interns and may not be sufficiently attractive to be of benefit, noting increasing costs. It also should be enshrined within the Award and actively promoted to ensure that doctors are encouraged and able to claim it.

For the promotion of a GP workforce in rural NSW, AMA (NSW) supports the continual expansion of programs that provide doctors-in-training (DiTs) with prevocational general practice placements in those rural areas. Such programs will both support the workforce in these areas and promote generalist careers in rural areas by providing valuable insight into life as a rural GP. AMA (NSW) also supports the introduction of a single employer model (SEM) as one option for GPs in training to ensure equity of employment conditions with non-GP specialist trainees and to encourage a career in general practice. However, in implementing this model, it is essential that it is done with the full support and engagement of local general practices and the recognition that one of the primary goals of the SEM should be to build capacity in general practice, not simply to develop a hospital workforce.

Anecdotal evidence from our members suggests that complex bureaucracy and a lack of support navigating it, is a continuing issue for VMO retention in RRR areas. VMOs feel unsupported, and, in some cases, feel that barriers are imposed in areas such as submitting billings and gaining access to their Professional Support Payments ("PSP"). AMA (NSW) strongly believes small gestures can go a long way here, such as LHDs providing billing support and not pushing back on PSP to the point where it renders the program ineffective in retaining the regional workforce.

An AMA (NSW) Councillor has emphasised how the requirement for repeat referrals to specialists is contributing to many GPs' books remaining shut and long wait times. When these referrals expire, which can occur where a planned surgical procedure does not occur in the designated clinical timeframe, patients must return to their GPs for referrals back to their specialist for reassessment.

Contracts for GP VMOs

AMA (NSW) acknowledges the work NSW Health has undertaken since the release of the Committee's report regarding GP VMO arrangements. The Ministry of Health has created a working group and facilitated a mediated process to seek to identify and implement changes to the payment arrangements for GP VMOs. AMA (NSW) has been pleased to support this process and encourages the Ministry to continue to work towards innovative, flexible solutions for workforce issues. We note in this regard that the discussions have occurred around the existing budget framework. We recognise

that there is a need to ensure that different models of engagement do not adversely impact on regional LHDs and AMA (NSW) calls for sufficient additional funding for LHDs to implement the changes.

Ensuring flexible and patient centred focus towards medical roles

Doctors working in RRR areas have deep concerns in relation to the trend towards increasing qualification requirements, which can make it impossible for staff currently working in clinical settings to fulfill roles for which they are skilled and able.

AMA (NSW) members have reported that there are doctors in RRR areas who have the skill and experience to safely work in roles that hospitals are struggling to fill and who would like to work in these roles. However, they are barred by the increasingly niche nominal qualifications for such positions.

The ability to acquire appropriate specialist qualifications is restricted due to geographic isolation, forcing doctors to move to metropolitan areas to acquire further formal education – thereby exacerbating the loss of doctors in RRR areas. Otherwise, they become victim to skill decay.

AMA (NSW) acknowledges that patient safety is of utmost importance, and specialist titles and nominal qualifications may be a tool protecting patients from underqualified care. However, it is important to note that in non-metropolitan areas, patient safety is also undermined when service offerings in rural and remote areas are so limited and specialist expertise becomes consolidated elsewhere, forcing patients to travel significant distances to access care that is technically, but not necessarily substantively, superior.

One member noted *"The drive towards 'standard of care' has devolved to an insistence on nominal qualifications that are interminably elusive in a rural area - whether it is another Fellowship or some other additional specialty qualification; it also deskills, demoralises and deters existing providers from long term commitments to service provision."*

It is our strong view that the RRR workforce should be offered greater training and education opportunities to increase qualifications in the location of their employment. There must also be increased flexibility in recruitment to enable doctors with adequate training and experience, but no conferral of formal fellowship or either title, to provide services to their communities.

One positive example was noted by a member from the Illawarra Shoalhaven Local Health District who observed a palliative care hospital recently removed the restriction that only palliative care specialists could apply for the role as a GP VMO. AMA (NSW) believes this kind of flexibility will lead to greater patient care.

Staff accreditation and training:

Some of our members have observed a noticeable improvement in efforts to increase mandatory training compliance within the medical profession.

Once again, the lack of effective training opportunities in RRR NSW needs to be addressed. There needs to be greater continuation and expansion of training in rural NSW to promote medical careers in these areas and provide support to the hospitals.

This includes increased exposure to rural practice as part of medical school placements and prevocational training and expanding the capacity of remote learning in rural sites.

AMA (NSW) supports recent moves to address the lack of training opportunities, particularly the introduction of the SEM as referenced above.

Workplace culture

Engaging external consultants to complete independent reviews of workplace culture has culminated in a failure to appropriately consult and seek input from the local workforce providing health services. AMA (NSW) emphasises that by listening to the feedback and opinions of the health workforce at first instance, the costs of engaging these independent reviewers could be minimised and increased resource efficiency could be realised.

Feeling valued in the workplace is important, possessing strong links to staff retention and well-being. Members of AMA (NSW) working in remote, rural and regional areas continue to feel underappreciated by their LHDs, which should be of serious concern to the NSW Ministry of Health given the scarcity of staff and difficulties of recruiting in rural and remote Australia.

Transport

In NSW Health's examination of the funding for air transport in rural and regional NSW per recommendation 4, AMA (NSW) encourages the consideration that any mobilisation of air transport prior to a local clinical assessment is inappropriately wasting of health funding.

Additionally, AMA (NSW) notes that many of the agencies, programs and incentives recommended have not been enacted. For example, while recommendation 4 was accepted by NSW Health, the introduction of a Rural Area Community Controlled Health Organisations (RACCHOs) pilot did not make an appearance in the 2022-23 budget.

Therefore, AMA (NSW) encourages further review on the current funding models in NSW Health and reiterates the need for further funding in all the areas covered by the recommendations mentioned above: promotion and maintenance of an effective GP and staff specialist workforce in rural and regional NSW, increased training opportunities for rural doctors and rural work experience for medical students, and the maintenance of a healthy workplace culture for NSW health employees.

Attempts at addressing the lack of funding, and the subsequent issues with resource distribution and workforce shortages, convey the need for further review of the funding of rural and remote health care. For example, an AMA (NSW) Councillor has raised the issue that the transfer of patients between smaller hospitals and their designated referral hospital, including community hospitals to base hospitals and base hospitals to tertiary centres, is not working. On a daily basis, the hospitals can frequently decline the transfer of patients due to a lack of beds and resources. As a result, unwell patients are left in centres that do not have the expertise to treat them, causing a deterioration of their condition. Thus, funding for agencies, programs and incentives, such as those outlined in the recommendations, must continue to be reviewed and analysed to ensure patients are given fair access to quality treatment.

Lack of innovation

Lastly, AMA (NSW) notes that there is still a startling lack of innovation when it comes to the programs and incentives. An AMA (NSW) councillor has noted that there is the potential to use latent private capacity in general practice to help alleviate pressures on the emergency departments. For example, there exists 'win-win' opportunities for rural LHDs to engage and incentivise rural GPs in after-hours 'sweeper roles' to ensure that those in residential aged-care facilities stay out of hospital and emergency departments on the weekend.

AMA Recommendations For Focus in RRR Health

AMA (NSW) does not believe that recommendations previously provided to the Legislative Council have been heeded. These recommendations provide a broad range of opportunities to continue to develop and attract a high-quality RRR workforce and are

1. **Doctors in Training (DiTs)**
    - The provision of allowances and incentives for DiTs to rotate from regional hospitals. It is noted than an allowance has been implemented via policy, however there should be a review on whether the allowance is sufficient in quantum and scope.
    - Review the accreditation of Rural and Regional hospitals to allow for further College training programs across more specialties
    - Audit of and reporting on the number of interns preferencing regional hospitals
2. **Visiting Medical Officers (VMOs)**
    - Greater flexibility in relation to on-call commitments; and
    - Access to Professional Support Payment to VMOs in regional areas in accordance with the terms of the Determination and to give effect to the policy behind the payment – namely, to attract and retain VMOs in regional communities and the indexation of the payment.
    - Review of current workforce and Department structures and future intentions
3. **Career Medical Officers (CMOs)**
    - An increase in CMO roles to attract those medical practitioners who are not seeking to practice as a specialist seeking to establish themselves and their families in a regional or rural location.
4. **Remuneration**
    - Review of VMO Fee-for-Service rates and allowances to access additional payments, such as claiming sessional rates in circumstances where the CMBS prevents payment for service; and
    - With the Commonwealth Government, review of CMBS for General Practice item numbers for rural and regional GPs.
5. **Relocation Grants**
    - An extension of relocation grants to specialists, for those specialities in shortage, including but not limited to psychiatry, cardiology, neurology and oncology.
6. **Oncology**
    - Decentralisation of radiotherapy and chemotherapy services to reduce travel time for cancer patients, particularly in the Western NSW and North Coast NSW Local Health districts.

Conclusions

The Remote, Rural and Regional Health Inquiry presented both risks and opportunities. It provided the opportunity for greater focus on the needs of RRR communities and their right to access comparable levels of healthcare to those living in metropolitan areas. However, it also presented the risk of undermining the trust and confidence of rural and regional communities by unduly highlighting situations in which there were challenges to delivering care.

For too many decades, it has been too easy to focus on the need to compel healthcare workers to work in rural and regional NSW. AMA (NSW) continues to maintain that the key to attracting and retaining doctors to rural and regional areas is to provide excellent and supported working opportunities. There is a need to ensure that contractual arrangements do not disadvantage those living and working in regional and rural areas and that every effort is made to highlight the value of working in these areas.

We note the efforts to improve the support available through the Ministry including the establishment of a Deputy Secretary for Regional Health and the establishment of the Minister's Advisory Group on Regional Health. As both of these arrangements have only been in place for a short period of time, it is difficult to evaluate the effectiveness of these structures, however, we welcome any dedicated focus on rural and regional health and clear channels of accountability and engagement.

AMA (NSW) also recognises the important role of other key organisations within the sector. In particular, we acknowledge the contribution of the Rural Doctors Network in strengthening links in the sector and the state and federal level leadership they offer. We note that it is common for governments at both state and federal levels to seek to change structures in response to what they see as challenges. We would be concerned to see any reduction in the role and significance of the Rural Doctors Network.

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AUSTRALIAN MEDICAL ASSOCIATION
NEW SOUTH WALES

AMA (NSW)
Regional Specialist Workforce Forum
Wagga Wagga, 3 December 2013

Background paper

Welcome to the AMA (NSW) Regional Specialist Workforce Forum and thank you for your commitment to address medical specialist shortages in regional, rural and remote New South Wales.

This Forum brings together representatives of the profession from colleges, specialists, doctors-in-training, medical schools and students, together with the NSW Minister for Health, the NSW Parliamentary Secretary for Health and members of the Ministerial Advisory Committee for Rural Health, to consider practical strategies to broaden the clinical services available to non-metropolitan patients.

Issues of health equity for Australia's rural and regional populations, including medical workforce supply and distribution, have long been a concern of governments, the medical profession and communities. Over the last decade, governments in particular have sought to redress imbalances in the medical workforce with successive initiatives, of which there are now dozens, including the development of recent policies, such as the NSW Government's NSW Rural Health Plan (currently in development) and the Commonwealth Government's National Rural and Remote Health Workforce Innovation and Reform Strategy. We acknowledge and commend the work done by stakeholders in this area that has to date particularly focussed on provision of primary care to rural and remote communities. While all areas of rural and regional medical service delivery need ongoing support, the focus of this forum is to address issues relating to the regional hospital specialist workforce, to ensure that regional centres offer excellent secondary levels of care to their own communities and catchment areas.

By way of background to discussion at the Forum, this paper provides an overview of:

1. **The health of regional and rural NSW**
2. **The medical practitioner workforce in regional NSW**
3. **Keythemes in the recruitment and retention of doctorsinregional NSW, particularlyin relation to the specialist workforce.** A description of existing government policies, a summary of evidence-based policy approaches, and data from recent AMA (NSW) surveys are also included as **Appendices A-C.**

1. The health of regional and rural NSW

Forty per centof NSW'spopulation does notlivein Sydneyanda quarter, or 1.8 million, live outside of metropolitan areas.[1] Although NSW's regional and rural communities are highly varied inmany respects, overall they face similar issues of disadvantage relative totheir urban counterparts in relation to their health and welfare.[2]

LimiTed ACCeSS To ServiCeS

People in rural and remote areas have more difficulty accessing health services for a variety of reasons. Some of the factors affecting access to medical services for regional and rural populations include:

- **Socioeconomic disadvantage:** Many regional communities are at a relative disadvantage in terms of lower income and lower levels of education, as well as higher rates of unemployment, less access to public transport and poorer telecommunications. This affects the ability of these populations to access health information and services, and make informed choices about their health, as well as their ability to pay for health services.[3]
- **Fewer doctors, furtheraway:** Not only are there fewer doctors per capita outside of major cities, but patients have to travel longer distances to access services, especially specialist services, with accompanying financial, time and social costs. This results in a higher proportion of patients delaying seeing a GP due to cost and reporting higher than acceptable waiting times to see a GP or specialist. In addition, those in inner and outer regional areas experience significantly longer wait times for elective surgery as compared with those in major cities. People outside of major cities also have higher rates of potentially preventable hospitalisations for chronic conditions, again reflecting a possible lack of outpatient services. It should be noted, despite some negative sentiment relating to time spent with clinicians and longer wait times, patient satisfaction with their treating doctors remains high across geographical locations.[2]
- **visiting health services:** rural and regional areas also receive a greater proportion of their services from visiting health professionals, in particular specialists. Visiting health professionals help to lessen the travel burden on patients, and may be ideal options in certain specialty areas or as relief for local clinicians. However, they often provide services at increased costs, without the benefits of continuity of care and regularity of access that are likely to come from local services.
- **Telehealth:** video consultations are increasingly being used since the introduction of Medicare rebates and incentives forpractitioners.[4] Telehealth has thecapacity to provide aneffective adjunct to(but not replacement of) traditional health services for regional and remote communities. In the areas of specialty to which it is amenable, Telehealth offers advantages of access to a wider range of specialists without patient travel, as well as continuity of care. Significant issues however remain with regards to adequacy of the current technology, skill sets of local staff and the provision of a service that is not equivalent to an in-person consultation.
- **other health services:** There are also deficits in relation to numbers and provision of dental, mental health, and allied health services, [5] and longer wait times for residential aged careoutside ofmetropolitan areas.[2]

HigHer riSK FACTorS

Lifestyle factors play a significant part in the poorer health of regional communities, with higher rates of smoking, alcohol consumption and obesity, and lower levels of physical activity. Health risk behaviours are even higher amongst those who live in areas of socio-economic disadvantage outside of major cities.[6] Health promotion in regional communities must continue to be an ongoing priority of governments and health professionals.

HeALTH ouTComeS

Many health outcomes are worse for regional and rural populations.[7] Regional and rural communities also have a proportionately higher Indigenous population, whose health risks and outcomes across all measures are significantly worse than non-Indigenous Australians.[8,9]

These disparities in health outcomes include:

- higher incidence of death from all causes, resulting in a lower overall life expectancy, with the greatest gap in life expectancy experienced by the Indigenous population;
- higher incidence of low birth weight neonates andperinatal mortality;
- increased incidence of death, injury and disability amongst the Indigenous population and young adults in regional communities due to higher rates of violence, accidents and suicide;
- higher incidence of many chronic conditions that together with later diagnosis and limited treatment options impact survival rates of patients. Cancer is one such condition,[10] although it is hoped that through increasing Cancer Care Centres across NSW outcomes will improve.

2. The regional specialist workforce

WHy Are regioNAL CeNTreS imporTANT?

Regional populations continue to grow, primarily through net migration (intrastate, interstate and overseas), and secondarily through natural increases (births minus deaths). Areas projected to experience the greatest growth are along the coast, surrounding the ACT, and in the Hunter region and mining boom areas, while many remote areas, particularly in the north west and south west of the State, will continue to see a decline in populations.[1] Populations in regional and remote areas will also continue to age at a faster rate than metropolitan areas,[1] creating increased health service needs.

With centralisation and rationalisation of services, and decreasing numbers of rural and remote GP proceduralists, regional towns are becoming increasingly important centres of service delivery to their own growing populations and surrounding rural and remote areas. It is therefore critical to ensure that these centres have adequate health workforces, including appropriate specialist services and associated infrastructure. Understanding the patterns ofpopulation growth and individual community characteristics is critical to the long-term health services planning required.

WorKForCe NumBerS, diSTriBuTioN& NeedS

The number of medical clinicians has increased in recent years on average across all areas of remoteness in Australia. These numbers are likely to grow with increasing domestic and international graduates seeking employmentlooking toregional and ruralareas. However, modelling suggests most of this growth will be in the GP rather than specialist workforce.[12]

As at June 2012, there were 1153 full time equivalent (FTE) doctors employed by rural LHDs and 2,778 VMOs (headcount), representing an increase of 59.3% and 20.2% respectively, from 10 years earlier.[11] However, as indicated by the significant number of regional areas that are classified as Districts of Workforce Shortage and/or Areas of Need there continues to be considerable service shortages across the State. Distribution of the specialist workforce by specialty is not possible to accurately ascertain from published statistical measures, making assessment of the (in)adequacy of the workforce difficult to quantify. It is understood that NSW Health together with the Colleges is currently improving data collection and transparency in relation to the specialist workforce and unmet need, a task that is critical for targeting appropriate specialties and communities and as a benchmark to assess the success of existing and future policies.[13]

Australia-wide, there continues to be a significant discrepancy between numbers of clinicians in major cities (408 FTE per 100,000) compared to more remote areas, with the lowest being (237 FTE per 100,000) in outer regional areas. This discrepancy is even more marked when considering the specialist workforce. In major cities, over half of clinicians were specialists and specialists in training (234 FTE per 100,000). This proportion decreases with remoteness, with 104, 81 and 55.4 FTE specialists and specialists in training per 100,000 in inner regional, outer regional and remote/very remote areas, respectively.[6] The low number of specialists in regional areas is particularly concerning as these areas are not only serving their own populations but also remote/very remote populations.

By contrast, the numbers of GPs (including GP proceduralists) per 100,000 population increases slightly in regional and remote areas,[6] reflecting their broader scope of practice and the provision of services to smaller populations over bigger distances. Ongoing support of comprehensive primary healthcare to these communities is essential.

Regional and remoteareas are also heavily reliant on international medicalgraduates, and amore transient workforce of short-term placements, visiting staff, fly-in-fly-out and drive-in-drive-out workers.[14]

proFeSSioNAL CHArACTeriSTiCS

The work of a specialist in a regional centre is often characterised by a wider scope of practice as they work across generalist specialties (eg in general medical wards) and subspecialties (because of less access to subspecialists and fewer specialist numbers), and across a wider geographical reach of practice (as they cater to catchment areas). Many also do a variety of hospital and private practice work.[15] Maintaining training programs that cater to both the generalist and subspecialist skill set required of a regional specialist is key to ensure younger specialists feel competent in these settings.

Regional specialists also play a key role in teaching and supervision ofstudents, junior doctors and specialists-in-training, as well as providing mentoring and support for medical colleagues, including GPs and international medical graduates in regional and rural settings.

In regions that have attracted a 'critical mass' of specialists, professional satisfaction is likely to be high. However, where this has not been achieved, work life can be overly demanding with onerous on-call rosters, difficulty taking leave for professional development and holidays, and a sense of professional isolation.

"Adequate staffing in regional health services is key. Regional and rural health services need relatively more specialists per head of population than metropolitan services, due to the lack of sub-specialists, the lack of private providers, limited access to private hospitals, and greater distances needed to travel to outlying clinics. Unfortunately the reverse seems to be the case, with regional services having funds allocated for fewer specialists and registrars than city-based health services."

Psychiatrist, Mid North Coast

"Most specialists that work rurally feel like they are the end of the stick with little support from city areas (eg. locums). Education requires travel away. Affiliations with specific city tertiary centre services would help. Most specialists left because they felt unsupported, on their own and left to service greater numbers of patients with less resources compared with city colleagues."

GP, Western

3. Recruitment & retention of regional specialists: key themes

The rural and regional workforce face similar issues to rural GPs, particularly in recruitment, as most doctors need to move to go there. As the numbers of medical graduates swell, doctors may increasingly look to or be forced to find work outside of major centres. However, the feminisation of the medical workforce,[16] dual career couples, older graduates and a desire for work-life balance may mean that a higher proportion of doctors will be less keen to go regional. It is therefore imperative that we explore initiatives to ensure that regional practice is an attractive option.

The majority of current initiatives focus on the important issue of provision of primary care services to rural and remote populations, with fewer initiatives targeted specifically towards either the regional workforce or specialists. Programs that have specifically targeted regional areas include expansion in GP training and the Specialist Training Program places, (STPs), as well as the creation of academic centres through the Rural Clinical School (RCS) and University Departments of Rural Health (UDRH) program.[15] A description of existing government policies, policy documents and key organisations are provided at **Appendix A.** In addition, a summary of available evidence on rural and regional recruitment and retention policies may be found at **Appendix B.**

From our research, member surveys (see **Appendix C**) and discussions with clinicians we have identified the following important themes in recruitment and retention of regional and rural specialists:

- **Supporting the rural/regional pipeline** - recruiting rural/regional students and creating opportunities for rural/regional immersion throughout medical training has proved a long term but effective strategy to maintain and increase the rural and regional medical workforce, especially the GP workforce. Some advances have also been made in developing the specialist pipeline, such as increasing STPs. However, further STPs and more generalist training options are needed to cater for the numbers of junior doctors wanting to train and practise regionally.
- **multiple initiatives** - Not all doctors with a rural background will practise in regional/rural areas, and because of the smaller number of medical students with a rural background, the majority of regional/rural doctors have an urban background.[16] This emphasises the fact that multiple bundled initiatives - professional, organisational, personal and financial - that target other key driving factors in a doctor's choice of geographical location, such as regional training and support, streamlined recruitment processes, succession planning, reviewing family and spousal needs, and financial incentives, are required to recruit and retain doctors in regional and rural settings.[17]

- **Critical mass** - Building and retaining a 'critical mass' (multiple doctors with the same specialty in a particular location) is imperative for recruitment and retention.[18] A 'critical mass' ensures seamless high quality services to the community and partly counteracts the professional, organisational and social disadvantages of remoteness from urban centres.

- **Appropriateinfrastructure**–The specialist workforce is in many ways a more difficult beast than the GP workforce, requiring adequate infrastructure and hospital appointments.[15] Adequacy of health infrastructure, including availability and long-term certainty of theatres and lists, diagnostic services, access to specialist drugs, specialist nurses and staff, access to private hospitals as well as connections to metropolitan colleagues, are all key issues for recruitment of specialists and maximising their benefit to their community.

- **engagement & planning** - Doctors on the ground are often keen to be involved in succession planning and recruitment and more broadly in planning and service delivery decisions. Engagement of clinicians by hospital administration in workforce planning is critical to the success of recruitment and retention drives in regional and rural areas.

"I have observed over the years that people stay in regional positions if they like them, if they feel that regional positions are not treated as second class, if there are teaching and research opportunities and if there is registrar support. People leave for a variety of reasons, sometimes related to family illness, seeking better educational opportunities (or the perception thereof) for their children, if the local hospital fails to provide a reasonable level of service/ contract, if they feel undervalued or if they just don't like the lifestyle. Not everyone can handle bumping into their patients in Coles or at the parent teacher night."

Psychiatrist, Mid North Coast

"[We need to] Create and support rural training positions for the large number of early career JMOs so they can become rural specialists of the future."

Psychiatrist, Southern NSW

"I am concerned about how "metrocentric" we are - supervision, continuing education, colleague support, professional representation all become so much more complicated out of regional centres, we need to address this by establishing connection."

Psychiatrist, Hunter Region

"There is a critical number of doctors needed in an area which when reached makes on call, meetings, continuing education etc so much more manageable."

Rheumatologist, Mid North Coast

"The health care provider generally comes with a family and it is often the spouse and children who are the forgotten ones but who have significant influence on whether to come or go."

GP Proceduralist,Western NSW

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Appendix A: Key policies, policy documents and organisations

exiSTiNg goverNmeNT poLiCieS Aimed AT reCruiTmeNT & reTeNTioN oF rurAL SpeCiALiSTS

NSW goverNmeNT FuNded poLiCieS

poLiCy	overvieW
Area of Need program	The Program assists employers who are experiencing difficulty recruiting GPs and specialists, to recruit suitably qualified IMGs to vacant positions that have been approved by NSW Health as an Area of Need. Further info: www.health.nsw.gov.au/AoN/Pages/default.aspx
Rural and Remote Scholarship Program	A scholarship program to provide financial assistance for rural and remote NSW healthservicestaff to attend State, National or International conferences / workshops / seminars and to assist in writing up research. Funded and administered by HETI. Further info: www.heti.nsw.gov.au/rural-and-remote/rural-and-remote-scholarships/
HETI Rural Medical Scholarship (HRMS) Program	A scholarship program to support medical trainees committed to training and providing patient care in rural locations in NSW through the continuum of their training and education years. Trainees who have completed a minimum number of regional or rural terms are eligible to apply from the following areas: • Prevocational(PGY1or2) • Surgical skills trainees (note: SET trainees are not eligible) • Basic Physician - basic and advanced • Paediatric Physician - basic and advanced • Emergency Medicine - basic and advanced • Psychiatry - basic and advanced • Radiology - basic and advanced • Medical Administration- standard pathway only Funded and administered by HETI. Further info: www.heti.nsw.gov.au/funding/heti-rural-medical-scholarship-hrms/

NSW goverNmeNT FuNded poLiCieS	
poLiCy	**overvieW**
Rural Research Capacity Building Program	Support of selected health workers to undertake a formal research project with the aim of increasing the number of rural and remote health workers with knowledge and skills in evaluation and research methods and to contribute to the literature on both innovation and evidence-based practice around rural and remote health care. Funded and administered by HETI. Further info: www.heti.nsw.gov.au/rural-and-remote/research-capacity-building
Rural Leadership and Management Essentials	A program designed to give rural and remote area health service staff access to a progressive, interprofessional and innovative evidence-based approach to leadership and management development. The course involves six full-day workshops. Run by HETI. Further info: www.heti.nsw.gov.au/courses/rural-leadership-and-management-essentials/
Clinical Team Leadership Program	The Clinical Team Lead Program (CTLP) focuses on 'program pairs'. Each team completing the program consists of a GP/VMO and a Local Health District clinical team member. The program consists of four two-day workshops covering leadership and clinical governance principles, self-awareness, interpersonal communication and clinical practice improvement. Coordinated by HETI Rural and Remote Portfolio in collaboration with the CEC. Furtherinfo:www.heti.nsw.gov.au/rural-and-remote/clinical-team-leadership/
Rural Preferential Recruitment (RPR)	A merit based recruitment process for final year medical students who are interested in working in a rural setting. Currently participating facilities: Albury Wodonga Health, Coffs Harbour Health Campus, Dubbo Base Hospital, Lismore Base Hospital, Manning Rural Referral Hospital, Orange Health Service, Port Macquarie Base Hospital, Tamworth Rural Referral Hospital, The Maitland Hospital, The Tweed Hospital, Wagga Wagga Base Hospital Furtherinfo:www.heti.nsw.gov.au/programs/internship-nsw/rural-preferential-recruitment-rpr/

NSW goverNmeNT FuNded poLiCieS

poLiCy	overvieW
NSW Rural Resident Medical Officer Cadetship	Funded by NSW Health and administered by RDN. Twelve Cadetships of $15 000 per year for medical students during the final two years of their medical degree (income for taxation purposes). Recipients must undertake two of their three post graduate years at NSW Rural Base Hospitals (Tamworth, Wagga Wagga, Orange, Dubbo or Albury) for which they also receive a relocation allowance. Recipients cannot also hold a RAMUS or an MRBS. Further info: www.nswrdn.com.au/site/index.cfm?module=RDNSCHOLARSHIPS&leca=275&pagemode=indiv&page_id=1839
NSW Rural Resident Medical Officer Cadetship for Indigenous Medical Students	Funded by NSW Health and administered by RDN. Two cadetships are available for Indigenous medical students. See NSW Rural Resident Medical Officer Cadetship for further details. Further info: www.nswrdn.com.au/site/index.cfm?module=RDNSCHOLARSHIPS&leca=275&pagemode=indiv&page_id=223045
Various other rural scholarships	• Bush Bursaries & Country Women's Association Scholarships • Cotton Industry Medical Scholarship • CRANAplus scholarships (Australia-wide)
Rural High Schools Medicine Career Workshop	A week of activities at the Medicine Faculty of the University of New South Wales for students in Year 11 from rural and remote high schools in NSW, with the aim of motivating rural students to gain entry into a medicine program. Run by UNSW and RDN. Further info: www.nswrdn.com.au/site/high-school
Health Careers Kit	Information related to health, medicine and nursing programs offered at all NSW universities for dissemination to rural high school students. Developed by UNSW and RDN. Further info: www.nswrdn.com.au/client_images/1362382.pdf

CommoNWeALTH goverNmeNT FuNded poLiCieS

poLiCy	overvieW
Health Workforce Fund	Designed to support activities to improve capacity, quality and mix of the health workforce to meet the requirements of health services, including through training, registration, accreditation and distribution strategies. Consolidated approximately 26 existing programs in 2011, including: • General Practice training • Specialist medical training • Telehealth - training of health professionals • Recruitment, retention and support of Overseas Trained Doctors (OTDs) • The ATSI health workforce through the provision of education, training, mentoring • Health workforce locum schemes • Increasing numbers of, and support to, regional, rural and remote health professionals • Development and regulation of the health workforce • HECS reimbursement scheme • Medical Rural Bonded Scholarship (MRBS) Scheme. Administered by DoH. Further info: www.health.gov.au/internet/main/publishing.nsf/Content/budget2011-flexfund-workforce18.htm
DoctorConnect	Provides centralised information on regional, rural & remote incentives for doctors, including a map that identifies the areas eligible for each incentive. Further info: www.doctorconnect.gov.au
Specialist Training Program (STP)	A number of programs were consolidated to form the STP in 2009/10. In 2013, 750 specialist training places will be supported. This will be expanded to 900 in 2014. Objectives: • Increase training opportunities for specialists in training • supplement specialist workforce in outer metropolitan, rural and remote locations • develop specialist training beyond traditionalinner metropolitan teachingsettings for Australian specialist trainees, IMGs, SIMGs What is provided: • funding for specialist training posts: $100k salary contribution per FTE trainee plus up to $20k for posts in ASGC-RA 2-5 (GSTexcl) • fundingfor system wideeducation and infrastructureprojectsmanagedbyspecialist colleges, to enhance training networks, with a focus on rural and regional training • funding for private sector clinical supervision and infrastructure • funding for support projects for specialists IMGs

CommoNWeALTH goverNmeNT FuNded poLiCieS	
poLiCy	**overvieW**
	The following bodies can apply for funding: specialist colleges; State and Territory Health Departments, hospital networks and regional hospitals; private healthcare organisations; Aboriginal Community Controlled Health Services; and, Community Health Organisations. Administered by DoH. Further info: www.health.gov.au/internet/main/publishing.nsf/Content/work-spec
GP programs & incentives	Various State and Federal programs encourage GPs to train and work in regional and remote settings, including: NSW Rural Generalist Training Program, NSW Rural GP Procedural Training Program, GP training rural pathway, Australian College of Rural & Remote Medicine (ACRRM), Remote Vocational Training Scheme (RVTS), and the General Practice Rural Incentive Payments Scheme (GPRIPS). Further info: www.heti.nsw.gov.au/Global/HETI-Resources/rural/GPPTP/NSW%20RTP%20Brochure%20-%20Web.pdf www.gpet.com.au
Rural Health Continuing Education Sub-program (RHCE)	A number of programs were consolidated to form RHCE in 2009/10. Objectives: RHCE aims to provide access to training and support in rural and remote areas for health professionals. What is provided: Funding for medical specialists (Stream One) is open to specialist colleges and medical specialists, is funded by DoH and managed by CPMC. Funding is available for: • CPD initiatives that promote Multi-disciplinary Teams and help build vocational support and learning capacity for health professionals in rural and remote locations; and • Support for individual specialist CPD participation up to $10k To date, 25 program grants to 11 specialist colleges and 70 individual grants have been awarded. Total funds available for per year is approximately $1.3 million. There is commitment to run the program until December 2014. Further info: www.ruralspecialist.org.au

CommoNWeALTH goverNmeNT FuNded poLiCieS	
poLiCy	**overvieW**
Rural Obstetric and Anaesthetic Locum Scheme (ROALS)	ROALS is funded by DoH and administered by RANZCOG. There is commitment to run ROALS to 30 June 2014. Objectives: ROALS subsidises obstetric and anaesthetic locum services to: • maintain and enhance access to services • improve workforce retention of specialist and GP obstetricians and anaesthetists in ASGC-RA 2-5 by enabling them to access personal or professional leave or take breaks from on-call commitments. What is provided: • A brokerage type locum placement service • Subsidies for the daily locum fee (up to 14 days per year - $825-$1100 per day), travel time ($825-$1100) and travel cost ($2000) (GST excl) • Organise Medicare Provider Numbers where required Further info: www.roals.org.au
Medical Specialist Outreach Assistance Program (MSOAP)	Established in 2000 to increase access to specialist services for rural and remote regions. DoH funded. Different administrative arrangements by region. RDN administers the Rural Health Outreach Fund (RHOF) and the Medical Outreach Indigenous Chronic Disease Program (MOICDP) across NSW and the ACT. RDN also administers the Indigenous Specialist Outreach Program (ISOAP). Further info: www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/MSOAP-VOS-evaluation-volume2-toc www.nswrdn.com.au/site/outreach
More Doctors for Outer Metropolitan Areas Measure Relocation Incentive Grant Program	Financial incentives of up to $40,000 for doctors who commit to relocate from an inner metropolitan area to an outer metropolitan area. Further info: www.health.gov.au/internet/publications/publishing.nsf/Content/work-relocation-incentive-grant-toc
Visiting Optometrists Scheme (VOS)	VOS supports optometrists to deliver outreach services to remote and very remote locations (ASGC-RA 2-3), and rural communities (ASGC-RA 2-3) with identified need, through funding of travel and related expenses, facility and equipment costs, administrative and locum support, and absence from practice allowance Further info: www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-vos

CommoNWeALTH goverNmeNT FuNded poLiCieS	
poLiCy	**overvieW**
Medicare 'ten year moratorium' for IMGs	Overseas trained doctors are required to gain an exemption under section 19AB of the Health Insurance Act 1973 (the Act) in order to access Medicare benefits for the services they provide. Exemptions under the Act are generally only granted if the medical practitioner works in a recognised area of workforce shortage for five to ten years, depending on remoteness of the area. As at 30 June 2012 there were a total of 8,455 overseas trained doctors who had been granted exemptions under Section 19AB of the Act. Further info: www.doctorconnect.gov.au
District of Workforce Shortage (DWS)	DWS was introduced in 2001. A DWS is a geographic area in which the local population has less access to Medicare-subsidised medical services when compared to the national average. These areas are identified using Medicare billing information. Doctors affected by the ten year moratorium on provider numbers must work ina DWSinorder to obtain a Medicare Provider Number. DoH is responsible for making DWS determinations. DoctorConnect provides a map of DWSareas. Further info: www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-dws-fact www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator
Telehealth programs	Medicare rebate for telehealth services was introduced in 2011. The Telehealth Support program funds projects to assist in the introduction of Medicare rebates now available for telehealth consultations. Organisations funded include some specialist colleges. Eg The Physicians Telehealth Support Project (www.racptelehealth.com.au) Further info: www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-tele
Bush Support Line	A service for remote health workers and their families run by CRANAplus, providing a confidential, free 24-hour, nationwide telephone/email/Skype support, staffed by registered psychologists who have experience working in remote and rural areas. Further info: https://crana.org.au/support/about-bush-support-services/

CommoNWeALTH goverNmeNT FuNded poLiCieS	
poLiCy	**overvieW**
Commonwealth medical internships (CMI)	The CMI initiative is designed to increase capacity to train medical interns in alternative settings, such as private hospitals, and in rural and regional Australia, where there are traditionally fewer options for internship training. CMI positions are only available to international full-fee paying international medicalgraduates who have completedtheiruniversitymedicalcourse in Australia. Further info: www.health.gov.au/internet/main/publishing.nsf/Content/work-commonwealth-medical-internships
Rural Health Multidisciplinary Training (RHMT) Program	The RHMT Program, established in 2009-10, brought together a number of existing programs that facilitate education and training of medical, nursing and allied health students in rural and remote regions to encourage the recruitment and retention of rural and remote health professionals. Medical component initiatives of the RHMT Program are currently: • The University Departments of Rural Health Program; • The John Flynn Placement Program; and • The Rural Clinical Training and Support program. See detailed program information below for each of these components.
University Departments of Rural Health program (UDRH)	Provides opportunities for students to practise their clinical skills in a rural environment and supports health professionals currently practising in rural settings. Further info: www.health.gov.au/udrh#more
John Flynn Placement Program	Medical students are matched with a doctor mentor in a rural or remote location. Students are expected to spend 8 weeks with their mentor over the course of their medical degree. 300 students per year are accepted into the program. Costs of student travel, accommodation and expenses are covered as well as honorary payments to mentors, community contacts and hosts. Fundedby DoH and administered by ACRRM. Further info:www.acrrm.org.au/about-john-flynn-placement-program

CommoNWeALTH goverNmeNT FuNded poLiCieS

poLiCy	overvieW
Rural Clinical Training and Support program (RCTS)	RCTS is a recently merged entity consisting of the Rural Undergraduate Support and Coordination (RUSC) and Rural Clinical Schools (RCS) Programs **ruSC program** Established in 1993-94, RUSC supports rural student admissions, with a target of at least 25% of Commonwealth Supported students from a rural background, and mandatory four week rural placements for all Commonwealth Supported students. RUSC also seeks to contribute to increasing the number of Indigenous Australian doctors and ensure incorporation of Indigenous issues into university medical education. **rCS program** Established in the late 1990s with the intention to develop and maintain an effective medical student training infrastructure in rural Australia around which the development of the local medical workforce can be assisted and promoted. The main program target requires 25% of all Commonwealth Supported students to undertake at least one full year of their clinical training in a rural setting. The program also aims to encourage health professionals to take up rural academic positions, often through joint funding arrangements with local area health services. The following universities have rural clinical schools in NSW: • The Australian National University Rural Clinical School: Cooma, Goulburn, Bega, Young, Batemans Bay and surrounding regions. • The University of New South Wales Rural Clinical School: Coffs Harbour, Port Macquarie, Kempsey, Wagga Wagga, Albury, Griffith, Leeton and surrounding regions. • The University of Sydney School of Rural Health: Dubbo, Orange, Bathurst, Broken Hill and surrounding regions. • University of Newcastle Department of Rural Health: Tamworth, Armidale, Moree, Taree and surrounding regions. • University of Notre Dame Australia (Sydney Campus): Wagga Wagga, Ballarat and Lithgow • University of Western Sydney: Lismore and Bathurst • University of Wollongong Rural Clinical School: Nowra, Milton/Ulladulla, Lismore, Grafton, Murwillumbah, Broken Hill, Bowral, Mudgee, Murrumbidgee.

CommoNWeALTH goverNmeNT FuNded poLiCieS

poLiCy	overvieW
Rural Australia Medical Undergraduate Scholarship (RAMUS)	Scholarships for medical students with a rural backgound (minimum of 5 consecutive years or 8 cumulative years from age of 5), financial need and committment to working in rural Australia. There is a maximum of 587 scholarship holders with approximately 120 new scholarships awarded each year. Recipients receive $10,000 per year (tax free), are allocated a rural doctor as a member and are required to be a member of their university's student rural health club. These scholarships are not bonded. RAMUS is funded by DoH and administered by NRHA. RAMUS was established in 2000. Since then, about 2,000 scholarships have been awarded and almost 1,300 RAMUS scholars have graduated from medicine. About 500 rural doctors participate as mentors. Further info: http://ramus.ruralhealth.org.au
Medical Rural Bonded Scholarships (MRBS)	Commencedin2001. Currently, 469 (2.8%) of enrolled students Australia wide were participating in this scheme in 2012. Students receive a scholarship of $25,500 a year tax free (indexed annually) during their degree, and must work for six continuous years, less any credit obtained through Scaling, in locations within ASGC-RA 2-5 after completing their vocational training. Further info: www.health.gov.au/mrbscholarships
Bonded Medical Places Scheme (BMPS)	Commencedin2004. Currently, 3282 (19.5%) of enrolled students Australia wide were participating in this scheme in 2012. Students participating in the BMPS have a return of service obligation to work in a District of Workforce Shortage (DWS), for a period of time equal to the length of their medical degree, less any reduction as a result of scaling for remoteness. Up to half of the return of service obligation can be met while completing prevocational and vocational training, the other half must be completed after completing their vocational training. Further info: www.health.gov.au/bmpscheme

KeypoLiCydoCumeNTS

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Key orgANiSATioNS/ BodieS:

NSW

- Ministerial Advisory Committee for Rural Health
- Rural Health Unit, NSW Health
- Rural Health Network, Agency for Clinical Innovation
- NSW Rural Doctors Network (RDN)
- University Rural Health Clubs:
  - o NSW Rural Health Clubs
    - BREAATHHE University of Newcastle
    - MARHS Charles Sturt University, Albury
    - MIRAGE University of Sydney
    - NERCHA University of New England
    - RAHMS University of New South Wales
    - RHUUWS University ofWestern Sydney
    - ROUNDS University of Notre Dame, Sydney
    - SHARP University of Wollongong
    - WARRIAHS Charles Sturt University,WaggaWagga
  - o ACT Rural Health Clubs
    - ARMS Australian National University
    - CRANC University of Canberra

CommoNWeALTH

- Department of Health (DoH)
- Rural Health Workforce Australia (RHW)
- Medical Training Review Panel rural subcommittee
- Rural Health Continuing Education Sub-Program (RHCE) - Stream One
- Specialist colleges
- National Rural Health Alliance Inc (NRHA)
- Australian Rural Health Education Network (ARHEN)
- Federation of Rural Australian Medical Educators
- National Rural Health Students Network

Appendix B: Evidence-based policies: existing initiatives & opportunities[1]

THiS TABLe SummAriSeS THe evideNCe reLATiNg To reCruiTmeNT ANd reTeNTioN oF rurAL mediCAL prACTiTioNerS, WiTH A pArTiCuLAr FoCuS oN modiFiABLe FACTorS, ANd THe regioNAL WorKForCe ANd HoSpiTAL SpeCiALiSTS WHere poSSiBLe.

FACTor	ASSoCiATioN WiTH regioNAL empLoymeNT	exiSTiNg iNiTiATiveS	SuggeSTioNS For FurTHer iNiTiATiveS
	perSoNAL & FAmiLy CHArACTeriSTiCS		
Regional/ rural origin	• Strong[2,3,4,5] • Association increases with increasing years of regional/ rural background.[3] • Size of town of origin not significant.[3]	• RCTS • RAMUS • Marketing to rural schools • In 2012, 32.2%(289) of commencing medical students in NSW and 23 (27.1%) of commencing medical students in the ACT had a regional/rural background.[6]	• Increase intake of students with regional origin: marketing, preferred entry schemes eg remoteness index, scholarships etc.[3] • Continuous regional university to vocational pathway
Gender	• Strong[2, 3] • Men make up a greater proportion ofspecialists in a rural/regional setting regardless of background.[3]	• Ad hoc • Currently lack of family-friendly options eg part time, significant on-call demands for regional specialists[3]	• Initiatives to support work-life balance, flexible training, and support for partner's employment
Regional/rural origin of partner	• Strong[7, 8]	• Promoting and supporting rural residents to study medicine (see above)	• Increase intake of students with regional origin • Continuous regional university to vocational pathway

FACTor	ASSoCiATioN WiTH regioNAL empLoymeNT	exiSTiNg iNiTiATiveS	SuggeSTioNS For FurTHer iNiTiATiveS
	perSoNAL & FAmiLy CHArACTeriSTiCS		
Partner's employment	• Strong[2, 8] • Partner's employment opportunities more important for female doctors[2] • Partner's preference generally is a strong influence	• Ad hoc • Some LHDs provide social opportunities for partners	• Initiatives need to cater to needs of partners • Should be considered an opportunity for communities, especially considering a significant proportion of doctor's partners are also health professionals
Children's schooling options	• Moderate[8,2] • Moving children generally also has an impact		• Marketing of educational facilities in regional areas, advantages ofrural lifestyle/ upbringing • Financial incentives for travel/ boarding arrangements
	rurAL expoSure		
Medical school	• Moderate. • Rural clinical school placements increase interest in regional/rural practice and location of internship and future practice.[9,10,11,5]	• RCTS • Regional Medical Schools eg JCU, Armidale • John Flynn scholarships • NSW RDN Cadetships	• Increase length of regional placements • More entirely regional-baseddegrees • Increase regional academic posts • Support regional clinicians to provide teaching, supervision, mentoring
JMOcurriculum	• Moderate. • Evidence for retention • Strongest in relation to GPs[12] • Structured exposure is relatively recent; full impact maynotyetbeapparent.	• Cadetships • RPR • Rural JMO rotations	• Support regional clinicians to provide teaching, mentoring, supervision

FACTor	ASSoCiATioN WiTH regioNAL empLoymeNT	exiSTiNg iNiTiATiveS	SuggeSTioNS For FurTHer iNiTiATiveS
		rurAL expoSure	
Vocational training	. Moderate. . Evidence for retention, increases with length of rural postgraduate training . Unclear whether compulsory regional registrar rotations increases desire to work regionally or if these opportunities are sought out by those already regionally inclined.[8] . Strongest in relation to GPs.[10,8] . Structured exposure is relatively recent; full impact maynotyetbeapparent.	. STPs . Regional registrar rotations	. Support regional clinicians to provide teaching, mentoring, supervison . Funding of additional regional-based STPs . Accreditation of more regional hospitals for registrar training programs . Longer regional registrar rotations
Locum exposure	. Observational evidence only.	. ROALS . Various locum support programs run by Colleges	. Offer locum positions to doctors interested in experiencing local practise . Longer term contracts
		FiNANCiAL iNCeNTiveS	
Bursaries and scholarships	. Moderate. . Cadetship program appears to show good retention in regional centres[12]	. RAMUS . NSW RDN Cadetships . HRMS . HECS reimbursement	. Extend existing programs for students and clinicians committed to regional practice
Financial Compensation	. Moderate. . May assist with recruitment and short term retention for the period of time related to the incentive.[13, 8]	. RDA contracts . Conference leave . More Doctors for Outer Metropolitan Areas Relocation Incentive Grant Program	. Relocation incentives . Flexible incentive budgets for LHDs . Increase staff specialist and VMO pay[14] . Differential Medicare rebates . Higher on-call pay

FACTor	ASSoCiATioN WiTH regioNAL empLoymeNT	exiSTiNg iNiTiATiveS	SuggeSTioNS For FurTHer iNiTiATiveS
		FiNANCiAL iNCeNTiveS	
Practice ownership	• Strong for retention (evidence comes from GP study).[15] • Moderate evidence also for being an associate (rather than employee).[15]	• More Doctors for Outer Metropolitan Areas Relocation Incentive Grant Program	• Support succession planning • Incentivise inclusion of new recruits in practice ownership/profit structure
Varied income sources/ roles eg non-govt income, hospital appointments	• Moderate (evidence comes from GP study).[15]		• Encourage hospital appointment of local doctors • Support new and existing private hospitals in regional centres
Affordable housing	• Moderate.[8]		• Accommodation assistance • Marketing of regional advantages eg housing costs
		CoerCioN	
International recruitment	• Moderate. • Evidenceforrecruitment but longer term retention unknown in regional areas.[16,17]	• 10 year moratorium	• Support and mentoring for international doctors in relation to their clinical work and vocational aspirations
Medical student bonding for future rural commitment	• Weak • No published evidence yet, however projections indicate that between 2011 and 2020, 13% (858) of the total increase in regional & rural clinician numbers will be bonded.[16] • Coercive practices often not preferred by workforce[16]	• BMPS – applies to Areas of Need which include areas within major cities • MRBSS – ROS in RA2-5	

FACTor	ASSoCiATioN WiTH regioNAL empLoymeNT	exiSTiNg iNiTiATiveS	SuggeSTioNS For FurTHer iNiTiATiveS
	proFeSSioNAL CHArACTeriSTiCS		
Specialisation & intention to specialise	• Specialisation and intention to specialise are negatively correlated with working or intention to work in a regional setting.[12, 3,5] • However, specialists with rural background are more likely to provide visiting/ outreach services.[3]	• STP • RHCE	• Extend programs targeted to GPs to targeted specialist groups as has happened with ROALS, RHCE etc
Generalist skill set	• Moderate. [6,2]	• RSCPinitiatives	• Generalist vocational training options • Bridging/ generalist refresher courses
Onerous on-call	• Moderate. [8]	• Locumseg ROALS, various College programs • Telehealth options eg in psychiatry, stroke	• Workforce planning • Adequate staffing • Critical mass • Extend existing locum programs • Links with metro, Colleges
Difficulty in returning to metropolitan/ tertiary centres	• Moderate.[2] • This perception affects interest in practising regionally • Moderate effect of lack of access to ongoing education and difficulty meeting Maintenance of Professional Standards requirements.[8] • Weak evidence for CPD support • Specialist support by application only-not evaluated	• RHCE • NSW Health support via TESL • Online modules provided by various Colleges • Conference leave • Rural and Remote Scholarship Program • Rural and Remote Scholarship Program	• Options to return to metro/ dual appointments • Extend existing initiatives • More online training • Locum • Support to meet MOP requirements • Greater links with metro hospitals to support training in regional hospital • Links with metro, Colleges • Critical mass
Continuing professional development/ Professional isolation			

FACTor	ASSoCiATioN WiTH regioNAL empLoymeNT	exiSTiNg iNiTiATiveS	SuggeSTioNS For FurTHer iNiTiATiveS
		proFeSSioNAL CHArACTeriSTiCS	
Lack of infrastructure/ administrative support	• Moderate effect on recruitment and retention eg private hospitals, theatre lists, specialised staff etc[13]	• Clinical plans	• Engage clinicians • Identify infrastructure needs by specialty
Recruitment process, generally	• Ease of recruitment processes, local clinician engagement (including invitation by colleagues) and a targeted and individualised recruitment process in line with regional workforce plans appears to have positive impacts on recruitment.[18]	• Ad hoc	• Support succession planning • Clinician engagement in workforce planning and recruitment • Marketingofamenities of town/ region and rural lifestyle • Identifying appropriate candidates and targeting marketing/ incentives/ support to individual and family needs/ concerns

References

[1]This table is based on the work of Wilson, et. al., 'A critical review of interventions to redress the inequitable distribution of heal hcare professionals to rural and remote areas', Rural and Remote Health, 9:1060, June 2009. It should be noted that lack of evidence in some areas may reflect the fact that they are new initiatives, have not been studied in depth or have an effect that is not easily quantifiable.

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[14]Rural Doctors Association of Australia & Kristine Battye Consulting Regional, Rural and Remote Medical Specialists Survey: Final Report, October 2012

[15]Russell, et.al., 'What factors contribute most to the retention of general practitioners in rural and remote areas?', Australian Journal of Primary Health, 18, 289-294, 2012

[16]Deloitte Access Economics for the Department of Health and Ageing, Review of the Rural Medical Workforce Distribution Programs and Policies, August 2011

[17]Hawthorne, Health Workforce Migration to Australia: Policy Trends and Outcomes 2004-2010, Scoping Paper Commissioned by Health Workforce Australia, May 2012.

[18]Mason, Review of Australian Government Health Workforce Programs, May 2013

[19]AMA(NSW), Survey of Senior Regional and Rural Doctors (unpublished), October 2013

Appendix C:
AmA(NSW) surveydata: keyfindingsin rural & regionalrecruitment and retention

iN oCToBer 2013, AmA (NSW) SougHT THe vieWS oF iTS regioNAL ANd rurAL SeNior doCTor memBerS ANd THoSe oF iTS doCTorS-iN-TrAiNiNg ("diT") memBerS iN TWo SepArATe oNLiNe SurveyS iN reLATioN To THeir experieNCe oF rurAL ANd regioNAL prACTiCe ANd poLiCy iNiTiATiveS iN THiS AreA.

demograpHiCS

Senior doctor survey:

- 220 senior doctors practicing in regional and rural locations completed the survey.
- Responses were received from doctors working in a variety of specialties:
    - 96 (44%) were GPs (61 (28%)) or GP proceduralists (35 (16%))
    - 120 (55%) were specialists (non-GP), including:
        - 35 (16%) psychiatrists
        - 30 (14%) physicians
        - 26 (12%) surgeons, with a majority either orthopaedic or general surgeons
        - 14 (6%) anaesthetists
        - 6 (3%) ophthalmologists
        - 5 (2%) obstetrician/ gynaecologists
        - 3 (1%) emergency medicine physicians
        - 1 (1%) radiologist
- There was also variety in terms of how long the doctor had been practicing in a regional or rural setting with 35 (16%) of respondents having practiced in a regional or rural areas for 5 or less years and almost half for over 20 years.
- In addition, 75 (34%) respondents provided services to a rural hospital under an RDA contract.

diT survey:

- Of the 116 doctors who completed the survey, 106 had done or were currently undertaking a rural or regional rotation, and a majority had chosen to do an internship at a rural hospitalunder the HETI Rural Preferential Recruitment Scheme.
- Respondents were at various stages of their training: 18 were interns (16%), 34 were residents (29%) and 64 registrars (55%).
- Two thirds of respondents were women and the age of respondents ranged from 23 to 59, with a median age of 30.

Key FiNdiNgS

Below is a list of key factors that were found to encourage or deter from rural or regional practice, with the most important in **bold** font.

Why doctors go & stay rural or regional:

- **personal factors**
    - **rural background**
    - **ease of partner and family relocation – employment & schooling options**
    - **positive rural experiences during university, as a Jmo and in vocational training**
    - **connection with family or community**
    - **lifestyle preference**
    - interest in health equity
    - motivated by a sense of being valued
- **professional factors**
    - **scope of work**
    - **invitation to area by colleagues (especially important for specialists)**
    - **collegiality and culture of individual hospitals**
    - hospital appointments
    - clinical autonomy
    - academic, teaching & research opportunities
    - university associations
    - competitive metro environment

- **organisational factors**
  - o administrative support
- **Clinical infrastructure**
  - o **hospital infrastructure** - equipment, specialist staff eg nursing, theatre lists etc
  - o **local private hospital**
- **Financial factors:**
  - o **Financial incentives for remoteness, reflecting added expenses and lack of private work**
- **Locational factors:**
  - o Physical amenity (especially coastal areas)
  - o Town facilities

Why doctors doN'T go or stay rural or regional:

- **personal factors**
  - o **Family preference**
  - o **Lack of partner employment opportunities**
  - o **Lackofpreferredschoolingoptionsforchildren**
  - o Social isolation
- **professional factors**
  - o **Lackofavocational rural pathway**, and concern about the capacity of regional centres to provide adequate teaching and support for trainees
  - o **Lack of 'critical mass' of doctors – sense of professional isolation**
  - o **Lack of Cpd opportunities/ lack of funding for Cpd attendance**
  - o Lack of recognition of skills by metro colleagues/ hospitals
  - o Fear of not being able to return to the city
  - o Requirement for generalist skill set
  - o Lack of professional networks with metro colleagues/hospitals
- **organisational factors**
  - o **Lackof'criticalmass'ofdoctors,includingother specialists,registrars,Jmos-excessivework demands–toomuchoncall,difficultygettingleave, lackofflexibility**
  - o **Lack of administrative support**
  - o Lack of efficient recruitment processes/ ease of transfer between LHDs
- **Clinical infrastructure**
  - o **Lack of hospital infrastructure** - equipment, specialist staff eg nursing, theatre lists etc
  - o **Lack of private hospital**
  - o Lack of ease transferring patients to metro hospitals
- **Financial factors:**
  - o Inadequate financial compensation

AVP..

AUSTRALIAN MEDICAL ASSOCIATION
NEW SOUTH WALI!:S

AMA NSW Regional Specialist Workforce Forum: discussion & recommendations

Recommendations

1 Enhancing the rural pipeline

1.1 Career paths for junior doctors

The Forum acknowledged the investment and work of governments, universities, LHDs and HETI in developing a rural medical pipeline. These efforts are related to ensuring there are significant numbers of medical students with a rural background in NSW universities, that medical students have opportunities to have a positive experience of rural medicine during their clinical training, and to promote rural internship and residency options. These policies have been successful in increasing numbers of junior doctors in regional centres and the evidence suggests these are vital foundational steps towards a regional and rural workforce.

There is, however, concern that presently there is no articulated career path for doctors who have completed their initial clinical years in a regional hospital. The Forum called on rural clinical schools, Colleges, governments, LHDs and HETI to work together to articulate this career path to ensure that junior doctors were aware of, and have training and employment opportunities available to them, beyond their first two clinical years. It was also reported that in some instances, Colleges had received funding to promote rural or regional selection processes but had not clearly articulated their commitment to selecting or promoting students from a regional or rural background.

AMA NSW Position

The AMA is concerned by the reliance on policies that are punitive or coercive in terms of rural or regional practice. In some instances, we believe those policies reinforce the stereotypical view that regional and rural practice is such a poor career option that doctors must be forced to relocate there. Therefore, we would support governments developing appropriate accountability around funding allocated to Colleges or other organisations to enhance the regional and rural workforce. Such accountability may include agreement on regional entry criteria, confirmation of the use of the funding for dedicated regional training places or to support enhancements such a regional Fellow positions or CPE or similar.

Recommendation

No.	Recommendation
1.1.1	That the rural pipeline continue to be supported and strengthened as a proven strategy in improving the equitable geographical distribution of the medical workforce.
1.1.2	That the career pathway for junior doctors in regional centres be more clearly articulated to ensure that junior doctors are aware of, and have access to, employment and training opportunities beyond their PGY2 year in line with long-term workforce plans.

1.2 Career paths for bonded medical students

The Forum noted that a significant number of doctors, many who are attaining specialist qualifications, now have a return of service obligation as a result of holding a medical bonded student place (e.g. MRBS, BMPS). The Forum discussed the opportunities available to these doctors in regional centres and considered that the career paths and job opportunities available to them should be more clearly articulated in line with long-term workforce plans.

Recommendation

No.	Recommendation
1.2.1	That the career pathway for doctors with bonded places be more clearly articulated and that doctors with return of service obligations be supported in fulfilling those requirements in line with long-term workforce plans.

2 Vocational training opportunities

2.1 Expanding training opportunities in regional centres

Specialist colleges and LHDs currently offer regional rotations to trainees, which are compulsory requirements in some training programs. There are, however, few training positions that are based in regional hospitals. Thanks to the success of policies supporting the rural pipeline, including HETI's rural preferential recruitment scheme, there are increasing numbers of junior doctors in regional areas, who may prefer to be based in regional centres for their vocational training if given the opportunity. Regional-based trainees are likely to offer significant benefits to their hospitals particularly as they enter advanced training and, extrapolating from evidence on the success of other rural pipeline initiatives, be more likely to remain in practice in a regional location. Accordingly, the Forum noted the appeal of expanding the number of regional based specialist training places, with city rotations as required. Such training places should also be seen as an opportunity to succession plan and expand services in line with the clinical plan of each LHD.

Some Colleges are proactively developing regional-based training programs, such as the Royal Australian and New Zealand College of Psychiatrists (RACP) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). The RACP had 26 regionally-based trainees in 2013 and is currently undertaking an extensive review of their regional training programmes. And RANZCOG will be piloting a new Provincial Specialist Training Program in Orange and Dubbo in conjunction with Westmead in 2014 and is developing modules for advanced training in regional practice.

As important referral centres for surrounding rural hospitals and with academic research and training credentials through relationships with regional clinical schools, regional hospitals increasingly have the potential to provide vocational training. Issues regarding adequate academic and administrative support for trainees in regional centres and support for senior doctors to provide supervision and mentoring are key issues to be addressed for the successful roll out of further regional training places. Some suggestions in this regard were to increase links with metropolitan hospitals and continue to bolster rural clinical schools.

It was also noted that the current industrial arrangements do not support regionally based training programmes. JMOs who are rotating from metropolitan areas to regional areas receive some support in terms of housing, relocation and other payments. Doctors from regional areas rotating into metropolitan areas receive no access to such payments, despite the

fact that housing, travel and other payments can be considerably more expensive. These arrangements also serve as a further disincentive to JMOs from a rural or regional background.

In addition to the provision of appropriate funding for positions, Colleges need to ensure that there is appropriate administrative and professional support for the supervisors and trainees undertaking regional training. Networking remains an important consideration, particularly given that some locations may only have one or two trainees of a similar speciality.

A further issue identified at the Forum was the level of experience of registrars on regional rotations. There was a concern that a majority of registrars on regional rotations were at the beginning of their training, at a stage when they require significant training and supervision. In the context of a regional hospital, junior registrars increase the teaching burden on a limited number of specialists and are unlikely to have the diversity of skills needed for the generalist practice in keeping with a regional setting. Subject to implementation of other recommendations regarding regionally based trainees, thought should be given to the capacity of a regional hospital to supervise junior registrars, and where possible mid-level and senior registrars should also be rotated to regional hospitals.

AMA NSW Position
Current workforce modelling confirms that Australia will need all of the medical students currently graduating from universities. We would be concerned by any reduction in the existing budget for training positions but would support expanded or additional commonwealth or state government investment in regional based specialist training positions

Recommendations

No.	Recommendation
2.1.1	That the number of regionally-based specialist training places be increased.
2.1.2	That academic and administrative support for trainees in regional centres be reviewed for adequacy and equivalence with metropolitan centres, and appropriate levels of support be provided.
2.1.3	That Colleges and LHDs consider formalised networked arrangements to ensure appropriate professional support for trainees and supervisors.
2.1.4	That existing industrial arrangements be reviewed to ensure regionally based JMOs are not disadvantaged with respect to their entitlements relative to metropolitan based trainees.
2.1.5	That Colleges and LHDs seek to rotate more experienced trainees to regional hospitals.

2.2 Ensuring the right skill mix

Specialists working in regional centres often need a different mix of skills to their counterparts in tertiary metropolitan hospitals. In addition to their area of subspecialty, they may be required to work across subspecialties and cover general medicine wards or general surgical lists. It is important that vocational programs and continuing professional development courses offer appropriate training for doctors who intend to practice regionally to ensure that they are confident and competent to work in a regional setting and can be fully-contributing members of their teams.

Recommendations

No.	Recommendation
2.2.1	That training programmes and ongoing CPD recognise the need for both specialised and generalist skill sets.
2.2.2	That continuing professional development opportunities be offered to regional specialists, tailored to the needs of regional practice, and that support continue to be provided and extended for regional specialists to attend ongoing training.

2.3 Training scheme selection criteria

It was noted that although some Specialty Colleges highly value rural experience, there is at least a perception that some Specialty Colleges may not be appropriately recognising the experience of junior doctors who have practiced in regional and rural settings when reviewing applications for vocational training positions, making it more difficult for junior doctors from regional areas to get an accredited training position. It was suggested at the Forum that individual Specialty Colleges, as well as the Australian Medical Council (AMC) and Committee of Presidents of Medical Colleges (CPMC) be asked to consider issues of equity and community expectations with regards to Specialty College selection criteria and their impact on regional and rural applicants.

Where specific commonwealth or state funds are allocated to support regional training places or regional positions, clear accountabilities should be developed (in consultation with the AMA and the Colleges) to ensure funds are directed towards appropriate programmes.

Recommendations

No.	Recommendation
2.3.1	That a principled approach to selection criteria be adopted factoring in issues of equity and social accountability and that]the selection criteria for vocational training programs be reviewed, in particular with respect to issues of equity in relation to junior doctors in regional areas.

3 Planning

One of the key messages from the Forum was the need for greater transparency and certainty at the State-wide, LHD, local hospital and specialty level regarding rural and regional hospital strategy, around which service, infrastructure and workforce strategies may be built. The primary role of LHDs was noted but with the additional input of the private and community care sectors (including Medicare Locals) also desirable. Such planning strategies would allow for LHD administration and Specialty Colleges to plan for the future and enable individuals to make sensible career decisions in keeping with these plans. Many called for a "hub and spoke" model, formalising the trend towards regional hospitals becoming full service operations catering to their own community and catchment areas. In terms of the medical workforce specifically, there is a need for the roles and demand for staff specialists, VMOs, locums, GPs and GP proceduralists, FIFO, DIDO and Telehealth services, to be delineated.

The importance of good hospital administration and engagement of local clinicians in planning was emphasised, as was support for retaining a broad scope of practice in regional

areas where volumes of patients allow for it. A "critical mass" (multiple doctors of a particular specialty in a locality), and sufficient nursing, allied health and infrastructure, were all considered necessary for seamless, sustainable services.

AMA NSW Position

While acknowledging the importance of localised autonomy and decision making, we also see the need for a level of commonwealth and state wide co-ordination and planning. In terms of state wide planning, we would see the Ministry as having a role to develop policy (in conjunction with relevant LHDs, the AMA and colleges) to consider:

- *the nature and scope of appropriate clinical services planning. This would ensure that services plans relied on consistent data, required engagement with other key stakeholders such as Medicare Locals and the private sector and that consistent language and accountabilities would apply across the state; and,*
- *workforce requirements to meet clinical services needs. For regional and rural LHDs, workforce is clearly a benefit but it is also a cost. A state-wide approach to consistent workforce planning (as is currently underway) would assist in establishing transparency and accountability around workforce requirements for a community*

Recommendations

No.	Recommendation
3.1	The NSW Government, the Ministry and LHDs continue with their planning processes to develop medium to long term strategy for regional and rural hospitals be developed and published, which would underpin service, infrastructure and workforce planning.

4 Data

Availability of accurate data was considered critical to all other recommendations reached by the Forum, and particularly those with respect to planning, recruitment and expansion of training opportunities. It was recognised that the Ministry had undertaken considerable planning around medical workforce, however, it was also noted that medical workforce data is currently collected by multiple bodies using disparate sources and definitions, making the data difficult to source, compare and analyse. The Forum called for a transparent centralised repository of data using standardised definitions, a move which would greatly aid medical workforce planning.

Recommendations

No.	Recommendation
4.1	That a centralised and transparent repository of regional health workforce data be established by Federal, State and Territory governments to enhance analysis of workforce adequacy and distribution and aid workforce planning.

5 Recruitment and retention

5.1 Incentives

The Forum noted that multiple factors influence recruitment and retention of regional practitioners. In terms of modifiable factors that drive recruitment and retention, of critical importance are scope of practice, workplace culture and positive experiences, work/life balance, sense of community and family considerations (e.g. partner employment, children's

education), barriers to setting up practice and knowledge of job opportunities. Establishing and maintaining a critical mass of doctors in each specialty area in a locality, is also essential to recruitment and retention because it allows for professional support and enables workable rosters. Hospitals and LHDs that are able to address these drivers reap the benefits in terms of ease of recruitment and retention of doctors.

In addition, it was recognised that financial incentives also play a role, with compensation of regional practitioners generally below levels enjoyed by metropolitan practitioners. This discrepancy exists for a variety of reasons, including higher rates of bulk billing and less access to private work, as well as higher costs associated with certain activities, including travel and time away for continuing professional development. While there was inadequate time at the Forum to discuss the details of which incentives, financial or otherwise, should be available for the regional and rural medical workforce, there was general agreement that existing incentives relating to locum cover (e.g. ROALS) and continuing professional development (e.g. RHCE) were important and appropriate, and that further incentives should be considered, particularly where expense and responsibility differ from that available in metropolitan areas. Issues regarding eligibility for, and transparency and administration of, incentives should also be considered, with some participants suggesting incentives should be standardised State-wide and others suggesting LHDs should have flexibility in provision of incentives.

Recommendations

No.	Recommendation
5.1.1	That existing programs aimed at rural and regional practitioners, including locum and continuing professional development support, are important and should continue to be provided in an integrated way.
5.1.2	That awards and incentives targeted to recruitment and retention of the medical workforce in regional and rural areas be reviewed for adequacy, efficacy and fairness.

5.2 Transparency of vacancies

The Forum noted that positions in regional hospitals were often poorly advertised and that there was no centralised directory of hospital vacancies. As a result, clinicians interested in regional and rural practice often find it difficult to identify job opportunities. This could be addressed through more effective marketing strategies, including a publicly available list of job vacancies. It was also agreed that the public and private hospital systems should work co-operatively to advertise for and retain specialists in regional areas.

Recommendations

No.	Recommendation
5.2.1	That a list of hospital vacancies at the LHD or State level be published and maintained to ensure job opportunities may be easily identified by interested doctors.
5.2.2	That public and private hospitals be encouraged to work co-operatively regarding recruitment of specialists.

5.3 Administrative support

Administrative support and efficiency were highlighted by many Forum participants and key factors identified in AMA (NSW) surveys influencing how positively doctors felt about regional practice and whether they would stay or return. Specifically, issues relating to rostering, lack of flexibility, adequacy of accommodation and ease of transfer between LHDs impact the experiences of doctors rotating through regional areas. These rotations should ideally be treated as opportunities to advertise the benefits of regional practice.

Doctors rotating from regional areas to metropolitan hospitals should also receive equivalent support to metropolitan doctors rotating to regional areas. Regardless of the direction - metro to regional or regional to metro - rotating doctors provide an important service and should be supported away from their home and base hospital.

Doctors also noted the difficulties with a lack of continuity with experienced hospital and LHD management. It was noted in this regard that there needed to be support for local management. It was recognised that to work effectively, there needed to be a sense of partnership between management and doctors. This requires a sense of mutual respect, a commitment to engagement.

Recommendations

No.	Recommendation
5.3.1	That regional LHDs be appraised of the importance of positive experiences of regional practice to rotating doctors, with administrative support recognised as playing a key role.
5.3.2	That doctors rotating from regional to metropolitan hospitals be given support for travel and accommodation in keeping with the support provided for doctors rotating to regional areas.

5.4 Streamlining recruitment

Recruitment processes for local and international doctors are often significantly delayed both at the local level and due to lack of coordination between accreditation bodies. Anecdotally, the delays involved result in loss of promising job candidates. It was recommended that these processes be reviewed and improved.

Recommendations

No.	Recommendation
5.4.1	That recruitment and accreditation processes for local and regional doctors be reviewed and streamlined at the State and Federal level.

5.5 Local flexibility

Recruitment and retention of doctors in regional areas often means long-term planning, including in relation to engagement with local practitioners, coordination with other local providers (e.g. private hospitals), and identifying promising candidates. Once a candidate is identified, successful recruitment and retention will be affected by the employer's ability to address candidate and family concerns, which may range from support for accommodation, travel, practice set up, partner employment (many of whom are also health professionals) and children's education. Accordingly, regional LHDs need flexibility and a strategic approach, with an accompanying budget, to ensure successful recruitment and retention of doctors.

Recommendations

No.	Recommendation
5.5.1	That regional LHDs be encouraged to develop flexible and creative strategies for recruitment and retention of doctors and be provided with a budget for this purpose.

5.6 Access to work

As noted in Dr May's research,[1] the key reason for doctors to move to a regional area was that there was a job. Access to work and long term certainty around that work are critical to ensuring the recruitment and retention of regional specialists.

According to an AMA NSW Survey, significant numbers of regional doctors (118) indicated that they or a member of their department is planning to retire from clinical practice within the next two years, and in 75% of these retirements there are no arrangements in place for succession planning.[2]

Doctors in regional areas generally report that they are required to give up lists or work to allow a younger specialist to take a position. This reinforces the need for state-wide co-ordination and planning to ensure that LHDs have the funding to consider appropriate increases to specialist workforce and infrastructure to meet long term service need. This should go beyond the limits of simply replacing existing workforce and ensure a sufficient workforce to offer a safe, sustainable and high quality practice.

LHDs would benefit from a flexible centralised budget to assist with succession planning and allow for short term staffing overlaps so that there may be a smooth handover of services and new doctors are supported in developing their practice. For example, some hospitals employ potential candidates who are registrars nearing the end of their training for fellowship year to ease this transition.

Recommendations

No.	Recommendation
5.6.1	That regional LHDs have access to a centralised, flexible budget to assist with succession planning, including for the employment of potential candidates to fellowship positions.

6 Regional – metro relations

The Forum considered maintenance and enhancement of links between regional hospitals and major metropolitan centres as critical and to combat issues of professional isolation, make regional practice more appealing and ensure ongoing excellence in service delivery for regional and rural patients.

6.1 Transfers

Links with metropolitan hospitals were considered important in various contexts, including for transferring patients to metropolitan centres when they require tertiary levels of care. Many clinicians were frustrated by the time wasted and difficulty involved in attempting to arrange such transfers. The current system should be reviewed to ensure smoother and easier transfers for the benefit of patients and regional practitioners.

Recommendations

No.	Recommendation
6.1.1	That the system for transferring emergency patients and in patients from regional hospitals to metropolitan hospitals for tertiary levels of care should be reviewed for efficacy.

6.2 Training

Links with metropolitan hospitals were also considered important with respect to training and teaching, including:

- for registrars and supervisors to support vocational training and rotations of regional to metro and metro to regional registrars; and
- for access to, and participation in, continuing professional development opportunities.

What is currently on offer needs to be reviewed and options to enhance existing links explored.

Recommendations

No.	Recommendation
6.2.1	That training links between regional and metropolitan hospitals be strengthened and supported to ensure clinicians in regional hospitals have access to supported training, learning and supervision.

6.3 Recognition

Promoting ongoing high standards in regional health service delivery, and recognising the value and efforts of regional practitioners were primary drivers behind AMA NSW convening the Forum and a concern for those participating. AMA NSW is committed to addressing issues relating to regional health services and recognition of the work of regional doctors. As part of this commitment, AMA NSW will be taking responsibility for acting on the recommendations contained in this document where appropriate and for addressing these recommendations to state and federal governments, Colleges and other relevant bodies.

Unfortunately, a frequently voiced belief at the Forum and in AMA NSW surveys[2] is that regional practitioners do not receive appropriate recognition and respect for their skills and experience from their metropolitan colleagues, translating into discrimination and reduced vocational opportunities. The medical profession generally, and Colleges and AMA NSW specifically, need to review this issue and work to address any issues of casual and structural discrimination against doctors working outside metropolitan areas.

Recommendations

No.	Recommendation
6.3.1	That appropriate respect and recognition for non-metropolitan medical practitioners be encouraged and that areas of perceived or actual discrimination be addressed.

7 Telehealth

Although Telehealth has the potential to be a valuable adjunct to traditional models of health service provision, there was agreement that regional centres need to offer a broad range of services by locally-based doctors.

According to AMA NSW surveys, doctors believe that Telehealth needs further development, including in terms of infrastructure, support, education and guidelines.[2] Developments in Telehealth should be considered as part of a broader plan for regional, rural and remote health with consideration of the impact on quality of health care and delivery of in-person services to regional areas, as well as defining appropriate scenarios for its use.

It was noted that, regional hospital emergency departments are now offering Telehealth support and services to smaller rural hospitals, with some benefits, however the time commitment involved in providing these additional services, are not being acknowledged and accounted for in staffing and budgets with resulting impacts on services.

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[1] Dr Jenny May, *Rural or Urban –a study of medical workforce in regional centres* (unpublished doctoral dissertation), University of Newcastle, Tamworth, Australia, December 2013

[2] AMA NSW, *Survey of Senior Regional and Rural Doctors* (unpublished), Sydney, Australia, October 2013