The Page Research
Centre Limited

Improving Access to Health Services in Rural & Regional Australia

A Discussion Paper by the Page Research Centre

About the Page Research Centre

The Page Research Centre has been established to undertake research and develop policy aimed at enhancing the prosperity of regional Australia. Policy issues which impact on rural and regional Australia, whether directly or indirectly, are the focus of the Centre's research.

The challenge raised by recent trends is to ensure that regional Australians can share fairly in the growth and prosperity of the nation. The Page Research Centre aims to progress imaginative, yet practical, measures to assist in this process.

The Centre is named in honour of Sir Earle Page, an early champion of the distinctive needs and interests of people in the regions. Sir Earle Page was the longest serving leader of the Country Party, and for brief time Prime Minister of Australia. Although the Centre is a policy think-tank organisation affiliated with the National Party of Australia, it is a distinct and separate unit.

Improving Access to Health Services in Rural & Regional Australia

A Discussion Paper by the Page Research Centre

Introduction

There is an acknowledged workforce shortage of doctors and other health care professionals in Australia. This shortage is felt acutely in rural and regional areas.[1] It's a matter of principle that people in rural, regional and remote Australia will be as healthy as other Australians, and have the skills and capacity to maintain healthy communities. This has been acknowledged by governments in the last Australian Health Care Agreement between Commonwealth and States. The expectation that there is parity in health care is also reflected in both common law and professional ethics. To date, the federal government has put in place initiatives to improve the workforce situation. Since 1996 the number of rural and remote GPs has increased by more than 20%, including a 10% increase in the last 3 years. This discussion paper will explore the question: what further practical steps can be taken now, and into the future, to ensure a "fair go" for people living outside the capital cities?

Workforce Shortages: A Key Underlying Problem

Irrespective of how much money is allocated to health care and facilities, if there are insufficient health professionals to deliver the desired health services then the corresponding health benefit cannot be expected. Rural and regional health services experience difficulty attracting and retaining medical, nursing and allied health personnel[2].

Our aging population in Australia is also reflected in the health industry. Between 1986 and 2001 the proportion of GPs over 40 years of age rose from 42% to 58%. The number of working nurses aged over 40 also rose from 30% to 60% in 2001. Specialists over the age of 40 rose from 60% to 65%.[3] Greater emphasis on postgraduate medical training has also meant there are fewer doctors completing their full training by the age of 30.

The impact of this demographic change in the health industry means there are a greater number of medical practitioners close to retirement, compared to those who are entering the workforce. This suggests future sustainability problems as the older group begins to retire.

Any workforce shortage of health care professionals is likely to be acutely felt in rural and regional Australia. In their 2006 Medical Journal of Australia article, *When the Tide Goes Out: Health Workforce in Rural, Remote and Indigenous Communities*, Richard Murray and Ian Wronski point out that should the workforce tide recede, it would expose further health service short-comings in regional populations and those in outer metropolitan areas. While 34% of all Australians live outside major cities, the authors note that the share of medical professionals outside urban areas is considerably less: 23% in the case of medical specialists; 27% for general practitioners.[4] This reduction in rural and remote health provision may significantly

impact a demographic that is already disadvantaged. There is domestic and international evidence that the link between socioeconomic status – measured by income, employment and educational levels – and health outcomes is unequivocal: people in lower socioeconomic groups experience higher rates of morbidity and premature mortality, on average, than those materially more fortunate. The ABS Index of Relative Socio-Economic Disadvantage shows that non-Metropolitan Australia scores lower on the Socio-Economic Index for Areas (SEIFA) than urban areas. Non-metropolitan households are more likely to be in receipt of government income support and, in spite of the confounding effect of mining areas, mean annual taxable incomes are lower. [5]

"Despite useful gains (around 20% of medical students are now classified as being of rural origin)," Murray and Wronski state, "the rural medical workforce still does not reflect population share, and nursing and allied health have a long way to go." While there has been effort to encourage rural school leavers to study medicine it remains difficult to encourage school leavers to choose a career in rural and remote health.

Initiatives to Improve the Workforce Situation

A number of innovative strategies have been adopted by government and others to address the deficiency in workforce numbers. The federal government's *Rural Health Strategy*, for example, funds a range of rural health initiatives designed to support the recruitment and retention of doctors, and increase the size of the rural workforce.[6]

It will take time, however, for some of the longer-term strategies (such as new educational facilities, scholarships and additional medical school places) to have an effect. It may be 10 years or more before any real effect is seen in the workforce numbers.[7]

The question is what can be done now to improve the health care of people in the country? What realistic, practical solutions can be implemented in the near term to improve health care delivery for those outside the major cities?

Fairness for Rural and Regional Australians

When one looks at the common law, one sees that the same standard of reasonable care is expected irrespective of one's location. While the law courts do seem to take into account that modern health care is not delivered in an environment of limitless time and resources, it would be very difficult to argue (one would suspect) that country Australians deserve a lower standard of care than their city cousins.[8]

Professional ethics, which aspire to a higher standard than the minimum prescribed by law, advocate equity, justice and fairness as central tenets. Part of this is ensuring that members of the community can fairly access the profession's services. For instance, the AMA's *Code of Ethics* states in its section on the doctor and society: "Endeavour to improve the standards and quality of, and access to, medical services in the community".[9] This is echoed in the AMA's *Position Statement on Regional/Rural Workforce Initiatives*, which notes that "the profession has a responsibility to ensure that there is equitable community access to a well-trained medical workforce".[10]

As already highlighted there is a tendency for rural and regional people to comprise

some of the nations most socio-economically disadvantaged. The propensity for unequitable health care is also apparent in the current Medicare rebate model. The Rural Doctors Association of Australia (RDAA) has undertaken some considerable research in the area of Medicare and health provision in rural and regional Australia. Subsequently, it is worth summarising some of their findings as a means to illustrate some of the problems associated with Medicare and rural and regional health.

The Medicare funding system is founded on five principles: Universality, Access, Equity, Efficiency and Simplicity. The RDAA has identified some inadequacies in regard to Medicare and rural and regional health provisions based on those principles.

The RDAA argues:

Universality is not achieved: though Medicare may be available to all, the 30% of the population which lives Rural Australia receives about 20% of the rebates for general practice services. In 1999-2000, the average per capita Medicare benefit paid was $195.87 in urban areas, $139.70 in rural areas and $83.11 in remote areas.

Access to medical services in rural areas is limited by the shortage of rural doctors. The gap between the standard rebate and the costs of rural practice is a factor in this shortage and leads to lower levels of bulk billing which constrains access further.

Equity demands that those whose health needs are higher receive a rebate commensurate with their needs and appropriate to their environment.

Efficiency in the expenditure of Medicare funds would suggest the benefits of allocating what is estimated to be an under-spend of $250 million in rural and remote areas to supporting the health and vitality of individuals and communities as a means of sustaining regional development.

Simplicity would be served by a differential rebate for medical services delivered within the boundaries defined by appropriate classifications already in place. It has been estimated that the cost of higher rebates payable to those in smaller rural centres, other rural areas and remote areas would cost about $80 -120 million annually – or less than the shortfall noted above.[11]

Access to adequate health facilities is also essential in encouraging growth in country areas. Small hospitals are often the largest single employer in rural towns, and nursing salaries are often used to offset the more variable family income within agricultural industry. Indeed, health and medical services are part of the "glue" that binds rural and remote communities together. The continuity of health services helps to ensure the long-term viability and sustainability of such communities and towns.

But recent events have demonstrated that country Australians are not always getting a "fair share" when it comes to health care. Standards have, on occasion, come a poor second in the drive to secure staff. Patients having to travel long distances when local health care dries up has become more common. "Going without", which can be disastrous when coupled with the traditional reluctance of country people to seek medical assistance, is also a problem. Whilst patient assisted travel schemes (PATS)[12] play an important role, and e-health initiatives offer promise, the benefits of clinicians

treating rural patients in their home communities cannot be overemphasised. Subsequently, properly funding facilities and infrastructure is undoubtedly part of the solution[13], but so too is ensuring that rural people can access medical and nursing personnel when they are in need.

But there are also some non-financial drivers that need to be considered. The Rural Specialists Group of the RDAA has identified that roster and locum arrangements need to be better organised. They argue: After-hours rosters should be no more than 1 in 4 except for brief and infrequent periods. However, workforce shortfalls and the exigencies of working in some areas means that it is not always possible to achieve this standard and therefore doctors working in these regions must be supported by triage back-up, special locum relief and specific additional recreational leave. Guaranteed locum arrangements are essential, particularly for those who are working regular after-hours rosters where they are likely to be required to provide personal attendance after-hours on a regular basis.[14]

Health and a "Social Contract" with the Community

The Deputy Prime Minister's speech at September's (2007) AMA Rural Health Summit indicated a clear intention to recognise and support a community based health care system in rural and regional areas.. He had emphasised greater community self-determination regarding the kinds of health services required. The Deputy Prime Minister has also cited the need for greater conditions placed on state health funding to enure that it reaches country hospitals. But government can only go so far in providing the resources for creating incentives to attract health professionals to regional and rural areas. There also requires a spirit of co-operation and civic duty amongst the medical community.

It is fair to say that the medical profession, on the whole, is doing pretty well financially these days. A recent news story cited Medicare figures showing a GP's income from Medicare rose from an average of $195,000 in 2002-03, to $251,000 in 2004-05.[15] It also stated that many doctors are earning more than this, as they charge one in five patients above the Medicare rebate.

There are further incentives and earning opportunities available, as an article from the November 2006 edition of the *Australian Doctor* reveals:

"Primary Health Care pledges to make GPs million-dollar earners as part of a recruitment campaign that also offers sign-on payments of up to $600,000. Non-Primary GPs received letters outlining the offer last month along with a company brochure that claimed the corporate's GPs earned $1 million more than non-Primary doctors 'over years'. The brochure claimed Primary's 100 top-earning GPs grossed, on average, $623,000 each year. Doctors paid about half their gross income to the company, but the amounts involved have again highlighted both the potential revenue generated in corporate medicine and the financial health of the sector."[16]

Medicine is a demanding, stressful profession and should be appropriately compensated. But with the lion's share of medical earnings coming from the public purse, it is not unreasonable to consider what the community is getting on its side of the bargain.[17]

In this context, what about the medical profession's *civic duty*? That is, its obligation to contribute to the development of health care in local communities and nationally? There appears a failing in civic duty amongst parts of the medical profession. It's important that medical students are encouraged to think seriously about why they are entering into medicine beyond the economic rewards. In addition, training medical practitioners needs to not only incorporate the technical aspects of medicine but also the human aspects. Medical practitioners particularly in rural areas are often seen as community leaders and highly valued not only for their medical expertise. Some consideration needs to be given to the latent role of medical practitioners in the community. Medical practitioners who fail to appreciate or accept this role are reducing their standing in the community and thus the community's trust in the profession. As was pointed out by Sir Donald Irvine in his Medical Journal of Australia article, this idea "cannot be considered in abstract. The value and acceptability of this broader contribution will be directly proportional to the public's perception of the trustworthiness of the profession."[18]

Recent well-publicised incidents have shaken public confidence in the medical profession.[19] Should the public perceive, rightly or wrongly, that the profession sees itself as beyond service to the community, it can only damage the image of the profession, and add weight to calls for greater external regulation. And it is the public's perception that counts.[20]

Meeting Demand: Additional University Places

In his paper *Mismatch: Australia's Graduates and the Job Market*, Andrew Norton of the Centre for Independent Studies notes that unmet demand for university places is particularly high in health-related courses, with many applicants missing out every year. "While we turn bright young Australians away from medical courses", he states, "we have to bring thousands of overseas-trained doctors to Australia to fill workforce shortages."[21]

Norton's paper suggests that a market system, in which universities determine the number of available places and student fees, would do a more efficient job of supplying Australia's workforce. Under a market model, the government would not set maximum or minimum numbers of university places, and would not limit student fees. According to Norton's paper, the government's role in such a system would be to ease problems that arise in the marketplace, through student loans, income support, and incentives for universities and students.[22]

In the *2007-08 Budget*, the Treasurer announced that by January 2008, the federal government will remove all caps on the proportion of domestic full-fee paying university places. The *Budget* also stated that the Commonwealth will increase its funding to the disciplines of medicine, nursing, dentistry, clinical psychology and allied health.

While keeping in mind equity[23] and postgraduate training considerations, providing additional places in courses where there is unmet demand, such as medicine, would seem to be a step in the right direction. More doctors coming into the marketplace could only have a positive effect on easing the workforce problem.

But Norton's market system approach has a shortcoming. Universities are now dominated by a different set of market drivers. International research investment and publications that meet the new research quality framework criteria are largely incompatible with rural clinical care.

Another issue for consideration is that the doctors who are training in Australia are sub specialising rather than choosing the generalist qualifications that are needed by rural communities. As a generalisation, the more specialised the practitioner, the less well distributed they are in parts of Australia. For instance, using AIHW data, in 1999 the Australian Medical Workforce Advisory Committee (AMWAC) reported that 86.1% of the specialist psychiatrist workforce mostly practised in capital cities, compared to 4.9% who practised in a large rural centre and 3.5% who practised in 'other' rural or remote locations.

Encouraging Rural Practice: Recent Graduates

As the Deputy Prime Minister has stated; the policies released since 1996 have had a positive impact on increasing the number of health professionals in rural and regional Australia.

- The Bonded Medical Scheme has played an important part in increasing the number of medical practitioners. Changes to link the length of the degree course to the length of the return of service obligation have also been important. It is now easier for students to meet their obligation by allowing up to half of this return of service to be offset during the prevocational and vocational training phases.

- Further provisions have been made to provide stability for families who want to settle permanently in rural and regional areas by introducing tenure, allowing doctors who do their training in a District of Workforce Shortage.

- A support scheme has also been introduced, to assist students, junior doctors and qualified GPs and specialists as they do their training, and as they complete their return of service.

- For the past six years, the HECS Reimbursement Scheme has further encouraged new medical graduates to spend time in training or service in rural and remote areas. Last financial year, 312 medical graduates took advantage of this offer to reduce their HECS debts.

- There are currently 14 Rural Clinical Schools operating throughout Australia, ensuring that at least 25 per cent of Australian Government-supported medical students complete a year of rural training before they graduate.

"One-for-One" HECS Relief

It appears that relief from HECS fees, as an incentive to undertake rural practice following graduation, has broad support.[24] The idea has much to recommend it, and indeed, it has been implemented through the federal *HECS Reimbursement Scheme*.

Participants in this scheme who undertake training or provide medical services in designated rural and remote areas of Australia have one-fifth of their HECS medical fees reimbursed for each year of service.

The advantage of HECS relief is its simplicity in both application process and benefit received, but the scheme can be improved and expanded:

- One-for-One - Students "sign up" for a period of rural service while still at university. A simple formula applies: one year of rural service post-graduation attracts one year of HECS relief. Students can voluntarily decide the amount of service they wish to provide, and hence the level of support they wish to receive. The HECS benefit could be structured to apply immediately, up-front, as opposed to being reimbursed in the future. The service obligation would commence upon qualification, allowing the doctor to complete his or her service requirement early in life. This approach provides certainty, and brings the HECS relief system into line with other contracted support methods, such as the Medical Rural Bonded Scholarship Scheme. The arrangement underpinning the one-for-one scheme would need to be clear and transparent, with consequences for non-performance.[25] In an environment of high wages, incentive payments, and a global market for medical services, this latter aspect cannot be overlooked.

- Opening the Scheme to other Professions "in Short Supply" - Doctors are not the only health professionals needed in regional Australia. Perhaps HECS relief could be extended to other professions that are needed in the bush, such as dentistry[26], nursing, pharmacy and allied health. Of course, we do not live in an environment of unlimited health care resources, and funding limitations may militate against, or limit, such an extension.

Continue with "What's Working"

The AMA has stated that the early and continuing exposure of medical school students to rural medicine, and measures to encourage students from rural and regional areas to enrol in medical schools, are the most likely of all initiatives to increase the rural workforce.[27] Put simply, "if you can get your medical students into a rural training program early on, then you're likely to retain more of them in rural practice."[28] There are a number of initiatives, consistent with this, that appear to be working:

Rural Scholarships - Under the Medical Rural Bonded Scholarship (MRBS) scheme, students receive $22,744 (indexed) each year for the length of their undergraduate medical degree. In return, upon completion of their qualification they commit to working in a rural area for 6 years. These scholarships appear to be popular with medical students, with requests exceeding the number available. The MRBS scheme has been fully subscribed since its inception.[29] Clearly such scholarships are a good idea and should be supported. However, the terms of any bonded arrangement should be sufficiently rigorous so as to be a disincentive to students arbitrarily avoiding their service commitment. Recent media reports have suggested that some students who initially signed up to a related federal scheme, Bonded Medical Places (BMP), are now considering "buying their way out" of their rural service obligation.[30] To permit "buying out" arguably distorts the purpose of

such schemes, is unfair to students who miss out, and allows bonded university places to be treated as de facto “full-fee paying” places.[31] Whilst maintaining some flexibility, perhaps the consequences of non-performance should be reviewed.[32]

Rural Practice Rotation - The AMA states that junior doctors “should be encouraged to undertake rotations to regional/rural areas as part of their training program. The rotation should be included in the postgraduate medical education/medical college accreditation processes.” In other words, postgraduate medical training programs should include a rural service component.[33] Exposure to rural practice is an ideal way for students to explore the lifestyle and professional benefits of work outside the capital cities.[34] As was mentioned in a recent Medical Journal of Australia article: “Chris Mitchell, Chair of the National Rural Faculty of the Royal Australian College of General Practitioners (RACGP), says that a lot of people, including him, ended up in rural general practice because they found they liked it during a mandatory rural term in their early postgraduate years. The two specialty college representatives we interviewed would also like to see some sort of mandatory training in the rural setting as part of specialty training programs.”[35] The rural practice rotation has much to recommend it.

The “Rural Pipeline” - The evidence for the success of the “rural pipeline” in medical education and training seems beyond doubt.[36] This “pipeline” involves recruiting students from rural backgrounds, delivering training in the regions through repeated rural exposure, and building regional postgraduate training pathways. Some support is available to assist rural students meet the costs of attending medical education. Through the Rural Australian Medical Undergraduate Scholarship (RAMUS) scheme, each year 500 undergraduate students with a rural background and limited financial means are provided with a scholarship of $10,000 to help them meet accommodation, living and travel expenses incurred while studying medicine. Like the MRBS scheme, it appears to be popular with medical students, and has been fully subscribed since inception.[37] There is also The Rural Resident Medical Officer Cadetship Program introduced in 1989 which provides financial incentives to induce young doctors to consider taking up rural practice. Under the auspices and initial administration of NSW Health, the Program offered undergraduate medical students from the three NSW Universities financial support in their penultimate and final years to complete their undergraduate studies[38]

Encouraging Rural Practice: Experienced Practitioners & Specialists

Encouraging experienced practitioners and specialists to “make the move” into rural practice can be difficult. Many have partners, families and practice commitments that make relocating from the city inconvenient, to say the least. Opportunities are also more abundant, and frankly lucrative, in the capitals.

However, as mentioned above, it is arguable that the medical profession has a civic, if not ethical, duty to contribute to the equitable distribution of health care, and to improve community access to its professional services. With this in mind, the idea of rural “community service” is proposed for experienced practitioners and specialists.

Profession-Led Rural & Regional Community Service

Ask a person in rural and remote Australia and they'll tell you: it can be tough enough to see a doctor, let alone a specialist. Unless, of course, you want to travel long distances. Those experienced practitioners who do visit country towns are much valued and appreciated. We need more "champions" like these; professionals who undertake to regularly visit country areas and make available their expertise and experience. To facilitate more experienced practitioners visiting rural and regional areas The Medical Specialist Outreach Assistance Program (MSOAP) was introduced. It encourages more medical specialists to visit rural areas by providing specialists with funding to cover some of the costs associated with delivering outreach. These include travel, accommodation and consulting room hire costs. It also makes payments to visiting specialists who provide up-skilling and/or professional support to local general practitioners, specialists and, in some cases, other health professionals such as allied health professionals[39]

A Professional Requirement?

An alternative could be to make such rural community service by some means obligatory. The benefit of such an idea is that it would be universal and spread across the profession, and hence any service expectation could be quite modest. As with the voluntary proposal above, pro bono work is not envisaged; the idea is to facilitate rural *access* to professional services.

Perhaps, in consultation with the medical colleges, a community service expectation could be incorporated as a professional requirement of State-based medical registration. Practitioners would then need to attach proof of rural, regional or community service with their registration renewal application. Such an arrangement could operate in a similar way to existing "continuing education" requirements. The Productivity Commission has proposed national standards for the health professions.[40] Maybe professional standards could incorporate such a civic service expectation?

A compulsory approach, however, faces a number of serious issues which would need to be considered:

- <u>Constitutional Limitation</u> - A federal legislative scheme would have to be consistent with section 51(xxiiiA) of the *Australian Constitution*, that is, it could not authorise any form of "civil conscription". Any compulsion to provide medical services would likely fall foul of this prohibition.[41]

- <u>Difficulties in Implementation</u> - A non-federal scheme would have to be implemented in all jurisdictions, both for uniformity and to avoid any distortion of the market. This would require a considerable amount of political will.

- <u>Professional Resentment</u> - The use of a "stick" to require doctors to undertake rural practice could generate resentment and a "minimum involvement" attitude.[42]

The RDAA view the concept of Geographic Provider Numbers as impractical as a means to increase the number of medical practitioners. The Association believes that, rather than forcing doctors into the bush, an integrated package of incentives should attract them to the challenges of rural practice. Benefits should be attached to the provider numbers of those working in rural areas. These could come through robust fee for service payments or other support mechanisms.[43]

A profession-led, voluntary scheme is clearly the better option. However, it may be that some new, innovative approach is the only way to facilitate reasonable access for country Australians. Take a look at many of the articles discussing the rural workforce situation and one sees the same solution - indeed the same word - appearing time and time again: “incentives”. Country towns are advised to provide incentives to entice doctors from the cities. They should compete with city opportunities; offer higher salaries and benefits. The question inevitably has to be asked: how many incentives can the community afford to offer one professional group?

Practical Measures to Help Retain Practitioners in Rural Areas

Helping those practitioners who live and work in rural areas should continue to be a priority. Practical measures such as assistance from practice nurses[44], and improved locum support[45], have been mentioned in the literature. Recent changes to Medicare have increased payments to rural procedural GPs, and facilitated the funding of certain work performed under delegation.[46] Improving local facilities and infrastructure would also be an obvious help to rural practitioners.

In addition to the demands of a busy medical practice, country doctors are often called on to perform a range of social-support tasks: “the doctor and/or spouse become[s] the [town’s] de facto spiritual adviser, grief counsellor and socio/emotional counsellor as well as social security adviser”.[47] An intent behind the rural “community service” idea mentioned above is to provide some additional support for rural doctors, already struggling with high workloads. They shouldn’t have to shoulder the burden alone.

The Role of Governments

If the medical profession is being asked to “step up to the plate” and contribute to the health of rural communities, so too should government. Government is, after all, inextricability linked to the delivery of health care. The President of the RDAA, Peter Rischbieth, has called for a minimum health service obligation for country areas:

“Community service obligations for rural and remote Australia should not be restricted only to telephones. Rural communities also need a minimum service obligation to ensure they have better access to rural doctors, local rural hospitals and rural health services.”[48]

State and federal governments should work together to ensure that rural tax dollars are reinvested back into rural health, says Dr Rischbieth. The RDAA has suggested a rural service obligation be introduced into future Australian Health Care Agreements.[49] Whether expressed as a service obligation or otherwise, a statement providing country people with some clarity as to what they are entitled to expect by way of health services would be seen by many as a welcome development. It could also provide the necessary impetus for a range of rural health initiatives.

The work of communities

Communities need to be empowered to take on a greater responsibility in planning their own health care facilities and services. One mechanism could be assisting local government to become better resourced to develop community health plans, as part of their annual strategic plans. These community health plans would start with a community audit of the current health services and facilities. The audit would then provide a realistic evaluation of the areas where there existed the greatest weakness in health services and facilities. Once the needs are identified, consultation with the community and health professions should be arranged and a lobbying strategy put in place.

Conclusion

Much has been written on this topic. As one commentator was moved to say:

"The rural doctor shortage in Australia is one of the most over-researched issues on the medico-political agenda. Rural doctors and their families have been surveyed by numerous social workers, university researchers and thesis writers. The result of most of this research is to call for more research."[50]

This discussion paper does not claim to be a comprehensive academic review of the literature, nor does it claim to have all the answers. It does not delve into detail on each and every issue, and it does not call for more research. It merely seeks practical, workable solutions to implement in the near future. As is often said, there are no "easy fixes" to problems in health care delivery. However, targeted initiatives such as the ones mentioned in this paper - some government-funded, some initiated by rural communities, and some profession-led - have the potential to improve access to health services, and quality of life, in rural communities.

Endnotes

[1] "The AMA has identified medical workforce shortage as a major health issue. Not only is there a nation-wide shortage of doctors, the overall distribution of doctors is skewed heavily towards the major cities such that regional, rural and remote areas shoulder a disproportionate workforce shortage burden." *AMA Position Statement on Regional/Rural Workforce Initiatives*, 2005, Australian Medical Association Limited.

[2] Joyce C, Wolfe R. Geographic distribution of the Australian primary health workforce in 1996 and 2001. ANZJPH 2005;29(2):129-135

[3] Deborah J Schofield & John R Beard Baby boomer doctors and nurses: demographic change and transitions to retirement, MJA 2005; 183: 80–83

[4] *When the Tide Goes Out: Health Workforce in Rural, Remote and Indigenous Communities*, Richard Murray and Ian Wronski, Medical Journal of Australia, Vol 185 No 1, July 2006.

[5] (Bureau of Rural Sciences (BRS) & Rural Industries Research and Development Corporation (RIDC) (2003) Country matters: social atlas of rural and regional Australia. Canberra, BRS [RIDC 03/015])

[6] Including funding and support for rural health services, rural clinical schools, University Departments of Rural Health and rural health scholarships. For full details, see http://www.health.gov.au/ruralhealth.

[7] *Rural and Remote Health in Australia: How to Avert the Deepening Health Care Drought*, Ann Gregory, Ruth Armstrong and Martin Van Der Weyden, Medical Journal of Australia, Vol 185 No 11/12, December 2006.
[8] Whilst recent legislative reforms have altered the principles of civil liability in many jurisdictions, it would be very difficult to suggest that country people are entitled to expect a lower legal standard of care.
[9] Section 4(a), "The Doctor and Society", *AMA Code of Ethics* (2004, editorially revised 2006), http://www.ama.com.au/web.nsf/tag/amacodeofethics.
[10] *AMA Position Statement on Regional/Rural Workforce Initiatives*, 2005, Australian Medical Association Limited. It should be noted that the AMA also emphatically supports the right of doctors to live and work where they choose in this document.
[11] Taken from *Susan Stratigos* Equal Is Not Equitable Medicare in the Bush, *Rural Doctors Association of Australia*
[12] Patient assisted travel schemes provide a partial reimbursement of travel and accommodation costs incurred by rural patients when traveling long distances to receive medical treatment. Some concerns have been expressed in recent times as to the effectiveness of these schemes. See, for example, *Patient Transport Woes*, ABC News Online, May 14 2007, http://www.abc.net.au/milduraswanhill/stories/s1920913.htm. The Senate Community Affairs Committee is currently conducting an inquiry into the operation and effectiveness of patient assisted travel schemes. The Committee will report its findings by the 20th of September 2007.
[13] "Governments must ensure that regional/rural hospitals are properly resourced with adequate infrastructure, information technology support and staffing to ensure that doctors work in an environment that is conducive to delivering quality patient care." *AMA Position Statement on Regional/Rural Workforce Initiatives*, 2005, Australian Medical Association Limited. See also the *AMA Rural Health Issues Survey* (May 2007) which identified staffing, along with modern facilities and equipment, as high priorities.
[14] A sustainable specialist workforce for rural Australia: A position paper prepared by the Rural Specialists Group of the Rural Doctors Association of Australia http://www.rdaa.com.au/uploaded_documents/ACF1338.pdf
[15] *$50,000 a year extra for GPs*, The Daily Telegraph, 27 February 2007. The article also mentions that taxpayers are spending $160-180 million a year subsidising medical indemnity premiums.
[16] *Primary promises millions as GP lure*, Australian Doctor, 2 November 2006.
[17] Such an examination is common in other areas that attract a significant amount of public funding, for example, higher education.
[18] *Time for Hard Decisions on Patient-Centred Professionalism*, Donald Irvine, Medical Journal of Australia, Vol 181 No 5, September 2004.
[19] "These have included (in the United Kingdom) the children's heart surgery scandal in Bristol, the murder of at least 18 patients by the general practitioner Harold Shipman and the covert postmortem collection of paediatric body parts in the Alder Hey case, and (in Australia) the alleged poor management and clinical performance at King Edward Memorial Hospital, the Campbelltown-Camden affair and the Bundaberg Hospital scandal." *Task Transfer: Another Pressure for Evolution of the Medical Profession*, Martin Van Der Weyden, Medical Journal of Australia, Vol 185 No 1, July 2006.
[20] *It is public perception that counts*, Martin Van Der Weyden, Medical Journal of Australia, Vol 185 No 11/12, December 2006.
[21] *Mismatch: Australia's Graduates and the Job Market*, Andrew Norton, The Centre for Independent Studies, 23 March 2007, http://www.cis.org.au/IssueAnalysis/IA84/ia84.pdf.
[22] Examples of which can be seen in the next section, Encouraging Rural Practice: Recent Graduates.
[23] The concerns regarding equity are succinctly summarised in this quote from Senator Barnaby Joyce: "We have to make sure that ... someone growing up in Cunamulla or someone growing up in Ipswich, if they work hard enough at school and they get into medicine, can get through medicine. We would never want the position where these people can't actually go to university because they can't afford it." *Rudd Reconsiders University Fee Policy*, ABC News Online, 10 May 2007, http://www.abc.net.au/pm/content/2007/s1919909.htm.
[24] Including bipartisan support; see *Australia's Universities: Building our Future in the World, A White Paper on Higher Education, Research and Innovation*, issued by Jenny Macklin MP, July 2006, at p64.
[25] In the interests of fairness, the arrangement could provide for relief from performance in specified exceptional circumstances.

[26] The Australian government announced in the *2007-08 Budget* that it will be expanding regional dental training, with clinical placements in rural training settings for up to 30 metropolitan dentistry students annually.
[27] *AMA Position Statement on Regional/Rural Workforce Initiatives*, 2005, Australian Medical Association Limited.
[28] *Rural and Remote Health in Australia: How to Avert the Deepening Health Care Drought*, Ann Gregory, Ruth Armstrong and Martin Van Der Weyden, Medical Journal of Australia, Vol 185 No 11/12, December 2006, quoting John Graham at p654.
[29] *Health Fact Sheet 4: A Continuing Commitment to Rural, Regional and Remote Australians*, www.health.gov.au/internet/wcms/publishing.nsf/Content/health-budget2004-hbudget-hfact4-cnt.htm.
[30] *Govt Rural Doctor Scheme Backfires*, The World Today, ABC, 6 March 2007, http://www.abc.net.au/worldtoday/content/2007/s1864594.htm*; Too Quiet for Comfort*, Lynnette Hoffman, The Australian, April 14 2007, http://www.theaustralian.news.com.au/story/0,20867,21546 670-23289,00.html.
[31] *Incentives and Bonding to Encourage Medical Students to Rural and Remote Practice: Policy Position Paper*, Australian Rural and Remote Workforce Agencies Group, October 2005.
[32] Currently, if in breach of contract, participants in the MRBS scheme cannot practice privately nor bill Medicare for 12 years, less those years already worked in a rural or remote area. They are also required to repay the scholarship amount, with interest, less a credit for rural service completed. A participant who has breached their MRBS contract can still work as a salaried medical officer in hospitals, some state funded community health services, government, medical education, and research institutes. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/work-mrb-info. The fact that there is a global market for medical services should not be forgotten in this context.
[33] *AMA Position Statement on Regional/Rural Workforce Initiatives*, 2005, Australian Medical Association Limited.
[34] The *AMA Rural Health Issues Survey* (May 2007) identified the many positive aspects of rural practice, including autonomy, personal interaction with patients and staff, diversity of practice, quality of rural life and being a valued member of the community.
[35] *Rural and Remote Health in Australia: How to Avert the Deepening Health Care Drought*, Ann Gregory, Ruth Armstrong and Martin Van Der Weyden, Medical Journal of Australia, Vol 185 No 11/12, December 2006, at p654.
[36] *When the Tide Goes Out: Health Workforce in Rural, Remote and Indigenous Communities*, Richard Murray and Ian Wronski, Medical Journal of Australia, Vol 185 No 1, July 2006.
[37] *Health Fact Sheet 4: A Continuing Commitment to Rural, Regional and Remote Australians*, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-budget2004-hbudget-hfact4-cnt.htm.

[38]Sandra Heaney, NSW Rural Doctors Network Discussion Paper :Almost a decade down the track a review of the new south wales rural resident medical officer cadetship program http://www.nswrdn.com.au/client_images/6163.htm

[39] http://www.health.gov.au/internet/wcms/publishing.nsf/content/ruralhealth-services-msoap
[40] *Australia's Health Workforce*, Productivity Commission Research Report, December 2005. Note, however, the constitutional limitation posed by section 51(xxiiiA) on any federal legislated scheme.
[41] This may include schemes involving the geographic allocation of Medicare provider numbers; see *Position Statement on Geographic Allocation of Medicare Provider Numbers*, 2002, Australian Medical Association Limited, http://www.ama.com.au/web.nsf/doc/SHED-5FZ3B3.
[42] *Shortage Of Rural Doctors In Australia (And What Can We Do About It, If Anything?)*, Stephen Milgate, Australian Doctors Fund, http://www.adf.com.au/archive.php?doc_id=70.
[43]Rural Doctors Asscoiation of Australia Geographic Provider Numbers, http://www.rdaa.com.au/uploaded_documents/ACF7503.pdf
[44] *When the Tide Goes Out: Health Workforce in Rural, Remote and Indigenous Communities*, Richard Murray and Ian Wronski, Medical Journal of Australia, Vol 185 No 1, July 2006.
[45] *Rural and Remote Health in Australia: How to Avert the Deepening Health Care Drought*, Ann Gregory, Ruth Armstrong and Martin Van Der Weyden, Medical Journal of Australia, Vol 185 No 11/12, December 2006. See also the *AMA Rural Health Issues Survey* (May 2007) which identified funding for locum relief as a high priority.
[46] *Extra Funds to Keep GPs in Rural Areas*, ABC News Online, 9 January 2006, http://www.abc.net.au/news/newsitems/200601/s1544349.htm. *New Medicare Item for Nurses to*

Provide Antenatal Checks in Rural Areas, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/C78F960B4E3BB995CA2570F1000BC1DD/$File/abb002.pdf.

[47] *Shortage Of Rural Doctors In Australia (And What Can We Do About It, If Anything?)*, Stephen Milgate, Australian Doctors Fund.

[48] *Rural Doctors Chief Wants Minimum Health Service Obligation*, ABC News Online, 20 November 2006, http://www.abc.net.au/news/newsitems/200611/s1793120.htm. *Rural Service Obligation Needed for Health Services*, Dr Peter Rischbieth, ABC News Online, 1 December 2006, http://www.abc.net.au/news/opinion/items/200612/s1801763.htm.

[49] *Rural Service Obligation Needed for Health Services*, Dr Peter Rischbieth, ABC News Online, 1 December 2006, http://www.abc.net.au/news/opinion/items/200612/s1801763.htm.

[50] *Shortage Of Rural Doctors In Australia (And What Can We Do About It, If Anything?)*, Stephen Milgate, Australian Doctors Fund.