



NATIONAL RURAL  
HEALTH  
ALLIANCE INC.

**Submission to**

**the Office of Rural Health**

**related to its Review of**

**Rural and Remote Health Service Programs**

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*This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies*

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## EXECUTIVE SUMMARY

The Alliance's vision of good health and wellbeing for people in rural and remote Australia is complemented by the seven goals of *Healthy Horizons*. In the Alliance's view they make an appropriate frame of reference for the current review of rural and remote health service programs, pending strategic frameworks emerging from broader reviews of the health system.

The special health programs for rural and remote areas should be effective, flexible, adaptable, innovative, accountable and strategic in their distribution of benefits and should help achieve equitable health outcomes for all Australians. The current review of rural classification systems is important in its capacity to contribute to achieving equity.

Because of the importance of Commonwealth-State partnerships in improving health outcomes in rural and remote areas, the Alliance's submission addresses Theme 5 as its first priority. Among the many complexities involved in a health system being co-managed by two levels of government, is the imperative that cost-shifting be avoided and that relocation of responsibilities between governments results in net gains to communities in terms of services and outcomes. Cooperative agreements should be put in place so that when health services face budget difficulties, the funding pressures of acute health care do not place other services at risk.

Other complexities relate to workforce shortages, funding arrangements, business viability, sparse populations, and linkages between rural and metropolitan health services. The Alliance advocates a broad concept of partnership which includes governments and other health organisations, professionals and individuals in order to best address this complexity of issues.

The development of a National Rural Health Strategy, agreed by the Commonwealth and State/Territory governments, would give greater certainty and visibility to the intentions of all jurisdictions and be a basis for coherent planning and service provision. The Alliance advocates a National Rural Health Plan as a component part of such a strategy, which would allow actions, timelines, resources and outcomes to be more precisely and more openly measured and evaluated. A Plan would include goals and strategies relating to national health priorities, Indigenous health, primary health care, mental health and preventative health. Its provisions would encompass both private and public provision of services, needs-based funding, compensation for additional costs of rural services and local access to basic primary health care.

Because improved rural access to specialist and tertiary care will help narrow the gap in health outcomes, stronger and more consistent patients' travel and accommodation programs remain an important priority for Alliance members.

Any consolidation of rural health programs should take account of the benefits they provide to rural communities, including their capacity to address service gaps, provide integrated models of care, expand the range of services and respond to local needs. Efforts to consolidate existing programs should be informed by thorough evaluation. Maintenance of quality is crucial. Principles and objectives should be established, and performance monitoring undertaken, to allow for systemic evaluation and the replication of best practice approaches.

Care should be taken that consolidation of programs does not result in a net loss in funding for rural services. Funding packages should include measures for reducing difficulties associated with maldistribution of the workforce by effectively attracting and retaining health professionals to rural and remote areas. The new GP Super Clinic in larger centres represents a financial and political commitment that should, in some way, be extended to smaller and more remote communities. In smaller rural communities, flexible health service funding models, such as Regional Health Services and MPSs, are well regarded and highly valued.

Some rural areas and some of the new cohorts of health professionals are not well-suited to the traditional health service model that is based on private businesses and fee-for-service. For some areas and individuals, a 'walk-in, walk-out model' is the preferred means of ensuring continuity of health services. To serve an integrated and multi-disciplinary primary health care environment, infrastructure needs to take account of the needs of a range of professions. The availability of reliable information technology and communications has the capacity to provide particular benefit for rural health. For this reason, priority national attention should be given to reversing the present situation where those areas likely to gain the most benefit from e-Health have the least means of accessing it due to poor infrastructure and inadequate resources.

With regard to targeted support for peak rural and remote health organisations, this submission cites the recent external evaluation by Urbis of the National Rural Health Alliance. The National Rural Health Alliance has a membership of 28 national organisations with a core focus on rural health. Its roles include identifying current issues, synthesising responses and opinions into an agreed view, and advocating on behalf of its members and rural communities for equal health. Member organisations provide valuable and particular input from a range of professions whose perspectives are important in contributing to development of a final comprehensive and inclusive position.

Planning for rural health would be well informed by a strong evidence base. While Australia is recognised as a leader in rural and remote health education and training, related research is hampered by limited resources. Contributions are being made by University Departments of Rural Health, the Australian Primary Health Care Research Institute and others. This submission proposes a range of options for shaping a more strategic research agenda to ensure that optimum results are derived from analyses of research, evaluation of programs, and the changes likely to flow from the current health reform agenda.

Better distribution of health professionals across the country would reduce the number of rural and remote areas suffering acute workforce shortages. Where health professionals choose to practise is influenced by the availability of high quality education, training and professional development, adequate infrastructure, choice with regard to service models, remuneration levels, health practice viability, family considerations and ease of moving in and out of rural practice. Greater focus should be given to income differentials between urban and rural/remote health professionals of all kinds.

The impact of the general trend for Australian trained doctors to cluster in metropolitan areas is offset by the recruitment of International Medical Graduates (IMGs) who are required to serve for a period in rural areas. Therefore, any programs to support rural GPs should provide special assistance for IMGs. This should include providing greater access for IMGs and their families to Medicare and public schooling. Other strategies for retention will include flexible and cooperative models of service that support preferred lifestyles, opportunities for continuing professional development (CPD), adequate funding for staff and infrastructure.

Schemes in place for CPD are valuable and should be expanded in scope to cover other health professions, disciplines or sub-disciplines in short supply in rural Australia. Training scholarships are useful and should also be increased to better match demand and supply in priority areas.

Adequacy of undergraduate training places for rural students, rural clinical placements and vocational training for a range of health professions will contribute to the provision of multi-disciplinary primary health care, including in rural areas. Rural Clinical Schools and the University Departments of Rural Health (UDRHs) provide valuable access for rural students to health professional education. The UDRHs should be supported to expand their placements for nursing and allied health, and are well positioned to facilitate interdisciplinary training, provide pilot sites to test innovative work models, undertake research, and support rural health professionals and communities – for which they should be adequately funded.

Clinical placements are dependent on having clinicians available and provided with the financial incentives and back-up to do the training, as well as good quality infrastructure (including student accommodation) and equipment to provide a high quality experience, including in primary care and multidisciplinary settings.

A range of rural health scholarships currently operate to meet a variety of needs and to serve a range of professional groups, and they could usefully undergo a major effectiveness review. There is great demand for these scholarships and it is the Alliance's view that there should be greater scholarship equity across the various health professionals.

Some anomalies are apparent in conditions between various scholarships and there have been changes in the educational environment for which adjustments have not been made to affected scholarship schemes. Attention could be given to assessment of scholar intentions with respect to rural and remote practice.

Overall, any changes to existing rural health programs should not discriminate against or disadvantage those professionals or services already established in rural areas. Careful consideration should be given to change management processes and grandfathering of current arrangements to avoid any unintended or unjust penalisation of particular individuals or businesses.

## INTRODUCTION

*“People living in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities.”*

This is the vision enunciated in the *Healthy Horizons* Framework, as well as the *raison d’être* of the National Rural Health Alliance (NRHA).

To achieve this end, the *Healthy Horizons* Framework has seven goals:

1. improve the highest priorities first – National Priority Areas and rural specific issues;
2. improve the health of Aboriginal and Torres Strait Islander people living in rural, regional and remote Australia;
3. undertake research and provide better information to rural, regional and remote Australians;
4. develop flexible and coordinated services;
5. maintain a skilled and responsive health workforce;
6. develop needs-based, flexible funding arrangements for rural, regional and remote Australians; and
7. achieve recognition of rural, regional and remote health as an important component of the Australian health system.

The Alliance notes and supports the approach indicated in the Issues Paper *Review of Rural Health Programs* that a second stage of the Review will consider programs in the light of the national strategic reforms and policies in health services and systems. In the interim, the vision and goals of *Healthy Horizons* would seem to provide a logical frame of reference for the review of the Commonwealth funded rural health programs administered by the Office of Rural Health, as well as for other programs administered by other areas of the Department.

As noted in our submission to the Department in February 2008, the Alliance sees it as critical in the longer term that programs to improve health and access to health services by rural Australians are guided by a strong strategic framework that establishes service access standards, provides a clear basis for evaluation of programs and seeks to augment the evidence base on which programs are founded. (A copy of that February 2008 submission is attached for ease of reference.)

These other programs include the Multipurpose Services Program, the National Rural and Remote Health Infrastructure Program, rural pharmacy allowances, COAG-based initiatives to improve access to mental health services by allied health professionals and to improve access to Medicare benefits for state-provided primary care services, and a range of national workforce planning and support programs that are vital to health services provision in rural Australia.

The Alliance considers rationalisation of the existing array of Commonwealth funded rural health programs to be a timely step in the Government’s reform agenda to deliver better health outcomes for all Australians. It is critical that these programs be highly effective and have the flexibility to allow adaptation to changing paradigms of health provision and new models of service to best meet the health care needs of rural Australia. They should help achieve an equitable distribution of benefits and health outcomes. They should be readily

transparent for the individuals, health professionals, health services and communities who are seeking to access them, and simple in administration and accountability. They should also be capable of systematic evaluation, as a basis for the extension of programs that work and the modification or cessation of programs where there are better ways of meeting overall goals.

Any changes in programs should be accompanied by careful consideration of change management. The existing level of rural services, and the decisions of health professionals to locate in rural areas as a result of incentives provided by current arrangements, could potentially be seriously upset were programs to be withdrawn. Consideration should be given to the investments of communities and health professionals in these services. The Alliance considers that grandfathering of current arrangements should be considered so that any changes do not weaken rural service provision in the short term or unfairly penalise individual practitioners or businesses.

## **THEMES**

The Department's work on the review of rural classification systems has the capacity to guide programs and resources to where they are most needed. Where health is concerned, concepts of rurality and remoteness have many dimensions, but ultimately should provide guidance on how accessible, or otherwise, health services are to individuals and communities, and what measures need to be taken to remove barriers to accessibility. The Alliance has given particular consideration to this issue and has provided a separate paper to the Department (*A new geographic classification for a new health system*, 22 December 2008).

The Alliance also supports the thematic grouping of programs within the ORH review. These themes provide greater clarity about program purpose, and provide a strategic framework for considering how programs can be consolidated and made more flexible and outcome-oriented, and how their conditions for eligibility and accountability can be rationalised. They also provide a sensible framework within which to add or enhance programs over time as the impact of the major strategic reviews of the health sector begins to take effect.

In terms of the specific themes, the Alliance is generally satisfied that the goals and principles of *Healthy Horizons* have been covered at Theme level or as subsets of the themes (or are taken up in the *Closing the Gap* agenda).

### **Theme 5: Fostering partnerships between the Commonwealth and state and territory governments to improve health outcomes in rural and remote areas**

**1. *What opportunities are there to foster partnerships between the Commonwealth and the State and Northern Territory governments to improve the planning and implementation of services and programs to address the health needs of rural and remote communities?***

**2. *Is there benefit in developing a national rural health strategic plan or strategy?***

The Alliance addresses this issue first because strategies to improve overall planning and service provision are crucial to overcoming the complexities inherent in funding of services by these two levels of Government.

The 2008 Review of the *Healthy Horizons* Framework (HHF) found that 63 per cent of indicators of health status, determinants of health and health systems performance (59 of 93 indicators) show at least some rural categories at a significant disadvantage. Clearly there is

an ongoing need for both levels of government to continue to work to redress these inequities. It is axiomatic that additional funding provided by one level of government for rural health services will offer no net gain to the community if there is withdrawal or diversion of such funds by the other level of government. Better integration of services is also crucial to making the most effective use of the health professions and to meeting the COAG principles of person- and family-centred services.

The Alliance understands that delineation of responsibilities and proposals for better planning, coordination and performance monitoring is a major strategic question for the National Health and Hospitals Reform Commission, and looks to the Commission's report to provide the overarching framework of national planning, service provision, and performance monitoring and review.

However, planning for health services in rural Australia has additional dimensions of complexity. There are shortages of many health professions, especially those funded through fee-for-service arrangements, lower attractiveness from a business viewpoint in establishing services among more thinly spread populations, and complexities in effectively linking rural and metropolitan health services for patients whose health journey requires sophisticated service provision. The Discussion Paper outlines many difficulties arising from a lack of coordination between governments, including service gaps, inadequate longer-term planning, imbalances in infrastructure and workforce requirements, compliance and reporting burdens of a large number of compensatory programs and inadequate performance monitoring and review.

In addition to the inadequacy of inter-Government planning and coordination, the 2008 review of *Healthy Horizons* also undertook an analysis of how the health plans of State and Northern Territory Governments were addressing the HHF goals and principles. Inspection of the Review's assessment of jurisdictional strategic directions against HHF goals and principles found that they were less focussed on addressing issues of flexible funding, partnership, research and information, service access, and safety and quality. However the Review found that the jurisdictions' plans had a strong focus on flexible and coordinated services, high priority issues and skilling the workforce.

The Discussion Paper from the Department, *Towards a National Primary Health Care Strategy*, notes State Government initiatives to better integrate primary health care services, such as Victoria's Primary Care Partnerships, Queensland's Connecting Healthcare in Communities and New South Wales' Healthone initiative. South Australia has recently released its Strategy for Planning Country Health Services. These initiatives have a strong focus on regional partnerships, community engagement, service coordination (including with Commonwealth-funded General Practice and other medical services funded under the Medicare Benefits Schedule), fostering multidisciplinary care, patient pathways and addressing key priorities such as chronic disease, health promotion and prevention, mental illness, and the primary-acute care interface. They also provide for measures of performance and for evaluation in meeting their strategic goals.

Such initiatives at the State and Territory level offer a valuable opportunity for partnerships between the Commonwealth and the States. In the view of the Alliance, the objectives and benefits of such partnership would include:

- a national approach to building on and promulgating the strengths of these initiatives;

- providing for some equity across Australia in what people, especially in underserved areas, should expect by way of local provision of services;
- enabling the Australian Government to ensure that developments of its own policies and programs, especially through MBS funding and in workforce planning and development, are well integrated with the strategic directions of the States and Territories;
- coordinated approaches to continuous improvement and to overall evaluation of health services provision; and
- enabling each level of Government to address its particular areas of responsibility within a well-articulated national context.

### **A National Rural Health Strategy**

The NRHA has always supported the existence of a formal National Rural Health Strategy on the basis that it is agreed by both levels of Government. The benefits of such a Strategy for the people of rural and remote areas include greater certainty and visibility of the intentions of Commonwealth, State and Territory jurisdictions, and a platform for national collaboration and coherence in service planning and provision. *Healthy Horizons* has been the *de facto* national rural and remote health strategy, agreed by the Australian, State and Territory Ministers for Health and the NRHA, and provides a clear indication of some of the principles and directions that have been agreed for rural and remote health. The NRHA's position in the past has been that the Strategy of the day should be accompanied by a National Rural Health Plan that would convert the general principles into explicit and measurable actions, be accompanied by timelines and indications of resource allocations, and go also to specified targeted health outcomes.

With the possibilities of national goals and performance monitoring foreshadowed by the NHHRC, the Alliance considers that a rural and remote health plan would be a specific subset of this new national health framework rather than a stand-alone entity. It is crucial, in fact, that rural health services provision is well integrated with overall health services provision, to ensure that people in rural Australia have integrated access into the best health services that Australia has to offer. As well as its rural component, the national health plan would also include goals and strategies relating to national health priorities, Indigenous health, primary health care, mental health and preventative health.

The most fundamental issues that the Alliance would wish to be reflected in a rural subset of a national planning and performance framework would include the following:

- that the overall distribution of health services resources should be dictated by health care needs, while allowing for both private fee-for-service and public provision of services;
- that needs-based funding especially take account of those with special needs, including Aboriginal and Torres Strait Islander people, the aged, those with mental health conditions and very particular groups such as refugees;
- that policies and programs generally should compensate for any added cost of providing service in rural and remote areas;
- that particular attention be given to attracting an equitable share and a well-balanced group of health care professionals to rural and remote areas;
- that structures should be in place to allow local access to basic primary health care and emergency care services for everyone, irrespective of their location; and
- that models of care are integrated and patient-centred, to reflect consumer expectations and the increasing complexity of effectively addressing the health needs of those with

chronic conditions, the aged, those with multiple and substantial risk factors, mental illness and/or cultural or socio-economic barriers to health service access.

While all governments have a key role in health services, Australian Government leadership of this strategic approach is vital in terms of its responsibility for primary health care, especially through MBS/PBS funding or ‘possible cash-out’ or mixed fee-for-service/capitation equivalents; its leadership in innovation and reform – in mental health, in aged care-acute care interfaces, in multi-disciplinary or interdisciplinary models and in preventative health; and also in its funding and national performance setting role through the Australian Health Care Agreements.

The Alliance would welcome the opportunity to participate in the development of more detailed work on priorities for attention, a work program, specific targets and performance measures that a rural planning framework would include.

### **Regional Planning**

To meet local needs, planning at any level will require understanding of the locality in which services are to be provided. Each area of Australia has its differences, relevant to such planning. It is for this reason that the HHF includes among its principles:

- *community capacity*; including the social capital and physical capacity for a community to identify, develop and implement local programs to improve and maintain their health; and
- *community participation*; focusing on systematic approaches to enable individuals, communities and special groups to identify priorities, access information, participate in planning and provide feedback on progress.

An ultimate objective would be to put in place a regional governance and planning framework to deliver on these principles and to ensure service coordination, integration and performance monitoring and review at a meaningful level.

### **Patients’ Accommodation and Travel Scheme (PATS)**

The Alliance has made improved patients’ travel and accommodation one of its top priorities.

Improving access to specialist and tertiary care for people living in rural and remote areas will help narrow the gap in access to health services and in health outcomes. Where this cannot be achieved by providing local services, the only reasonable alternative is subsidised travel and accommodation to enable these patients to access care in major centres. Because much diagnostic testing, complex treatment and follow-up care will only be available at tertiary hospitals, patients’ travel and accommodation schemes should be seen as a key part of the core services for health in more remote areas.

The Alliance understands that the PATS is subject to consideration by the Australian Health Ministers’ Advisory Council and subsequently by COAG. This is a highly necessary scheme although with considerable weakness in terms of its inadequate funding for individuals and inflexibility in its applicability across state borders. The development of a more nationally agreed, adequately funded system of supporting patients’ essential travel for health services, and more public accountability, is a matter of high priority for many members of the Alliance, and one that requires the exercise of the governmental partnership espoused in the Discussion Paper.

## **Broader Partnership and Collaboration**

While it is understandable that the theme in the Discussion Paper has focused on Commonwealth/State and Territory Government partnership, it is narrower than the concept of partnership proposed in the 2008 Review of *Healthy Horizons*, which stakeholders proposed should comprehend collaboration:

- government to government;
- between health organisations, local NGOs and private providers;
- between rural and metropolitan health services in terms of the patient journey; and
- among health professions.

In the longer term, the Alliance sees merit in adopting this broader concept of partnership to promote and provide for initiatives that seek to engage all parties, including local communities, in pursuing the objective of a healthier Australia.

## **Theme 1: Improving access to appropriate health and medical services, improving health promotion and prevention**

The Discussion Paper poses the question:

- 1. If rural health programs were to be consolidated and refocused to ensure they better target genuine need in rural and remote communities, what issues and factors should be taken into account?*

Theme one, and its proposed grouping of programs, is particularly important from the consumer perspective in shaping how health services will be delivered and meet the COAG principles of person- and family-centred services.

Consistent feedback to the Alliance over time suggests that the programs funded under this theme are generally well known and highly valued in the communities in which they operate. The goals of these programs are strongly supported, with some programs focusing on enhancing allied health services generally or for mental health services, on enhancing primary health care (MBS-funded) provision, specialist outreach and supporting and integrating acute care and aged care services and home care services.

The key benefits of these programs are well expressed in the Discussion Paper: addressing gaps in service, providing more integrated models of care, expanding the range of services, building connections with communities, being more responsive to local needs and building community capacity and health literacy. Given the deficits in rural areas in access to MBS-funded services because of lower accessibility to doctors, these programs should be seen as an essential element of a broader strategy to deliver investment in health services provision based on population levels and health and socio-economic status.

Nevertheless, the multiplicity of program types and titles can give rise to difficulties. One such problem stems from the multiplicity of titles, conditions of eligibility and reporting frameworks. While each of the models will have its place, depending upon the characteristics of the communities they serve, the Alliance considers that it would be instructive for future development, expansion and evaluation to have common management information on the range of key performance measures. Ideally, there would at least be a standardised set of principles and objectives and a minimum data set for monitoring of quality and output performance so that programs can be evaluated at the systemic level and best practice approaches promulgated across all these service types.

Making best use of scarce resources is essential in rural Australia and efficiency benchmarking where practicable across the service types would be valuable in driving innovation and reform. Quality is also crucial. The Alliance notes the existence of National Principles for Quality Improvement for Multi-Purpose Services, and considers that there are features of these principles, including active participation of communities, the engagement of consumers, integration of care and good corporate governance that add value to the more usual and obviously crucial clinical safety and quality and output measures.

Another issue is to ensure that funding under these programs does not substitute for funding that would otherwise be provided by other levels of government. There has been a concern among Alliance members, for example those working in Regional Health Services, that when health services face budget difficulties, the funding pressures of acute health care place allied health services, for example, at risk. It is essential that the partnership arrangement in place between Commonwealth and State/Territory governments and local communities avoid these problems and maximise linkages among services.

A third concern is that funding for ongoing service provision is not supported by adequate investment in the package of measures really required to attract and retain the health professional workforce, or to offer the scale of resourcing to ensure fully effective services. As noted in the Alliance's February 2008 Submission, research undertaken by the Australian Primary Health Care Research Institute identified the essential features of effective services including:

- workforce organisation and supply;
- adequate funding;
- governance and management structures;
- well developed linkages, including clinical referral pathways;
- adequate infrastructure, including accommodation, vehicles, equipment and information systems; and
- critical population mass (perhaps reached through outreach or hub and spoke type arrangements) to provide a range of primary health care services.

There are a number of proposals for new integrated care services for smaller towns, characterised by:

- integrated and multi-disciplinary patient care;
- continuity of patient record management;
- a range of workforce training, continuing professional development and peer support needs; and
- single service management systems.

### **The GP Super Clinic Benchmark**

The Australian Government's GP Super Clinic program has allocated \$275 million for 31 clinics and provides an average of \$9 million per clinic for capital, health profession relocation expenses and management systems. These proposed clinics are largely in outer-metropolitan areas and large regional centres with reasonable amenity. Their critical mass means that they will generate considerable ongoing funding through MBS-funded services, employ a range of health disciplines and generally provide well-resourced and comprehensive primary care services.

The GP Super Clinic program represents a financial and political commitment that should, in some way, be extended to smaller and more remote communities. Flexible health service funding models in rural areas such as Regional Health Services and MPSs appear to be effective and could benefit from such a commitment.

Like regional centres, smaller communities need effective strategies to ensure the availability and viability of health care services and the retention of health professionals. Additional investment in smaller rural communities would help to ensure that the Super Clinics do not attract health professionals away from areas of greater need, notwithstanding restrictions on the payment of relocation incentives outside areas of workforce shortage.

Both Super Clinics and regional health service-type models should also be considered for their capacity to provide hub services for outlying towns (eg information management) and outreach such as emergency response, allied health and preventative health programs, to ensure that people in smaller rural communities also benefit from investment in larger-scale multidisciplinary service models.

***2. Are there gaps in existing health service provision for rural and remote communities which the Australian Government should have a role in addressing?***

The lower level of access to services in rural and remote areas, higher rates of morbidity and mortality, and greater out-of-pocket costs (due to both lower rates of bulk billing and greater health transport and accommodation costs) all point to substantial gaps in health services provision.

The Australian Government has continuing major responsibility for primary health care services, especially through MBS and PBS funding. Service gaps of this kind will continue to exist while ever there is maldistribution of health professionals reimbursed through the MBS system or where referrals to other health professionals may be largely generated through visits to a GP.

The Alliance notes the COAG initiative on access to MBS in State-provided primary care services as one means of improving access to primary care services, but considers that a population-needs based funding framework with possible 'cash-out' or mixed fee for service/capitation equivalents is required to meet the goal of equivalence in access to primary health care services. Within that framework, there is a case to consider extension of the COAG principles to include access to MBS for services provided by other health professions including mental health services, nurse practitioner and midwives' services where there are no GPs, and to include services provided by nurses and allied health professionals for and on behalf of GPs in areas of greatest need.

However, the MBS is essentially a private sector market based program that has not delivered as well as it should for rural communities to date and overall the Alliance would prefer more targeted approaches to ensuring distribution of health professionals to provide equitable and accessible primary health care services.

The Australian Government has also assumed responsibility for national leadership for innovation and reform, for example in Aboriginal health, in mental health, in preventative health, in aged care-acute care interfaces, in eHealth and in multi-disciplinary or interdisciplinary models. The Alliance considers that it is essential that the Australian

Government continue to provide this leadership in promoting high quality patient-centred health services

### **Medical Specialist Outreach Program (MSOAP)**

The Alliance supports the continuation and expansion of MSOAP. Resident medical specialists across a range of disciplines are not available in many larger regional centres, and certainly not in smaller and more rural areas. Outreach by specialists to local communities is therefore critical to providing patients with joined-up care, and to minimising disruption and cost to themselves and their families when they are forced to seek medical attention in major cities.

Irrespective of the adequacy of the PATS system, it inevitably represents cost shifting from the Government to the individual and their families when they are required to travel long distances from home for a service that is essential in their health condition.

Another valuable approach to specialist outreach is through e-Health. The Australian College of Rural and Remote Medicine (ACRRM) has successfully developed such services for dermatology and radiology through its TeleDerm and TeleRadiology initiatives. Research and development on the scope to extend such initiatives is warranted, especially where the MSOAP cannot fully meet need.

### **Patient Pathways**

People with chronic disease now account for about 80 per cent of the burden of morbidity and mortality. There have been many initiatives, including in rural Australia, that have no doubt contributed substantially to more integrated approaches to assisting and supporting people in managing chronic conditions. The Alliance is concerned to ensure that best practice among these approaches is assessed and promulgated to imbed the best of chronic disease management and to further shift from the episodic, specialist and acute care to holistic primary health care.

Patient pathways for rural Australians are complicated by distance, waiting times for access, fewer allied health professionals, longer working hours by GPs and in many cases geographic separation of primary care providers and specialists and acute care where rural patients are forced to travel to major cities for treatment.

Accordingly, the Alliance would like to see research and development on patient pathways in priority areas, including for mental health, maternity services, post acute care and specialist services to support services in providing linked and integrated care. Work on patient pathways could also build better linkages with communities on preventative health measures.

### **Preventative Health**

In its submission to the Preventative Health Taskforce, the Alliance noted the higher incidence in rural Australia of many risk factors and therefore the higher potential gains to be made from a focus on health promotion and illness prevention. However health education and preventative health programs must be designed or adapted to meet rural needs, and local ownership is crucial in many cases. In this context, the Rural Primary Health Projects program assumes greater importance. The Alliance considers that there would be merit in support for programs that provide ongoing rather than time-limited support for such

initiatives, and healthy community initiatives should be part of the fabric of the Australian health system.

## **Theme 2: Investing more effectively in rural health infrastructure**

### ***1. What are the major infrastructure gaps facing health services in rural and remote Australia?***

The Alliance's vision is good health and wellbeing for people in rural and remote Australia. Among other things this will require sustainable health services in rural Australia and one measure of infrastructure gaps is the extent to which they contribute to the failure to date to achieve sustainable service systems.

A key concern for rural communities is the downgrading and/or closure of rural hospitals, driven by the search for efficiencies within the state health system, but one which

- shifts the costs to local residents who are forced to travel some distance to regional hospitals; and
- discounts the value of the procedural, obstetrics and emergency skills of local GPs and forces their relocation and/or reduces their practice viability.

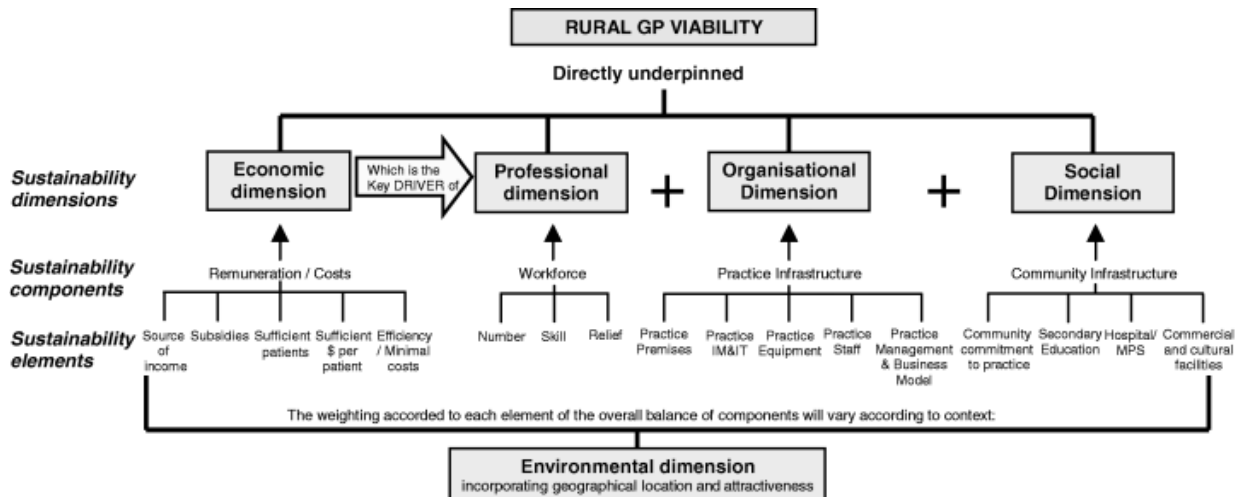
The Alliance believes that planning in relation to rural hospital locations and scopes of service should be a particular element of Commonwealth/State cooperation and coordination in health system planning.

Overall, the Alliance believes that substantial reliance on privately funded infrastructure, supported in many cases through MBS and patient co-payments, is becoming less and less feasible or attractive to new entrants to practice in rural Australia. The 'easy access/graceful exit' or walk-in-walk out model of health services infrastructure is now becoming a more practical model for attraction and retention of health professionals. This entails government and community-sourced funding, sometimes accompanied by salary-based systems of remuneration for health professionals.

The Alliance would also like to see a shared approach with the States to infrastructure funding of Multi-purpose Services and Regional Health Services, recognising that restrictions in infrastructure inhibit the attraction and retention of health professionals. Such investments have the capacity to bring together doctors and other health professions and to provide training facilities.

Conversely, where infrastructure funding is available for privately owned practices, it should be directed to facilities to enhance infrastructure for student clinical training or to co-locate services, rather than to meet private capital costs that would otherwise be funded from business turnover which is underwritten by the MBS system.

The figure below represents a systems-based model of sustainability of a rural general practice and is presented here for the merits of its systemic approach.



With the increasing focus on more integrated and multi-disciplinary primary health care, this system needs to be expanded to comprehend the systems needs of primary care service governance, and the practice infrastructure needs of psychologists, nurses and allied health professionals who are part of the primary health care team. This may include the need for subsidised accommodation and incidental allowances eg travel and air conditioning subsidies. Currently gratuities are available to some professional groups but not others eg in Western Australia they are available to nursing and medical staff but not to allied health staff.

### e-Health Paradox

The Australian Journal of Rural Health (14, 95-98, 2006) noted that rural areas stand to benefit most from e-Health but have the poorest infrastructure, resources, capacity and capability for successful implementation and uptake of it. There needs to be a strategic national approach to this issue and a focus on delivering e-Health initiatives that are relevant in and will work well in rural Australia. A Canadian study (Canadian Journal of Rural Medicine, Winter 2007) also suggested that telehealth could potentially impact positively on attraction and retention, especially in relation to knowledge update, peer support and provision of a more stimulating workplace.

While the Alliance understands that this issue is beyond the scope of this current consideration of rural health programs, it nonetheless wishes to keep this issue on the agenda for national leadership and investment.

2. *The Commonwealth is considering a more consistent and targeted approach to its support for peak rural and remote health organisations. What factors should the Commonwealth consider in shaping its approach?*

### Organisational Infrastructure

The Discussion Paper asks whether funding to peak organisations should be linked to specified outcomes which either benefit the Commonwealth e.g. administration of government programs, conduct of research or undertaking of specific projects, or which directly address the health needs of rural and remote communities. The Paper also noted the piecemeal approach to funding of rural health research and insufficient synthesis and application of research results to inform policy decision-making.

As part of the drive for greater efficiency and better targeting in the health services sector, it is only appropriate for the funding of rural health organisations to be closely examined.

Close scrutiny of the Alliance occurred through the external review undertaken by Urbis in 2006-08 and provided the opportunity for all of its major stakeholders to have their say. That review showed clearly that the Alliance has a valuable role to play through its current objectives and practices which include:

- a variety of formal and informal information dissemination and communication activities;
- linking its Member Bodies through regular communications, the Australian Journal of Rural Health, the biennial Conference, consultation with its members on submissions and representation of views to government;
- policy consideration on health priorities, effective approaches to the delivery of services and improving access, including through investigation and promotion of approaches to providing an adequate and relevant health workforce; and
- administration of RAMUS.

Alliance Council members represent a range of health professions as well as consumers, service provider organisations, rural health workforce education institutions and students. In developing its positions, the Alliance engages in a rigorous process of consultation, and considers that this process of broad input of its members and sign-off by Member Bodies provides a valuable synthesis and balance of perspectives, knowledge and experience. Bringing the parties together to advocate for integrated approaches is essential for workforce development and to pave the way for new and improved models of health service. The Alliance has contributed effectively to the *Healthy Horizons* Framework, has helped keep rural health issues on the national agenda, and has canvassed and espoused many of the broad principles and issues that underpin good health outcomes in rural Australia.

The external evaluation report noted that the Alliance could give greater emphasis to building the capacity of rural communities, consumers and students to participate and be heard in health care discussion. It sees this task as a priority in future. The Alliance also considers that there is scope to do more in terms of identifying what works in health services provision in rural Australia and in seeking to promulgate good practice models and build better links between research/innovation and national policy/practice.

The Alliance sees merit in funding various separate bodies that represent the interests of rural health professionals and can provide expert information and advice on their particular profession or service sector. For example, understanding the professional, economic, social, cultural and other drivers on decisions by individuals in a particular profession to take up rural training and placements is a crucial component of the overall workforce challenge.

***3. In order to strengthen the evidence base for rural health programs and services, what are the factors and approaches that need to be taken into account?***

The Alliance supports the view in the Discussion Paper that there is significant scope for synthesis of the research and data and better linking research to the policy formulation agenda. A review of the literature shows that much research is limited by resources to smaller scale research at the project level that is not easily scaleable and transferable to the broader rural platform. The Alliance considers that a more coordinated and structured approach to research

on rural health issues would be very beneficial. Consolidation of rural health programs itself will be conducive to broader evaluation and evaluation

Australia is now recognised as a world leader in rural and remote health education and training, but rural and remote health research here is still relatively piecemeal and generally consists of short-term projects based on limited short-term funding. The Alliance is already involved in some research promulgation and it uses the results of research in its considerations. The organisation is well-placed to enhance the rural and remote health research effort and to link it more effectively to policy and program development at the national level.

There is a range of University institutions with at least substantial interest in rural health issues. While some of these are dedicated to the rural health agenda, others have a more general focus but with major contributions to make in rural health. Advice from the Australian Primary Health Care Research Institute is that about 25 per cent of its work also has a rural focus. The educational clinical placement and professional development roles of the dedicated rural and remote health organisations make them ideally based to link with health services in undertaking research on health systems and health outcomes. Strengthening the rural research and evaluation capacities of these institutions through at least medium term funding for postgraduate research appointments would be a clear priority in driving the evidence-base forward.

Options to shape a more strategic research agenda would include:

- an Office of Rural Health convened Steering Group on priorities in rural health research;
- a new (virtual) rural health institute to promote a rural health research agenda and to conduct meta-analyses of rural health research; and/or
- nationally commissioned research to ensure that the rural health agenda engages with and influences implementation of the broader strategic change flowing from the current health reform agenda.

In terms of the specifics in shaping the research agenda and its applicability to policy development and implementation, the Alliance notes and supports the call of the Australian Primary Health Care Research Institute to move the agenda in part from identifying innovative or exemplary models of primary health care in some rural communities or in relation to some episodes of care, towards examination of the requirements to implement and sustain these models more broadly in rural Australia.

Other research and development options could include:

- work on linkage and clinical support pathways for the patient journey between rural and metropolitan health services;
- comparative assessments among service models to identify the most cost-effective approaches to service provision; and
- consideration of the factors that would determine 'service access standards'. These would provide benchmarks to assist regions and others in planning health services and to define for Australians the publicly-funded health services to which they can reasonably expect access.

Another valuable approach to dissemination of evaluation and research would be an undertaking on the part of all parties, governmental and non-governmental, to make the results of annual monitoring and more substantive evaluation work publicly available and accessible for use by researchers and policy developers.

### **Theme 3: Addressing workforce shortages through better workforce distribution and support**

- 1. What factors should be taken into account in devising incentives to encourage medical and other health practitioners to move to, and stay in, rural and remote areas?*
- 2. Are there any new approaches to health workforce distribution that could be applied?*

Overall, the Alliance considers that addressing workforce shortages is a key issue – and one that is the primary responsibility of the Commonwealth. Accordingly workforce should continue to be a top priority for the Department of Health and Ageing, and for the Office of Rural Health in particular. It is a multi-faceted challenge, requiring long-term planning and funding, the provision of education, training and professional development, adequate infrastructure of various sorts, a range of effective and attractive models of care, attractive remuneration and health practice viability. A fully integrated approach is required and programs to address these issues also need to be on a sufficient scale to make a real difference.

A Rural Health Workforce Australia Discussion Paper of October 2008 makes a range of cogent arguments to suggest that current policies directed to the provision of more adequate health services in rural Australia, especially in relation to increased training places for general practitioners, are not likely to be sufficient to address the problem. The paper notes that:

- the marketplace for health professionals is now truly global, with Australia having been a substantial net beneficiary of this to date, with substantial immigration of international medical graduates, initially from the United Kingdom, and more recently from Asian and African countries; but this cannot be so assured in future;
- the rural shortage of medical professionals has been a phenomenon, even in times of national plenty, for at least the past 40 years;
- AMWAC estimates (2005) that 50 per cent of medical graduates, around 1100 to 1200 per annum, would need to enter general practice to cover retirements and population-derived demand at the national level;
- there are only 600 [now 800] vocational training places currently available, and acceptances have fallen short by 40 to 70 places in three of the last four years to 2008, with all of the shortfall being in rural Australia; and
- there is an increasing trend for medical students to opt for specialisations other than general practice, exacerbated by requirements for vocational training before access to a Medicare provider number “turning general practice into a speciality where remuneration does not generally reflect that of other specialities”.

The RHWa paper also notes that of the increase of 1845 rural and remote GPs over the period 1995-96 to 2006-2007, 1417 or 76 per cent were international medical graduates (IMGs) and that 62 per cent of Australian medical graduates accepting rural pathway training places are

subject to the 10 year moratorium on practice in non-designated areas. The paper concludes that trends clearly indicate that international medical graduates and international Australian graduates will comprise the bulk of the new additions to the rural and remote medical workforce and that the only policy measures that have been shown to definitely improve the numbers of rural and remote GPs are those that relate to IMGs.

### **Support for GPs and Other Health Professionals**

This situation lends strong support to the view that support, coordination and assistance for international medical graduates should be an essential feature of programs of support for rural GPs. This view was put by many (including the Alliance, the Rural Doctors' Association, Health Consumers of Rural and Remote Australia, the Australian General Practice Network and the NSW Rural Doctors Network) in their respective submissions to the National Health and Hospitals Reform Commission. While Australian and State/Territory Government programs seek to provide support for entry to medical positions in rural Australia, these programs do not seem to provide the level of support in the ongoing professional development, and in cultural, familial and community engagement dimensions. Where IMGs are concerned, the lack of eligibility for Medicare and limited access to public schooling for their children are also major weaknesses in the current system of support.

Clearly support programs for IMGs are crucial for quality health provision in rural Australia and improvement in their adequacy and scope of support should be subject to urgent consideration. This support should include:

- initial training and ongoing professional development and training pathways equivalent to that offered to Australian trained doctors; and
- a case management approach to orientation and support for IMGs in settling them and their families into the community in which they are working.

The RHWA paper makes the case that greater focus might usefully be placed on peer support, continuing professional development, infrastructure, models of service and practice management that better reflect the preferences and interests of younger medical graduates and other health professionals. This case is supported by a range of other Alliance members and by research on attraction and retention issues. Central Queensland University studies examining attraction and retention of professionals generally to regional areas indicated that professional support, perceived career opportunities, lifestyle (such as preference for reduced work hours and on-call requirements), the level of education available to those with children, employment opportunities for partners and the higher costs of living in regions are major barriers to professionals seeking to establish themselves in rural areas.

While some aspects of attraction and retention are beyond the scope of the health sector to address, many Alliance members consider that initiatives to get the work and service environment right are crucial. The study by Humphreys et al *Workforce retention in rural and remote Australia; determining the factors that influence length of practice* (MJA 2002, vol176) indicated that on-call demands and access to professional development were the two major barriers to retention of GPs in rural Australia. Studies on influences for the attraction and retention of nurses in rural areas (*Who stays in rural practice; an international review of the literature on factors influencing rural nurse retention*) concluded that job satisfaction was a major influence on retention with access to tools such as diagnostic tests, work variety including management and educator roles, peer feedback, collaborative teamwork and professional development being key elements.

In this regard the favoured work environment for health professionals will include models of service that foster cooperative and valued relationships among health professions and that provide the working hours to support preferred lifestyles and full opportunities for continuing professional development. The multidisciplinary model, in which work is shared among appropriately trained health professionals, can deliver these benefits provided there is adequate funding for the infrastructure and the staffing resources to deliver the models of care, quality of work environment and work hours balance.

Professionals' perceptions of the importance of long-term career development, including through high quality work placements, peer support and substantial opportunities for continuing professional development suggest that professional development is highly important to attraction and retention. Measures to provide support for continuing professional development for professionals in rural Australia are therefore a high priority for Alliance members.

For these reasons the schemes in place for CPD for GPs involved in procedural practice and for specialists should clearly be retained. Evaluation of the Training for Rural and Remote Procedural General Practitioners Program indicated its value to GPs, with over 60 per cent of eligible GPs receiving support. The evaluation made suggestions for improvements and increased flexibility, including covering a wider range of eligible disciplines and providing additional support for those in more remote areas through increasing levels of grants and including distance education as training.

The Alliance would place priority on this type of program being expanded in scope to cover other health professions, disciplines or sub-disciplines in short supply in rural Australia and also to give more adequate weighting to the needs of those in more rural and remote areas. While the Australian Rural and Remote Health Professional Scholarship Scheme administered by SARRAH is designed to provide opportunities for other health professionals to take up training opportunities, it is highly restricted in the opportunities it offers. Covering some 25 health professions, it has provided scholarships for only 692 people over six years. There would appear to be strong case for expanding these programs to achieve greater equity in provision of career progression and CPD scholarships and to better match demand and supply in priority areas.

Support for health professionals in mental health, dental health and in maternity services would be areas for priority and urgent consideration. These are three key areas of health services provision in rural Australia in demonstrable inadequate supply and in which current programs of support are clearly lacking in comparison to those available to GPs engaged in procedural services and to medical specialists.

### **GP Remuneration Levels**

The issue of remuneration and practice viability in rural Australia has long been identified as another crucial issue for determining workforce distribution. Where GPs are concerned, programs that recognise this include rural loadings for practice incentives and the Rural Retention Program.

The Alliance is not aware of information on the effectiveness of the rural loadings on practice incentives or of the distribution of practice incentive payments among urban and rural general practices. It is possible that bigger and well-resourced urban practices may be better placed to undertake the initial investment in, and ongoing administration of, practice incentive programs to attract the lion's share of payments. It would be instructive to examine the split

of incentive payments for practice nurses between rural and urban areas, which would give some idea of relative capacity of rural and urban practices to implement these programs and increase the capacity for service provision to patients.

It seems anomalous that the rural loadings do not cover the incentive payments for service delivery, which is the ultimate objective and outcome of these programs. The Alliance is not aware of the rationale for exclusion of rural loadings in this way but considers that extension of rural loadings for service delivery to patients would help to support quality care for rural patients.

In its submission to the National Health and Hospitals Reform Commission the Rural Doctors' Association cited a joint RDAA/Monash University study completed in 2003 that showed that economic viability issues as well as professional, organisational and infrastructure issues must all be addressed if any impact is to be made on the rural workforce crisis. The study asserted that the principal issue still to be adequately addressed is economic viability. The RDAA cited the significant increase in bulkbilling as a result of the bulk-billing incentives included in the previous government's Strengthening Medicare initiative to show that that well designed financial incentives can work. It therefore proposed financial incentives specifically for rural and remote areas that would address the isolation of rural practice and reward those doctors that undertake the procedural work usually performed by specialists in the city. These financial incentives would comprise activity-based rural isolation loadings and rural procedural and emergency/on-call loadings, both tiered according to RRMA classification, and to include similar levels of remuneration for salaried doctors.

Such an approach would be vitally dependent upon an up-to-date and well-based classification of rurality that would need to take into account remoteness, population size, socio-economic status, amenity and ease of access to major cities. The proposed incentive system would also need to be considered for extension to the wide range of health professionals who are not remunerated through the Medicare benefits system if it were to contribute over time to the attraction and retention of a well-balanced multi-disciplinary health workforce at the regional level.

On the issue of practice viability, the current National Rural and Remote Health Infrastructure Program already provides for capital funding to assist rural communities to establish walk-in walk-out primary health care facilities for medical practitioners and a range of allied health professionals. This program would seem to be of vital importance, and should be subject to ongoing monitoring and evaluation to assess the level of need and the adequacy of funding in total and at the individual project or community level.

Overall, the Alliance considers it compelling that greater focus be given to income differentials between urban and rural/remote health professionals of all kinds, and that serious consideration be given to further financial measures designed to retain health professionals in rural and remote Australia. To be both effective and efficient in the use of public funding, there should be greater targeting and scaling to areas of greatest need. The Alliance considers that a major study of remuneration levels should be undertaken by the Office of Rural Health as an essential basis for workforce distribution programs in the longer term.

Many rural doctors are employees or contractors who are paid a percentage of the medical income that they earn. This percentage is determined competitively in the GP labor marketplace and can vary from as low as 40 per cent to as high as 70 per cent. The raw MBS

data or the per-GP payment from the rural programs is not a good indicator of actual net take home earnings and any remuneration survey would need to take this into account.

The availability of restricted area IMGs in the rural GP labor market has tended to keep the percentage lower than it would have been in their absence. This is good in some respects but it has effectively stopped the recruitment of unrestricted GPs to rural areas as the earnings are not competitive with urban practice or other medical specialties.

This situation will continue as long as restricted-area IMGs dominate the market for rural GPs.

The Alliance notes the review by Health Outcomes International of the Rural Retention Program. While funding per GP is likely to be regarded as insignificant in economic terms (average annual payments of about \$11,000 per annum, pre-tax), recognition does play an appreciable role in morale of GPs in rural Australia. However, the Program currently covers only 2100 of the approximately 7000 primary care physicians in Australia outside major cities, the average level of payment has not increased in nominal terms for some years, and it is not reaching younger doctors, with only 8 per cent of its recipients under the age of 40. The program also requires continuous service as an eligibility criterion for payment. There would appear to be a case for increasing the quantum of average funding, expanding its scope to provide for attraction of younger doctors, and increasing its flexibility to recognise rural service that is not continuous.

Attraction and retention bonuses in future may need to be reconsidered and reshaped to take account of career patterns and the mobility of health professionals. An ABS study on labour mobility (ABS Labour Mobility 6209.0 April 2001) showed that only 25 per cent of professionals and about the same proportion of people working in health and community services had been in the same job for more than 10 years. While ABS Surveys of labour mobility over the past thirty years do not show any general increase, the career aspirations and patterns of health professionals suggest that approaches such as shorter term 'tours of duty', or short service commissions as practised in the military to engage professionals, might be considered as viable and practical approaches. Currently recruitment and retention bonuses are not available across the board to all health professional groups.

Rural health support programs are needed, therefore, that promote competency in both rural and urban practice so that practitioners can move in and out of rural practice, and that take into account their lifestyle and family commitments, educational requirements and so on. The overall aim of workforce strategies should be to increase the number of health professionals who will work in remote or rural areas at some stage in their career.

#### **Theme 4: Strengthening workforce education and training**

- 1. The Commonwealth is examining ways to improve and refocus education and training opportunities to address workforce shortages, including in rural and remote areas. What are the factors, including incentives, strategies and approaches, which should be taken into account?*

Alliance members have a key objective to ensure adequacy of rural undergraduate training places, clinical places, vocational training and post-vocational development across the spectrum of health professions, to better position the health system in general - and the rural

sector in particular - to attract and retain people to rural health, to provide multi-disciplinary primary health care and to improve efficiency in health services provision.

It is crucial that this education, training and vocational development be high quality and specially targeted to equip health professionals with the broad range of skills needed to meet the health needs of people in rural Australia, taking into account the lack of local specialists, tertiary facilities and diagnostic services. The Alliance notes and agrees with the Discussion Paper that there is a lack of vertical integration in training and development throughout the continuum of professional development, inhibiting innovation and the best use of experienced rural health professionals in developing the next generation.

The Alliance agrees that better integration of professional development, to meet rural health needs under rural conditions and provide peer support through continuing professional development, is vital to the development of appropriate and high quality services for rural Australians.

The Rural Clinical Schools (RCSs) and the University Departments of Rural Health (UDRHs) have been crucial in providing better access for students from rural Australia to health professional education and training and also, importantly, to provide opportunities for students from urban Australia to undertake some of their training and/or clinical placements in a rural setting. The UDRHs and RCSs have performed this role extremely well. The initial focus of many UDRHs on medical training and the development and resourcing of the RCSs has meant a major focus on support for medical graduates.

The Alliance believes that this system should be strengthened and broadened in a number of ways to help ameliorate health workforce shortages in rural areas:

- by providing a needs-based and equitable level of support for students across the spectrum of health professions;
- to cover the geographic gaps in the spread and reach of UDRHs;
- to ensure that there are sufficient rural clinical places to match the increase in health profession training places and to ensure that requests for rural clinical places can be met;
- to offer all health students opportunities for subsequent vocational training and continuing professional development in rural Australia and strengthen and reinforce the existing experience offered by the RCSs/UDRHs; and
- to ensure that training, clinical placements and subsequent vocational training have a strong interdisciplinary dimension.

A substantial enhancement of the network and role of University Departments of Rural Health, through the establishment of some new and the augmentation of some existing UDRHs, should be considered to service regions that currently have no connection with a UDRH. Regions newly covered could include the Kimberley, the Wheatbelt in WA, Katherine, the Torres Strait, Southern Queensland, the Murrumbidgee Irrigation Area, the NSW South Coast, the Riverland and Sunraysia. Some of the new institutions could be associated with Universities that have health science courses but, as yet, no associated UDRH.

The Alliance considers that all UDRHs should be funded to develop and provide rural placements for students across the spectrum of health professions with particular reference at this stage to the nursing and allied health professions, to bring them more proportionally into balance with the medical workforce. In some regions existing UDRH placements are

approaching saturation and new placement sites, including infrastructure for student accommodation, need to be established.

Clinical training is a key priority and has been recognised by recent Government initiatives to increase the number of medical, nursing and allied health supervisors, and to fund the expansion of education and training facilities at regional hospitals, as well as by research work undertaken by the National Health Workforce Taskforce. The clinical placement program for rural Australia should be of the highest order, to provide for highly positive experiences for undergraduate and graduate students and to assure them of the prospects of good career development in rural health.

However, Alliance members have concerns that the rural health system's capacity to provide quality clinical placement experiences is not as robust as it might be. There are problems with attracting professionals to supervisor positions in rural areas, and providing the range of clinical experiences and accommodation needed to house trainees and their families.

In their submissions to the NHHRC, several members of the Alliance stressed the importance of integrating planning for training, undergraduate clinical places, internship and vocational training, building the infrastructure and providing the locum support and financial incentives that support rural health professionals in their training of the next generation of professionals. Many allied health practitioners are so busy and unrewarded for the task that they have stopped taking students on placement. Organisations responsible for training or representing GPs and nurses, such as AGPN, RDAA, RCNA and SARRAH, have argued for particular financial incentives and support, and for the rapid development of new roles such as medical educator and nurse educator positions in a range of clinical settings. This would help to ensure high quality and positive experiences in clinical placements and vocational training, ease the burden on existing clinical trainers, provide attractive careers in rural areas and capture the wisdom and experience of long-term rural health professionals before they retire.

It is not clear to the Alliance how the expanded program of supervisor positions will meet the particular needs of rural Australia. Unless arrangements are made to ensure the equitable distribution of such positions, it could result in the vast bulk of increased clinical training occurring in urban areas at the expense of rural clinical experience, and make more remote the goal of integrated rural education and training.

The UDRHs are well placed to provide opportunities for interdisciplinary training that would prepare graduates in more integrated and multi-disciplinary models of primary health care. Health professionals in rural Australia are ready for this change. UDRHs could well be used as pilot sites to develop and test innovative models that could become an integral feature of health workforce training at a national level.

UDRHs also have key performance requirements in relation to research, innovation in health services and partnerships, support for rural health professionals and communities, and in pursuing a population health focus. While all these objectives are commendable, they present a very broad remit for which the University Departments are not adequately funded.

University Departments of Rural Health receive substantially lower levels of funding than do the Rural Clinical Schools, both through the per capita HECS funding and from the range of funding top-up sources. A long-term commitment to multidisciplinary training and service provision will require these funding differentials to be examined and addressed.

As a final point, while absolutely essential to health infrastructure in rural Australia, the Alliance questions why funding for the educational activities of the Clinical Schools and University Departments is taken from the health budget. There seems a case for such expenditure to be considered an essential but normal part of the tertiary education sector and funded and accounted for accordingly. Much of the infrastructure should be considered for funding through national infrastructure programs rather than considered as ‘special’ funding for rural health.

**2. *In considering the consolidation and refocusing of scholarships, what opportunities, barriers and approaches should be taken into account?***

**Scholarship Programs**

On this topic the key objective should be to ensure that the scholarship program as a whole is effective in its multiple aims and delivers the numbers and the balance among professions that will best provide for improved health outcomes of people in rural and remote Australia. A major effectiveness review of the suite of scholarships should be a strategic priority to ensure in particular that the scholarships do result in health professionals in rural practice. As a subsidiary objective, the Alliance believes there is a strong case for working towards greater scholarship equity across the various health professionals – equity in terms of both proportional numbers and terms and conditions.

Scholarship programs identified under this theme are designed to serve a number of different purposes; including:

- to financially assist people from rural Australia to participate in tertiary education in medical, nursing or allied health professions;
- to encourage health graduates to take up clinical placements in rural Australia; and
- to support health professionals in rural Australia to undertake ongoing professional development.

The first two types of scholarship are premised on research evidence that a range of factors, including experience living in a rural setting and rural exposure to clinical practice at undergraduate and post-graduate phases, are two of a number of factors influencing choice of a rural location for practising as a health professional. (The importance of supporting continuing professional practice for rural health professionals has already been discussed above and is considered by the Alliance to be a high priority.)

If people from rural Australia already had good access to tertiary education, it could be argued that the scholarships to assist people from rural Australia into tertiary study would not be necessary. However, the findings of the *Bradley Review of Australian Higher Education* support the strategy of scholarships targeting students from rural, regional and remote Australia and Indigenous students, with the key findings of the report including:

- at Section 3.2, an emphasis on providing opportunities for all capable students to participate in higher education. People from lower socio-economic backgrounds, from regional and remote Australia and Indigenous Australians are under-represented in higher education. The Review also found that participation of people from regional and remote Australia has worsened over the past five years and that, once enrolled, people from these groups require higher levels of support to succeed, including financial assistance and mentoring;

- rural/regional constituted 25.4 per cent of the general population but only 18.1 per cent of higher education participants, while Indigenous people were 2.2 per cent of general population but only 1.3 per cent of higher education participants; and
- these same groups are poorly represented in medicine (less now than in the past), dentistry and the allied health professions, but not so much in nursing.

Successful projects which have improved the participation of low socio-economic, rural and Indigenous students have been highly targeted and operated in partnership or collaboratively with other sectors.

The Bradley review also found (Section 3.3) that income support and other financial assistance are critically important to attracting financially disadvantaged students into higher education and keeping them there.

Thus, until and unless these issues of equitable access and support are effectively addressed within the tertiary education sector, there is a strong case for continuation of effective scholarship schemes. This is more the case as the undergraduate scholarship schemes are targeted at areas of workforce shortage at the national and the regional level. Some of the targeted rural health scholarships also have the advantage of being ‘holistic’, providing not only essential financial support but also assistance through mentoring.

Scholarships to support students taking up rural placements are well-targeted and particularly important, as they also encourage students of urban origin to consider a rural placement. As noted above, high quality clinical placements in rural settings are an important factor in attracting health professionals to rural practice. Alliance members consider these scholarships to be vital in that process and some of the current allocations are insufficient, with many good quality applications being turned down. The new clinical placement scholarship scheme for allied health, managed by Services for Australian Rural and Remote Allied Health, was able to provide only 55 scholarships for the 289 applicants and there are indications of an even larger demand once the scholarship is better known.

Overall, enhancement of the scholarship program to satisfy a greater proportion of the demand from students for rural clinical placements, especially in areas of greatest shortage or for disciplines in shortest supply, would seem a valuable investment.

### **Anomalies in Scholarship Conditions**

The range of scholarships and conditions available for medical undergraduates is broad and warrants consideration. These programs (in increasing order of value) include Bonded Medical Places; the John Flynn Scholarship Scheme, offering students ‘rural living experience’ and continuity over four years in one location with a mentor; Rural Medical Undergraduate Support Scholarships; and Medical Rural Bonded Scholarships.

The Alliance notes that the Bonded Medical Places scheme was introduced in 2005 when there were substantially fewer overall medical places available and that this scheme may no longer be as relevant as it was. Alliance members are also concerned that bonding of students without any financial support is inequitable and, also, may not engender a willingness and commitment to substantial rural service.

Consideration should be given to combined evaluation of the scholarship program to test its overall effectiveness and to identify the most positive aspects of each part of it.

One particular challenge in administration of RAMUS is the assessment of financial need. Given the primacy of the scholar's intentions with respect to rural and remote practice, it may be possible to include some direct assessment on this criterion as well as on other complex criteria such as true financial need.

### **Administration and Evaluation of Scholarships**

The scholarship programs are administered largely by professional organisations representing the interests of the scholarship applicants and holders. This professional knowledge of the issues facing students and graduates in training and in clinical placements, as well as in placing scholarship programs within the overall context of the profession's needs in rural Australia, is a valuable element of program administration, and in the view of the Alliance should be retained. However, there would seem to be merit in consideration of standardisation of aspects of management and accounting for these programs to ensure that they are being directed to areas of greatest need. The consolidation of results on an annual basis from standardised performance measure would help in evaluation and in the management of emerging issues.

The Medical Schools Outcomes Database (MSOD) should provide some model of a standard minimum data set, while the work of the Australian Rural Health Education Network in consolidating and reporting on the activities of the University Departments of Rural Health could form a useful model for annual consideration and consolidated reporting on the impact of the scholarship programs.

In terms of scholarship agreements, effectiveness could be enhanced through:

- providing consistent 3-year funding agreements/contracts to provide certainty, continuity and better opportunity for improvements and innovations by administering bodies;
- shifting the Department's focus to policy and outcomes; and
- matching funding agreements to academic years.

### **NEXT STEPS**

The Alliance understands that this review by the Office of Rural Health will be followed by a more strategic consideration in the light of the directions of the major reviews commissioned by the Government. The Alliance would be pleased to work closely with the Department, and the Office of Rural Health in particular, to examine how rural health policy and programs can be best shaped to take advantage of broader strategic directions to improve the accessibility, affordability and effectiveness of health services and improve the equity in health outcomes for rural Australians.

In this context, the Alliance would also see merit in a focus on programs targeting improved outcomes in rural Australia currently administered by other areas of the Department, and on broader health policies and programs that influence health outcomes but do not take account of the particular needs of rural Australia in their design and implementation.