Health Workforce Study
Productivity Commission
PO Box 80
Belconnen ACT 2616

5 August 2005

**Re: Submission for the Health Workforce Study**

The Australian Rural and Remote Workforce Agencies Group (ARRWAG) is pleased to have the opportunity to present this submission on the Health Workforce Study.

We believe the study provides an excellent opportunity to debate issues that are of vital importance to Australian communities.

This submission highlights a number of issues that ARRWG and its members believe to be of particular interest in relation to the work of the Health Workforce Study. However, ARRWAG deals with such a wide range of rural workforce issues that it would not be possible to canvass them all as part of this submission. We would, therefore, welcome the opportunity to provide further input to an Inquiry hearing.

Please feel free to contact me at any time for further details or information.

Yours sincerely

Carol Bennett
Chief Executive Officer

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AUSTRALIAN RURAL & REMOTE WORKFORCE AGENCIES GROUP

# Challenges and Opportunities for the Medical Workforce in Rural and Remote Australia

**August 2005**

**Submission to the Productivity Commission Report on the Health Workforce**

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# About ARRWAG

ARRWAG is a national non-government organisation, funded by DoHA to improve access for Australians to appropriate and high quality care (especially medical practitioners) in rural and remote Australia. ARRWAG provides information and policy advice on medical workforce issues through workforce data analysis, planning and research, program development and evaluation.

ARRWAG represents RWAs, established in 1998 in each State and the Northern Territory (NT) to recruit and retain doctors for rural and remote communities, through the Australian Government's Rural and Remote General Practice Program (RRGPP). RWAs also work closely with their respective State and Territory Governments to support recruitment, retention and professional development of rural doctors.

# Executive Summary

Australia currently faces a critical workforce shortage of doctors, particularly in rural and remote areas. The Australian Government has implemented a number of successful workforce initiatives over the past ten years in order to attract doctors to rural and remote areas. In spite of the improvements these have achieved, there is a need to find solutions that will result in an on-going supply of health professionals with the right skills, in the right place at the right time.

It has not been possible to address all relevant issues in this paper, but ARRWAG welcomes this opportunity to highlight a number of the key issues that need to be addressed and to suggest some practical ways of developing solutions. ARRWAG's thinking is rooted firmly rooted in the practical realities of supplying a medical workforce for rural and remote Australia – experience that has been gained by Rural Workforce Agencies (RWAs) that deal with these issues as part of a practical day-to-day reality.

In particular this paper aims to highlight a number of key issues:

> **There are no quick-fix solutions to medical workforce shortages in rural and remote Australia.** The reasons for the current level of demand are complex and have developed over a period of time. Similarly, the solutions will need time to develop. In the meantime, it is important to continue to defend those values that have made our health system one of the best in the world rather than resorting to half measures.
>
> **This generation of doctors has its own personal and professional expectations.** We will need to be creative to find ways of working that acknowledge the importance of work-life balance and family needs that address the needs of females in the workforce, and allow us to compete in a global market for professional skills.

**Overseas Trained Doctors (OTDs) make a significant contribution to the rural medical workforce**

At present more than a third of the rural medical workforce was trained overseas. Australia will need to rely on OTDs for some time into the future and will need to ensure that there is an appropriate response to negative community perceptions about OTDs.

**Improved coordination between jurisdictions, including minimum standards for assessment and induction, will help Australia to continue to attract the best medical professionals.**

The current degree of variation on a wide range of important workforce issues makes it difficult to maximise opportunity and minimise risk when dealing with the medical workforce.

The recommendations below are intended to provide some practical, positive suggestions to addressing the current challenges in planning for the future of rural and remote communities in Australia.

# Summary of Recommendations from the Report

## General Recommendations

1. **ARRWAG believes that governments, communities and professions will need to continue to develop solutions for the ongoing medical workforce shortages by investigating models of practice that acknowledge the changing context of rural medicine. This includes taking into account changes to views of doctors on their professional and personal priorities and developing new ways of working a more mobile workforce in an increasingly competitive workforce market.**

2. **ARRWAG recommends the following principles to assist communities, government and employing agencies in giving appropriate consideration to the needs of doctor's families in rural and remote Australia:**

    - **The rural medical family is vital to the recruitment and retention of doctors to rural and remote practice and the subsequent health and wellbeing of rural and remote communities**
    - **Matching the personal needs of doctors and their families with the choice of location for employing a doctor will result in better retention of doctors in rural and remote communities**
    - **Recognising the financial and social pressures and the way they affect individual families not only shows respect for their personal needs, but will also help them to feel supported in the challenges they face.**
    - **Addressing the role conflict of balancing work and family is essential for modern families**

- **Flexible practice and training opportunities, part time and job sharing opportunities and locum cover are some of the practical means for supporting doctors**
- **Families need to be provided with realistic expectations of living and working in a rural and remote community**

3. **All efforts to recruit OTDs into Australia, should be guided by a deep respect for the professional experience, culture and personal needs of the OTD as well as considering the specific needs of the local community. To this end, ARRWAG supports the principles of ethical recruitment including the Durban Declaration and the Melbourne Manifesto.**

4. **Although AARWAG supports the recruitment of OTDs, longer-term, creative solutions for dealing with workforce shortages need to be considered. This includes on-going re-assessment of undergraduate medical training and consideration of new workforce models such as the expansion of multi-disciplinary workforce models.**

## Recommendations regarding OTDs

### Recruiting OTDs

1. **ARRWAG recommends a co-ordinated national approach to attracting new OTDs to Australia. This may include initiatives such as the "Doctor Connect" service that provides a single entry point for those applying for positions from overseas but would also include more national consistency in recruitment methods.**

2. **ARRWAG recommends on-going funding of programs such as "Strengthening Medicare" which provides funding for overseas recruitment drives and which enables prospective OTDs to visit Australia prior to making the commitment to work in Australia.**

## Recognising skills and experience of OTDs

1. **ARRWAG supports a nationally consistent approach to OTD assessment processes in order to achieve safe, high quality primary health care for the Australian community.**

2. **ARRWAG strongly recommends that nationally consistent assessment criteria are developed to meet standards of the learned colleges and university medical departments. The entry level may vary depending on the program (the Scheme, Rural Locum Relief Program etc) and the training, supervision and examination requirements associated with that program.**

3. **ARRWAG recommends that the state Medical Registration Boards establish nationally consistent criteria and processes for granting AoN registration, to ensure that all OTDs granted AoN registration have the skills and experience required for rural general practice in Australia. Further, ARRWAG recommends that these standards are set at a level that ensures that no State or Territory lowers their standards to achieve national consistency.**

4. **In recognition of the important role of clinical placements as a further means of assessment as well as supporting induction of new OTDs, ARRWAG supports consideration of minimum national requirements for clinical placements for new OTDs.**

## Improving retention of OTDs

1. **ARRWAG recommends the introduction of structured induction programs for newly arrived OTDs. These programs should include a range of components to ensure that the program facilitates a smoother transition into the community. Ideally these programs should involve the community, local government and, if appropriate, the practice.**

2. **ARRWAG recommends careful consideration of the impact of lifestyle issues including financial pressures, family transitioning and differing clinical practices prior to the arrival of an OTD. This includes the responsibility of employing agencies to provide relevant information before bringing OTDs into the country.**

3. **In ARRWAG's view, Temporary Resident OTDs (TROTDs) would find it easier to remain in rural communities if they were able to access essential services such as Medicare for themselves and their families and if there was a national approach to providing exemption from additional charges including government school fees.**

4. **As appropriate resources become available, ARRWAG believes that GPs who are willing and able to supervise and/or mentor OTDs should be identified and offered training and financial support for supervision. RWAs could play an important role in co-ordinating such programs.**

5. **ARRWAG believes that public recognition of the positive contribution made by OTDs will help to balance the negative perceptions that currently prevail in the Australian community. Such recognition will improve the status of OTDs and ultimately lead to making them feel more comfortable about working in Australia for the longer term.**

# Challenges and Opportunities for the Medical Workforce in Rural and Remote Australia

## Introduction

This submission has been prepared in response to the Productivity Commission's Issues Paper, *The Health Workforce* (PC: May 2005). The information provided is largely based on the experience of Rural Workforce Agencies (RWAs) and therefore reflects the learnings from practical experience of attracting doctors to rural and remote Australian communities and then keeping them there. In general, this experience will provide support for some of the issues already identified in the Issues Paper, but it will also suggest practical solutions to dealing with the challenges of providing health professionals for rural and remote communities.

Given the recent public interest in the issues surrounding Overseas Trained Doctors (OTDs), this paper will focus in some detail on specific issues relating to the recruitment, recognition and retention of OTDs as part of the solution to the challenge of providing adequate primary healthcare to communities in rural and remote Australia.

## Longer-term shortage of medical professionals in rural and remote Australia

ARRWAG acknowledges that there is a steady increase in the number of rural practitioners in Australia. For example, between November 2002 and November 2003, overall numbers increased by 171 doctors which represent an increase of 4.38% (ARRWAG: 2004: 15). ARRWAG believes that this positive increase can at least partially be attributed to the effectiveness of the RWAs as well as a number of programs initiated by the Australian Government. These include:

- The five-year OTD scheme
- Rural Locum Relief Program (RLRP)
- Rural Other Medical Practitioners (ROMP)
- Strengthening Medicare (formally known as Medicare Plus)

However in spite of this positive trend, ARRWAG believes there is likely to be an on-going medical workforce shortage in rural and remote areas of Australia for a number of reasons including past decisions of successive government to curb the number of undergraduate medical places.

The reasons for continuing workforce shortages, particularly in rural and remote communities, are well documented and varied. Data compiled by ARRWAG, as well as some examples from individual RWAs around Australia, illustrate a number of key factors that are likely to contribute to continuing workforce shortages. The following section will highlight some of these issues.

# Key Issues

## Poor job satisfaction

As acknowledged in *The Health Workforce* (PC: 2005: 21), low job satisfaction is widespread amongst Australian health professionals. In particular, the report points to factors such as low remuneration, long working hours with limited locum services, restricted peer support as well as a range of other issues.

These issues are particularly relevant to rural and remote communities as the ability to respond to key job satisfaction issues is very limited. ARRWAG concurs with these observations which have been discussed in a variety of forums, including the recent ARRWAG national forum, "*How Can We Keep Doctors in the Bush?"* (ARRWAG: 2005) and believes that job satisfaction issues are central to addressing rural workforce shortages.

## Lack of consideration for family issues

While there is increased acknowledgement of the importance of job satisfaction, the impact of family issues is less widely discussed and represents one of ARRWAG's current policy priorities. ARRWAG firmly supports the concept that family needs must be taken into account when planning to recruit doctors to rural and remote communities. As result, family perspectives are highlighted throughout this paper.

Doctors will generally only make a commitment to a community if they believe the physical and social needs of their families will be accommodated. More importantly, strong family support will enable doctors to make a long-term commitment to their community. In addition, if doctors who are separated from their spouses and/or children or their families are unhappy, it will be difficult for them to maintain their commitment and focus on caring for the medical needs of the community.

## The reluctance of younger doctors, both male and female, to work the long hours sustained by older doctors

Today's generation of doctors places a higher degree of importance on issues relating to work/family balance. As a result, family issues weigh more heavily in decision-making about employment options than might have been the case in the past.

The data below from South Australia illustrates the point that both males and females in the younger age groups prefer to work less hours. For example, while there were no males under 45 years who worked less than 20 hours in 1998, 20% of those who worked under 20 hours in 2001 were under the age of 45.

**Number of clinical hours worked per week by Age Group**

| Clinical Hours Worked | | Age Groups | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | >35 yrs | | 35-44yrs | | 45-54yrs | | 55+years | |
| | | N | R% | N | R% | N | | N | R% |
| Males | | | | | | | | | |
| 1998 | 1-20hrs | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 100.0 |
| | 21-40hrs | 2 | 3.6 | 26 | 47.3 | 18 | 32.7 | 9 | 16.4 |
| | 41-60hrs | 7 | 7.1 | 43 | 43.9 | 36 | 36.7 | 12 | 13.3 |
| | 61-80 hrs | 9 | 63.0 | 7 | 28.0 | 7 | 28.0 | 2 | 8.0 |
| 2001 | 1-20 hrs | 0 | 0 | 2 | 20.0 | 3 | 30.0 | 5 | 50.0 |
| | 21-40 hrs | 11 | 13.4 | 32 | 36.0 | 26 | 29.2 | 20 | 22.5 |
| | 41-60 hrs | 5 | 7.8 | 23 | 36.0 | 28 | 43.08 | 8 | 12.5 |
| | 61-80 hrs | 0 | 0 | 0 | 0 | 1 | 50.0 | 1 | 50.0 |
| Females | | | | | | | | | |
| 1998 | 1-20hrs | 1 | 14.3 | 5 | 71.4 | 1 | 14.3 | 0 | 0 |
| | 21-40hrs | 5 | 23.8 | 7 | 33.3 | 7 | 33.3 | 2 | 9.5 |
| | 41-60hrs | 3 | 23.1 | 4 | 30.8 | 4 | 30.8 | 2 | 15.4 |
| | 61-80 hrs | 3 | 25.0 | 4 | 33.3 | 4 | 33.3 | 1 | 8.3 |
| 2001 | 1-20 hrs | 5 | 29.4 | 9 | 52.9 | 3 | 17.6 | 0 | 0 |
| | 21-40 hrs | 9 | 27.3 | 15 | 45.5 | 7 | 21.2 | 2 | 6.1 |
| | 41-60 hrs | 1 | 12.5 | 7 | 87.5 | 0 | 0 | 0 | 0 |
| | 61-80 hrs | 1 | 11.1 | 7 | 77.7 | 1 | 11.1 | 0 | 0 |

*From South Australian Workforce Agency (2005)*

## The rapid feminisation of the general practice workforce

ARRWAG data suggests that about a third of the GP workforce is female. With the exception of the Northern Territory, this proportion is relatively consistent across the jurisdictions and does not appear to vary significantly according to RRMA classifications.

| Practitioner numbers by gender and State/Territory | | | | |
|---|---|---|---|---|
| **State** | **Male** | **Female** | **% Female** | **Total** |
| **NSW** | 821 | 300 | 26.76 | 1121 |
| **NT** | 50 | 47 | 48.45 | 97 |
| **QLD** | 641 | 294 | 31.44 | 935 |
| **SA** | 304 | 107 | 26.03 | 411 |
| **Tas** | 107 | 46 | 30.07 | 153 |
| **VIC** | 612 | 277 | 31.16 | 889 |
| **WA** | 358 | 157 | 30.49 | 515 |
| **Total** | **2893** | **1228** | **29.80** | **4121** |

From ARRWAG (2004) *Minimum Data Set Update Report, 31 May 2004*

The implications are varied, but as the data below illustrates, increasing feminisation has had an impact on workforce supply because of the documented preference by women for part time work, less on-call and less procedural work.

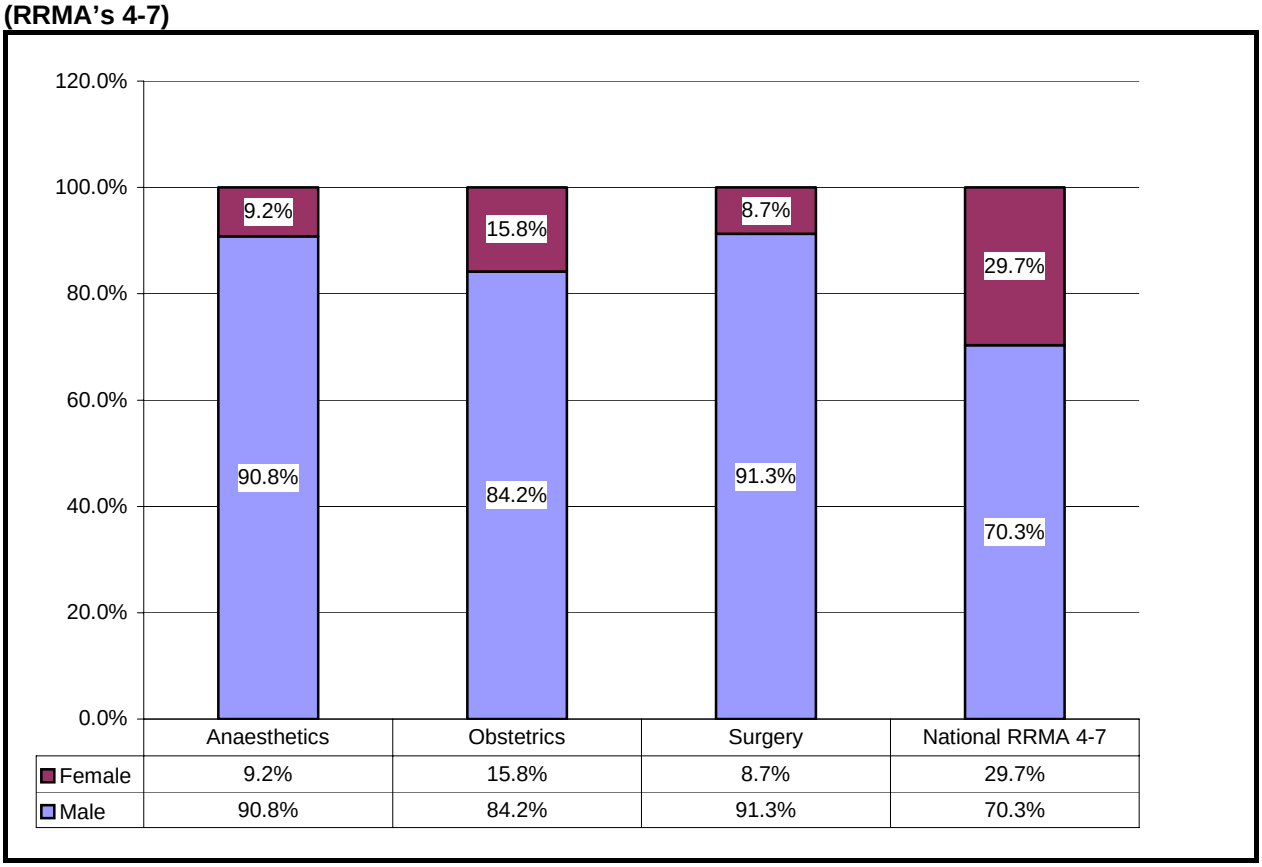
As the following table shows, females are less likely than males to work full-time (35+ hours). Correspondingly, females are more likely to work in part-time roles (less than 20 hours).

| Self-reported GP clinical hours by gender | | | | |
|---|---|---|---|---|
| | **Male** | | **Female** | |
| **Clinical Hours** | Number | Percent | Number | Percent |
| Less than 20 hours | 130 | 6.1 | 171 | 19.6 |
| 20 to 35 hours | 398 | 18.7 | 321 | 36.8 |
| 35 hours plus | 1601 | 75.2 | 381 | 43.6 |
| Total | 2129 | 100.0 | 873 | 100.0 |

From ARRWAG (2004) *Minimum Data Set Update Report, 31 May 2004*

As illustrated by the table below, women are also less than half as likely to practice procedural medicine (ARRWAG: 2004: 2).

**Gender composition of proceduralist and general rural and remote medical workforce (RRMA's 4-7)**




| | Anaesthetics | Obstetrics | Surgery | National RRMA 4-7 |
|---|---|---|---|---|
| Female | 9.2% | 15.8% | 8.7% | 29.7% |
| Male | 90.8% | 84.2% | 91.3% | 70.3% |

From ARRWAG (2004) *Minimum Data Set Update Report, 31 May 2004*

Data such as this suggests that increasing feminisation of the GP workforce will mean that fewer procedures are being carried out by the doctors in primary care settings. Although this information is not focused on examining the overall provision of procedural care, there is other information to indicate that the gap left by these female doctors is not being adequately covered through other means.

## Increasing mobility of the medical workforce

It appears that both in Australia and overseas, the medical workforce is increasingly mobile and less likely to stay in a particular location for extended periods. While the information provided below serves to describe the situation, ARRWAG believes that there is a degree to which the community will need to become accustomed to the increasing mobility and focus on improving strategies for dealing with it.

**Total number of years practicing in current rural and remote practice location by gender and age group.**

| Years worked in current location | Age Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | >35 yrs | | 35-44yrs | | 45-54yrs | | 55+years | |
| | N | R% | N | R% | N | R% | N | R% |
| **Males** | | | | | | | | |
| 1998 | 0-5yrs | 10 | 37.0 | 10 | 37.0 | 6 | 22.2 | 1 | 3.7 |
| | 6-10yrs | 1 | 2.7 | 34 | 91.9 | 2 | 5.4 | 0 | 0 |
| | 11-15yrs | 0 | 0 | 23 | 63.9 | 13 | 36.1 | 0 | 0 |
| | 16-20yrs | 0 | 0 | 9 | 29.0 | 18 | 58.1 | 4 | 12.9 |
| | 21-50yrs | 0 | 0 | 0 | 0 | 23 | 54.8 | 19 | 45.2 |
| 2001 | 0-5yrs | 14 | 32.6 | 19 | 44.2 | 8 | 18.6 | 2 | 4.7 |
| | 6-10yrs | 2 | 7.7 | 16 | 61.5 | 5 | 19.2 | 3 | 11.5 |
| **Years worked in current location** | **Age Group** | | | | | | | |
| | >35 yrs | | 35-44yrs | | 45-54yrs | | 55+years | |
| | N | R% | N | R% | N | R% | N | R% |
| 2001 | 11-15yrs | 0 | 0 | 17 | 56.7 | 13 | 43.3 | 0 | 0 |
| | 16-20yrs | 0 | 0 | 5 | 20.8 | 17 | 70.8 | 2 | 8.3 |
| | 21-50yrs | 0 | 0 | 0 | 0 | 15 | 35.7 | 27 | 64.3 |
| **Years worked in current location** | **Age Group** | | | | | | | |
| | >35 yrs | | 35-44yrs | | 45-54yrs | | 55+years | |
| | N | R% | N | R% | N | R% | N | R% |
| **Females** | | | | | | | | |
| 1998 | 0-5yrs | 6 | 50.0 | 3 | 25.0 | 2 | 16.7 | 1 | 8.3 |
| | 6-10yrs | 3 | 23.1 | 7 | 53.8 | 3 | 23.1 | 0 | 0 |
| | 11-15yrs | 0 | 0 | 4 | 80.0 | 1 | 20.0 | 0 | 0 |
| | 16-20yrs | 0 | 0 | 2 | 25.0 | 5 | 62.5 | 1 | 12.5 |
| | 21-50yrs | 0 | 0 | 0 | 0 | 1 | 33.3 | 2 | 66.7 |
| 2001 | 0-5yrs | 13 | 46.4 | 14 | 50.0 | 1 | 3.6 | 0 | 0 |
| | 6-10yrs | 2 | 16.7 | 10 | 83.3 | 0 | 0 | 0 | 0 |
| | 11-15yrs | 0 | 0 | 6 | 60.0 | 4 | 40.0 | 0 | 0 |
| | 16-20yrs | 0 | 0 | 1 | 20.0 | 4 | 80.0 | 0 | 0 |
| | 21-50yrs | 0 | 0 | 0 | 0 | 2 | 50.0 | 2 | 50.0 |

From: South Australian Workforce Agency (2005)

Mobility appears to increase even further with increasing remoteness. As illustrated in *Table 3* below, doctors' tenure rates tend to be lower with increasing remoteness.

| Length of stay in current practice by RRMA | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Duration | | | | | | | |
| **RRMA** | < 6 mths | 6-12 mths | 1-3 yrs | 3-5 yrs | 5-10 yrs | 10-20 yrs | 20 yrs + | Total |
| **4** | 110 | 156 | 238 | 136 | 188 | 219 | 180 | 1227 |
| **5** | 160 | 192 | 378 | 182 | 284 | 358 | 254 | 1808 |
| **6** | 50 | 54 | 79 | 28 | 32 | 25 | 15 | 283 |
| **7** | 33 | 47 | 82 | 27 | 32 | 20 | 12 | 253 |
| **Total** | 353 | 449 | 777 | 373 | 536 | 622 | 461 | 3571 |

From ARRWAG (2004) *Minimum Data Set Update Report, 31 May 2004*

This data indicates that while 77.5 % (N 2769) of respondents have practiced in their current rural and remote locations for more than a year, 22.5% (N802) are relatively new to their current practice and have been practising in these locations for less than 12 months.

An additional factor contributing to increased mobility is the increased dependence on OTDs. Research in Victoria, for example, confirms that OTDs as a group tend to be characterised by "hyper-mobility" in search of better opportunities for themselves and their families. In Victoria, for example, 66% of these families reported five major geographical moves prior to their current position in Victoria (Kosmina: 2003).

## Global competition for doctors

Several countries have formal policies and processes to attract OTDs to address their workforce shortages. The pool of available doctors is therefore beginning to 'dry up'. Although Australia boasts a good lifestyle and strong economy, other countries may be able to offer better salaries and conditions

(even if only through strong exchange rates) or may be more attractive because of the relative isolation of Australia from the rest of the world.

Evidence of increased global competition, as well as an increasingly global market, is provided by the dramatic increase in the mix of countries of origin for OTDs coming to Australia. The AMA reports that "in 1997/98 the great majority of OTDs cam from the United Kingdom (70% of arrivals), whereas this number dropped to 43% by 2002/03. " The AMA further reports that this means that "increasing numbers of OTDs are arriving from countries with quite different medical training structures to those in Australia" (AMA: 2005).

## Lack of employment opportunities for spouses

Doctors relocating from larger population centres, or from overseas, have probably enjoyed a relatively good financial and social position. Spouses are often accustomed to working in professional, well paid positions. However, many small rural communities cannot offer the range of employment opportunities the family may be accustomed to. In order to find employment locally, spouses may need to undertake training for new types of work or take a lower paid position. In other cases, spouses will travel long distances or live away from home in order to pursue their professional interests.

Matching the professional needs of spouses with placement of doctors in rural communities, as well as providing assistance for further study or for job searches, is an important way of meeting the needs of rural doctors and their families.

## Long working hours

It is well known that doctors working in small rural and remote communities generally face long working hours with considerable on-call requirements. As a result, burn-out is not uncommon and doctors. Amongst other things, this puts additional pressure on spouses who may be looking after a family

and juggling their own professional commitments. It also means that finding the appropriate work/family balance becomes a considerable challenge.

Providing flexible practice models, job-sharing opportunities and locum cover will help to relieve the pressure of long working hours and the subsequent impact on families.

### Lack of adequate childcare facilities

Professional childcare facilities are often limited in rural communities. Female doctors in particular, may need to rely on childcare in order to fulfil their responsibilities as a medical professional. If spouses are successful in finding employment, or choose to pursue educational opportunities, the need for childcare support becomes even greater.

Ensuring that doctors and their families who require childcare support have access to quality care will help to ensure that doctors can focus on the demands of their profession and the needs of the community.

### Lack of educational opportunities for children

Families with school or university aged children will often be deterred from taking up employment in rural communities because of the lack of good educational opportunities. While families of past generations were prepared to consider boarding school, very few families that have not grown up in a rural community will consider this a realistic option.

Planning for the educational needs of children when placing a doctor in a rural community will make it more feasible for doctors to consider working in those communities.

## Financial pressures

OTDs, particularly those who have recently arrived in Australia, face significant financial pressures when moving to a rural community. They may be faced with purchasing and furnishing a home, purchasing a car, new school uniforms, clothing suited to the local climate and a host of other necessary items when they arrive.

Even the option of taking up a personal loan to relieve some of the immediate financial pressure, is not available to new immigrants, and particularly temporary residents.

For families of Temporary Resident Overseas Trained Doctors (TROTDs), there may be additional hurdles as they may have to pay school fees to attend public schools, colleges or universities. Particularly those with more than one child, the cost of education may therefore put the family under unreasonable financial pressure. These same families may also be unable to access Medicare benefits or even private medical insurance, thus further increasing the financial pressures they face.

In the experience of RWAs, this matter is of crucial importance when recruiting doctors. Recognising financial pressures and implementing strategies for assisting families is a vital part of making it possible for doctors to work in rural and remote communities.

## Feelings of physical and social isolation

Doctors and their families will often feel the impact of physical and social isolation more acutely than the doctors themselves. Families may find it difficult to pursue particular sporting interests, take up music lessons or develop a large circle of friends. While some doctors and their families may enjoy some aspects of rural living, other personality types may feel stifled and lonely without a great deal of social interaction.

For families from overseas, the impact of isolation will be increased because of the lack of contact with others from their own cultural, social or religious

background. For those who do not speak or understand English, or particularly local slang, lack of ability to communicate effectively presents another hurdle. Providing families with information and support for pursuing social interests and helping them to become part of local social networks will significantly assist doctor's families in feeling at home in rural communities.

### Lack of infrastructure and/or adequate, quality housing

Recent years have seen a sudden rise in property values in some rural communities. As a result housing is not always very affordable. More importantly, in those communities like Port Hedland, for example, where the increase in property values reflects a sudden demand for housing, it may be difficult to find a suitable house quickly.

Conversely, the rates of return in other rural communities are so low that OTDs who would normally wish to invest in the local community may not be able to do so if they wish to realise a financial return.

Lack of infrastructure such as sporting facilities, shopping centres, movie theatres or public transport can add to the pressures experienced by families. Providing information about lack of infrastructure or quality housing prior to employing a doctor in a rural community will help families to prepare for these challenges and ensure that these issues can be addressed adequately.

# Recommendations

1. **ARRWAG believes that governments, communities and professions will need to continue to develop solutions for the ongoing medical workforce shortages by investigating models of practice that acknowledge the changing context of rural medicine. This includes taking into account changes to views of doctors on their professional and personal priorities and developing new ways of working a more mobile workforce in an increasingly competitive workforce market.**

2. **ARRWAG recommends the following principles to assist communities, government and employing agencies in giving appropriate consideration to the needs of doctor's families in rural and remote Australia:**

    - **The rural medical family is vital to the recruitment and retention of doctors to rural and remote practice and the subsequent health and wellbeing of rural and remote communities**
    - **Matching the personal needs of doctors and their families with the choice of location for employing a doctor will result in better retention of doctors in rural and remote communities**
    - **Recognising the financial and social pressures and the way they affect individual families not only shows respect for their personal needs, but will also help them to feel supported in the challenges they face.**
    - **Addressing the role conflict of balancing work and family is essential for modern families**
    - **Flexible practice and training opportunities, part time and job sharing opportunities and locum cover are some of the practical means for supporting doctors**
    - **Families need to be provided with realistic expectations of living and working in a rural and remote community**

# New workforce models: Are they the answer?

As stated earlier, ARRWAG supports the ongoing consideration of new workforce models and creative solutions to medical workforce shortages. As a result, ARRWAG proposes to make the discussion about future models a policy priority for the coming year.

However, while ARRWAG is not in a position to comment on specific workforce proposals in the mean time, there are a number of principles that guide ARRWAG's thinking with regards to such issues:

**Importance of quality outcomes**

There is considerable evidence to support the view that Australia has one of the best health systems in the world. It derives this status from its performance on a number of key success factors such as cost-effectiveness and relatively equitable access, but particularly on quality of health outcomes. Australia can take pride in the quality of its health system and as a result boasts one of the highest rates of life expectancy in the developed world. (Power: 2005)

ARRWAG believes that, particularly in the context of workforce shortages, it is important to maintain the focus on quality. ARRWAG concurs with the view that, "no one will regard it as a particularly clever achievement to claim to have provided substantially more health services if those services are provided at a lower level of quality" (AMA: 2005).

**ARRWAG believes that rural and remote communities are entitled to the best quality of healthcare possible. This care should be focussed on continually improving the health quality indicators for the community.**

**An evidence-based approach to workforce models**

Increasingly, the medical focus of current workforce models is being called into question with corresponding discussion about new ways of increasing the role of nursing and allied health professionals. While ARRWAG accepts that there is much room to improve the functions of multi-disciplinary teams, it is important to ensure that the questions about current models are not primarily driven by the need to address workforce shortages.

If the evidence suggests that existing models have worked well to reduce risk and improve health outcomes, any proposed changes need to be considered with care. It is worth noting the recent comment by the AMA which states that,

> Many of the proposals for substitution would have a marginal impact on the availability of medical practitioners and create very significant quality and safety issues at first consideration. It is up to the proponents of these schemes to make the case that they can be introduced without detriment to quality and safety. The burden of evidence needs to be with them (AMA: 2005: 4)

Ideally, new models should be adopted because they add to, or improve, the existing model. This is not always the case with substitution models.

**ARRWAG believes that new workforce models should be introduced where the evidence points to improved outcomes. If, on the other hand, existing models are shown to be effective, the aim should be to enhance rather than replace the systems that currently exist.**

# Overseas Trained Doctors – Dealing with the challenge

### Recruiting OTDs: Should we or shouldn't we?

The questions surrounding the employment of OTDs are complex and varied. As identified in *The Health Workforce* (PC: 2005), the Australian Health Minister's Conference set out a strategic framework which suggests that "Australia should focus on achieving at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market" (PC:2005:34).

Although ARRWAG believes that there will need to be on-going assessment of medical workforce needs to ensure that Australia reaches a higher degree of self-sufficiency in providing for its own medical workforce needs and to anticipate growing demand for OTDs in other countries, operating in a "global market" is not necessarily a bad thing. In medicine, as in many other professions, younger professionals seek the professional and personal stimulation that comes from working in other countries. Australian communities benefit from this exchange of practical professional experience that occurs as Australians travel overseas and as OTDs come to work in Australia.

ARRWAG also believes that some of the factors that determine the market "drivers" in the global professional "market" lie outside the control of policy makers and government instrumentalities. As a result, it may be more profitable to focus collective energies on finding ways of working more effectively to manage the increasing globalisation of the professions than to try to control it.

At the same time, ARRWAG believes that unethical recruitment, particularly from poorer, less developed nations is not an acceptable alternative for Australia. ARRWAG therefore supports the "Melbourne Manifesto" (2002) and the Durban Declaration.

## Recommendations

ARRWAG believes that all decisions about whether or not to recruit OTDs should be guided by the following two broad principles.

1. **All efforts to recruit OTDs into Australia, should be guided by a deep respect for the professional experience, culture and personal needs of the OTD as well as considering the specific needs of the local community. To this end, ARRWAG supports the principles of ethical recruitment including the Durban Declaration and the Melbourne Manifesto.**

2. **Although AARWAG supports the recruitment of OTDs, longer-term, creative solutions for dealing with workforce shortages need to be considered. This includes on-going re-assessment of undergraduate medical training and consideration of new workforce models such as the expansion of multi-disciplinary workforce models.**

## Ongoing reliance on OTDs

Notwithstanding the importance of addressing the question of whether Australia should actively recruit OTDs, ARRWAG believes that Australia will continue to be heavily reliant on OTDs for most of the next decade. At present, more than one third of the rural medical workforce is made up of OTDs (Haikerwal: 2005). It is unlikely that workforce reforms could replace such a large proportion of our medical workforce in the short term.

ARRWAG therefore believes Australia will to need continue attracting OTDs for some time into the future. More importantly, the community, governments and policy makers will need to become more explicit in recognising the contribution made by OTDs. Without the contribution of these medical professionals, many rural and remote communities might be even further disadvantaged when it comes to accessing primary medical care.

It is also worth noting that rural and remote locations are even more dependent on OTDs than other regions. The data below illustrates the proportion of OTDs in RRMA 4 to 7 locations by using Queensland as an example:

| Citizenship status and number of Australian/Overseas Trained Doctors in Queensland | | | | | |
|---|---|---|---|---|---|
| | Citizenship Status | | | | |
| RRMA | Australian | Permanent | Temporary | Total | %Temporary |
| 4 | 232 | 52 | 60 | 344 | 17.44% |
| 5 | 293 | 59 | 79 | 431 | 18.33% |
| 6 | 58 | 13 | 35 | 106 | 33.02% |
| 7 | 59 | 10 | 15 | 84 | 17.86% |
| | 642 | 134 | 189 | 965 | 19.59% |
| | | | | Number | Percent |
| Australian trained doctors | | | | 559 | 57.93% |
| Overseas trained doctors | | | | 406 | 42.07% |
| | | | | Number | Percent |
| Overseas trained and Australian citizens or permanent residents | | | | 217 | 53.45% |
| Overseas trained and temporary residents | | | | 189 | 46.55% |

*From Health Workforce Queensland (2004)*

In some more remote communities in areas like the Northern Territory, for example, the OTD may be the only doctor as multi-doctor practices are fairly rare.

ARRWAG is therefore focussed on continuing to find ways of improving the ways in which Australia can deal with the challenges of appropriately dealing with the OTD workforce.

## Satisfaction Levels of OTDs working in Australia

As indicated earlier, keeping doctors happy is an important part of addressing workforce shortages. A number of RWAs have collected anecdotal as well as survey information to identify some of the issues affecting OTDs. The information below has been compiled in Queensland from a survey of International Medical Graduates (IMGs) (HWQ: 2005).

**A recent targeted survey undertaken by Health Workforce Queensland and the Rural Doctors Association of Queensland sought to explore issues that impact on overseas trained doctors from their perspective. Some of the major themes that have emerged include:**

- Significant dissatisfaction with access to training and supervision (47.5%) of respondents.
- Significant dissatisfaction with professional support (31.0%) of respondents.
- Significant dissatisfaction with employment opportunities for partners (48.6%)
- Significant dissatisfaction with access to friends and family (45.8%).
- a significant number of respondents believing that have been disadvantaged in practicing in their current location (44.4%).
- a significant number of respondents indicating that they have not been able to advance their careers as expected (44.4%).
- Indications that many respondents feel they have been disadvantaged due to:
    - a lack of recognition of their qualifications
    - a lack of acknowledgement of prior work experience
    - prejudice against IMGs
    - employment restrictions placed on IMGs

- Data further indicates that over 70% of respondents did not undertake any orientation programs prior to commencing their current positions.

- Concerns around their vulnerability as temporary residents and the associated higher health cost associated are a further concern for many TRDs.

- Difficulties faced by IMGs in their current location include; distance, isolation, housing, children's education and partner employment.

- Services requested by IMGs tend to cluster around themes pertaining to improved support, supervision, mentoring, orientation and financial assistance to undertake CME and exam preparation.

## Recommendations on Recruitment, Recognition and Retention of OTDs[1]

ARRWAG has recently prepared a draft policy paper *Recruitment, Recognition and Retention of Overseas Trained Doctors for the Rural and Remote Medical Workforce in Australia* which provides a discussion of these issues (ARRWAG: 2005a). The report provides a range of practical observations and suggestions for improvement. However, for the purposes of this submission, the summary of recommendations for that report will highlight some of the key issues.

### Recommendations to improve the recruitment of OTDs:

1. **ARRWAG recommends a co-ordinated national approach to attracting new OTDs to Australia. This may include initiatives such as the "Doctor Connect" service that provides a single entry point for those applying for positions from overseas but would also include more national consistency in recruitment methods.**

2. **ARRWAG recommends on-going funding of programs such as "Strengthening Medicare" which provides funding for overseas recruitment drives and which enables prospective OTDs to visit Australia prior to making the commitment to work in Australia.**

### Recommendations for improvements to recognition of skills and experience of OTDs

1. **ARRWAG supports a nationally consistent approach to OTD assessment processes in order to achieve safe, high quality primary health care for the Australian community.**

[1] Further discussion of these recommendations is provided in ARRWAG's draft policy paper *Recruitment, Recognition and Retention of Overseas Trained Doctors for the Rural and Remote Medical Workforce in Australia which was unpublished at time of writing. Copies of the draft paper can be obtained by contacting the ARRWAG office on (03) 9662 2625.*

2. **ARRWAG strongly recommends that nationally consistent assessment criteria are developed to meet standards of the learned colleges and university medical departments. The entry level may vary depending on the program (the Scheme, Rural Locum Relief Program etc) and the training, supervision and examination requirements associated with that program.**

3. **ARRWAG recommends that the state Medical Registration Boards establish nationally consistent criteria and processes for granting AoN registration, to ensure that all OTDs granted AoN registration have the skills and experience required for rural general practice in Australia. Further, ARRWAG recommends that these standards are set at a level that ensures that no State or Territory lowers their standards to achieve national consistency.**

4. **In recognition of the important role of clinical placements as a further means of assessment as well as supporting induction of new OTDs, ARRWAG supports consideration of minimum national requirements for clinical placements for new OTDs.**

## Recommendations for improved retention of OTDs

1. **ARRWAG recommends the introduction of structured induction programs for newly arrived OTDs. These programs should include a range of components to ensure that the program facilitates a smoother transition into the community. Ideally these programs should involve the community, local government and, if appropriate, the practice.[2]**

[2] An example of such a program can be found in the recent South Australian Government publication "*Recongising the past – rewriting the future: a new partnership with rural doctors"*, p.14. Key points are summarized in Appendix A.

2. **ARRWAG recommends careful consideration of the impact of lifestyle issues including financial pressures, family transitioning and differing clinical practices prior to the arrival of an OTD. This includes the responsibility of employing agencies to provide relevant information before bringing OTDs into the country.**

3. **In ARRWAG's view, Temporary Resident OTDs (TROTDs) would find it easier to remain in rural communities if they were able to access essential services such as Medicare for themselves and their families and if there was a national approach to providing exemption from additional charges including government school fees.**

4. **As appropriate resources become available, ARRWAG believes that GPs who are willing and able to supervise and/or mentor OTDs should be identified and offered training and financial support for supervision. RWAs could play an important role in co-ordinating such programs.**

5. **ARRWAG believes that public recognition of the positive contribution made by OTDs will help to balance the negative perceptions that currently prevail in the Australian community. Such recognition will improve the status of OTDs and ultimately lead to making them feel more comfortable about working in Australia for the longer term.**

# Conclusion

There is no doubt that the challenge of addressing medical workforce issues, particularly in rural and remote Australia, is considerable. The solutions will not be simple nor will they be found instantly.

However, having the opportunity to consider these challenges provides a means of identifying new opportunities and better ways of doing things. These new ways will need to build on the strengths of our current systems while taking into account the expectations and ways of working that characterise this generation of doctors.

ARRWAG commends the Australian Government for commissioning this study. ARRWAG looks forward to being part of the continuing debate and the quest for new solutions.

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# Appendix A

## Example of a formal induction program that could be used as a model for developing future programs

**Summary of South Australian Department of Health recruitment and support initiatives for overseas-trained doctors.**

- enhancing the Fellowship assistance for 10 year overseas-trained doctors to match Commonwealth five-year support
- increasing relocation grant to $10,000
- providing all overseas-trained doctors and their spouses with an opportunity to visit South Australian prior to contracts being agreed
- developing interest free loans - the Rural Doctors Workforce Agency will cover interest for two years on resettlement loans and will negotiate a loan product from Medfin or other suitable financial institution.
- giving all overseas-trained doctors and their spouses between two weeks and four weeks orientation on arrival in South Australia
- paying all overseas-trained doctors $1,500 per week during orientation, and arranging accommodation
- paying orienting practices $1,000 per week
- introducing an 'Understanding Australian Language' program which will be available for all overseas-trained doctors for whom English is a second language.
- facilitating the renegotiation of the HIC orientation to be delivered locally
- standardising orientation throughout South Australia
- providing a mentor for each overseas-trained doctor
- developing and providing workshops for overseas-trained doctors to assist them in understanding the range of non-medical/social issues they will face in country communities
- introducing education grants to their spouses at resettlement to assist with their employability
- developing and producing the definitive guide for overseas-trained doctors relocating to South Australia.

**Reference:** Department of Health. (2005). *Recognising the past - rewriting the future a new partnership with rural doctors*. Adelaide: DOH.