COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Provision of health services to outer metropolitan, rural and regional Australians

(Public)

THURSDAY, 4 NOVEMBER 2021

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 4 November 2021

Members in attendance: Senators Askew, Green [by video link], Hughes [by audio link], O'Neill, Patrick, Rice [by video link], Urquhart.

Terms of Reference for the Inquiry:

The provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians, with particular reference to:

a. the current state of outer metropolitan, rural, and regional GPs and related services;

b. current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:

i. the stronger Rural Health Strategy,

ii. Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,

iii.GP training reforms, and

iv. Medicare rebate freeze;

c. the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia; and

d. any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

WITNESSES

WITNESSES

CLEMENTS, Dr Michael, Rural Chair, Royal Australian College of General Practitioners [by video link]

MAGUIRE, Associate Professor Peter, Australian Medical Association Council of Rural Doctors, Australian Medical Association [by video link]

MOY, Dr Chris, Vice President, Australian Medical Association [by video link]

PRICE, Dr Karen, President, Royal Australian College of General Practitioners [by video link]

Committee met at 08:59

CHAIR (Senator Rice): I declare open this hearing of the Senate Community Affairs References Committee's inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians. I want to start by acknowledging the traditional owners of the land in which we meet. I'm here in Melbourne, on Wurundjeri country, but, wherever we are, we're on First Nations lands, and I want to acknowledge and pay respects to elders, past, present and emerging and to all First Nations peoples and any first Nations people who may join us today.

These are public proceedings, and a *Hansard* transcript is being made. The hearing is also being broadcast via the internet. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It's unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

The committee prefers all evidence to be given in public, although the committee may determine or agree to a request to have evidence heard in private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may also be made at any other time. The committee understands that all witnesses appearing today have been provided with information regarding parliamentary privilege and the protection of witnesses. Additional copies of this information can be obtained from the secretariat.

I welcome, via videoconference, representatives from the Royal Australian College of General Practitioners and the Australian Medical Association. Thank you very much for appearing before the committee today. I now ask each of you to make a brief opening statement should you wish to do so, and after that I'll ask the committee members to ask you some questions. I just note that we've read your submissions, so, if you keep your opening statements very brief, it will give us more time to have the conversation and the questions and engage with you. Does the college wish to make an opening statement?

Dr Price: Yes. I'd like to acknowledge the land which I'm on today, which is Boonwurrung land, and I'd like to pay my respects to elders past, present and emerging and acknowledge their spiritual connections to country. Thank you, everybody. Dr Clements and I are here today on behalf of the RACGP, or Royal Australian College of General Practitioners. We'd like to thank the committee for the opportunity to give evidence. The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or towards a career in general practice. Dr Michael Clements today represents the chair of the rural faculty, which represents 20,000 GPs, of whom 10,000 are providing general practice services across rural and remote Australia. We'd like to note that 80 per cent of rural doctors are RACGP members.

We do need a system that supports general practitioners. We know the issues. Chronic underfunding and increasing complex care mean GPs are working harder, or less, and we need to see doctors as people—people who want portable leave entitlements, flexibility and attractive remuneration. We need to address the Medicare compliance burden and regulatory pressures which make general practice a less attractive option for the future workforce. Supporting general practitioners is supporting the communities that they serve. We need an MBS system that supports longer consultation times and supports the changing needs of consumers with the rise of chronic and complex conditions. We don't see just one issue at a time. We need a system that trains and supports GPs to go rural and to stay rural.

General practice is a fantastic career, both Michael and I can attest. We need to get the distribution priority areas right. We need the right frameworks to support international medical graduates. We really do want the best trained GPs doing the best work in the right locations. To do that, we need a nationally consistent training program, and we have been working tirelessly to enact our vision for college-lead training. We will be training the future workforce to ensure they have the right mix of skills, control over their career journeys and the best possible supervision and support, without which this program won't work. We know it is community based.

Our rural GPs love their jobs. We want future GPs to love it just as much. This inquiry is an opportunity to look at how we can encourage current and future GPs to discover the joys and challenges of this highly rewarding career using the best evidence available. Thank you again for the opportunity to appear before you. We look forward to answering your questions on our program.

CHAIR: Thanks, Dr Price. AMA, do you wish to make an opening statement?

Dr Moy: Yes, thank you. I will probably adapt my words. It will be rather informal after what Karen has said, which probably does cover many of the things we were going to cover. I'd like to firstly acknowledge the traditional owners of the lands on which we meet, pay respect to elders past and present and thank the committee for the opportunity to appear today. I'm appearing with Dr Peter Maguire, who's an experienced GP with many years of rural practice behind him in Western Australia. He's also someone who's been really deeply committed to training the next generation of general practitioners and rural doctors.

The bottom line: I live this and so does Peter—all four of us here. General practice is the humble foundation of the world-leading health system in Australia. We provide exceptional care and coordinate access to the rest of the health system and have done this incredibly cost effectively for many years now. Through this whole pandemic there has been a tremendous effort to care for and advise a nervous population; adapt to telehealth and new technologies, and that has been quite an amazing effort; and lead the vaccine rollout, which, despite what you may hear, I think general practice has been the one that has actually been the bedrock of the vaccination program.

In all this, I think the thing that has become clear is the central role of general practice. It has also shone a light on the significant challenges faced by GPs that successive governments have failed to address in terms of resourcing. Investment has not matched the increases in the costs and demands general practice has needed in terms of support to provide high-quality care, in terms of rebate freezes and also inadequate indexing. I think the other thing is that there has been quite a change in job practice, as Karen has said, in that we're looking after much more in terms of aged, complex care, chronic disease and mental illness, for which the funding model currently may not fit and is not as adaptable. While the Medicare fee-for-service model really needs to be maintained, we do need to look at new models and evolve in practice in a way to be able to care for a new population, just as we've adapted with things like telehealth.

I understand that the scope of this inquiry may have shifted slightly over time, because I think it has really found the fact that the matters of outer metropolitan and rural general practice and the problems you're seeing there are really greatly due to the fact of the inadequate resourcing of general practice as a whole. These are exacerbated in outer metro because of the fact that there is increased associated economic disadvantage in outer metro areas and increased need to bulk-bill, and therefore inability to provide the resources needed in outer metro. Also increased demands on the general practitioners having to travel but also increasing pressure on them because of the reduced resourcing that they're under. I think then we extend out into the rural areas, where I think everything is even more severe, where obviously you've got distance, reduced support and reduced economies of scale. I think also reduced support for not just the doctors themselves but the potential family units that are out there. We're talking about families that actually need to go out there. The lack of support for them has to be kept in mind when considering future changes to support rural general practice.

AMA is in strong support of the sort of work in rural generalism and the rural generalist program, but we see that general practice as a whole, but particularly rural general practice, has become less and less attractive because of the reduced support for general practice as a whole. While we support the moves in that area, we do think we need to do things now. There is desperate need to make changes now. That really needs to get to the heart of things like recognition of rural doctors and their working conditions and looking at remuneration—and also smart. We need to be thinking about the things that would support general practice and a general practitioner out in the community and their families. We do have current classification systems and components to try increase incentives into the country, but they're blunt instruments and we need some flexibility to keep rural practice going and to support the future of rural practice.

Ultimately, what I'd say is general practice as a whole has done an incredible job recently. I hope that's now appreciated. We do need support for general practice as a whole, but particularly the lack of support over time has really magnified the problems in outer metro and rural areas. For that reason, we need to consider increased support for general practice as a whole. If we don't do this, the health outcomes will deteriorate for both the general community and those in outer metro and rural areas. Thank you.

CHAIR: Thanks, Dr Moy. We have six senators on the line; plenty of us to ask you lots of questions now. I will ask Senator Green to begin.

Senator GREEN: Hopefully I've got past the technical issues we had the other day and everyone can hear me okay. Thank you so much for joining us today and kicking off the public hearings of this really important inquiry. Can I start off by thanking you and all of your members for their efforts over the past 18 months, almost going to two years now, over the COVID pandemic. I live in a rural and regional area, in Cairns, and so I certainly appreciate the efforts from our local GPs here in managing COVID-19, not just testing but also administering the vaccine. We really do appreciate it. I moved the motion in the Senate to establish this inquiry. There are a lot of policy reasons but also, from a personal point of view, it's very hard locally for us to be able to get access to GPs at the moment. There's another story in the *Cairns Post* today about the lack of access to GPs and the impact that is going to have. I have some questions about not only the extent of the issue and some short-term issues that may be arising but also long-term and specific issues about training.

To begin with, I have been out and around regional Queensland for the last six months talking to people about this issue. I had a doctor in Emerald who should probably be retiring very soon but can't, because he's one of the only GPs in Emerald. He turned to the people in the room I was in and said to them that this is a dire situation—those were the words he used—and really tried to impress on the people in his community that this is something that needs to be fixed now. Is this a crisis? Are we in a crisis of GP shortage around the country particularly in outer metropolitan, rural and regional areas, and is this something that needs urgent attention from all of our governments?

Dr Price: The short answer is yes. I think you might be referring to Dr Ewen McPhee—

Senator GREEN: Yes, I was.

Dr Price: Of course. It is a dire situation. This is really the pointy bit, the sort of things that Dr Moy was just talking about in terms of a decade of underfunding, but also we have a maldistribution in particular. Trying to draw that out, we've had temporary fixes like IMG recruitment into rural areas and bonded medical schemes, which are good short term but they're not really a sustainable solution. We do need, as you would attest, living in a rural area, and I know Ewen's area, rural and remote infrastructure to support doctors in place who want to be there who are committed to the community. This is a long-term program, which is what the PLT is going to be addressing. I've noted various submissions referring to the PGPPP program, which is developing a pipeline of rurally interested students right back from medical school. In fact, we're even talking about developing talks for work experience students in high school so that we get rurally interested students engaged in that community focus and engaged in the communities on a long-term basis so they know the people and they know the relationships around them. This is a really critical part of developing that pipeline into a sustainable model.

We've also got to be mindful of some of the workload on rural practitioners and to make sure there is relief and support for their educational needs and so forth. But it's much more complex than just providing a pool through money. It is, as Dr Clements noted, also about family, it's about education and it's about lots of those complexities.

Senator GREEN: It's a complex but urgent problem—difficult.

Dr Price: It's an urgent problem that's been a long time coming.

Senator GREEN: Dr Moy, did you want to add to that?

Dr Moy: I've felt this in South Australia. We've got a particular crisis in South Australia at the moment. It's been in the news already. I was just recently the South Australian president and just ended that job. We'd started negotiations with the various rural doctors. What I found after a while is that certainly there need to be long-term solutions, and they come back down to starting at medical school, flowing right through training and really trying to align, making sure we've got enough medical students who actually come from rural areas, following them through, supporting them right through, making sure they're aligned to particular areas so they can go back to where they came from potentially with the right skill mix for the populations that they have there—they're long-term things—and to really favour them, in fact, right through both medical school and training.

They're the long-term solutions, but then you've got to consider what's going to attract them to do that and to stay there. They are matters like relative remuneration, understanding that they do not have the economies of scale out there—and not just financial, but we're talking about support, which is becoming worse and worse, because we are talking about a different population of doctors over time; many may not be prepared to be on call 24 hours a day seven days a week now, and we need to take that into account. We need more support, not just for the individuals but also for their families, and we need to consider things like support for housing, schooling, and employment of partners who may be going with them so they're more likely to stay. All those things are things to consider over time, as well as support for infrastructure and matters like that. We've had some blunt instruments such as the areas of workforce disadvantage and things like that. One rural GP said to me: 'Think about mining

companies. What does it take to get them to get a family to go out into a rural area?'—start to think smart like that and be flexible like that in actually trying to consider what it would take.

Senator GREEN: I do have more questions about training, and I really want to get into that, because there's a lot of evidence that if you train someone who's from the bush they're more likely to stay in the bush. I want to come back to that, but I do want to understand the short-term difficulties that this problem is creating right now. This is something you deal with day in day out, but I think people in government, in departments—and possibly even the public—don't appreciate what is actually happening on the ground right now. I don't want to get too far into COVID, but there is one question that I think is relevant right now. I want to understand, if you could let the committee know, how the GP shortage right now in rural and regional areas particularly will impact the plan that we have to live with COVID, particularly Hospital in the Home. What we've seen, in Cairns at least, is that a lot of people are being turned away from GPs and ending up in our emergency departments in our hospitals. That's a short-term impact of the crisis, and I've got some questions about the longer-term impact it will have on the wellbeing of Australians. I tried to explain this to officials and ministers in estimates last week and it just didn't seem that they were understanding how immediate the issue is.

Prof. Maguire: Thank you for the question. I work in a small town of 5,000 people in WA. We are desperately under-doctored as it is, and patients wait two or three weeks for appointments. We regularly have difficulty staffing our emergency department and rely very heavily on locums who drive in from Perth. If we add COVID to that mix, we are seeing the impacts even with the vaccinations. That has significantly cut down the number of appointments for patients. So, there's only so much time that our GPs have. We certainly are concerned about what's coming.

You mentioned Hospital in the Home and the idea that many COVID patients who are not particularly unwell but who may deteriorate will need monitoring, probably by telehealth. That's going to impact severely on the already stretched business as usual—just looking after patients with acute problems and preventive care. So, there is a very real impact, and we've seen this for many years now in our town. We struggle to recruit. Like my colleague from Emerald in Queensland, I'm very close to retirement. In fact, out of our GPs, three or four of us are at my stage of our careers, and we struggle to recruit young doctors. So, the situation really is dire, and unfortunately, as we've discussed, there are no quick fixes; there's no single solution. We've been trying this for years. It is a crisis situation, I agree.

Dr Price: In terms of COVID-positive pathways, it needs to be an integrated solution, for sure, and in rural and regional areas it's very complex because of the need for more infrastructure in terms of how to manage. Some of the recent initiatives have been helpful. Telehealth will be helpful. We're hopeful that with the increased vaccination rates—although they're lower in some of the rural communities—we will mostly see mild COVID. And we're having to recalibrate our practices to handle infectious disease, which they were doing probably 50 years ago, but now we've got more information about how to manage this. It is going to require some infrastructure and support in reconfiguring how we actually work with infectious disease patients. In a rural community of course that's critical, because there is much less reliance on staff. So we're going to need increased support for nursing staff and allied health, to help us manage, as well as continuation of telehealth but also the infrastructure within practice, and that includes Medicare benefits, to support doctors being able to see these patients.

Dr Clements: I'm from Townsville. I've got two general practices in Townsville and one on Magnetic Island. We certainly are in a crisis, and if we think of GPs as a community's bridge to better health care, which makes strong, sustainable communities, we've been on fire for a long time, and COVID's really fanned that; it's given oxygen to the fire. Our GPs are burnt out and are leaving. Julia Creek lost its only doctor this year. It was in the paper in the last couple of days that in Wudinna, in South Australia, their last doctor just resigned. There is a swathe of the middle of the Eyre Peninsula where one doctor is responsible for whole regions. In the midst of COVID, this is very dangerous.

GPs work best in collaborative models, where we're working within teams and we're providing oversight and support—using telehealth, using nurses, using nurse practitioners—but if we don't have the doctors there leading that team then there are people who are going to be missed. There will be people who are sick from COVID who don't get the assessment they need. There'll be people who can't access a GP. And don't think about just the COVID infection itself; we're looking at an epidemic of long COVID coming, and we know that those patients are going to require extreme support from their GPs, and we know that long COVID mimics some of the other chronic diseases we've seen. If you're in a rural and remote community without a GP, your risks of not surviving COVID are higher and also the management of your long COVID symptoms are going to be a lot worse.

Senator GREEN: That leads into my next question before we head on to talk about training. The doctors I've spoken to around regional Queensland in particular but also in other parts of the country talk about their concern around the long-term impacts on their patients. Because there is a lack of GPs in an area, people are less likely to come in for preventive health appointments and maternal health appointments Right now I'm actually being kicked by a 24-week-old pregnancy. I know it's really hard for me to go and see a GP, so sometimes if there's something I'm a bit worried about I might skip it and wait until the next scan. What are the long-term impacts on health and, particularly for government, the cost of that on the budget? Departments and officials like to think about the bottom line. By not investing in our GP practices and our primary health network, are we actually costing the budget more in the long term?

Dr Clements: I might jump in because I was the last person to speak—sorry, Karen—just to quickly say we got a taste of it. We got a taste of what it's like when people don't see GPs, with the COVID lockdowns. I had 60-, 70- and 80-year-olds too scared to leave their house for months. They didn't come and see us, because of the COVID fear. We saw what happened. We saw later diagnoses of cancer. We saw people with abdominal pain for four months present with metastatic colorectal cancer. One of my GP friends' partners is a pathologist and said: 'Oh my gosh! I've never seen such advanced cancer. Normally I see cancer much earlier. Now I'm doing pathology samples on things that are a lot further.' We are seeing the health burdens. We are seeing a cancer increase. We're seeing the mental health burden when people don't have access to GPs for that preventive aspect. We are seeing it already, and it's just going to get worse.

Dr Price: I was going to say that across all the cancer streams—it's not just rural, of course—if there's an access issue it will be exacerbated. There are 10 different cancer streams for which, from Cancer Australia stats, we're seeing a delay in presentation, and a dip, and we know that with chronic disease also. We've got the PricewaterhouseCoopers vision for general practice, which we can deliver for you if you'd like, which talks about the ongoing saving from having these chronic diseases managed in primary care, particularly in primary care teams. Having access to vital primary care as well as general practice really saves forward costs onto the hospital system. We've got a whole range of initiatives within that, that show billions of dollars of savings that occur over the forward estimates for investment in primary care. We know that other countries have done it successfully and turned around some of that ongoing cost for chronic disease. But we need to act now, that's for sure.

Senator GREEN: When it comes to training, what are we getting right and what are we getting wrong? That's a very broad question, but the doctors that I've met talk about the fact that they did part of their training, or most of their training, in a rural practice. They were attracted by the different type of work that is involved, and that's why they decided to stay, but the stats show that's not happening enough. We don't have enough doctors who are choosing to stay, or even to study, in rural areas. What are the key things in the recommendations that you've made that you want us to concentrate on when it comes to training GPs to become rural and regional practitioners?

Dr Price: Nita, what a great question. The answer is one that you don't often hear in the Senate, but that is one of community based relationships. We know that the supervision relationship between a supervisor and a registrar is one of the key determinants of how well that registrar learns, how much they enjoy their experience and how likely they are to stay. Having repeated exposure to rural communities is a dose-dependent relationship; there was a recent article from the MABEL data that demonstrated that. We know that this primary relationship of learning really helps to engender that passion for rural practice. We also know that, in gaining advanced skills, rural origin, rural clinical schools and these sorts of things are all going to contribute.

We would like to deliver a nationally consistent program which overcomes some of the limitations of having nine different jurisdictions. That means that there are people who can transfer from Western Australia—sorry, Peter—over to Queensland or back again because they've got flexibility. What they are looking for is flexibility, a really good training experience and a broad scope, as you say, that's intellectually challenging.

Parallel to this—and it can't be neglected—is that only 15.2 per cent of graduates are considering a career in general practice. That's related primarily to the remuneration and the status that has been, sadly, degraded—even though, I believe, general practice is the most intellectually demanding. We are the general diagnosticians of the health system. There's a whole reorientation needed within general practice that relates to training but also to funding and the attractiveness of the career.

These are bright young graduates, and they're going to make choices. We want them to make choices that are headed in generalism—which has been, throughout all the submissions I've read, one of the prime concerns—and we want them to make those decisions in a way that enables rural and remote communities to have access to high-quality medical care. If they have a bad training experience, that may well colour them for the rest of their lives about rural and remote practice. Michael Clements has demonstrated really ably on his practice on Magnetic

Island exactly how he can turn around an area that has a workforce shortage. I'd really like Michael to speak to that.

Senator GREEN: Just before Michael does: it sounds like one of the issues is that we're getting a lot more women who want to study medical practice, but it's not an attractive workplace for someone who is planning on maternity leave or managing a family. Maybe Michael can comment on that.

Dr Price: I would really like to comment, being an ardent previous chair of the Women in General Practice Committee. Absolutely, entitlements is a key issue; I know it's a key issue for young graduates. Back in the 2000s, a young registrar could leave the hospital system, go into general practice and experience a pay rise. That's now not the case. Now they're talking about entitlements. Parental leave is a big consideration, and those entitlements are needed to transfer across into general practice. We're calling for an independent body who can hold those entitlements and travel with that registrar as they go through their training, so they don't make a decision based purely on the support they can receive. I don't believe it's enough support for working mothers—but that's another story and another Senate!

Dr Clements: I might jump in. With Magnetic Island, we turned it from zero doctors to five doctors working on the island, through a commitment to training and supervision. I've got a female registrar joining me next year. Her hospital salary as a third-year doctor is about $150,000, given she works overtime and weekends. Her first pay cheque with us will be based on $90,000 per year, because that's what the minimum terms and conditions are. Seeing only two or three patients an hour as a GP, using GP rebates, that's all she'll get. Already she's facing a massive cut in pay. Also, she loses any maternity or paternity or long service leave entitlements by coming to join us. It's a big financial hit for this doctor to move out of a hospital and into community general practice.

We know, as a college, that more of our trainees are female, which is great—they do great work—and the evidence is that they carry a large burden of the longer consults, which means they earn less; Medicare doesn't reward long consultations. We also know the average age of our GP registrars is not in the early 20s like it used to be; it's actually in the early 30s. The people now coming to us in general practice training are more mature, largely because of graduate medical programs and people coming to medicine later in life, so they're coming to us right at an age when they're thinking about family and actively thinking about and planning children. And a career in community general practice without access to those entitlements is a massive barrier. I know that the AMA have some thoughts there, too.

Dr Moy: As the AMA SA president, I visited Port Lincoln and spoke to some of the GP registrars there. I'm not sure if you've been to Port Lincoln; it's an absolutely beautiful part of the world, and all the registrars love working there. But particularly the female registrars there said to me: 'I love working here but it's not worth it to me. I'll earn more money in the city. I won't have to deal with all of the stress of on-call that they put me through with the hospital and all the other things that I've got concerns about in terms of schooling for my children. Things like that are going to be far too problematic.' So, in the end, they moved back to the city, even though they loved where they were.

The AMA's position—and I will ask Peter to speak—is that we need to work from both ends. We need to work out what towns. We need to do much more workforce planning, which we've unfortunately failed to do; we had the loss of Health Workforce Australia early on, and we're catching up now on health workforce planning. We need to work out what towns and rural areas need, and work backwards. We need to start from medical school—make sure that at least a third of the graduates come from rural areas, follow them through and support them through in terms of lining up what skills are needed, give them a leg-up through getting the right training to go back to those communities, and keep them linked to those communities right through their training so that they don't disconnect and end up in another training program and go into metro. These disadvantages they've got to face, such as the things I've just said—relative income disadvantage, reduced support for their children and their family, and relatively increased stress, fatigue and concerns about being on call, all for less—have to be overcome, I think, to tip the balance and keep them in rural areas.

Prof. Maguire: To that I would add that some of the successes we had in Western Australia in the past involved identifying students who showed interest and having them mentored by someone who had oversight through their late student years into their junior doctor years and then through GP doctor training. That was quite successful. I think it's important that we also look at the first couple of years of hospital training, which are often done in metropolitan hospitals with very little opportunity to go and experience working in a rural hospital. While that's improving, there's a long way to go. I think an important transition from student to GP is actually in those first couple of years. I think those are important issues.

Dr Price: I'd like to go back to the gender lens, if I can. It's a really important point that you've raised, but it's not just about parental leave but also about a rural doctor being after hours, on call—all of those sorts of things.

So child care and spousal support are really critical. I do think a whole gender lens needs to be put upon this, in terms of what we mean by work and how that translates into a family unit as well. I mean no disrespect to my colleagues here, but I always maintained that the position of rural doctor was a two-person job, with a full-time GP—I'm talking about 50 years ago, guys, so you're off the hook—with a very devoted partner at home managing everything else. That old model of work has gone, and we haven't really adapted into those areas. I know that child care, and particularly in Western Australia—CEO Janice Bell talks about this a lot—is one of the biggest needs of the registrars in that area, because it gives them flexibility but also consideration for on-call and after-hours commitments.

Senator GREEN: I will hand over to my colleagues, because I know they have questions. Before I do, Dr Clements, congratulations on what you managed to achieve on Magnetic Island. From having no GP at all to building it up to what you have now is an incredible achievement. Thank you.

Dr Clements: Thank you.

Senator HUGHES: Can you confirm for me, Dr Price, how long it takes for someone to become qualified as a GP?

Dr Price: Generally, it's three years full time once they enter the program, but there might be a few years of hospital training before that. If they do it part time they—

Senator HUGHES: No-one's gone to university, though, and after three years has gone into general practice, I'm guessing.

Dr Price: No. They usually spend two or three years or more in hospitals—I would say the average is probably three years or so—to gain other experience. Particularly if they're contemplating a rural career, they may get advanced skills in obstetrics or anaesthetics before they leave, and then they go out into rural areas for three years, generally, on the program. For rural training, it may be an extra year on top for rural generalist training. Also, to FRACGP—many rural doctors are FRACGPs—they may bolt on additional training.

Senator HUGHES: So we're generally talking a minimum six- to seven-year training program.

Dr Price: Yes.

Senator HUGHES: Similarly to Senator Green, I went through three pregnancies in rural and regional areas. One was in Orange, which has a particularly large specialist area—they've done very well in building a specialist network around Orange—but the next two were in Moree. Unlike Cairns, with an international airport and a fabulous reef, Moree, I would imagine, is a slightly more challenging environment to attract people to. As much as I love broadacre farming, I'm not quite sure that everybody else would find the joys in it and the remoteness. I've had a look at some of the jobs that are open and I've listened to what you've said with regard to remuneration. I've had a look today on some of the websites of jobs that are open as rural generalists, and pretty much the lowest paying one was $2,000 per day. Would that be considered insufficient pay? Most of them were $2,300 to $2,500 per day, in a rural and regional area.

Dr Clements: That's a locum rate. That's not a salaried rate, so if you committed to that region—

Dr Price: Yes.

Senator HUGHES: No, no, I looked at it. [Inaudible] full-time job.

Dr Price: They may well [inaudible] whether they're paid through the hospital or paid through community general practice, because there's a difference in which area you work in. Michael, you might want to elaborate on what we mean.

Dr Clements: What we're seeing in South Australia is $2,600 a day. What we've seen in New South Wales is up to $3,200 a day. In community general practice we can only offer abut $1,500 a day before we start losing money, so we just can't compete. Those are the locum rates. People are now being drawn into those locum roles. Those roles, those pays, work. So $2,600 a day, or per 12-hour shift, has worked in rural South Australia, but you're getting mercenaries that come and go from that town with no continuity. They don't have any ownership to the community or to the practice. They stop making discharge summaries. They kick them out of the ED as soon as they can because it's no longer their problem. Port Pirie is a good example. There have been some media reports and complaints about the service received at Port Pirie Hospital, which was reliant on locums. The reports are that they just didn't care. That's the report. I wont say that it's true.

Dr Price: It's that commitment to community, isn't it, Michael?

Dr Moy: I'll just add that the experience in Port Lincoln was very interesting because, yes, they did get locums in Port Lincoln for the hospitals because the GPs, unfortunately, because of the amount of pressure and fatigue, but also because of a dispute with the working with the local hospital, but then the hospital needed the local GPs

to still look after paediatrics, because the locums couldn't do that, which defeats the whole purpose of what you're trying to do there. It's really not what you're trying to do. This is not a model which builds continuity, loyalty, the foundation on which—and I think that this is really important for a lot of towns, that having the doctor there is more important than having the bank or the post office there, because health care is such a critical component of people wanting to stay in that town. It's not just the health care but everything else, as you probably understand.

Senator HUGHES: I guess this is one of the things that kind of, not confuses me—I understand—but it's not just doctors. If you live in a small rural and regional community, absolutely every person who is working in that town, whether they are a farmer, a GP, a pharmacist or a teacher or run a retail store—every single one of those people is facing the same sorts of issues and challenges around childcare, challenges around education for their children, all of those sorts of things that families look to, to make living in a particular area attractive. We're not suggesting in any way that GPs—I heard you talking about more support for them and their families and their partners. Are you suggesting there should be more support for someone who's a GP than for anybody else living in that community? Because obviously it would be something that those communities need to focus on, that towns need to focus on, making themselves more attractive for people to live in long term. It's not just GPs affected by the shortages and challenges.

Dr Price: You're absolutely right. Back in the 1950s, there was 'Paris and the French desert'—a description of how they needed to deregionalise France—and this is what I've been talking about. There needs to be a whole lot of regional and rural infrastructure development that, obviously, supports general practitioners and supports the entire town, because it's a symbiotic relationship. If you've got a thriving town you've got a thriving general practice. It all supports each other. So I totally take on point what you're saying there.

Senator HUGHES: My local GP when I lived in Moree, who also did a lot of rural, generalist, obstetrics et cetera, his wife started our ballet school, so our little girls could do ballet. They were definitely a part of our community and made it so. But they obviously, like lots of people where I lived, had to send their children away to boarding school. So it's not just the GPs.

Dr Price: [Inaudible]

Senator HUGHES: I just want to move away from that, though. With regard to the Rural Junior Doctor Training Innovation Fund, we have seen more junior doctors getting experience of rural general practice. We've seen over 50 towns and 80 sites receive over 800 rotations since 2018, and that's been increased to another 60 interns and postgrad doctors taking training in country practices. How important is it that those programs are working with—for example, I know the University of Newcastle undertakes lots of rural generalist programs in areas out as far as Bourke, Cobar et cetera because it looks after those areas.

Dr Clements: I might jump in there, if that's alright, Karen. It's a fantastic program, and we're glad to see it and glad to see the expansion. We'd love it if every hospital was able to offer it. But the crucial, key part is that it has to be a positive experience. If we don't make sure that the practices they go to are well supported and RACGP led, with good supervision and good clinical education and teaching, it actually will have been negative. We have had people come back who have been in a churn-and-burn clinic, where perhaps they're trying to fit as many patients through the door as possible, and their experience under RJDTIF has been a negative one. It's important that we, as a college, work with those placements and make sure that the places that they're going to are well funded and supported so that it turns into a positive experience.

Senator HUGHES: We've obviously heard in previous inquiries some stuff around bullying within hospitals and medical centres and students being burnt out. That's really a cultural thing, isn't it, more than numbers? If kids are coming back with terrible experiences and not wanting to go back, that's a broader medical cultural issue, isn't it?

Dr Price: That's right. Our program is enabled to try to manage some of that cultural change, and we know that it's not just geography because we know, as Michael said, that there's a big difference in attractiveness between Julia Creek and Cloncurry. For instance, Goondiwindi has no problem in attracting people, whereas Tenterfield, up until recently, had some troubles. It is often some local issues that may be related to culture and personality, and they need to be devised by and sorted out by local communities and people who can oversee that. We have some remediation in place for both supervisors and registrars, should that turn into a negative experience. We do not want to send young doctors or medical students into a negative training experience. That is a disaster for all of us.

Prof. Maguire: I can add there that I totally agree that it's important that the young doctors get a positive experience. One of the challenges—and it really is a dilemma—is that those parts of Australia that have the worst shortages of GPs are the ones where adequate supervision is difficult to provide. In many of those towns, the GPs

who are there are so busy that it's very difficult to devote the time that the young doctors need for supervision and, in many cases, those towns have international graduates who themselves are under supervision and are not eligible to take on the supervisory role. So there is a mismatch between the need for the junior doctors and the ability to supervise them adequately and give them a good experience. That's a challenge that we all need to work on, I think.

Dr Moy: Just to put it in perspective, the innovation fund will provide, I think, about 800 rotations, as you said. But Australia graduates about 4,000 medical students per year, so that gives you some perspective of how many we're missing out on. I think the loss of the PGBBBP in 2014 really left general practice, in particular, as the only specialty unable to offer junior medical officers a really structured prevocational training experience before they make their career choice. I think we do need to consider relatively where we've been, where we are at the moment and where that fits overall, even though the 800 is obviously a positive thing.

Senator HUGHES: I have one question, which you may want to take on notice, about all medical schools doing rural rotations with their students so that they're exposing all of their students to rural environments, because we know that, as people go out there, they're young, quite often they meet their partner et cetera and decide to stay. It's one thing to talk about government responsibility, but isn't it really a broader responsibility of the RACGP to ensure that your fellows are investing in the next generation of doctors? There's some responsibility to make sure that all of the fellows that are part of the RACGP are providing that positive experience. I'm interested to hear what sort of work you're doing in that space to ensure that that is improving. I spoke to my old rural GP and asked him why he stayed in Moree—he was a Sydney boy. It was because rural general practice, to him, was more interesting than being a GP in a city, because he actually got to do other stuff. He was a GP, but he also got to deliver babies and do other things that, if he had been a GP in Wahroonga, he wouldn't have got the experience of.

Dr Price: I think it depends.

Senator HUGHES: Shouldn't the fellows be imparting that?

Dr Price: I think that you're talking about some of the burnout issues, and I have to say that that's a problem in medical practice generally. But there is also the remediation that we've built in. Our college hasn't had training, at least for this last little bit, so we are going to enable a pastoral care program to manage that issue of lateral violence within medical culture. James Brown, who designed the educational curriculum, has focused very much on the relationship—which I talked about; we don't hear about it a lot—between supervisor and registrar. My PhD, not yet finished, is on the peer related connections between doctors and how important they are to enable high-quality practice. The college, by having training back with it, is going to enable that pastoral care, development and mentorship that are so critical to develop not just the clinical education but also the vocational education, the role modelling and the medical cultural leadership which are so necessary to enable our profession to deliver high-quality care. If one of our students has a negative experience, we've got a services model which is going to go out and investigate that and try to work out what's actually going on. So this is relationship work, and it's very important work. I dare say that, not just in medical culture but probably across Australia, we're seeing too much of the abuse of power and bullying and so forth in workplaces, which is detrimental to everybody.

Senator HUGHES: Thank you.

Senator PATRICK: Thank you very much. I'll try to keep this brief. I might go to Dr Moy, since he's a fellow South Australian and my issues, whilst general, will focus on that. First of all—I have an engineering background, but I think it's the same in the medical world—in order to be able to fix a problem, you need to know what the problem is. I have had a year of trying to get information out of health officials—who are great at obfuscation, and I'll take that up with them this afternoon—and trying to understand where the holes are. In some respects, maybe this is a suggestion to your organisations: all I want is a map of South Australia that shows where there are doctors missing and how many are missing. Getting that out of health officials is just an impossible task, but I think it's probably something that you guys could do. Dr Moy, I'm asking you to take that on notice to be able to produce that. That sort of picture—just a map with the number of doctors missing in each location—is a powerful political tool, which is why health departments don't want to give that to us. Do you want to comment on that, Dr Moy?

Dr Moy: Can I just say that when I visited the west coast, which is where there is a crisis, I was quite shocked by how few doctors there were there and the relative lack of care but also by the lack of funding that goes into health in those areas and by how scared they were. I think there were something like 100 doctors on the entire west coast of South Australia, which was equal to the number in Gawler, one of the outer metro towns in Adelaide, which just gave me some idea of how scary it was and how lacking they were in the number of doctors in that area. I absolutely agree. That goes to the point of whether there is equality of funding there, because if you

don't have the doctor there then the services aren't provided to that area and therefore the funding to that area is less as well, because it follows the doctor to some degree. South Australia is in a particularly bad situation at the moment. There are a lot of things. I think Michael and I spoke yesterday and said it's an example of how not to do it, unfortunately. There is not the necessary level of support out there. In particular, the relationship between the doctors and the local health districts is pretty much toxic, unfortunately.

Senator PATRICK: I'll come to that with Dr Lewis, who I spoke to yesterday. But is there a map from your side?

Dr Price: We're looking to develop a big data map within the HeaDS UPP tool and so forth. As you would understand, being an engineer—my son's an engineer—this is a complex system, so the data needs to be in real time. We're actually working ahead of schedule on our IT infrastructure to intersect with the workforce to develop that kind of real-time data. Obviously, there's a big data map, but that has a lag on it. Some of that lag is what we can fill in with local community context. So it's the complexity theory of big data down, which you would understand as an engineer, and then we need the small data up, in real time, to get some real understanding of what's going on. Has someone just got sick? Has someone just gone on parental leave? This changes the whole data map instantly. Even if you have a big data map it may be wrong because you don't have the local context. You've got to have both.

Senator PATRICK: In some respects, this is the problem I get when I talk to the Department of Health. They say, 'Oh, it's all too complex.' You know what? I can tell you how powerful a simple map with locations would be, one that said, 'This is how many doctors are missing in that location,' or in fact, 'This is how many doctors there are in that location.' That doesn't have to be an extensive IT network. We can draw zero at Wudinna. We can draw maybe half or a quarter at Kimba. That's the sort of thing we need, and that is politically powerful. That is what we can present to shame our health officials and shame our ministers. But I just can't seem to get access to that information. I'm wondering if it's possible to get a map, on notice. Let's keep it simple. Let's keep it to South Australia to start with, because that's a simple jurisdiction. You can qualify it and say, 'This is the number of GPs, as opposed to nurses or whatever.' We can have another map for that.

Dr Price: I'm sure we could work something out. We'll take it on notice and try to get back to you about that.

Senator PATRICK: That would be really powerful. I spoke to Dr Lewis, who's announced that he's leaving Wudinna. I've had a bit of a relationship with him over time, trying to get NBN into Wudinna. He tells me—and I don't think I'm saying anything that's not public—that his biggest frustration is that he's got people in Adelaide who haven't practiced remotely and are making decisions without consultation, who are just not getting the right amount of support. Is that something that needs to be addressed? This is not about trying to put doctors into regions. It's a worse situation: we've got the doctors and they're leaving.

Dr Price: I can hear Scott's words—and they're not repeatable here—about what he thinks about some of the tertiary centres. This is about being able to transfer critically ill patients and how there's often a very tricky intersection with the hospital. That, again, is a cultural attitude towards rural doctors. I'm sure that Michael has also had that experience in rural and remote regions. It's not isolated to Scott Lewis, who I know well.

Dr Moy: We worked a lot with Scott last year, and it's amazing that he's stood up to this for so long. Unfortunately we've got this terrible situation in South Australia where there's been a lack of respect between the local health services and the local GPs, and a lack of real recognition of what the GPs do. They set up a private practice there, trying to provide services to the community at a private level, but the hospital services were required for emergencies and care for there. The local health services haven't shown the respect that's required, in terms of both remuneration and understanding. For example, when Scott had to go across the road, called to an emergency, he had to leave all of his patients in his waiting room, or he'd have to wake up in the middle of the night and go see these patients. He was fatigued and he was having to leave a waiting room full of patients. The state health system wasn't covering any of that opportunity cost, in terms of remuneration, and his patients weren't getting care. The demands on him were terrible. They didn't cater for simple things, like making sure that he had priority access to a computer, for example, or that he was supported properly with other staff.

There had been negotiations—because I was initially part of that—between AMA South Australia and the Rural Doctors Association of South Australia. They had been working together trying to find a solution to get a better relationship between the local doctors, the state and the local health areas. Essentially, the proposal that was put showed absolutely no respect for their needs at all, and so there really has been, unfortunately, a longstanding terrible relationship between the local doctors and the local health areas, which has meant that those doctors have got more and more tired, frustrated and angry. That's what you see in Scott and that's why it's come to a head.

You mentioned the locums earlier in the discussion. Unfortunately, that's what's happened. Because it's been a terrible stand-off, to a great degree, they're reverting to locums. That is a terrible way to provide care, because there isn't that long-term sustainability and also loyalty to the local population. It's actually a much more expensive model, as well.

Dr Price: It [inaudible] in rural practice, isn't it? It happens throughout the medical system. I've got a daughter working as a physician in the Melbourne metropolitan area, and that kind of experience is also trying to transfer patients because the system itself is under pressure. That's what's happening, and it's felt most in the rural and remote areas.

Senator PATRICK: I'll just make a quick comment, as we've got to move on because of time. One of the other things that Scott mentioned to me is that the health department will pay for a locum to fly into the area; they'll spend lots of money on a daily rate but won't direct that money towards the people who are already there. I'll just finish by saying: if you get me the map of South Australia that shows the lack of doctors—something simple that the people can digest—I reckon the *Advertiser* will run it, and that will put pressure on South Australian officials. Don't worry about the complexity; keep it simple.

Senator O'NEILL: Can I put in a request for the same map for New South Wales? There's incredible denial there as well. Indeed, in the health department's submission they make this point:

> Australia's primary care GP workforce grew from 24,737 FTE doctors in 2014 to 29,419 in 2020. This represents an annual growth of 2.9%, compared to an increase in population of 1.5% annually.

I guess we're supposed to swallow that and go, 'It's all good,' but your evidence provides the reality of the crisis that is now occurring right across the country, particularly in regional and rural contexts. I have two questions. Could you give me a sense of the impact of the PGPPP closure, under the Abbott government in 2014, on the training ground for GPs to meet Australia's need? Secondly, GPs have spoken to me for many years about the impact of the Medicare freeze on the sustainability of their business model, which appears to be coming home to roost right now. I have many more questions, but can I ask about those things? If you need to take it on notice, can I ask you to refer to hospitals in settings like Deniliquin, in the seat of Farrer, and places like Dubbo, Condobolin and Coonabarabran, in New South Wales—the intersectionality of the GPs and the hospital staff that you've spoken to. It seems extraordinarily defunct in New South Wales as well. I'll send more questions, and I seek a response.

Dr Price: Firstly, when the PGPPP was ditched, as you would remember, general practice positions were oversubscribed. Since then there's been a degradation, and we're trying to bring that back through end-to-end training beginning in medical school. We definitely want that back on the agenda. Just on notice, we are really happy to come back and present in more detail our PLT model to you. If you wish to have that presented, we're very happy to do that.

As for the GPs Medicare freeze, yes, that's been a persistent problem over many decades, and you are quite right: it is coming home to roost now, because of the infrastructure needed to even build the building, to even supply the allied health staff that we need. What's happening is that we do have increased numbers of GPs but we also have increased complexity of the problem. When I started in general practice [inaudible] could do all the procedures, including X-rays and so forth, in my urban practice, seeing refugees and so forth in a low socioeconomic area. But now you're pushing it, particularly the female doctor, to see three or four an hour, because of the complexity of the presentations and the aging population. Our healthcare needs have changed over time, and that has contributed to what you're seeing now.

Dr Moy: My short answer, in terms of the loss of PGPPP, is that general practice is the only major medical specialty which is unable to offer junior medical officers a structured prevocational training scheme. That's critical because the bottom line is that it reduces the legitimacy of general practice as a legitimate way to go. Then what you've got is all the other specialties sucking up a lot of the graduates at that point. We're building a very expensive health system at the moment, partly because of people being potentially better renumerated but also not actually starting off at that point. They're going the end up as very highly qualified other specialists, which is going to create a much more expensive but less flexible and less generalist health system.

Dr Price: And I think older and graduating the HECS debts, too.

CHAIR: Senator Askew.

Senator ASKEW: During your opening statement, Dr Price, you mentioned the fact that we were moving to colleagues-led training. I've got a couple of questions about that in particular. Being Tasmania based, I have concerns about GPTT and the transitioning across. They've had funding extended for the next 12 months. First of all, do you believe that they're ready to be transitioned across and that the colleges will be ready to run the

training from 2023? I think that's when it's due to start. Also, will you be guaranteeing that you will retain the same number of trainees coming through the process? At the moment, GPTT are retaining about 75 per cent of their trainees within the system, within Tasmania. I just wanted to make sure that you're ready to go and that we'll be able to retain those sort of numbers. The other part of my question is regarding telehealth and how that has impacted on the retention of doctors within rural and regional areas. Obviously, there's been a huge investment in telehealth over the past couple of years. I'm just wondering how that has impacted nationally.

Dr Price: Firstly, we are ready to go with our partners, KPMG. We've got 5,000 lines. As I said, on notice, we can come back and present that to you to give you some clarity on the time lines and our confidence in being able to deliver on those. As regards retention, we're absolutely trying to preserve the local community relationships and in fact enable them to better deliver for the communities, particularly in the north-west of Tasmania and so forth. So we're very aware of those issues.

Telehealth is an adjunct to usual care. It has benefits and it also had threats. It's a tool, so it all depends on how you use it. We're trying to make sure it enables high-quality care with the usual practitioner. That's what we're really looking forward to in that. Michael, you might want to talk about telehealth.

Dr Clements: Only to say that we've seen some novel models grow up, where you've got a FIFO face-to-face model with in-between telehealth. That has worked really well, and that's a model I use when I visit Karumba—face-to-face every two weeks with in-between telehealth, which has been enabled by the Medicare rebates. That's been a key enabler for the growth in health services in that town. So it's got to stay, and, in particular, rural does need different rules and different funding. Most of my rural patients don't have access to video conferencing; they don't have satellites on their roofs in the rural areas. We need to amend the telehealth Medicare rebates right now to respect rural and not assume that everybody has NBN on their mobile phone.

Prof. Maguire: Can I just add one more comment on telehealth? It certainly has been a great asset in many ways, and it has taken some of the pressure off rural GPs for after-hours care. But there has also been a downside. In WA we have an emergency telehealth system which has actually pushed the GPs out of the rural hospitals, in favour of telehealth support from the city. As Karen Price says, there are positives but there are also significant risks.

Senator ASKEW: My follow-up question to that, then, would relate to after-hours assistance. Obviously when you're working in rural and regional areas there's a 24/7 requirement to be available. In Tasmania we run something called GP Assist. I'm wondering how that would fit into your view of going forward with the new training and so on. GP Assist is a localised product which provides feedback—they can ring the doctor locally and get them to go and see somebody after-hours if necessary, but they're being managed by nurses on the end of the call. I know we have a national program, Healthdirect, but I'm wondering how GP Assist is viewed in your eyes.

Prof. Maguire: I was in Tasmania earlier this year and talking to the GPs. GP Assist sounds fantastic. I'd love it up here in North Queensland. The strength of GP Assist is the relationships with the GPs. The GPs trust them; the GPs rely on them. It's enabled them to not have to get phone calls in the middle of the night for aged-care facilities, but they trust that they're going to get contacted and have the follow-up, and that's the key. I think GP Assist is a good model.

Dr Moy: The only thing I'd say about telehealth is—and that's with any new service—you need to work in conjunction with any local rural health service and not undermine it. Whether that's telehealth or any other service, anything put in there needs to be in conjunction with the local existing health services. For example, if you have a general practice which is viable and providing face-to-face care as well as some telehealth, if telehealth is then provided from the city and—I'll put it in simple terms—does some of the easy work, it may affect the viability of that practice there. Then you've got a problem. So when considering all these things you have to get the right balance and understand, exactly as Karen has said, that telehealth is a tool that doesn't replace face-to-face care which is required. You've got to keep [inaudible] local face-to-face care if it's there is supported to the greatest degree. In the end, some things you just cannot replace by telehealth.

Dr Price: I'd just say that continuity of care has to be enabled in general practice. We don't want white-anting of a rural doctor who's built up a community over time by someone who wants to come in and just cream off what is considered to be easy but in fact are opportunities for a local GP who knows their patient's case well to intervene opportunistically in things that may seem simple but in fact are quite complex. I totally support that continuity-of-care model through telehealth.

Senator ASKEW: GP Assist—just to clarify—is an after-hours service, so it supports rural doctors after hours so they're not on that 24/7. They understand that if somebody needs urgent attention during the middle of

the night they will get the call from GP Assist, but only in that situation. From my understanding, in Tasmania this has helped retain quite a few doctors over the years in the regional and rural areas. Obviously it's a smaller model, but the issue is to try and see how it would fit across the country.

Dr Price: It's a triage system that's been locally developed. That's the key: having those local solutions developed by the GPs on the ground who know what they need.

Senator ASKEW: That's right. They have that relationship with each of the doctors around the state. I think that's something we could look at. The chair is looking at me anxiously to say, 'Please hand back,' so thank you very much for that indulgence.

CHAIR: Thanks, Senator Askew, and thanks all of you for your very useful evidence to the committee today. Thanks so much for hanging around, being with us for almost a quarter of an hour more than we had you scheduled for. It's been really valuable.

Dr Price: We'd love to talk more, of course, and present our training model to you should you wish, so please contact us. Thank you very much.

BELOT, Dr Megan, President, Rural Doctors Association of Australia [by video link]

CHALMERS, Dr Sarah, President, Australian College of Rural and Remote Medicine [by video link]

HALL, Dr John, Past President, Rural Doctors Association of Australia [by video link]

McPHEE, Dr Ewen, Past President, Australian College of Rural and Remote Medicine [by video link]

[10:13]

CHAIR: I now welcome representatives from the Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine. I'm sure many of the things we've been discussing in the last hour will continue in this discussion in the next 45 minutes. Thank you for appearing before the committee today. We've got lots of people interested in this very critical issue.

I now invite each of you to make a brief opening statement should you wish to do so, and then the many committee members we've got here will ask you some questions. If you could keep your opening statements brief, it will give us more time to ask you questions. Rural Doctors Association, do you wish to make a statement?

Dr Hall: I'll be speaking on behalf of the Rural Doctors Association with our opening statement. I'm also a rural GP of 20 years experience and a GP obstetrician by trade. I've worked for many years in rural Queensland, in rural maternity services and in private general practice. I've had the opportunity to work in many states, including remote western New South Wales and remote Tasmania, so I bring some broad experience as do my colleagues.

I'd like to acknowledge the traditional owners of the land on which we meet today and pay our respects to the elders past, present and emerging.

I'll start by saying that the Rural Doctors Association's reason for being is to support rural communities and their health outcomes; we're not just a doctors' industrial organisation. We have a very strong will and vision for better health outcomes for rural and remote Australia.

The blight on Australia's health system that exists today is that we still have significant disparities in health outcomes, and it's not just the Indigenous divide; it's the whole of rural Australia. A third of rural Australians have poorer health outcomes, including shorter life expectancies, significantly higher rates of series chronic disease with worse health outcomes from those and also from things like cancers when people can't access care.

We'd like to highlight the fact that there a significant underspend per capita in rural and remote health today. Before the last election, the National Rural Health Alliance published in its literature a $4.1 billion underspend per capita. That's real money. It's because rural Australians can't swipe their Medicare card. They can't see a healthcare professional to access their national health insurance, and that's a travesty.

This is about access to care. Again, it's not just about doctors. It's about access to doctors, nurses and allied health professionals as well—the whole multi-disciplinary team and significant access to care. We have good data that shows that this maldistribution exists. Today, in Australia, we have enough doctors, and we have enough healthcare workers, but they're seriously maldistributed: they're concentrated on the eastern seaboard and in our major cities. We have more granular data that we can give you, and that is in our submission as well.

Today, there are about 440 doctors per 100,000 of the population in metro and regional areas. When you get out to MMM 4 and beyond, there are 200. There are nearly half the number of doctors per capita in rural and remote Australia today than we have in metro areas. That statistic is real, and we can give you more of a breakdown on that.

There's also a maldistribution of skill. That is why we focus so much on training. The Australian College of Rural and Remote Medicine trains towards a rural specialty which includes procedural hospital practice, emergency and critical care, which are essential services in these communities. That's why we focus so much on training, because there's not only a maldistribution of doctors there's also a maldistribution of the appropriate doctors: the doctors with the right skills in the right place at the right time. I like to back that up by saying that when we have appropriately trained doctors in rural and remote health care, particularly in our rural hospital system, we provide exquisitely safe care.

I'm going to read out some statistics about the safety of rural hospitals and rural services, when done properly. We have a study from Queensland from the period 1991 to 2009, nearly 20 years of data, that shows that functional rural maternity units—this is babies being delivered, caesarean sections being done, services being provided by GPs, GP obstetricians and GP anaesthetists, without any specialty services on site—provided their rural communities with a perinatal mortality rate of 8.5 in a thousand. The national average at that point in time was 10.5 in a thousand. That's a statistic that shows you that health care can be delivered very safely, and we have

longitudinal data to back that up One of the unfortunate outcomes of the media and some of the circumstances, particularly in New South Wales, that highlight issues in rural health is any implication that rural health care is less safe. It's less safe when we don't have the staff on the ground, but when we have functional services they're very, very safe, if not safer than many of our metro hospital counterparts.

What we need going forward to fix this are joined-up systems from state and federal so that we can actually get these rural generalist doctors with skills in primary care and general practice but also additional skills to support their hospital services and maintain that range of service in these communities, ensuring that services like maternity care can be delivered as close to home as possible. To get there, we need this joined-up training and we need government investment that is intended for rural health to go to rural health. So one of the things the RDAA have been working on closely with the health minister over the last 12 months is a workforce plan, and we were tasked to look at what was being spent. In a quick summary, we found that nearly half of the money that's intended to be spent in rural health is being spent in regional areas and metro areas. We don't necessarily need additional money; we need to make sure that the money is going to the right places to support the healthcare teams in those areas but also, importantly, to make sure that we have strong training pathways and pipelines. We see the College of Rural and Remote Medicine to be the college for rural generalist training because it has a curriculum that trains doctors into that hospital space.

I think it's really important that we do not conflate issues around access to care and health outcomes with regional. It's a real problem in this industry and in this conversation that many of the fringe issues in your regional centres are seen as rural, and there is a unique and discrete problem in rural when you get beyond the regions into small rural communities and rural communities that have their own hospitals; it's a very different context. That's something that we've been able to put to government and we've been able to get recognition in the last budget for rural to be defined as MMM 3 to MMM 7, which is really clearly defining where rural is for funding purposes and for program purposes.

I'm going to wrap it up there, but I'll just say that RDAA is agnostic of all things. We essentially care about collaborative solutions, and certainly we represent many of the rural and remote doctors out there that have raised these concerns with us. Thank you for the opportunity to speak today.

CHAIR: Thanks, Dr Hall. The Australian College of Rural and Remote Medicine, did you want to make a brief opening statement?

Dr Chalmers: Thanks for the opportunity. I'd like to start by also acknowledging the Aboriginal and Torres Strait Islander peoples as first inhabitants of our nation and pay respect to owners of lands across Australia and pay respect to their elders past, present and future. I also extend respect to any Aboriginal and Torres Strait Islander people listening today.

I'm the president of ACRRM, and I am a GP and a rural generalist of around the same vintage as Dr Hall—for some 20 years I worked predominantly in the remote Northern Territory, so across Arnhem Land, but also in central Australia. I'm currently now working on a fly-in fly-out contract to parts of western Queensland.

ACRRM is a medical college that's dedicated to securing equity of access to high-quality continuity of care for people living in regional, rural and remote areas. We welcome the inquiry and hope that it will lead to strong, sustained, positive action to rebuild access to health care for rural and remote Australians. You'll be well aware of the unacceptable burden of illness, injury and death experienced by rural and remote Australians. These people record greater levels of healthcare needs and yet there's an estimated national health budget underspend in these regions of around $2.1 billion every year. The disparities of the health system of Indigenous Australians and those of remote Australia are intertwined with the general lack of services likely to be exacerbated to Aboriginal and Torres Strait Islander peoples living in this area by the well documented negative health impacts of colonisation and intergenerational trauma.

Our college submission provides a more detailed analysis of the key contributing issues of this current state of rural health services and puts forwards some recommendations to address these issues, but I would like to emphasise some key points. The first thing is that immediate action is required. ACRRM received an unprecedented amount of feedback from members during our consultation to inform this submission. Unfortunately, many indicated that they feel they may be forced to reconsider their future in the absence of some immediate action to address their professional, economic and workforce challenges. Our members are typically stoic and have a strong commitment to their communities, but for too long this commitment has been taken for granted and the skills and contributions of rural doctors have not been adequately recognised.

Rural doctors and their health colleagues have been significantly impacted by the COVID pandemic. COVID has unmasked the lack of resourcing, the lack of care and the lack of interest in rural and remote health systems.

Rural doctors are providing all levels of COVID management: patient education, testing, vaccination and unwell patient care. They are still providing their quality primary care, acute care and in-patient care, and they're doing this large any the absence of their usual locum and other relief support. The imminent decreasing of restrictions and opening of state borders has the potential to decimate an already overstretched workforce.

We need more than bandaids. In addition to some immediate relief, there needs to be a longer-term commitment to reform, and this must be adequately funded, designed and implemented in collaboration with rural doctors and rural communities. The key components of this reform should include the National Rural Generalist Pathway, new funding models for rural and remote practice, coordination of state and national health systems and some innovation, flexibility and respect.

ACRRM is the home of rural generalist medicine. ACRRM exists to recruit, train, and retain doctors for a fit-for-purpose and more-bang-for-your-buck rural and remote medical workforce. ACRRM trains and assesses doctors within the rural context to understand and embrace the practice of medicine in resource-poor and isolated practices, with an increased scope that encompasses primary and secondary care. ACRRM's rural generalist program should be considered a key solution to better provision of primary care, with nearly 80 per cent retention of fellows at five years and 75 per cent at 10 years. No other training program, no other incentive program and no other workforce initiative has achieved this.

Thank you again for the opportunity to appear before the inquiry. We are ACRRM are very passionate about improving the health outcomes for rural and remote Australians, and we look forward to working with all stakeholders to secure these outcomes.

CHAIR: Thanks. I will hand to Senator Green.

Senator GREEN: Thank you, everyone, for joining us today. We really do appreciate your evidence and, I must say, your very substantial submissions that have provided us a lot of detail. Thank you for that. Before I ask some questions about some of the policies that are in place at the moment and how they could be changed, I wanted to go first of all to Dr McPhee. It's lovely to see you. I know a lot of senators on the line have met you before, and we're very appreciative of your joining us today. Could you give us an overview of what you're experiencing in your practice right now and how that's impacting the community there in Emerald? Then I've got some questions for you about some of the policies and recommendations.

Dr McPhee: Thank you for the opportunity to be here as part of the ACRRM team. To answer the question directly: [inaudible]. To capture it with an example: I met with the director of medical services on Monday to say, 'We may not be here in January if we become critically disabled by COVID and the COVID response.' I have a practice that had 15 full-time equivalent. We've lost eight of those positions in the last 18 months through attrition, through people wanting to get back closer to the cities as they complete their training with the Royal Australian College of General Practitioners. We are about to lose another three through various means such as people wanting to return closer to family and closer to home. This leads to extended periods of delay of up to two to three months to see me for chronic and complex disease access.

We are at a critical juncture. We have been the primary COVID response so far in this community. Our practice has vaccinated over 11½ thousand people, yet Central Highlands still only has a 50 per cent double-vaxx rate, so we still have an enormous amount of work to do. We've run the GP respiratory clinic and seen an inordinate number of people with febrile illnesses. That has taken us away from our ability to deliver usual care. The opening of the borders will leave to critical stressors on our practice and to major implications for patients, particularly with chronic and complex disease, but also those patients falling through the cracks with acute illness. I might leave my initial opening comments about what's happening for me there.

Senator GREEN: Thanks, Dr Mcphee. I really do appreciate that. I go to the submissions that both of your organisations have made. I note that the submission of the Rural Doctors Association of Australia has a pretty stark warning that rural health in Australia is currently in crisis. There is a range of recommendations that you've both made to the committee, but I wanted to ask you if you could elaborate on how the current policy settings can be changed or made better. There are some suggestions that they need to be evaluated and implemented appropriately, and I'm particularly talking about the stronger rural—sorry, I have forgot the name of it now, but there are a few there and the Monash model as well. How can we make sure that these policy settings that are in place are implemented properly? I understand there are some concerns that there may not be as effective as the press release that went with them when they were announced. Dr John Hall, I think you know what I'm talking about.

Dr Hall: We saw some progress in the budget and we saw some commitment to some of these policy levers. Probably the key one for us in the recognition of rural as MMM 3 to 7. I'm not sure if the broader group is aware

of the MMM model, but one and two are cities and regional. The rest, MMM 3 to 7, is rural. In the past, many of the government programs have included MMM 2. As you heard in my opening statement, there are enough doctors in regional centres around Australia today for the most part. There are some pockets of disadvantage and some pockets where they are isolated, but, when you look at the broad statistics, the real lack of doctors is in those MMM 3 to 7 areas. Often that gets conflated because there are larger populations and more political gain in the larger populations of the region. Often, big regional centres and even some of the outer metro areas want to join the bandwagon when it comes to accessing some of the rural funding and the rural programs, and that leads to this situation where we find a lot of rural spending or rural intended moneys being spent in those areas. We thought it was a significant achievement to get the government to acknowledge MMM 3 to 7 as what we call 'real rural' and align programs to that going forward.

We don't want disadvantage in the regions. We don't want regional doctors to be disadvantaged. We're just saying that, going forward, any new programs that are under new or under review should have that delineation. If we're setting levers to attract doctors to rural areas, they should recognise that they are doing difficult work in austere circumstances, often in understaffed circumstances, doing more of the heavy lifting and after-hours work. They need to be recognised and supported for that but also recognised and supported for the fact that they are working in the hospital sector.

One of our other policies we put forward which we firmly believe is the workforce incentive program reform, which underpins recognising and funding rural generalist practice through the Medicare funding system. As I mentioned earlier, the problem that we have is that doctors are funded partially through the MBS and partially through state based awards if they're working in hospitals. At the moment, there are not many mechanisms whereby doctors working in primary care and general practice will get any advantage for that additional work through the MBS. That's why we're looking at that workforce incentive program reform, which is tied to the skills that doctors have but also the amount that they do after hours and on call.

Further to that, we want to see a joined-up system where we could have a single employer model where you could bundle up what they get from the state with the leveraged or premium package through the MBS. We could go to market and say, 'If you're going to do this hard work, this additional work, this work that requires more skills and more of it, we can go to market with some premium packages recognising that work.'

Senator GREEN: Dr Chalmers, in your submission I think you made reference to the Medicare rebate freeze as well, and how that has impacted rural practice?

Dr Chalmers: That is a significant issue. If I can go back to your original question about how we make policy better, we absolutely welcome policy and incentives to assist in encouraging people to work in rural and remote areas. But I think the issue that we have is that we've got people who do not completely understand exactly what it is that we do and how we do it. The policies need to be designed by the people who actually know what happens on the ground. I'm a big believer that if you want a solution for a rural and remote area, ask a person who lives in a rural and remote area—ask somebody who works there—what will work for them. They know their practice, they know their community, and they will tell you how to attract somebody to come and work with them. I think that if we had some more input into exactly what policies and processes are required to access incentives it would make this work better. In terms of the Medicare freeze, I am old enough to have started general practice when I earned more as a GP than I did in the hospital. Our hospital salaries have increased, just like everybody else in the world's salaries have increased over that time, and the Medicare rebate freeze has had a significant impact on the ability for all GPs to earn a reasonable income. We're not talking billions of dollars. That's not what GPs are here for, and that's not what rural and remote GPs are here for. But nobody else in the world has had their income frozen for a full 10 years. The other issue that that brings specifically for rural and remote health is that the business models for rural and remote general practices need to be different to those in urban areas, so the Medicare freeze had a more significant impact on rural and remote practices.

Senator GREEN: Thank you for that. I know we don't have a lot of time, but training is another issue that everyone has raised, and concerns have been raised about plans to change training models. With the PGPPP model—everyone is nodding their head—I've heard good things, but that was overtaken by the current circumstances that we have. I've also heard good things about the John Flynn Placement Program, but that was abolished as well. What was good about those programs, and what should we consider making recommendations about, such as bringing back parts of those programs or other things that we used to do well and might not be doing as well anymore?

Dr Chalmers: If I can start answering that, I know that Megan, John and Ewen will all also have comments. It was great for you to ask a question about PGPPP—remember I said, 'Ask a rural doctor'? PGPPP was designed by ACRRM. The idea of it, as you know, was to give junior doctors the opportunity to experience general practice.

In the rural and remote areas, we were able to give junior doctors the opportunity to experience rural generalism, because with primary care our service goes across general practice and hospitals. So that was a great program. I'm really sad and disappointed that it doesn't exist anymore. The John Flynn scholarship program was also, I think, a really good design. I had the good fortune to be one of the original John Flynn scholars. It was a great program. It really worked. I think the John Flynn program existed before the rural clinical schools. Now the universities have other ways to encourage students. The John Flynn program did give people the opportunity to have a little more flexibility with where they undertook their program. There are other rural clinical schools that require you to stay within your own region. So, yes, I think they both were really great programs, but the John Flynn placement has moved from medical students to junior doctors. So now we have rural clinical schools able to give medical students those opportunities, and the John Flynn program is moving into junior doctor placement. That will extend the opportunities that those young and aspiring rural doctors have to experience rural practice.

Senator GREEN: Dr Hall, you want to see that program expanded, I understand? I'm sure others will want to jump in on that question, too.

Dr Hall: Yes, absolutely. There are currently 100 placements funded a year. We are looking for that to be expanded up to 400. As you've heard, there are a large number of junior doctors who graduate every year—interns—and, at the moment, very few of them get any experience of general practice at all. Under PGPPP, we saw doctors experiencing general practice who didn't think they would want to do general practice or rural going on to train in it and stay in it. So these programs where you're giving good exposure early on certainly do have an impact, and the data supports that. I think Megan was going to comment on that as well.

Dr Belot: I had the pleasure of doing the PGPPP program, and it was amazing. It's quite sad to see that it's gone. I think it's really important that we get our medical students and junior doctors to have rural rotations from the beginning, and I really think that the Rural Junior Doctor Training Innovation Fund is something we definitely need to invest in, to allow junior doctors to have that rural exposure. That will also impact on our non-GP specialist colleagues as well—to get exposure and to have that understanding of the rural and remote context. Even if they go back and become a paediatrician in Melbourne or a surgeon in Brisbane, they actually have a true understanding of what it's like to work out in the bush, and to have that mutual respect so that the rural generalist is seen as the true specialist that they are.

Senator GREEN: Dr McPhee, I know you had some views on training?

Dr McPhee: I know I painted a grim picture of my practice, but I just wanted to identify that I have been taking interns under the Rural Junior Doctor Training Innovation Fund since its inception. I've managed to introduce, on a 10-week rotation, young doctors to a fantastic career. I've actually seen a number of those clinicians join the rural generalist training program with Queensland Health. So I think that is an important mechanism to support and to grow. There are other policy levers that you can look at to enable visibility of general practice. That includes incorporating general practice as a professional and an academic discipline within the rural clinical schools very clearly and within our health services. With the Stronger Rural Health Strategy and the More Doctors for Rural Australia Program, which is just looking at locum graduates, it's about looking at opening it out to doctors in the health system. We know there are 7,000 doctors who will never fellow in anything, who are cannon fodder for the health services and who are looking for alternative careers. There are mechanisms we can shift to make that work as well. The PGPPP program worked well where it worked well. It didn't always work well. It was co-opted at times by certain agencies and it was an expensive program. Whatever we do, we need to do it better and need to understand that it had hairs on it. I think that we can do things well. Some of these current policies can be improved very clearly to better enable it, but general practice primary care is an academic discipline. It needs to be seen as part of the training program for a junior doctor, so imbedding it within the intern program in the first two years of training is critically important.

The second matter—we haven't talked about transition to the college or training. There are fantastic opportunities. You've heard from our industry partners in this space about what [inaudible] that could be. I'll leave further comments there, except to say that the strength of the Queensland rural generalist program and the strength of the Australian College of Rural and Remote Medicine program have meant that over the last five years I have trained 21 Australian college of remote medicine fellows. Seventeen of them are still in this community, but they all work for the hospital, and I think there's a conversation to be had there. Thank you.

Senator GREEN: Thanks, Chair. I'll leave it there.

CHAIR: Thanks, Senator Green. Senator Hughes.

Senator HUGHES: Thank you, Chair. I will come back to the hospital point in a second, because I think it's an important one. Dr Hall, I noticed on your website that you welcomed this inquiry but indicated that we already

know what the issues are and that there is 'good and much-needed work that's already underway to address this nationwide issue.' What would be some of your concerns around how this inquiry might inhibit those programs? Could you give us a brief overview of some of the good and much-needed programs that are already underway.

Dr Hall: Thank you for the opportunity. We did have some concerns about the inquiry from the get-go. We've seen inquiries and investigations come and go, and they've been more about looking into a problem that we know exists. What you've heard from our group is that we need immediate action; we don't need more inquiries. We know what the problem is. We know what the solutions are, and you've heard some of those solutions.

What we really need is an acceleration of the National Rural Generalist Pathway. We've been calling for that. It was an RDAA policy platform. We basically learnt from the experience in Queensland. Queensland launched its rural generalist program in 2006, and, whilst it's not perfect, it saw a massive injection of highly skilled doctors into rural and remote Queensland. What we saw through that was the reopening of three maternity units and the expansion of many of those hospitals to maintain their services. Without that they would have been lost. I think that's probably the key platform.

We put together what the solutions are, but the progress of the National Rural Generalist Pathway has been painstakingly slow, and it's being bogged down by things like this—additional consultation, asking questions, redefining problems that we know exist. We need to move beyond redefining the problem. We've seen this with the Closing the Gap issue and our First Nations people as well, where they've made similar comments that having inquiry after inquiry doesn't fix the problem. We need action from government. We need people to be assertive and courageous within the department to move forward on programs, despite how politically unpalatable they might be for your metro colleagues and your metro constituents. I think we've been held back by that, by the politics of much of this.

As you've heard, for rural generalism to be successful, we need recognition. In Queensland there was legislated recognition of rural generalism as a specialty, essentially, and the remuneration matched it. These doctors are doing caesarean sections. They're doing anaesthetics. They're providing critical care. They're flying people with serious illness out. They're doing this high-level care. That's why we talk about them as specialists. But today in Australia they're not recognised as specialists and they're certainly not paid as specialists. We don't just need that to exist. We need funding for the training, the joined-up training, the pipelined entry, the marketing and the whole package. We presented solutions to this. What we need now is for government to work on it.

Senator HUGHES: Dr Hall, just quickly for those of us who don't understand, what is the difference between the rural pathway versus just having a rural curriculum as part of GP training?

Dr Hall: We have been critical of the rural pathway in the past. The rural pathway is a part of Australian general practice training that unfortunately has seen a selection process whereby doctors that performed poorly or least well in their selection process were streamlined through the RACGP into the rural pathway. The rural pathway is geographically constricted, so when they go into the rural pathway they can't come back into the city. But it's created a two-tier system where there's a feeling within the industry that if you choose rural you're choosing substandard.

As you've heard from me, to work across hospital and primary care, you need a higher level of standards. Just like some of the more competitive specialties in non-GP specialist practice are really difficult to get into, because they require a high level of skills, we feel the same about rural generalist practice. To practice across a number of disciplines at a high level of skills is challenging. At the end of the day, unfortunately—and I don't think this was intended—the rural pathways created a system whereby essentially doctors are conscripted into rural as their only option if they can't get onto a premium metro pathway. Obviously we like the concept of having a designated rural pathway, but when it's got selection and entry points that denigrate that and give the impression that rural medicine is substandard then it's not fit for purpose.

Senator HUGHES: Is the Australian Medical Council helping or hindering the rural generalist program?

Dr Hall: We've had a joint submission to the AMC to recognise rural generalist practice as a subspecialty of general practice. Again, that's been bogged down and is going very slowly. It's a very clear and simple question to answer. We don't know where that's going and we don't know what the progress is, but certainly we need them to act more quickly. One of the key pillars for the success of rural generalism is the recognition of rural generalist practice at the speciality level, really robust and strong training and then funding and support and remuneration to back it up at the end point.

Senator HUGHES: As someone who went through obstetrics in Moree and who also had a very bad car accident with a broken back and was treated in Moree hospital by one of the GPs who works in the clinic in town and was called into the hospital, I couldn't agree with you more with regard to GP rural specialisation. What

happens in rural and regional towns is innovative. I'm not talking about outer metro and large regional centres. I'm talking about rural and remote areas. They are very innovative with their staffing. Is there an issue with the state governments not providing enough doctors in their state-run hospitals such that GPs within towns are being called in to work in the EDs or perform obstetrics et cetera within the hospital system, and what can states do to help?

Dr Hall: I've worked in Moree as well. I've done caesareans in Moree, and I know my colleagues there well. I used to work with Scott Finlay at Frome Street, so I know the context well.

Senator HUGHES: He used to be my GP, and his wife was our ballet teacher.

Dr Hall: Yes, I know them well. Great people. Again, Moree is a really good example of a functioning, high-level rural hospital—when they've got enough staff. This is not about the states filling these hospitals with specialist who do obstetrics only. Rural generalist practice by definition is GPs that are trained with these additional skills. It works best when they are based in their general practice and they provide VMO or visiting services to the hospital. If we get that system right, we'll avoid this problem of doctors being employed only by the hospital or only by the general practice. When you do that, it splits the workforce in these towns.

What the states need to do is recognise rural generalism properly. New South Wales has a very clunky and difficult funding model for paying rural doctors to do their work. It's fee for service, it's clunky, it's difficult and it's not attractive to doctors. We need the states to reform their industrial arrangements around rural generalist practice, and it needs to be competitive with other specialties. If they do that and come up with a collaborative model of employment, a single-employer model where they can employ them across general practice and the hospital, we would see a much better situation across the nation.

Senator HUGHES: Just a final question. One of the things we just heard from the RACGP was around substandard and not significant supervision of junior doctors. If junior doctor places were expanded, what could the RDAA and ACRRM do to ensure that the experience is positive—that these junior doctors aren't just sitting in the corner of the consulting room, watching a GP for three months; that they're actually engaging and getting a full experience that encourages them to consider it as a full career or expand their time in rural medicine?

Dr Hall: Did you want to talk to that one, Megan?

Dr Belot: Just to go back to Moree, if I could just make one extra comment, John mentioned the rural generalists in Moree and functioning at the hospital. If anything, you probably need more rural generalists to make sure that the workload is shared and everyone gets to do their obstetrics and have the regular anaesthetic list so that the workload is shared, the on-call is shared and there is adequate time to be in private practice to provide the GP care for their patients. I think it's about having more rural generalists in a hospital like that, as opposed to another model.

Getting to being a junior doctor and making sure we have a good experience for them in rural and remote, it's definitely paramount to attracting them to either come back to that region or have a career in rural. I think there need to be those designated positions for them to go rural, but also there needs to be adequate funding for supervisors to have the time to actually do the teaching, to take them on ward rounds, to take them in to assist to do the caesar, to get them to help when you are doing an intubation, to get the hands-on experience. As a rural doctor—or just as a doctor—that's what we crave, that's what we love about medicine. I think it's about making sure that the systems are robust, that there is adequate time and adequate remuneration for that to happen. You also look at the social side of being in a rural and remote community, because there is that other element. Essentially what we are selling is a lifestyle, so it's important that they also get a good experience from that perspective—that they are engaged in the local netball team, if that's what they'd like to do, or if they like arts there is something to do around that. I think that's really important.

Senator HUGHES: Thank you. I will put anything else on notice.

Senator PATRICK: Dr Hall, I just wanted to let you know that whilst we have many inquiries and they are tiring, they are useful for informing senators who can then seek to get change. Whilst you may well know the problem, it is good for us to hear that, and it is good for us to hear multiple perspectives, so I apologise; this is more about us than it is about you.

You probably heard me talking to the previous witnesses about a simple map. Again, in your submission you talk about numbers, but it's not easily digestible to the average punter, who is the person we need to put pressure on or the person we need to inform such that we can put political pressure on governments. Do you have anything, or is this something you might want to cooperate with the previous witnesses on, to give to the committee for South Australia and, for Senator O'Neill, New South Wales?

Dr Hall: We do have additional data that we can provide. The numbers I provided were from the Australian Institute of Health and Welfare, and they were for all doctors, not just GPs, regardless of specialty. Those

numbers showed half the numbers of doctor per capita in rural and remote. We do have a breakdown on general practice across the ASGC-RA classifications which we can provide, which gives you numbers across that as well There is a commercially available tool called GapMaps, which maps out all general practices in Australia. It basically pulls their data from provider numbers but also from their websites. That's commercially available. You can look at a map and drill down to each practice how many doctors are there. I could provide that link to you. It's a very useful tool for looking at who's where. It's not complete. It's a commercial product that uses data that's openly accessible. But it certainly gives you a really good idea of where the practices are and how well staffed they are in the first instance.

Senator PATRICK: Yes, thank you. I don't mind if it just talks about a GP rather than a specialist, because most communities connect with the idea of a GP and understand the importance of a GP. You can help in that regard and maybe talk to the previous witnesses to come up with something very simple that is powerful in terms of changing the political narrative or guiding the political narrative. In your statement, Dr Hall, you talked about funding. I think you said that, MMM 5 to MMM 7, half of it was going to the cities and only half of it was going to the regions. Firstly, I want to make sure I have that right. Then, can you unpack that?

Dr Hall: Anything beyond large regional centres is what we call MMM 3 to MMM 7. I think it was about $2 billion annually that was being spent through government programs. We found that about $1 billion of that was going to MMM 1 and 2. So there are a number of heavily funded programs that are based on training, one of them being the specialist training pathway that was heavily funded. We found that the majority of that money was being spent on training metro specialists who went into the program with an intent to go rural but never actually landed. Much of the funding that goes to a number of the key non-government organisations and stakeholders in this industry for rural programs all start off in the city. Not many of these programs are held to account for an outcome where that body then actually ends up in the bush. That's why a number of the rurally intended moneys has basically sat in metro, and I think it needs reform. One of the key things we could do is actually hold organisations to account. I'm talking colleges, universities, workforce agencies, regional training organisations and hospitals. If we held them to account on process measures—not that you've got someone starting in a program—that body actually ends up working in Moree, working in Stanthorpe, working in Bourke. If they don't actually move to MMM 3 to MMM 7, then we spend all this money on rural communities that don't end up supporting rural communities.

Senator HUGHES: Dr Hall, are you saying the system's being rorted?

Dr Hall: No. I'm not saying this is all malicious intent. There are a number of reasons why people might start on a rural pathway and go sideways. Many of them are meeting partners that want to stay metro, or they change their mind about the specialty that they want to do. We know that, in any good rural training pathway, there's going to be natural attrition. A number of doctors that start on the pathway to training towards rural generalism might do a year of training in obstetrics and then decide they actually want to be an obstetrician, and then they would go sideways. So there will be natural attrition. But we would push more of this funding into genuinely providing rural workforce if we held the organisations to account on outcome measures, not process measures.

Senator PATRICK: So, in some sense, the money gets directed at a medical outcome, but perhaps some of these institutions are quite comfortable with receiving the money and not necessarily chasing up whether the outcome becomes of real benefit, not a rort per se.

Dr Hall: A lot of the KPIs for these programs include MMM 2, which is large regional centres. So, if you place someone in a large regional centre, you're ticking the rural box and getting your rural funding.

Senator PATRICK: Thank you. That's very helpful.

Dr Chalmers: Can I just add a quick comment? The other part of that is the actual training. The success that ACRRM has is because we actually focus on rural training—the experience, the training, the supervision and the assessment—and the context that they're learning in is to actually work in those places. If you take a metro program and try to stick it in a rural or a regional area it's not fit for purpose, it's not specific and it doesn't take into account all of the differences that occur. Initially in my opening statement I talked about resource-poor practice, about isolated practice. Even somebody who's working in, say, a regional hospital doesn't have access to all of the same services that their colleagues have in the big city. And if you don't train them to practise medicine in that resource-poor environment then it's a bit of a set-up. So rural-specific training actually needs to be considered as part of the solution. You don't just take a metro program and dump it in a rural area. It has to be specific for the context that you're training people in.

Senator PATRICK: Alright. I just have one question, and maybe this needs to have a collective answer. It goes to the effect, in a non-medical sense, of not having a doctor or losing a doctor, and whether or not there have

been studies in relation to this. I think not having a doctor in a community turns other people away. We know if Senator Hughes's doctor leaves, suddenly there's not a ballet teacher in town, and things like that. Can I get some sort of commentary? I think it goes beyond medical effects to other problems that are generally found in these rural communities. Maybe one from each of the two groups could answer.

CHAIR: Can we have very quick answers, because we are desperately short of time and I've still got Senators Urquhart and O'Neill, who want to ask some quick questions.

Dr Chalmers: May I start, because I've actually experienced this? I used to work in a small remote community where there'd been a general practice for some 40 years that was, for various reasons, in the process of closing down. It had an impact, with businesses around town telling us that they were unable to recruit people to move to town because everybody knew that the general practice was potentially going to close down. That was teachers and other people who were less keen to come to town to work in the army base because it was looking like there'd be no general practice service. There were quite a number of people in town who said, 'If you guys close, we are leaving.' It goes across the entire community. It also impacts the entire health service, because if there are GPs in town they are also working at the hospital. Does that then mean the birthing service is going to close down? And then even more people don't want to come to town, because they wouldn't be able to have their babies there. There's a massive ongoing effect. It's huge when a doctor leaves town.

Senator PATRICK: Maybe a quick answer from the Rural Doctors Association?

Dr Belot: I definitely echo Dr Chalmers's sentiments there. When a rural doctor does leave town it has a huge effect on the rural community. Even when a rural generalist stops practising his or her advanced skill it has a massive impact on the community. Where I currently work, one of the local GP-obstetricians recently stood down in one of the places and essentially we have lost our birthing service. As a GP-anaesthetist who has moved and bought a farm locally, I am absolutely devastated, because I love doing maternity anaesthetics. And the women of our region have missed out. It really has that ripple effect. So what's next?

Do we lose our urgent care centre? Do we lose our theatre capability? There is that real threat of our small rural hospitals being turned into nursing homes, and that's what they then end up as, but then you will see a degradation in the rest of the community. You won't be able to attract teachers for our high schools and our primary schools. You won't be able to attract further businesses to come to the region. You'll see factories close. This is actually a reality, so it is really important that this is acknowledged.

Senator PATRICK: Thank you for that important evidence.

Senator URQUHART: First of all, I'd like to say that I really look forward to the breakfast of the rural doctors coming back to Parliament House because that's somewhere where we get the opportunity to talk to doctors from rural areas. It's been really good. I really look forward to welcoming you back post COVID when we have the doors open. I want to pick up some things that I pulled out from a number of the submissions. I think, Dr Chalmers, in your opening statement you talked about rural doctors not being recognised. I'm not sure what the context was. There have been comments, and some of the submissions talk about the value of the work, bullying and harassment, and those sorts of things. We've heard about the Medicare rebate freeze, the opportunity for programs and training, and how difficult recruitment is. Can you tell me what can and should be done to help alleviate the issues around the mental health of doctors in rural and regional areas, and what support can or should be provided? I'm not fussed as to who kicks off. It's a big question, and I know we're really short of time.

CHAIR: If people could be quick, please.

Dr Chalmers: I can start. The recognition process—what I was referring to was that we're not recognised for the skills that we have. To be a doctor in a remote area, you practise medicine differently to what you do in an urban area because you don't have specialists nearby. You don't have access to tests. I used to work out in a really remote community where it took three days to get a normal test result, whereas in the city you can get that back in an hour. We do actually practise differently, and our skills are not recognised. The scope of practice that we practise is not recognised. That just adds another layer onto what is already quite a difficult job.

I'm really grateful that you've mentioned the mental health of rural and remote doctors because it's a big issue and, certainly, as I mentioned, we're facing the COVID pandemic moving out into rural and remote areas which have been mostly protected, with the exception of places in New South Wales and Victoria. We've got a group of people who have not had access to holidays, because they can't get another doctor to come and relieve them. If they go on holidays they will leave the town without adequate medical services. The commitment of these doctors is that they have stayed despite all of those issues.

We do worry about the mental health of our colleagues very significantly. How do we make that better? We've mentioned the recognition of rural generalism practice as a specialty. We've talked about better remuneration. The

last thing I would say—and I think it goes to one of the comments that John made earlier about the problem with inquiries and things like this—is that we're really talking about failure. We're talking about the bad side of rural and remote medicine, but it is the most rewarding and incredible career. One of the things that are really important that I really wanted to say today is that there are four really committed rural and remote doctors here talking to you today, and we do what we do because we love it and we want to support our colleagues. That's why we're in the positions that we are. I'd like to invite my colleagues to add to the answer.

CHAIR: Very quickly.

Dr McPhee: I want to quickly make a point to Senator Patrick's previous statements. Imagine the effect of a doctor approaching retirement age knowing that there's no-one coming in his place and what that means to the legacy he's going to leave behind and the gap he's going to leave. That is an incredible problem for doctors such as me approaching retirement age.

To comment on the mental health: one of the key enablers that I see is the rural generalist program—the identity, the camaraderie, the collegiality that that has delivered to young female doctors. Over 60 per cent of graduating medical practitioners are female. I have the most wonderful colleagues I work with in the Emerald Hospital. They live and work there because they have maternity leave, they have family leave, they have sick leave. None of those are available to them if they enter general practice. We have had about seven babies born to female doctors in this community, but they know, if they step outside that protective framework, they will have nothing; they will have to bow and scrape for every dollar. Those women have husbands and families. I was in theatre on Sunday night assisting a young doctor who I honestly think could be a top specialist in the middle of Sydney, but she chose to be a rural generalist, and she is doing an awesome job looking after women in this community, but she needs that wraparound support. I've seen, with those clinicians, when they have a terrible event—they make the wrong decision or whatever—how quickly a collegiate community can wrap around and support them.

We're at a critical juncture in our community, and I'm working very hard with our state and with Minister D'Ath to address that by looking at the whole pipeline, looking at how we elevate support and enable our rural clinicians so we don't go down the path of the band 11s. If you got rural, in the current training capacity, for our industry partners, that was the consolation prize. You weren't good enough to get a guernsey in the city. That's just not good enough. We have to acknowledge that there is a way to fix this, and our college and our industry partners have a clear mandate to deliver that, but we need to get on and do it, and we need to do it yesterday. But to speak to supervision: there are not many of me left out here to supervise. If we don't do something now, there's going to be no-one supervising young doctors, because there won't be anybody.

CHAIR: Thank you. Are you able to put the rest of your questions on notice, Senator Urquhart? We are already 20 minutes late.

Senator URQUHART: Fine. If there are any other responses that either Dr Hall or Dr Belot, or anyone else, would like to put in relation to that question, I'm happy to get them on notice.

CHAIR: Senator O'Neill, you said you had one burning question.

Senator O'NEILL: I do. It's about international medical graduates. Can I just clarify first if we have any international medical graduates amongst the people giving evidence today or are they all Australian home-grown?

Dr Chalmers: I think we're all Australian medical graduates.

Senator O'NEILL: We know that there has been an incredible reliance, since Mr Abbott was the health minister, on international medical graduates as a workforce, particularly for rural Australia and somewhat for regional Australia. Many of those have actually been conceived of as forced placements, as the only way to get a provider number. My experience of meeting these doctors has been very varied—some really good, some absolutely not meeting the community. But most of them kept their families in the city and they just did a sort of endurance test of staying out bush as long as they needed to and then returning to the city on the weekends as often as they could—not in all cases but in too many. So my question is: given the fact that the number of international medical graduates in Australia has increased from 48.2 per cent of the total GP full-time equivalences in 2014 to 52 per cent in 2020 and given that the most recent data shows that only 15.2 per cent of final-year medical graduates are listing their preference as GP, what is the damage of the IMG program, and what needs to be done to fix it? It looks like it's not going to go away, and the problem seems to be getting worse.

Dr Hall: I'm happy to answer that question if the others are happy. Our international medical graduates have done a lot of the heavy lifting in the last 20 years in rural Australia, and we owe them a massive debt of gratitude. We've had some amazingly skilled and talented colleagues that have gone into rural practice and have stayed there and have provided some great support. But, as you pointed out, we don't think that the 10-year moratorium

or forcing doctors to go rural is the solution at all, and it's not about where they have come from. We'd even say the same about Australian trained graduates. It's about having the right doctor with the right skills in the right place, and we want doctors who want to be there, and we want doctors working in rural communities that have got the skills to provide that range of service.

Many of our international medical graduate colleagues have come from overseas with different specialties, so they might have come over to Australia with an orthopaedic qualification. They're an orthopaedic surgeon and they can't get recognised in Australia as an orthopaedic surgeon, so their only option is to work as a GP in a remote town. They do some great work, but that particular doctor is not fit-for-purpose for that community. They need to be trained in general practice. They need to be trained in the maternity care and the hospital care that we spoke of. So it's actually not about where they've come from; it's about having the right doctor with the right skills. That's why the Rural Doctors Association have spoken openly against the 10-year moratorium. What we'd like to see is a training pathway that makes it attractive for these doctors coming into Australia to train in rural practice to see how good it can be and want to go there. A number of our really good and functional international medical graduates have done that through the ACRRM independent pathway, through RVTS, and they've stayed. The ones that have stayed are the one that have trained themselves up to that skillset, and, as I said, many of them have stayed and lived in those communities. So I think it's definitely part of the solution, but it needs to plug into our existing training pathways that exist and make sure that they're trained to purpose and then recognised for that skillset when they're adequately trained.

CHAIR: Thanks very much. We need to leave it there unless there are any extra burning things that people need to add in answer to that question, given that we're now 20 minutes over time, but that's okay. It's been really valuable evidence for the committee. Thank you very much for your evidence and your submissions today. They've been of great value to us. If you do wish to add some extra information or if you've taken any questions on notice, if you could get that to us by the close of business on Thursday 18 November, that would be really appreciated. The committee is now going to suspend for a break.

Proceedings suspended from 11:23 to 12:09

FITZMAURICE, Ms Clare, Policy and Data Analytics Officer, National Rural Health Alliance [by video link]

MITCHELL, Mr Chris, Chair, Rural Workforce Agency Network [by video link]

O'KANE, Ms Gabrielle, Chief Executive Officer, National Rural Health Alliance [by video link]

SWAN, Mr Edward, Executive Officer, Representation and Engagement, Rural Workforce Agency Network [by video link]

CHAIR: I welcome, via video conference, representatives from the National Rural Health Alliance and the Rural Workforce Agency Network. Thank you very much for appearing before the committee today. I invite each of you to make a brief opening statement, if you'd like to do so. After that, the committee members will ask some questions. We are pretty tight on time, so if you could make your opening statements brief, that would be appreciated. We have read your submissions.

Ms O'Kane: The National Rural Health Alliance thanks the committee for the invitation to attend this hearing and welcomes the opportunity to speak with you today. The alliance comprises 42 member organisations bringing together health consumers, healthcare professionals, educators, students, service providers and the Indigenous health sector. We are committed to improving the health and wellbeing of seven million Australians living outside major cities by working towards our vision for healthy and sustainable rural, regional and remote communities.

The alliance notes that this inquiry includes outer metropolitan areas in its scope, however, consistent with its remit, the alliance has focused its submission on rural, regional and remote Australia. While the alliance recognises the importance of holistic care provided by the full range of health professionals, again, consistent with the terms of reference for this inquiry, its submission focused on general practitioner services and other primary health services closely linked to general practice.

People living in rural Australia have poorer access to health services. The number of health professionals decreases as geographic isolation increases, and the shortfall in health providers and services means there is an annual deficit in health expenditure.

Despite the myriad of government programs and initiatives seeking to address the maldistribution of the health workforce across Australia, there has been little evidence of significant improvement to the health outcomes or workforce challenges in rural Australia over many decades. We must address this by ensuring policies and programs are evidence informed, their impact is thoroughly evaluated and learnings are widely shared. Proactive, innovative and whole-of-system change is required to address the challenges of delivering primary care services in rural settings.

Policies that target the medical training pipeline as part of the Stronger Rural Health Strategy are supported by a strong body of evidence. Selecting medical students from rural backgrounds and enabling students and trainees to undertake training in rural areas during both their entry-to-practice qualification and postgraduate training pathways have been shown to improve rural workforce retention. Full implementation and embedding of the National Rural Generalist Pathway, along with rural generalist trainee employment models, such as the Murrumbidgee model that's currently being trialled, have the potential to support this training pipeline to address rural workforce issues.

Once these training pathways are complete, offering employment models that provide team based care in rural communities, bringing together GPs, nurses and a range of allied health professionals, will also help to address the critical health workforce shortages in rural Australia. The alliance proposes a well-developed, secure, ongoing employment model for rural primary care workforce, the RACCHO model, as detailed in our submission. RACCHOs will be bloc funded in similar fashion to ACCHOs and will offer services that are placed based and adapted to suit the needs of every community. The alliance also continues to recommend that the Australian government take the lead in developing a new national rural health strategy with a focus beyond workforce, setting out a comprehensive, integrated approach to improving rural health outcomes with the inclusion of outcome measures, targets and an implementation and evaluation plan. We'd be happy to discuss with the committee any issues raised in the alliance's submission.

CHAIR: Thanks very much, Ms O'Kane. We will go to the Rural Workforce Agency Network.

Mr Mitchell: Good afternoon. I'm coming from Jagera and Turrbal country today. We're presenting a shared view of the rural workforce agencies across Australia. Whilst that's a shared view, we stress the significance of the variation in communities across jurisdictions, which you're well aware of. That's partly due to the jurisdictional arrangements. We haven't seen the dates for all the hearings, but it's important to understand the

context of jurisdictional level. It's not vanilla, as you know; there's a difference, and the difference is really important to the work and the outcomes for individuals and rural communities.

The workforce agencies are not-for-profit agencies funded by the Australian government, and their singular focus is to ensure remote, rural, and Aboriginal and Torres Strait Islander communities have access to highly skilled health professionals when and where they need them now and into the future. As workforce agencies, we've had more than 20 years experience working with communities and stakeholders to address health workforce shortages and to assist the rural health workforce and support them. Our work includes conducting an annual workforce needs assessment. That supports targeted work to develop place based work solutions for thin markets or market failure within remote and rural communes. We work with communities and all interested stakeholders, of which there are many, to develop solutions to deliver improved services to community or improve supports for the health workforce—in this case we're talking about general practice, but it's broader than that. This is done within a range of Commonwealth grant programs. We are at the coalface of the implementation of government funding of policies and we see firsthand the collective impact of the government funding of policies, the realities of the lives lived and the experience for the rural health practitioners and the communities they serve.

The inquiry's well aware of the considerable challenges facing remote and rural communities, specifically in relation to access to quality general practice and primary healthcare services—in particular, connections to acute and tertiary care. Maldistribution of general practice remains the single major barrier to access to services for remote communities. I'd like now to hand to Edward.

Mr Swan: There are five key points that, in addition, we'd like to highlight today. The first is that we're concerned that any changes made to policy levers to address outer metro areas could negatively impact on rural and remote communities, so please don't rob rural to address outer urban challenges. Second, a more-joined-up model is required to address distribution issues for GPs and improve the return on investment for Commonwealth programs. The joined-up model would provide clarity for the various pathways for general practice and span from undergraduate to retirement. Third, non-traditional models of healthcare service provision are required, with collaborative regional and local planning, including public, private and non-government providers, with community input based on health needs, support for innovative practice and new ways of working.

Fourth, the rural workforce agencies—that's us—can play a more significant role by contributing more to and working more closely with government on future policy and funding changes to provide real community-level perspectives of the likely changes to health workforce and the resulting service and outcome implications. We're working on this.

Finally, we're keenly aware of the need for change, improvement and innovative and responsive primary healthcare services for rural Australians. We look forward to the implementation of the GP training funding reforms that are in progress, the primary healthcare 10-year plan and a range of health workforce strategies for which there is much promise and potential.

CHAIR: Thanks, Mr Mitchell and Mr Swan. I'll now go to Senator Hughes to begin the questions.

Senator HUGHES: I was reading the submission from the National Rural Health Alliance and I was just a little surprised to see that you are estimating that health expenditure has a shortfall of around $4 billion. That would apply to PBS and Medicare, which are both demand-driven programs. Isn't it a little disingenuous to put those sorts of figures in which potentially could make it harder to attract people to work there?

Ms O'Kane: I'm not sure why it would make it harder for people to work there.

Senator HUGHES: If they're hearing you say that there's a $4 billion underspend when there's not—it's demand driven—aren't they then going to start to assume that the investment is not there, which is not the case?

Ms O'Kane: It's demand driven, but, if you haven't got a GP to actually go and see, you're not going to be drawing down on the MBS items or the PBS items. What it actually is trying to demonstrate in all of that is that we know that it's to do with the lack of access to health care. For the demand to go up, you have to have a rural health workforce there so that you can draw down on those MBS items. I think that's the way in which we've done our costings. We've also factored in the fact that, in rural areas where there potentially is no GP but there might be a rural hospital, they actually are being serviced by the EDs in those towns. We factored that in and, despite some increasing expenditure in the rural hospital space, there's also inadequate expenditure through that primary-care MBS model.

Senator HUGHES: We just heard from previous witnesses—I'm not sure if you were listening—that there are innovative ways that [inaudible]. In fact, there are more GPs working in local rural places. I'm talking about rural and remote. I was very pleased to hear Mr Swan reference rural, not outer urban. In a lot of rural towns, it's actually the local GPs in the clinics that are servicing the hospitals rather than the other way around.

Ms O'Kane: Yes. It depends on the jurisdiction. Certainly in Queensland—and I'm sure Chris will be able to speak to that more than I will in some respects—the rural generalist model does appear to make it more likely that the doctors are spending more time in the hospital and doing less in the GP space even though they can take advantage of the 19(2) exemption. In New South Wales the picture is different. It's more of a VMO model, so they spend more of the time in their general practice but then work some of the time in the hospital setting.

Senator HUGHES: That's not really that there are no GPs; they have to cover the hospitals as well. I notice you propose the RACCHO model. Have you got any concerns that that would become more bureaucratic? When you look at the list of groups we're hearing from today, you see there is obviously a substantial number of groups covering rural health specifically already, let alone the RACGP et cetera. Bringing in the RACCHO model, is it potentially going to be more bureaucratic, potentially more one-size-fits-all? Obviously, what happens in Moree is very different from what happens in Arnhem Land and very different from what happens in Cairns. Don't we need to have more flexibility than that?

Ms O'Kane: The four principles that we have underpinning the RACCHO model—and we're calling it RACCHO because it's similar to the ACCHO model. You would be familiar with the ACCHO model, I'm sure. What we're saying is that the four principles around that are about flexibility. It needs to be very much grounded in the community. What we're suggesting is that the RACCHO model is actually driven by the community, and that's going to be very different no matter where you are across the country. So there is no one-size-fits-all, and we're very mindful of that.

The governance also can be very flexible within that as well. It might actually be picked up by the local government area. There are already around Australia examples of that which could actually be RACCHO models. In other instances there are social enterprises that are currently doing that sort of work. They could potentially become an RACCHO into the future as well. What it requires is bloc funding though, and that's one of our other principles in the same way that an ACCHO is. What we're actually suggesting out of all of this is that we also want an employment model, because we hear time and time again that many young doctors in particular don't necessarily want to go out and work in a rural area where they've got to put up their own shingle and potentially run their own practice, including the business side. Many of them want to have a work-life balance and they want to do the doctoring rather than doing the administrative side of things. A RACCHO would have that ability to do some of those things. We don't think it's going to be any more bureaucratic. We hope it's going to be less bureaucratic than what's currently in the system. It's all about collaboration. Clermont, in Queensland, is a really good of how that's all happened. They've all worked together. The PHN, the local health district and the communities themselves have all got together to solve the problem. That's the way we see RACCHOs operating as well.

Senator HUGHES: My understanding is that that model is not supported by the New South Wales state government. I have two questions about RACCHOs, and then we can move on. What do you need the state governments need to do to help with the medical workforce shortage? Also, what would be the cost of setting up this RACCHO model? There's huge investment already occurring in rural pathways and generalist models. Wouldn't it be redirecting an awful lot of money into establishing another bureaucratic line rather than on the ground?

Ms O'Kane: It's not going to be so much of a bureaucratic solution. It's actually a model of care as well as being a business model. What is lacking in so many parts of rural Australia is multidisciplinary teams. People want to work in a space where they're working with other health professionals. Part of the reason people don't go to rural areas is that there's no professional or social support. There are also some of the financial issues that I'm sure everybody is well aware of. What we're suggesting here is actually a service model that's going to service the rural communities themselves in a comprehensive way through team based care.

In terms of the cost, yes, we're thinking at the moment that each of these RACCHOs might be in the order of $2 million to run per year, but, given many of the different initiatives that are being put out there, there's not a lot of really good evidence to suggest that a lot of the incentives at the moment are producing the results that we want to get. We have the view that we need to evaluate how well a RACCHO operates and see whether it is going to be cost effective. It's my view that it will be, and I think the reason we need RACCHOs as well is that, in the past, community health centres used to deliver a lot of that team based multidisciplinary care. At the moment, it's been sort of withdrawn—not entirely, but the communities aren't being well serviced by those models anymore. We need to make things affordable for rural people. At the moment, if we've got some allied health professionals as well as GPs that can't just do bulk-billing, because it's not financially viable, we want to have a model that's actually affordable for those rural people, and we think RACCHOs are going to be able to do that.

Senator HUGHES: Okay. It was interesting hearing the Rural Doctors Association previously say almost the exact opposite with regards to some of the programs that actually are delivering. They're reluctant to see a whole lot more conversation when we know what the issues are and it's more about getting those pathways fixed as opposed to going back and trying to reinvent the wheel.

I know we're short of time. Mr Swan, you did mention rural, not outer urban. As someone who lived in Moree, it's very much a rural and remote area as opposed to a Wollondilly, a Newcastle or somewhere in Wollongong or Sydney. What are the dangers of health policy not acknowledging rural and regional as a very independent, separate way of looking at health care if it gets mixed up with outer metropolitan areas?

CHAIR: That's your last question, Senator Hughes. If you could answer very quickly. We have two other senators.

Ms O'Kane: I suppose from the point of view of the alliance, we do want to avoid that. I guess that's why a RACCHO model, a rural area community controlled health organisation—

Senator HUGHES: I don't mean to be brash, but I was asking Mr Swan because Mr Swan actually said it in his opening statement.

Ms O'Kane: I beg your pardon. Sorry about that.

Mr Swan: I will ask Chris Mitchell to make a comment, too. We see it as a focus on distribution, and ultimately there is a single workforce in that sense. Currently we have a range of policy levers and distribution measures that encourage the workforce to work in more-rural and more-remote settings. If there's a change in that outer urban setting, incentives to go there, that is likely to impact on the existing workforce as well as intention to work more rurally and more remote. Chris, would you like to add anything there?

Mr Mitchell: Yes, just quickly. We've been here before. As a country we had an outer metropolitan strategy. It did damage the very remote and remote communities and rural. The incentives were watered down, if I can use those words. The current government policy has a visa for GPs program, which does not allow doctors coming from overseas to go into MMM1. We would have concerns, and remain concerned, about any change that needs to happen in outer metro. Let's be clear: there's a differential between outer metro availability to service, not discounting the fact that those services are needed for those communities across the whole stream of primary health care. There is a differential. If you do something for outer metro, you have to multiply it as you go from three to four to five to seven through the scale. It's really important. Connecting back to the comment before about the spend: the spend is due to the lack of service provision. There are a whole range of strategies to put more people on the ground. It's difficult. That's probably a short answer. Thank you.

Senator HUGHES: Thank you.

Senator GREEN: Thank you all for your evidence today. I want to ask about your thoughts or your views around the DPA classification. I understand it's a very new tool. I did notice that you'd raised some issues around the transparency of how DPA areas are addressed. Then, going forward, because I don't have a lot of time: the second part of that is around our reliance, previously, on overseas trained doctors and any views about what we should do post COVID. One of the things people talk about is that we have a choice after COVID. We can go back to the way we were doing things before, or we can try to come up with some different solutions so that we don't have the same problems we had before.

Mr Mitchell: In short, the DPA arrangements are under review, as you know, at the moment. There's an exceptional circumstance process that's being worked out, and we're having another briefing on that tomorrow. This actually allows an international Australian graduate to be placed in a community in the geography. That's an important differential. If you are in an area that is non-DPA, there are a whole range of Commonwealth programs you do not have access to. That sounds simple, but it isn't. It's complicated. It goes through 19AB, 19AA—under those exemptions it impacts.

We would say a couple of things. One is the transparency of the current process so a practice can understand, in applying, what it means; where they are with the threshold; and how that might be worked through. Having got to that stage, I would say to you that we think the blanket DPA that currently goes from seven through to five is fantastic. It's really good. It saves a lot of paperwork and says, 'There's a problem there. Go fix it,' and you have the ability to do it. And guess what? We haven't been swamped with doctors in those areas. We still have difficulty recruiting. As workforce agencies, we'd say we need to look at four as a blanket and three as a blanket as well. Remain with a view that testing of the market in MMM2 would be useful and we'd say don't go into MMM1 or outer metro.

Senator GREEN: On the model we had before, where we had the Visas for GPs program in 2019, we were getting doctors to come from overseas. How can we make that a better program post COVID? I'd love for these

doctors to come to our communities in regional Queensland, but I'd also love them to stay for as long as possible—and not force them to stay but show them what a great opportunity it is to stay here. We hear a lot that people come and do their time and then they leave after they've ticked the box; they head back to the city.

Mr Mitchell: Really quickly: the reliance on international graduates is still required in the country. There will be evidence presented during this inquiry that we have a maldistribution, and that's the issue. It's where we have them placed. Then it goes back to what are the attraction side of things, what are the retention strategies? We have a whole range of attraction and retention strategies, and a number of entities have presented today and will present. The issue is there is a cycle. Some of our training programs create a cycle. Then we have to be really careful—I hark back to a document called *Lost in the labyrinth*, which really outlined the system we created. The systems after that document and those hearings is actually worse, if I could say that to you. It's harder to get into the country. You have to maintain quality and safety but you also have to maintain distribution.

What is it that's attracting Australian graduates to go to a number of towns I won't mention along the various coasts? We have to work at that level. What is that and how can we help them? How can we encourage them to come, support them there and look after them? The regional training hub strategy, which you'll hear about in a moment, too, is awesome. It says to put the specialist training in the regional centres. We know that if you put a few together the critical mass can grow from there. We've seen that across the country. The long-stay programs we have and the various programs also do attraction for the Australian grant. The bright lights of the city may not be too bright anymore given COVID, but there are still people who think the only place to be a specialist is in the city. We're interested in rural generalists, we're interested in GPs for the bush who want to work in rural and we're interested in specialists who want to work in rural communities.

Ms O'Kane: Can I add to some of that discussion as well, if that's okay?

Senator GREEN: Of course. Thank you.

Ms O'Kane: Certainly from our research, forcing people into rural areas, which is what does happen with our international medical graduates, doesn't seem to be an effective mechanism. Having said that, there are doctors who are working rurally who say that, without that international medical graduate coming into the system, we'd be in a much worse situation than we are at the moment. In terms of post COVID, I think the Murray-Darling Medical Schools Network proposal—already there are some students who have already started in that. I think there is going to be some real promise in that because it is going to be picking up those rural people who then go into the medical workforce. I think that that, in time, will have some benefits overall.

Senator GREEN: Thank you. I will leave it there. I know other senators have questions and we're kind of out of time.

CHAIR: We are out of time. Thank you very much, Senator Green. I have time for very quick questions from Senator Patrick.

Senator PATRICK: To the Rural Workforce Agency Network: you're funded by both state and federal. Is it fair to say that's the dominant source of your funding?

Mr Mitchell: Predominantly Commonwealth.

Senator PATRICK: What MMM do you work with? Is it from two downwards or three downwards?

Mr Mitchell: A couple of programs go two to seven. Most of them go three to seven. We go worst first, so we go seven backwards.

Senator PATRICK: Thank you. Look, I'm going to be brutal here. I've asked that a document be circulated—it's an answer from the Department of Health that was provided to me recently through estimates. If I look at the GP FTE-per-100,000 population across each of the MMMs, I find that in most cases—and there are exceptions to this—the numbers have been static and in fact, just recently, have gone down. Standing back, if I were the health minister, I'd be saying to myself: 'Why wouldn't I seek an alternative to the rural workforce agency when I don't seem to be getting the outcome that I want, which is an increase in FTE in those MMM 7 through to 3 and so forth? Why would I not look elsewhere?'

Mr Mitchell: The context in which we work is Commonwealth programs and the policies that come and go. Some of those have been very helpful and have activated attraction and retention. As I shared earlier, some of the outer-metro things have, over a number of years, actually diminished the work that we had done in earlier years in MMM 5 through to 7, because you could go to an outer suburb and be employed. Thousands went there, thus the 'visas for GPs' programs. We have good returns on our programs. We saw, though, pre COVID, a number of systems where bringing doctors in from overseas became tougher and tougher. Earlier I mentioned quality and safety. I understand that, but actually there were some curious processes in there, if I could put it that way.

The second piece is that Australian graduate numbers have increased. Incidentally, in one year the graduates seemed to evaporate somewhere. Where did they go? When we looked at it, there were a number of doctors going to hospitals and staying in hospitals. In one state, the number in the public teaching hospitals increased by 10 per cent. The other one which is of real benefit to the community is the rural generalist program—both the Queensland generalist program and new national generalist program. That will have an impact as well. The issue in some of the states is that those doctors are GPs first and hospitalists second. In Queensland, they seem to be hospitalists first and GPs second. So the mix is important. We talked about the mix earlier, and that was really important for the town. The control of all that is both state and federal. The employment arrangements during the medical training for interns et cetera—most of the training but not all—is state, with federal funding covering off the end if you're doing general practice training.

Senator PATRICK: In some of the outcomes, in some sense you're sort of passing the buck back to the states and the federal government. Where is your submission that says, 'These are the things that we were going to do but the government wouldn't let us'? That's what I'm interested. I'm a bit frustrated. You're obviously federally funded, and it's not acceptable to me to say, 'The states and the federal government are resisting ideas and things that we think are successful,' without you saying to this committee, 'These are the things that we've been fettered in doing.' Again, the numbers look really flat. Maybe you might want to come back on notice. Your argument might be that, without you, the numbers would be worse, but I can't see where that is in the data. I can't see the value for money that we're getting from your organisation in respect of actual doctors out in the rural areas. Just to be fair, maybe you can respond to that particular question on notice and in detail.

CHAIR: You could give a quick, one-minute response now, and then I'd invite you to respond in more detail on notice.

Mr Mitchell: Thank you. The response clearly is that the tap for international medical graduates was turned off several years ago, making it harder to get in—and that was also for other international graduates. The second piece is that the attraction into general practice has been lower, and other presenters have said that today, as well. There has been a reduction in the attractiveness, and there's a lot to be said on that. The other point is the attractiveness into general practice—talking specifically about general practice: the business model is at risk and the funding for that business model is also at risk. So the attraction factors are really clearly an important issue.

CHAIR: Thank you very much for your evidence today. It has been of great value to the committee. If you do want to provide more information in response to that question on notice, if you could get it to us by the close of business on Thursday 18 November that would be really appreciated. I'm sorry we're short on time. It's been a busy day with lots of stuff to get through.

FELTON-BUSCH, Catrina, Associate Professor, Remote Indigenous Health and Workforce, James Cook University [by video link]

KNIGHT, Professor Sabina, AM, Director, Murtupuni Centre for Rural and Remote Health, James Cook University [by video link]

LANGDON, Mr Kane, Sixth-year Bachelor of Medicine/Bachelor of Surgery student, James Cook University [by video link]

MURRAY, Professor Richard, Deputy Vice Chancellor, Division of Tropical Health and Medicine, James Cook University [by video link]

NICOL, Dr Bryce, Senior Lecturer, James Cook University [by video link]

TEAGUE, Dr Peta-Ann, Associate Dean, Strategy and Engagement, Division of Tropical Medicine, James Cook University [by video link]

[12:46]

CHAIR: I now welcome representatives from James Cook University. Thank you for appearing before the committee today. Do you have any comments to make on the capacity in which you appear?

Mr Langdon: I'm presenting from Cairns, which is Gimuy, Yidinji and Yirriganydji country.

Dr Nicol: I'm also the medical superintendent of Joyce Palmer Health Service on Palm Island. Today I'm joining you from Thursday Island, in Kaurareg country.

Dr Teague: I'm also a doctor, and I join you today from Roma in south-west Queensland, on Mandandanji country.

Catrina Felton-Busch: I'm based at the Murtupuni centre out in Mount Isa. I'm coming to you from the Gulf of Carpentaria, in Burketown, which is Gangalidda country.

Prof. Knight: I, too, am coming to you from Burketown, in the Gulf of Carpentaria, which is Gangalidda country. Our centre for rural and remote health is one of the university departments of rural health, of which there's a national network of 16.

CHAIR: Thank you. I now invite you to make a brief opening statement. If you can keep it brief, it will give us a bit more time to ask you questions.

Prof. Murray: We are hoping that we can provide you and your fellow senators with an opportunity to interrogate a sense of what works rather than perhaps what doesn't work. I think that's probably the most important insight and perhaps something we can give you a lived experience of. You can see, perhaps, from the spread of perspectives that we've assembled for you today that there's going to be ample opportunity to interrogate lived experience, and I certainly agree that it would be fabulous to have enough time for that.

It's worth saying, just at the outset, that for my own part I'm a medically qualified academic, general practitioner and what these days we would call a rural generalist. I've had a career substantially based in remote and northern Australia. I was in the Kimberley for 14 years, working with Aboriginal community-controlled health services, and I've been in northern Queensland for the past 16 years. I've been deeply involved in just about every aspect and worn most of the hats, I would say, in the medical and GP training system over that period of time.

At JCU I have the privilege of leading Australia's most successful university, by far, in producing doctors and other health professionals who go on to non-metropolitan careers. We're one of a handful in the world with this level of achievement We're also one of Queensland's smallest public medical schools. But, nonetheless, with just on 2,000 graduates to date, we've had some impressive outcomes that I heard spoken about before. I have to say that I think outcomes are the most important thing to be discussing and focusing on at the moment. We're unusual at JCU in that we have not only Australia's first entirely regionally based so-called end-to-end medical program, which was established in 2000, but also Australia's only delivery of accredited general practice training on behalf of the two GP colleges. It is based entirely in the region and it is joined up. It's this notion of end to end, from high school essentially right through to fellowship and beyond. In that sense, we're unique and, I hope, can provide some of our experiences and explain some of our perspectives.

We could talk about many things in general practice. We're deeply committed to the notion that comprehensive primary care should be the cornerstone of an effective healthcare system, more so in regional communities and more so in disadvantaged Aboriginal and Torres Strait Islander and other communities. It's more important than ever. What we're seeing is that the system is, in a sense, going in the opposite direction, so we share your interest

and commitment to the cause. We could talk about many things. We could talk about financing and viable practice models. We could talk about what comprehensive care looks like. We could talk about the interfaces with state and territory governments and the federation around public hospital systems. We're not going to talk about those things. Instead we're going to focus on workforce, because ultimately it doesn't matter what insurance schemes you have, what employment arrangements you have or what jobs you've created, if there is nobody to fill them then there's no service at the level of the community. Workforce is absolutely critical in this.

For us, we look at the fact that as a country we graduate around 3,000 domestic graduates a year and that around 600-odd international students also graduate from our medical schools each year—and a fair proportion of those stay on for some period of time afterwards. We, in addition, however, top up the country, particularly remote and regional Australia, from overseas to the tune of around 3,000 per year. We are, sadly, the highest per capita importer of doctors in the OECD, and we have been, for a long time now, extraordinarily reliant upon international labour to supplement mostly the regional workforce. With that in mind, you can see that our argument that the single most important policy priority facing Australia as a nation, state and federal, is the supply of a domestic workforce who willingly, with incentives and the rest, pursue careers as GPs, rural generalists and indeed regional consultant specialists in regional Australia. That is by far and away the most important thing.

The problem with relying on importation—and many of my very good colleagues and friends are international medical graduates—is that (1) it drains countries who can often ill afford to lose their medical workforce and (2) it's temporary. What happens is we recruit people into the regions. There are a couple of mechanisms by which people are kept in regions for a while, but, overall, with notable exceptions, those numbers tend to percolate into the city. Then, in a sense, you need to press repeat, and the whole thing goes on. What you end up with is oversupply, supply-led demand, excessive specialisation in major cities, and undermining of general practice and primary care. While you have this itinerant and churning workforce in regional Australia, it's a completely crazy way to supply a medical workforce.

I will quickly turn to general practice before we have an opportunity to hear from others. We know what needs to be done. To provide our experience—it's international evidence now—around half the JCU graduates pursue general practice or rural generalist medicine within general practice, and that's very different to other graduate profiles and destinations for the remainder of the country and indeed the world. It is very unusual. About 75 per cent of our graduates overall go on to pursue work in regional areas, and around two-thirds at any point in time are based outside of major cities. The things that create this—and certainly our experience affirms it—are selecting people from, training in, with and for the communities where doctors are most required, and then providing the after-professional entry training, clear supported pathways into, in medicine's case, vocational training, general practice, rural generalist medicine or consultant medical practice based away from capital cities to the greatest extent possible, thereby allowing people to make networks, lives, partners and all the rest of it away from capitals. These are the ingredients, and they're well established internationally. We have innovative selection models. The way in which our curriculum experience is structured and the sort of experiences that our students have—and I welcome your interrogation of both Bryce and Kane, who are students or graduates of ours, so you can get some sense of it. I think these are the ingredients.

What we would argue is that, after 20 to 25 years of investment in what has substantially been good investment—Australia has been quite ahead of the pack in relation to trying to invest in rural and regional workforce—what we suffer from now is a lack of clear objectives and accountability and a lack of connectedness across programs, particularly federally but also at the state and territory level, with a common objective in mind. I think this might perhaps be an opportunity to get a clearer lead on what some of that realignment might be to focus on actual delivery of outcomes and accountability for that. I'll pause there, Senator. I hope that has set a scene. I would now very much welcome either questions, or we could indeed proceed with a bit of a thumbnail sketch from folk, perhaps starting with Kane. But over to you.

CHAIR: Let's go with questions, and I'm sure, if we direct some questions to the whole team that you have assembled, we'll get to hear from everybody. I'll hand over to Senator Green.

Senator GREEN: Thank you, Chair. Luckily my first question is to Kane, so, Professor Murray, thank you for the prompt there. Kane, I think you might be one of only the medical students joining us today. We've had a few graduates, but you are still currently studying medicine. Before I ask specific questions about policies and training, I want to ask you about your experience: what made you want to study in a regional area, what your experience has been training in a regional area and what you think that means for your future career. Hopefully it means staying in the regions as well.

Mr Langdon: Yes, absolutely. Thank you, Senator Green, for that question. I thought I'd start by giving you a little bit of background about myself. I'm originally from Gladstone in Central Queensland, a town of about

40,000 people, six hours north of Brisbane. As I grew up, I worked with my mother, who was a local pharmacist, and found that my interest and my passions were linked to the medical area, as a medical specialty. I thought that I was most aligned with treating patients in the capacity of a medical professional and, because of that, I decided that I would go on to study medicine at university. I think it was a natural progression to then go to JCU to study that because JCU focuses on providing skills for me to return to a regional, remote or rural community and practice medicine in a way that appropriately appreciates the healthcare needs of those communities.

I went to JCU, and, throughout JCU, I've had quite positive experiences, especially related to the rural placement side. Across our James Cook University degree, we have 20 weeks of rural placement. It starts with about four weeks in second year, then six weeks in fourth year, and recently I just finished 10 weeks in sixth year in Blackall. When I look back as a graduate and then as a junior doctor, of all my experiences at JCU, I think the rural placement experience will be what stays with me for the longest. I think that's because JCU selects supervisors, hospitals and regions that really want students, that are really passionate about both training up students and appropriately caring for the community they're in and that have a passion for rural health. By going through each of those rural placements and thoroughly enjoying all of them, I think I've gotten a good sense of the importance of primary care and a good sense of how difficult and rewarding it is to work in that sort of area. Going forward from there, because of my experience at JCU I would be highly likely to move on into staying where I am currently, in Cairns, and move on to care in that sort of capacity.

Senator GREEN: Thank you; I appreciate that. To Professor Murray, and other people that want to jump in: I have two main questions. I will get to some of the issues around the future of the training program in a second. First of all, you would have seen this morning, in the *Cairns Post*, more stories of GP practices closing down. You're training fantastic students like Kane, but there's going to be a gap, isn't there? I'm worried about the doctors that are retiring, or need to retire and just can't, and the students that are coming through right now. How do we get through that time frame until we've got students like Kane who are actually training students?

Prof. Murray: If only there was one big lever we could pull, we would all pull it. The other observation I've shared with people is: just because it takes a while, it doesn't mean you shouldn't get going. The best time to plant a fruit tree is 20 years ago; the second-best time is right now. In a sense, there is an imperative of investing in the future so that we do get it right and we have a lot more domestic pipeline coming through.

As a nation, we will continue to need to rely upon supplementary labour from overseas. I think that needs to be very deliberately tailored and reduced over time as we scale up domestic supply, and I think the scaling-up of domestic supply needs to be done very deliberately and on a whole-of-government basis. One of the difficulties for us as a country is: in an activity-funded public hospital system—or for activity funding that occurs anywhere, be it fee-for-service or Medicare or whatever—there is a great perversity in that public hospitals require a very large number of junior doctors to fulfil service roles. A lot of those are in major hospitals and urban areas. If you, as we've done, acutely crank the tap off or substantially down on international supplementary labour supply, you create a big sucking noise from the cities that will draw a lot of domestic graduates into cities. We need to do something quite deliberately to reduce the reliance of our major city hospitals on junior doctor labour.

We need to, very urgently, provide an obvious attractive career option choice. Kane's graduating this year, and he'll be off into internship. Oftentimes, with junior doctors in large hospitals, there will be for one reason or another a lot of influence brought to bear that will often persuade people away from rural and general practice. We need to make sure that Kane and his colleagues can still see the light on the hill whilst they're on the wards. For instance, typically in the second or third year out, not very far away, graduates would be thinking: 'Maybe I might be interested in general practice. I could go into short-term employment, with unfavourable remuneration, no transferrable entitlements, no maternity leave or benefits, or I could stay in the public hospital system and do well-paid shifts in an emergency department and have all of the above. Why would I choose the former?' That is the choice facing smart and ambitious people at critical junctures of their training and lives and careers, and we can and should be doing things now that tip the balance substantially towards making attractive employment and, indeed, life and work as a GP—and, in our case, in regional Australia, the broadly skilled GP, the do-it-all rural generalist—a really visible and attractive career. That's been our experience at JCU. Lining those things up really works. It's not mysterious. The things we can do are practical and tangent.

Senator GREEN: I know other senators will ask you about why your program works. I want to cut to the chase around a very important issue—the transition to the college-led training system. There are some parts of that transition that I understand JCU is supportive of, and some parts that it has some concerns around. What are those concerns? What should we be considering in that national transition? We heard from the college this morning, and I appreciate their evidence and their support, but what we've seen through your program is: if a program is based in a regional area and comprised of people who have talked the talk and walked the walk, we

tend to get better successes. What are some of the concerns around that transition, and what do we need to make sure JCU, or other programs like yours, retains to be successful in the future?

Prof. Murray: In just over 20 years now of the Australian general practice training program—it has been a long time—we certainly agree that there is, especially in more recent times, a lack of clear focus on outcomes. The accredited professional colleges, RACGP and ACRRM, were too far at arm's length from the quality and integrity of their training; I absolutely accept that. To the extent that college-led training means colleges assuming their proper role under Australia's national law and the accreditation system to determine standards, curriculum, accountability of the trainee experience and outcomes: I absolutely support that.

The question is: what is that vis-a-vis the need to produce a regional GP and rural generalist workforce? It's different but related. Our critique is that the role of colleges is in the former role—curriculum, standards, systems et cetera. No specialist college in Australia is primarily in the business of producing workforce people—individuals on the ground who have the right skills, the right models and so on. Out of all of this, we want to see some focus on outcomes for standards, in relation to fellowship and what it means to be a specialist GP fellow of either college, but, on the other hand, delivery on public investment—a substantial amount of which is actually meant to be for workforce outcomes—particularly but not exclusively for rural, remote and regional locations, where the workforce needs are greatest.

We have, as I said before, clear evidence internationally and in Australia that lining up what we would call vertically integrated—from school through to med school through to the junior doctor phase and into specialist training in one college or the other, including general practice—requires regional infrastructure and connectiveness. That is what the evidence suggests. That's the role we currently play, and that's what we would like to preserve. To that extent we're speaking with department ministers and the two colleges as to how we might preserve that critical element of workforce production in and for the regions.

Senator GREEN: What's the time frame around that, and when will those sorts of decisions be made? When will you know whether there is a negotiation in place?

Prof. Murray: There is a grant opportunity out for the two colleges to take a place in a new system, in a leadership role, of general practice education training. The detail of how that's operationalised out on the ground is currently under consideration all over the country but more particularly in the unique circumstance of Queensland, where there's a university—the only university—doing the whole pipeline. That's active. We should know, I would imagine, by the end of the year or early next year as to where that might land.

Senator GREEN: In the absence of other senators jumping in, I think I'm just going to keep continuing to ask some questions. Just through the sheer numbers of people that are joining you today from all parts of Queensland—very far and wide, all the way up to Thursday Island, I see—what you've identified there is the network of doctors who aren't just teachers but graduates who help mentor students and also new doctors. I wonder whether, Bryce, you might be able to jump in and explain what that network of support has meant to you. You seem to be working in some quite isolated places. And we've also got, I see, someone from Burketown there. When you're in an isolated place, it is a difficult work environment. How has the network of GPs at JCU helped you get to where you are now?

Dr Nicol: Yes, we're very remote up here in Thursday Island, and also in my practice location in Palm Island, where I operate out of the hospital and the general practice there. We often work in a very remote environment. Coming from Cairns, you'd be aware of all of the very remote locations around Cairns and into the Torres Strait and into the north-west.

One of the unique things that JCU managed to do is prepare its graduates, during their undergraduate journey and then through their GP training journey, for working in a remote area. James Cook University does that by embedding rural practice training into every element of its curriculum. It makes sure that, in a unique subject—rural, remote, Indigenous and tropical medicine—in second year, it teaches students the particular challenges that they'll have working in these environments. It then exposes them to those environments in fourth year and sixth year. Then, through the GP training pathway, it inoculates GP registrars to working in these environments by letting them operate in remote situations, with off-site support or onsite support, as well as with a robust group of medical educators and medical trainers.

This means that, as a junior GP, I had access to Peta-Ann Teague, who took me for lectures when I was a second-year medical student. When I was just emerging as a fellow, I was able to be supported by Catriona through my journey in Winton, when I was the director of medical services there. And now that I'm working on Palm Island, I have the support of senior academics like Aaron Hollins and Lara Wieland, who are able to support me through my journey as I go from a practitioner of medicine to a medical superintendent and work more in the

education and training side of my business. Through every step, JCU, by having a vertically integrated pathway, has near peers—people whom I can touch base with and talk to—as well as distant ivory towers of experience, such as Richard and Catriona and Peta-Ann, who can support me through the easy decisions and the hard decisions.

You only get people to stay in their jobs when they're embedded in a pathway which has support at every level, and one of the wonderful things about JCU GP training is that it works as a force multiplier to state government initiatives and other federal government initiatives to keep people based in their location. If you're a GP working at TAIHS in Townsville—TAIHS is the Townsville Aboriginal and Islander Health Service—you can rely not only on your colleagues working in that general practice to support you but also on a collection of peers at James Cook University, ranging from academics to doctors, nurses and allied health professionals who are able to give you meaningful support in your role. Having that embedded and structural approach to training and safety is one of the real multipliers that JCU gives, and it has certainly been one of the reasons I've stayed in North Queensland after going to James Cook University, after growing up in Childers near Bundaberg, and then doing my training in Townsville, Darwin, Alice Springs and then going out west to Winton and then going out to the islands, on Palm Island. It is one of the unique things that we have in North Queensland that we must work so hard to protect.

Senator GREEN: I just have one last question, and I'm sure others will have a view on this and will jump in on it. We've been discussing today with a number of stakeholders all the various types of Commonwealth training programs and the different initiatives. There are lots and lots of abbreviations, which we need a little guide for to understand, but one thing that you point out in your submission is that there's a lot of overlap from some of the Commonwealth health workforce programs, and they can maybe work against each other or be a little bit confusing sometimes. What do you want to see, in terms of the programs that are being funded at the moment, and how can we better streamline those programs to make sure we're getting good outcomes, as you say, Professor Murray, concentrating on those outcomes?

Prof. Murray: Thank you very much for that. I won't recite all of the acronyms, but it can serve to know that I know them. Indeed, for every new person in the Commonwealth department who comes into the division I try and get myself involved in inducting them in the complexity of their own environment. It's nobody's fault. What happens over the years is there tends to be that collision of programs. Medicine is complex. There are things you can do during a student phase—clubs, rural training opportunities and scholarships places. There is a variety of things that are all useful to do. There are various things you can do for graduates, such as additional spots in rural and regional locations for international fee-paying graduates. There's how a return of service might work for the bonded places. You might get a few of the junior doctors out of hospitals and having some rural and general practice exposure. It's how you invest in general practice training per se in about four different flavours and how you might provide extra skills opportunities to either develop or maintain. All of these things make sense in isolation, but if you jumble them all together as a giant set of acronyms—which, again, I could recite to you—they make no sense at all.

There is a severe lack of overarching policy logic. What is the ending that we have in mind? What are we trying to achieve? If, as I argue, we are looking to invest in a supply of domestic graduates who will willingly pursue remote, rural and regional careers as GPs, rural generalists and consultant specialists, then you wouldn't arrange the program pieces in the way that you do at the moment. I am sad to say that we don't even measure the outcomes. We measure process and how many placements. Then as part of a suite of portfolio programs you will have a primary care strategy that is currently under consideration and development. You would think that workforce—that is, the GP workforce—would feature largely in a primary care strategy. You might be disappointed to know that it doesn't. These things tend to occur in silos. It is a feature of the way these things go on either side of government. It is just time, with the impact of the pandemic as an acute and chronic shock to the system, to maintain or increase the investment but have a much greater accountability and constructive alignment of these different program interventions to achieve a stated desired objective which we have not articulated at this point.

Senator HUGHES: I was just wondering, in light of some of the other evidence we have heard this morning, with regard to the training and where it's taking place or being delivered and where the students are and with regard to MM 1, 2 and 3, versus MM 6 and 7 and with regard to rural areas versus outer-metro and regional centres, have you got a breakdown of those figures?

Prof. Murray: These are medical graduates training to be GPs. Is that—

Senator HUGHES: Yes. Where is this training being delivered?

Prof. Murray: The structure of the main piece of the GP training program that exists at the moment, AGPT, Australian General Practice Training, another acronym—it's longstanding; it goes back over 20 years—is that half

of the training needs to be outside of major metropolitan areas, meaning remoteness area 2-plus. That's in the aggregate. How that's achieved is by carving up a number of these training slots into what's called a rural pathway place or a general pathway place. There's competition as to who might get a flexible training spot. To be honest, the tendency then is that, from the applicants of the program's perspective, is that those who do not do as well as their colleagues get allocated the so-called rural training spot, which is more constrained and conscripted and less desirable to junior doctors. So again it is more lead in the saddles for the attractiveness of a general practice career. A lot of that—and it's a point that's really worth understanding—is the unintended interaction between the overseas migration dependence I spoke of before and the general practice training system results in a very large proportion of those who are effectively conscripted to train regionally in fact being international medical graduates who have no choice. That fills those slots, but that does not ultimately tend to result in a retained regional workforce—with the greatest respect to my colleagues who trained overseas and without whom the bush would collapse. As a design of a program, that's quite unintended.

If you take a snapshot of where people are spread at a point in time, you'll get a point of view. If you take out of that the international medical graduates, who often don't have a choice, and ask the question, 'How many domestic graduates are pursuing careers, and how many of those are able to stay on?' it's a very different picture. You're quite right that often—

Senator HUGHES: There are regional challenges and there are outer metropolitan challenges, but the real great challenge that's being faced is rural and remote—so, areas that would be classified 6 and 7. I'm just trying to understand your program. I know it's received substantial Commonwealth funding to run, and it's obviously had some great success for northern Queensland. Are 10, 20 or 30 per cent of those undertaking the training going into areas classified as 6 and 7? I'm just trying to get a bit of a ballpark figure.

Prof. Murray: I can come back to you on a precise figure. I'm going to say that, in RA 6 and 7—Peta-Ann Teague, you might be able to help me here—I would have thought that numerically, at any point in time, that would be perhaps 15 per cent or thereabouts—

Senator HUGHES: If you can just take it on notice, that would be great. I just know that the pressures we have been hearing about are particularly rural and remote. It would be interesting to see how the program is lining up with that.

Prof. Murray: That's true. The other thing I'd say is that we're also tracking what happens to people after they complete training. I think that's perhaps an even more important question—

Senator HUGHES: Step by step, yes? Thank you, Chair.

CHAIR: I think we have got no further questions. Thank you very much, Professor Murray and all of your team. It's been really valuable to hear from you at the coalface of training GPs for regional and rural areas, and your evidence has been of great value to the committee. If you do want to add some further information or you've been asked to provide responses to questions on notice, please get them to us by close of business on Thursday 18 November.

Prof. Murray: I might just flag—and we would certainly welcome it—that I think the piece that we haven't really touched on here is the importance of the Aboriginal and Torres Strait Islander agenda for us, for regional Queensland, for northern Australia and for the country more broadly. It's an area in which we're obviously very deeply invested. Catrina Felton-Busch, who is here today, leads that component of the JCU program both for general practice and more broadly. I think there are a number of elements of the GP training. Indeed many of our medical graduates and our GP fellows are themselves Aboriginal and Torres Strait Islander practitioners, but just as important is ensuring that GP fellows and graduates have the technical and cultural competence to practice in, with and for local Aboriginal communities. I think that's really important.

I'd just commend Catrina's perspectives on this. She's a very experienced and senior Indigenous academic. Through living, working, practising and breathing this stuff, Catrina, you've got great perspectives. I'm sure that, if the senators are keen to learn some more about it, we'd be delighted to come back.

CHAIR: If you did want to share something over the next couple of minutes, that would be really appreciated. Thank you for bringing it up, because it obviously is a critical issue of great importance to this committee.

Prof. Murray: Thank you. That puts you in the chair, Catrina.

Prof. Felton-Busch: As Richard said, we're really invested in Aboriginal and Torres Strait Islander health. I've been working in this area for 20 years. I actually come from Mornington Island, and I'm coming to you today from my grandmother's country, which is Burketown. We live and breathe this stuff. I've worked in rural and remote for most of my career with JCU. I think the important things to think about are the enduring disadvantage in our communities and the fact that we need to have more doctors—that's the biggest gap in our footprint—in the

large communities. We've got Aboriginal controlled health services that have been asked to do transition to primary health care—so they're taking on the bulk of primary healthcare work in these regions—without a workforce. So the cost of getting locums and trying to run this with other sorts of models is a real issue.

My job in GP training is to work with everyone, obviously, but we have great partnerships. Partnerships are the key to a lot of the work that we do. We have really strong partnerships with the Aboriginal community controlled health sector in Queensland. We service 20-plus Aboriginal community controlled health services throughout our patch. We have cultural mentors within those services that provide the cultural education and support for registrars, as Professor Murray said, to become not only clinically competent in Aboriginal health as a discipline but also, with cultural mentors, to have the cultural capability that they need to do their job.

I think we've got six Indigenous fellows who have graduated through the GP program at JCU. We've got 25 of our Indigenous medical students coming through, and we work very strongly with schools and other areas of the university to get that pipeline that Professor Murray and everyone are talking about. This is the important thing. We need to get more kids into medical school and into GP training who can go back into our communities, understand the challenges and want to be part of the solution.

I hope I'm covering off on lots of things that are really important about the work that we do. There is the research component. These are things that we have already mentioned in our submission. We need to have more research in terms of the evidence to support what we're doing. But we know what works. Most of us are all true believers. We live and work in these areas to provide that training. I'm happy to answer other questions.

CHAIR: Thanks very much.

Dr Teague: I'd like to return to the question of MMM if possible, just to say two things. One is that the Modified Monash Model, whilst useful in many ways, doesn't actually tell the story that needs to be told. For example, I'm in Roma in South-West Queensland, and we just had a workforce meeting this morning. It is classified as a 4, but it might as well be a 6 or 7. The workforce shortages here are acute and dire, and there is a cliff that this community is facing at the moment in terms of primary care services. Whilst I understand the focus on 6s and 7s, I sometimes worry a little bit that we're not necessarily being place based: What does this place, this community, this community controlled service, need? What's the wraparound that this community needs, no matter what the MMM, whether it's 3 to 7? I just wanted to say that.

Part 2 of that was that, the more remote you go, the poorer served it is in terms of workforce, the more the burden of supervision is. I know you will have heard that, but, if you are one or two doctors in a town and, as Bryce was saying earlier, you put your hand up and you want to support, train, mentor, to do that all the time is exhausting. It takes a lot of time and it takes you away from clinical care. If you're not seeing the outcomes on the other side, which is what Richard was talking about earlier, if you're not seeing the return for investment, year on year on year, it's pretty dispiriting to community. I don't want to end on a bad note, because we want to be solutions focused, and there are solutions and there are ways of doing it; it's just trying to join it up to deliver it in a coherent national way that I think is our plea. Stop the incoherence. Stop the [inaudible]. Bring it together. Base it on evidence and have an outcomes framework that is meaningful, that is not about processes but is about outcomes. I think that, as the Commonwealth Senate, it's within your gift to really influence that.

CHAIR: Thanks very much. I think that's a very good point to end on—the value of this committee. Thank you again for your contribution towards this committee's work and this hearing today.

BEKEMA, Ms Claire, Senior Pharmacist, Clinical Governance and Workforce, Pharmacy Guild of Australia [by video link]

BLACKER, Mr Simon, Australian Capital Territory Branch President, Pharmacy Guild of Australia [by video link]

[13:30]

CHAIR: I now welcome representatives from the Pharmacy Guild of Australia via videoconference. Thank you for appearing before the committee today. Sorry we're running a little bit late, but not too badly. I now invite you to make a brief opening statement. If you could make it brief, that would be appreciated. We have read your submission. After that, the committee will ask you some questions.

Mr Blacker: I would like to acknowledge the traditional custodians of the lands on which we meet today and pay respects to elders past, present and emerging. Today I join you from Ngunawal country in Canberra. Thank you for the opportunity to address the committee on this matter. I am a community pharmacist and pharmacy owner. I'm the national vice president and president of the ACT branch of the Pharmacy Guild, as well as the chair of the subcommittee Community Pharmacies for Rural and Indigenous Australia. I personally grew up in rural Australia, in Lake Cargelligo, a country town of 1,500 people in the middle of New South Wales, where there has always been a pharmacy but, at times, no GP, and I have worked in rural communities. I am a part owner, with other pharmacists, of pharmacies in Parkes and Dubbo in country New South Wales, and I understand the issues, challenges and opportunities for rural health and for the people and health professionals in rural communities. Today I'm accompanied by Claire Bekema, who is our senior clinical pharmacist for governance and workforce at the guild.

Ms Bekema: The Pharmacy Guild of Australia is the national peak organisation representing community pharmacies owned and operated by registered pharmacists and providing access to medicines and primary healthcare services to all Australians. The community pharmacy network is geographically dispersed, with over 1,850 pharmacies in Modified Monash Model 2 to 7 areas. Sixty-six per cent of Australians living outside capital cities are within 2.5 kilometres of a community pharmacy. This makes them a vital component of the health system, especially in rural and remote locations where they may be the only health professional in town. There are more than 400 pharmacies in towns where there is only one medical centre or none at all. Like other health professions, community pharmacy is experiencing significant workforce issues, most prominently in rural Australia. This is a major contributing factor to the lack of access to health services experienced by Australians living in regional, rural and remote areas. We'd like to highlight two key elements from our submission.

Firstly, the guild believes that service gaps could be addressed by pharmacists working to their full scope of practice due to their extensive professional training, skills and knowledge. Pharmacists are being underutilised, primarily due to legislative barriers currently limiting their scope of practice. Rural pharmacists working to full scope of practice would contribute to increased access to medicines and primary health care services in areas where medical services may be overstretched, limited in hours or unavailable. With a shortage of GPs in regional, rural and remote areas, future strategies need to be comprehensive and adopt an approach that looks at a suite of solutions that is focused not on one health profession but on how local collaborative models of care utilising all clinicians working to their full scope of practice can meet the health needs of their community.

Mr Blacker: Secondly, the guild believes there needs to be an equitable approach to support funding of rural primary healthcare workforce policies and programs. A stronger rural health strategy is focused on general practice. The Workforce Incentive Program Practice Stream provides support for a general practice to employ allied health professionals, including a non-dispensing pharmacist, potentially diverting the available community pharmacy workforce and placing at risk the sustainability of the local rural pharmacy. Whilst there are a number of community pharmacy workforce programs funded through the Seventh Community Pharmacy Agreement, these are not of the same quantum as GP workforce programs.

The guild believes that rural workforce strategies need to be holistic and equitable across all the health professions to ensure that Australians who are living in regional, rural and remote areas have access to the same breadth of primary and allied health practitioners and services as those in the city do. Thank you. Claire and I are happy to expand on issues raised in our introduction and to answer any questions the committee may have.

Senator GREEN: You wouldn't be surprised to know that one of the reasons you've been asked to join the committee today is to talk about scope of practice and how that could alleviate some of the pressures on GPs in regional, rural and outer metropolitan areas. First of all, I want to ask what the experience has been during COVID. I know that pharmacists are now administering the vaccine, but it wasn't an easy process to get to that

point, as I understand it; there was a lot of negotiation to get there. What's been the experience so far? And how are pharmacists delivering the vaccine to people, particularly in these remote areas?

Mr Blacker: You'd be aware that it was in rural Queensland that community pharmacies were first involved with the COVID vaccination rollout with regard to AstraZeneca, and pharmacies have been involved since June, with a wider range of pharmacies across Australia involved as of about August. Community pharmacies were excited to participate, because it's our natural inclination to want to help our local population in the community, and given the accessibility of community pharmacies. In the early phases and the late phases of the COVID vaccination rollout the opportunity to have a potential walk-in vaccination rather than an appointment certainly allowed community pharmacies across the nation to help lift vaccination rates. There is a portion of our population who for certain reasons may not have a regular GP or, in particular, may not have easy access to a GP to get an appointment, so pharmacies have filled that gap.

Anecdotally, with the rollout of the AstraZeneca vaccine being somewhat controversial at times, or marred by certain themes in the media, we believe that community pharmacies have helped to turn that conversation around and have helped to convince people that the first vaccine they could access was the best vaccine for them, and we've helped lift vaccination rates as a result. Claire, is there anything you want to add with regard to the vaccine rollout?

Ms Bekema: No, I think, as you said, pharmacies were really excited to be involved and to support their communities, but they're tired; they're burnt out. It will be interesting to see how much we can continue to do. I just want to say that today we heard that 1.75 million vaccine doses were given in community pharmacies as part of the COVID-19 rollout.

Senator GREEN: That's an incredible effort—1.75 million vaccines. You might be pre-empting my next question. I've got some workforce for pharmacies generally, but we'll get to that—that's my third question. The only other question I have is about scope of practice. Where is that up to? I know this has been a discussion about the COAG health ministers—I don't know what it's called now, under national cabinet. As you know, in Queensland you can get a UTI prescription over the counter, and that was a decision of the state government, but that isn't a national framework. How are we going in progressing scope of practice—getting more prescriptions over the counter so that you don't need to go to a GP and get a script?

Mr Blacker: In recent times the Pharmacy Guild has had a scope-of-practice document, or paper, that is part of our national strategic plan. We'd certainly be happy to share that document with any of the senators on the committee. With regard to scope of practice, we regulate at a state and territory level. As community pharmacists where we practice, we look to Queensland as an example where they have this trial happening. You mentioned the trial for uncomplicated UTIs. There is a process to follow to allow prescribing and the supply of antibiotics so that a person who may not be able to get in to see a GP is actually able to access that sooner, but it is a patchwork, to be honest, where you have different experiences. Queensland versus New South Wales; New South Wales versus the ACT—you cross a simple border and you have different regulations.

We remain committed to having pharmacists operate a full scope of practice. We trail other OECD nations with what pharmacists can do. We look to places such as Canada, where they operate a full scope of practice. In regional areas, but particularly rural and remote locations, where there is a lack of workforce, the Pharmacy Guild believes there is a real opportunity for community pharmacies and pharmacists to play a greater role in looking after patients health and to give patients that flexibility and choice so that they may seek other options if they can't see a GP.

A personal example is that when I was an intern pharmacist in Forbes, in country New South Wales, I was taught to use an otoscope to look into the ears of infants—not necessarily newborns, but infants and toddlers—for ear infections. Because the wait time would be two weeks to see a doctor, we were taught to triage and to work more closely with the local GPs, who had limited appointments. Certainly, if there was an opportunity for a pharmacist to provide a prescribed treatment, that's better than what we can do now. That's an example of working to scope and assisting a local population where there is a challenge to get in to see other health professionals. Claire, do you have anything to add with regard to scope?

Ms Bekema: Yes, I would just like to add to your specific question about being able to extend a prescription. Continued dispensing has been extended now to the end of June 2022, I think, which is a great announcement, but we would really love to see it made permanent. It's just one aspect of us being able to safely consider the person that's in front of us and solve their problem. If they can't get into their GP, if they can't access a prescription, we can make a clinical judgement as to whether it's safe to continue it for an extra month's supply. We would like to see that implemented permanently. There are some limitations with that, where some medicines aren't included.

For example, CTG scripts aren't included in that. Aboriginal and Torres Strait Islander peoples are actually being disadvantaged as they don't have the same access through that continued dispensing program.

Senator GREEN: Just on the workforce issues, we've been talking a lot about not being able to find enough GPs and the pressure that's putting on current GPs. They're worn out. I hear the same thing about pharmacists in rural and regional Australia as well, that it's really hard to get pharmacists in rural Australia. Is that what you're experiencing on the ground?

Mr Blacker: Senator, that has always been the case; it has just been exacerbated by COVID with restrictions to travelling across borders, but also people having to isolate from time to time. There is the continuous pressure of providing an essential community service in the pharmacy when there is COVID circulating. For example, I speak to the owner of a pharmacy in Bourke, Peter Carruthers, from time to time—my sister locumed for him quite recently—and Peter had chosen not to vaccinate with COVID vaccinations because he's the only pharmacy for a large distance. His view was that he needed to protect the essential service he provided with the PBS and medicine supply in servicing the outlying areas. Everyone is looking for a pharmacist, and I think that is going to continue to be the case. I don't see that changing any time soon. The Pharmacy Guild are keen to investigate areas where we can have funding opportunities to entice pharmacists to travel from the cities. There are a couple of pharmacies in Broken Hill that successfully attract a workforce by targeting universities for pharmacy student placements, and they have remarked that with COVID and the lack of student placements through that time they are now experiencing a shortage of pharmacists. The lockdown has had an impact, but we do have an ongoing issue and we can't expect a different by doing the same thing over and over again—hence our submission to suggest that we do need substantive changes with regard to workforce opportunities for pharmacies in rural and remote areas.

Senator HUGHES: Senator Green has covered a lot of the stuff that I was going to ask you. Following on from the workforce issue, with particular regard to rural pharmacies, do you think something like a skilled migration program might be an option to improve workforce issues?

Mr Blacker: Yes, we are strong supporters of that. I might let Claire talk to that in a moment. There have been changes in that space. I was a rural pharmacist previously, and we rely on any avenue to find pharmacists to help with the work that we do in our communities. I know of many examples where pharmacists who have immigrated from overseas are open-minded to going to work in rural, regional and remote areas. I have a guild colleague from South Australia who has the pharmacy in Coober Pedy, and he's originally from Pakistan. He's now attracting colleagues from overseas—they're immigrating to Adelaide and then going to rural South Australia. You have these unique stories that help relieve challenges in certain areas, and we need more of that. Claire, with regard to immigration, do you want to comment?

Ms Bekema: Currently, the pharmacists are on the short-term skilled occupation list. We were recently added to the priority migration skilled occupation list, which obviously expedites that visa processing, but the short-term skilled migration does not really help solve the problem. The pathways to permanent residency are limited, and therefore we're not attracting skilled pharmacists from overseas. We really need to be on the medium-to-long-term skilled migration list, and that's what we're advocating for. It's just opening up the options and the attractiveness of Australia for these skilled migrants. There is a pipeline issue as well in terms of the professional requirements that they need to go through to be able to practice in Australia. The benefits for the employer are seen only one or two years down the track, and because of the temporary nature of the current visas they get value for maybe only one or two years beyond that. So we see that the medium-to-long-term strategic skills list is the only option to help us solve this problem.

Senator HUGHES: You gave some examples of full scope of practice activities that would help rural communities access health care when they need it. I'm interested in your take. I know the TGA has recently blocked the contraceptive pill from being able to be dispensed by pharmacies, while the higher-strength morning-after pill is freely available. Do you have any comments on those sorts of medications that, particularly when someone is already prescribed it, could potentially be a continual prescription or an ongoing fill rather than requiring a recurring doctor's appointment?

Ms Bekema: We were disappointed with that interim decision about the oral contraceptive. We've safely provided emergency contraception for years now, and often in that discussion we talk about contraceptive options to continue to supply the oral contraceptive in a safe manner through protocol. Referring back to the GP after a certain period of time to make sure that a thorough risk assessment is done, or that their health is maintained, would be part of that protocol. Also, there is being able to prescribe or to suggest long-acting reversible contraception. That's something that we talk about in the conversation, but to be able to then prescribe that would be ideal, and it would give access to women early and when they need it, especially when they can't see their GPs.

CHAIR: Mr Blacker, did you want to add something to that?

Mr Blacker: I was going to add to Senator Hughes's question. With regards to scope, I have an example. It's not rural and remote; it's regional. I'm aware of a prostate cancer sufferer who is in the end stages of life who is required to travel 150 kilometres to Culburra to have an injection administered—a simple injection—for their cancer treatment, because there is no prescriber near where they live, inland from the coast. It is a simple injection that a pharmacist, potentially, could give, if our scope allowed that. It's an example of putting the patient's interests at the forefront, and giving a local solution wherever possible, through scope. I think examples like that demonstrate where there is an opportunity in rural and remote areas for pharmacists to do more, to assist patients and to give better health outcomes and increased quality of life.

Senator HUGHES: Considering you give COVID and flu vaccinations, you'd think you could do that.

Mr Blacker: Yes.

CHAIR: Thank you, Mr Blacker and Ms Bekema. Your evidence has been very useful for the committee today.

JONES, Mr Matt, Chief Executive Officer, Murray Primary Health Network [by video link]

STEWART, Dr Ruth, National Rural Health Commissioner, National Rural Health Commissioner [by video link]

[13:51]

CHAIR: I think we are still waiting for the National Rural Health Commissioner to come online. But I welcome Mr Jones from the Primary Health Network cooperative. I invite you now to make a brief opening statement—hopefully by the end of that we may have Professor Stewart with us as well—and then the committee members will ask you some questions.

Mr Jones: Thank you for the opportunity of speaking to the inquiry. I think this is a really important inquiry into a really significant issue that has been part of the health landscape for quite a while, but the solutions haven't been readily available. In essence, I think we need a health system that recognises the different contexts of health need and the capacity to address that need. I think that there are specific issues in outer regional, peri-urban communities that require more coordination to address increased access, given growing populations. That is a different context to the regional and rural areas, where it is categorised by small populations with limited access to primary care services for a range of different reasons associated with viability, capacity and scale. And that is different again from the remote context, which is characterised by very small populations that are very long distances away. That makes it difficult to have wholesale, significant health care, and there are a range of other challenges associated with that. We need a system that is more responsive to the health needs. That involves more coordination and the ability to have more funding and policy that recognises the different contexts. The Australian healthcare system seems to work best where we have large populations in close proximity with economic capacity, and that doesn't describe much of rural, regional and remote Australia.

Additionally, we need team based care to address the needs of our communities. We've got chronic disease, mental health and a range of conditions that require the complement of the Australian healthcare system, which is extremely difficult to provide in locations with small-scale services and small populations that are large distances from other areas.

Additionally, the third part that I really wanted to emphasise is that not only do we need team based care but we need team based settings for the delivery of the care. We've got a changing environment in which healthcare practitioners are wanting to work. They are wanting the professional support, the career opportunities and the ability to be part of a team. Again, that is very difficult to achieve in small-scale entities. We need to build scale at a regional level, not only to enable more access to the type of primary care services that our communities need but to develop a model that enables the provision of a sustainable and viable primary care system that is coordinated and organised according to needs but is also an attractive career prospect that is rewarding and enables the recruitment and retention of practitioners, which we are finding so difficult in regional Australia.

CHAIR: Welcome, Professor Stewart. Do you wish to make an opening statement?

Dr Stewart: Yes, thank you. I know that there are many people who have talked today about the maldistribution of general practitioners across Australia. We don't have a problem with the number of doctors we have in Australia; we have a problem with the maldistribution—both with the specialties our new doctors are choosing to enter and also where they are choosing to practice.

I want to focus on the things that we know can make a difference, because the difference between now and 10 years ago is that we actually now have a lot of evidence about what will make a difference, and there are some things that we could do that would make some moderately rapid changes, and there are things that we need to put in place to create a sustainable rural workforce. The thing that we could do that would make a faster change than most interventions is to significantly increase the opportunities for junior doctors to have training work experience in rural and remote communities, both in hospitals and in community practice—community practice in general practice and in rural hospitals.

We know that about 35 per cent of new graduates from Australian medical schools say that they're interested in working in rural and remote medicine, but we're not seeing that translate into rural doctors. There is some very clear evidence—somewhat old data, now—from James Cook University where they looked at their first five years of students and asked: where are they working? They found that the site of internship had a profound influence on where doctors go to work. You can turn a rural-origin student who has had six years of rural medical education into an urban doctor by giving them a year of internship in a metropolitan hospital. I put to you that we haemorrhaging the investment that we are putting into the education of these young people by not providing them with rural internships and rural training opportunities. If we can significantly increase—double, triple—the number of internships in rural and remote communities for junior doctors, we would translate that 35 per cent into

a much large cohort of rural doctors within four to five years. You might think that's not soon enough, but if we do any of the other options you don't create the sustainable workforce, nor do you create the workforce that rural Australians need.

There are particular skills. We've thought long and hard about what those particular skills are. We have a training program for it and we even have the scope of practice. It's called 'rural generalism.' We know that if a doctor is trained with the skills, competence and confidence to work in rural and remote Australia they are much more likely to stay, so that's what I want to see.

If we can connect the pipeline from rural undergraduate training to rural junior doctor training to rewarded and recognised clinical practice as a fellow of a general practice college, with the specific skills of rural generalism, we would have a very dramatic improvement in the rural workforce that we have in Australia. So I would encourage you to look at those options, please. There's strong evidence to show that those interventions will work. There are lots of things that seem easier and faster, but there's not a lot of evidence to show that those rapid things will actually make a sustainable difference and will provide rural people with the care that they want and need.

Everybody just keeps saying, 'How long are you going to stay for?' It's sort of told to us as an anecdote. Like many of you that I'm talking to, I'm rural born and bred. I've worked for all of my career as a rural doctor. I know the impact it has if somebody stays on and gets to know the community and their patients. I think it's absolutely the most rational question that patients can be asking the new doctor who's turned up in town: 'How long are you going the stay for?'

What I want to see is us putting in place policy that will encourage them to stay, make them feel comfortable to work in the environment of rural medicine and confident that they have those skills and they know what to do when the proverbial hit it is fan, which it does. As a rural doctor you can be one of the few people there—which brings me on to my next point. We focus a lot on the doctors. It's almost like they're the key predator. They're the signifier, the canary in the coalmine. Doctors do their best work when they're part of a multidisciplinary team that's comprised of nurses and allied health practitioners. And that can be Aboriginal and Torres Strait Islander health practitioners, nurse practitioners, pharmacists, physiotherapists, psychologists, dietitians, podiatrists. If we, as doctors, work in a strong team, you don't need as many of us for a start because we're not doing stuff that other people can do better than we can, and we're providing much better care for our patients. I'll stop there. I can keep on talking.

CHAIR: Thanks, Professor Stewart. Great—leave us a bit of time for some questions. I'll hand to Senator Hughes to begin the questions.

Senator HUGHES: Thank you, Chair, and thank you, Professor Stewart. You have certainly covered off on a couple of these programs. Even quite succinctly, maybe you might be able to let us know—we've heard of new programs being suggested today, older programs that've been rolling out previously—what are the tried and true programs? What is actually working at the moment, and any of the outcomes that we're seeing that are helping to address these issues?

Dr Stewart: I need to declare that I was previously employed by James Cook University, but I went there because I could see that they were actually making a difference. By preferentially selecting rural-origin students from their patch, by having an explicit rural curriculum within their medical education, and by linking with postgraduate vocational training, they've shown that if you provide that linked-up pipeline from high school to a job, you will have doctors who will stay in rural and remote communities. Those are the things that we absolutely know work: enrolling rural students, giving them educational experience in the rural communities that you want them to work in and making sure that those positions are well supported and educationally rewarding. You can't just sit someone in a corner of a clinic and say: 'Just watch what happens.' Students learn best by doing and they can contribute to the whole multidisciplinary team. And then, by giving those new graduates jobs to go back to in those kinds of communities, they then aren't lured away by the big lights of the city. I can tell you, 35 years ago when I was a junior doctor, I had so many consultants saying, 'You're clever. You're smart—why don't you become a paediatrician, an obstetrician or an emergency physician, something special?' But I was a rural kid who had been impressed by the doctors in my small community, and I wanted to do that. I wanted to be that kind of person for my community. So those are the major things that work.

We also know that, if a doctor is not sure whether they want to go rural or not—we have some students who are absolutely committed to becoming a rural doctor and who, like me, are hard to divert, but, really, the majority of new graduates are not quite sure; they think probably they want to be a rural doctor—we know that, with that cohort, the MABEL survey data tells us that if you show them that there are attractive packages, that's financial reward and also professional recognition, that helps. That supports them. So that's both an attraction and a retention.

We have what are called workforce incentive payments set up within the Medicare system, so that doctors who have provider numbers can be rewarded for the kind of activity we want to see. I would really like to see that leveraged more to reward practice in rural and remote communities—to recognise and reward after-hours care, care within a hospital, emergency care, obstetrics, anaesthetics and surgical work as part of your job as a rural generalist, and longevity of stay. My husband and I, when we were very junior doctors, went to a small town in south-west Victoria, saying that we'd stay there for two years. Within a year, we started noticing the difference that it made that we knew our patients and knew the system, how much easier it was to work and how much easier it was to convince people to make the changes that we wanted them to make. And we said: 'This is good. We should stay on for a bit longer', but what we found was that that compounded each year. It compounded and made the work that we were trying to do more successful. I'd really like a lot more of our young doctors to experience that—experience the privilege of being deeply involved in transformational care of patients and communities.

Senator HUGHES: Is the federal government entirely responsible for addressing this workforce maldistribution?

Dr Stewart: If it were, it would be so much simpler. We have a couple of issues. I don't need to explain to you that the federal government looks after the funding of primary care and community care, and distributes moneys to the jurisdictions to run hospitals. At present, most of the junior doctor training occurs within hospitals. Therefore, the jurisdictions are responsible for the training of junior doctors. I've already explained that we are haemorrhaging rurally interested doctors into the cities because we're not giving enough junior doctor placements in rural and remote Australia. It's the jurisdictions that can make that big change and ensure that those positions are supported.

I'm talking to you from Queensland. Queensland, many years ago, instituted what was known as the rural reliever program, which said: 'Our poor rural doctors are overworked and need some holidays every now and again. We can send doctors out to help them.' So they sent first- and second-year graduates out to some of the most remote communities in Queensland to work. I can't tell you the number of Queensland doctors of my vintage who I've spoken to, who go: 'I did a rural reliever once! I just went, "I can't do this." I was stuck there on my own without support.' They tell horrific stories of really critical clinical incidents where they didn't know what to do and they didn't even know what their support structures were.

Yes, we need junior doctors working in rural and remote positions, but they need to be well supported so that they have a positive experience and learn about the system rather than just being totally freaked out by it. We wouldn't dream of putting an intern into a major metropolitan hospital emergency department and saying: 'The toilets are over there, and here's a pen. You've got your stethoscope. Start seeing patients.' We wouldn't do it like that. That's almost what happens, and has happened in the past, in some rural sites. We must be very careful that we give introduction and support. Yes, the jurisdictions have a large role to play in changing.

I've talked about the junior doctor positions. There's also the issue of recognising the skills and competence that rural doctors need. If you don't feel that people are acknowledging what you're doing, and you're working really hard, it's easy to get burnt out. If [inaudible], and you're much more likely to encourage people to come and work with you and join your fraternity, really. We need to recognise the skills of rural generalists and reward them. I don't see why, if I deliver a baby for a mother who's had a prolapsed cord—that's a life-threatening situation for the baby. If I do the caesarean section for that baby, I get paid less than a doctor in a major hospital. We need to recognise the skills of general practitioners who do amazing stuff as rural generalists. If we do that, that will help retain those doctors who are there. It's about attraction and retention.

Senator GREEN: Leading on from that, around the interaction between the primary health network and our state hospitals, on the flipside of that, I wanted to ask you, Mr Jones, about the impact that the GP shortages or lack of access has on our hospitals. You mentioned that in your submission. I've asked a lot of questions about it before. Sometimes it's hard to get that acknowledgment or the data that relates to it. Are we seeing people head to the hospitals, the emergency departments, because they're not able to go and see a GP?

Mr Jones: I think that phenomenon of lack of access in primary care, resulting in attendances at unnecessary or avoidable presentations to the acute system, is apparent and certainly evident in regional Australia, exacerbated perhaps by COVID, in terms of the changing landscape of how primary care is delivered, with increased demand. As an organisation, as PHNs, we collect data in relation to clinical activity through the primary care system, and we also collect data around practice profiles in terms of changing capacity in terms of numbers of GPs and the profile information associated with how the practice is structured. It's quite fluid. It's very dynamic, as you'd imagine; it changes regularly. But the reality is that the shortage of primary care providers in rural areas impacts in two ways on the acute system. I think it means that more people delay getting access to care earlier and it

results in people attending, either delayed or directly, the emergency department's urgent care centres of the acute system, when it could be better serviced in the general practice environment. In regional areas, often those GPs are also the visiting medical officers at the hospitals. So there's an infrastructural capacity issue on the health system as well with shortages of primary care providers, which is also impacting on the capacity of the acute services directly across the road, in reality.

Senator GREEN: Thank you for that. In your submission, you go through a number of case studies of primary health networks and some of the good wins and some of the challenges. Do you collect data on how many GP practices close down in your PHN areas in a 12-month period?

Mr Jones: Yes. Our role in ordinating primary health care is not exclusively but specifically focused on supporting general practice. We have information around the number of practices, the way the practices are structured. That does change with the recruitment or the departure of GPs, and it does also result in changes in the number of entities, the number of practices and the way that they're operating. We do collect that information routinely. It's important for us to provide the coordinating role that we're funded to deliver.

Senator GREEN: For the 31 PHNs that there are nationally, could you tell us—if you have the information now, that would be great; if not, later would be alright—how many GP practices in those 31 PHNs have closed over the last 12 months? I am also interested to understand whether you keep an eye on or measure any data in relation to GP practices that have closed their books, for lack of a better term? What we're finding is that, although there are quite a lot of GP practices that are still operating, they are not taking new patients. So the fact that the practice is there or the GP is operating is being taken into account by department data, or even PHN data. But, if they're not taking new patients, then they're not open for people to then go and access them as well as if there were someone taking new patients. I'm keen to understand if you've got that data as well.

Mr Jones: We do collect data in relation to the number of practices in our respective catchments, and that does change. Some of those changes are associated with practices closing; some of those are associated with mergers, amalgamations or the corporatisation of practices. Importantly, that information is helpful for us in responding to the needs of the community and working with the primary care providers. The information that's currently provided might not have the detail and the description of the variety of different factors or elements that constitute the changing number. For instance, in our catchment region, we have 191 general practices. That number is likely to change, and has changed, and it's due to a range of different factors. But we report that total quantum through to the department and certainly capture that information.

In relation to your question around closing books, again we capture that information in our practice profile. That perhaps is reflective of an individual organisational approach, and I wouldn't necessarily say that every PHN, while they certainly have the same processes, has the understanding of the changing environments for ways in which practices are operating, but it would be captured at some level. But, again, it is a pretty dynamic environment—it can change according to the recruitment of a GP, for instance—and the number of practices opening books and closing books would be a fluid and evolving situation.

Senator GREEN: Sure. Mr Jones, respectfully, as senators, although we're not subject matter experts, we're quite capable of having a look at complex data, so if you do have that information, could you provide it to the committee. If it is data that you provide to the department, you could also let us know, and we can ask them for that information, because we are really struggling to understand the scope of the problem in certain areas. There might be areas where the number of GP practices has increased, but I suspect that over the last 12 months there has been a significant change, so we would appreciate understanding that information.

Professor Stewart, I know that there was some information you wanted to provide us with during the estimates hearing the other week, but unfortunately we had the minister in front of us and it was important to get him on the record on these issues. So thanks for joining us today. I was struck by what you said at the beginning when you said that we have enough GPs in Australia but that we just don't have enough GPs in rural areas and that this could take five to six years to solve. I certainly appreciate that, but it does feel like we're in an acute situation right now, and I'm wondering whether you've got any suggestions for the committee to consider over the next 12 to 18 months to try and alleviate this problem as we come out of the pandemic, because I can tell you that my community can't wait another five to six years at the rate it's going. We of course need to try and find long-term solutions, but we also need to find some short-term solutions to ask the government or governments to act on.

Dr Stewart: A short-term answer—we know that if we have more registrars in a community, they're providing services. They're doctors in training to become whatever specialty. In some parts of Australia the GP registrars form a significant part of the health workforce, sometimes up to 35 to 40 per cent, so encouraging junior doctors by giving them those early career internships and a post-graduate year to get work experience in rural and

remote would make a difference. You would see registrar numbers in rural Australia coming through in a year and two years.

The other thing that has a reasonable chance of enticing doctors who have the skills to work in rural and remote communities is to incentivise the kind of work that you need to do in rural I'm talking about providing after-hours care and providing both community and hospital in-patient care. I think that specifically rewarding that kind of activity within the Workforce Incentive Program would make a significant and quite rapid impact on the dearth of rural doctors.

I know that sometimes people think, 'We'll just make doctors go.' But doctors are very clever people. They know how systems work. They are incredibly clever at working out how not to do something they don't want to do. In my experience, you can work really hard at getting doctors to do stuff they don't want to do and it doesn't work very well. So we need to work out how to encourage them to do the activity we want to see. I think that is both direct reward for working in Modified Monash areas 3 to 7 and rewarding the provision of in-patient care, emergency care, obstetrics, anaesthetic care and aged-care-facility care. Those are the things that would really significantly make a difference. What we hear a lot from the general practice community is that running a small business with the number of employees that you need in a general practice is tough going, and it's much tougher in rural communities. The break-in point is much closer. So financial incentives do make a difference in private general practice. I'd commend those two via the Workforce Incentive Program, or WIP, as we call it.

Senator PATRICK: It wasn't clear to me whether the PHN Cooperative took on notice to provide Senator Green with the information she requested. Was that the case?

Mr Jones: I took away from the request that I'd be progressing through the PHN Cooperative the collation of the individual capture of information that occurs with each PHN.

Senator PATRICK: Thank you. I just wanted to go to an issue that you raised with Senator Green. I'm talking about the merging of practices. We see right across various different sectors that entities are merging to get efficiencies by way of economies of scale. Is that what you're seeing in the cities? Does that in any way ever affect rural and remote communities? I imagine it wouldn't. What's your view on it?

Mr Jones: You're certainly seeing that in metro areas. There are practices coming together under a larger entity. It's often driven by the financial imperatives that Dr Stewart spoke of. In regional areas, it's also a growing issue in that the prospect of existing providers being able to sell the practice, in a succession sense, to the next crop of GPs coming in and willing to move to the area and work for long periods is less and less likely. So then one of the options that I would say is becoming more of a feature is the prospect of selling the practice to an existing corporate primary care provider. I would be encouraging and exploring alternative and additional avenues to build partnerships and collaboration across existing providers rather than that as a last-resort avenue because it obviously has an impact upon the structure of the practice and the relationship with the local acute service. I would think that there are greater opportunities and areas for us to strengthen partnerships between existing providers to build more team based environments to enable more attractive career prospects, more opportunities for employment and provision of primary care skills in an environment that is more supportive and financially viable. But the small-scale nature of private primary care makes it very vulnerable to not being viable and having to look for bailout options.

Senator PATRICK: Thank you for that. That was helpful.

CHAIR: Thank you very much, Mr Jones and Dr Stewart for your evidence today. It's been of great value to the committee. If you could get answers to questions that have been taken on notice to the secretariat by Thursday 18 November that would be most appreciated.

Proceedings suspended from 14:30 to 14:45

CLARKE, Ms Louise, Assistant Secretary, Rural Access Branch, Department of Health [by video link]

GORONDI, Ms Teresa, Acting Assistant Secretary, Health Workforce Reform Branch, Department of Health [by video link]

PASCUAL, Mr Nick, Acting Assistant Secretary, Bonded Taskforce, Department of Health [by video link]

ROCKS, Mr Martin, Assistant Secretary, Health Training Branch, Department of Health [by video link]

SHAKESPEARE, Ms Penny, Deputy Secretary, Health Resourcing Group, Department of Health [by video link]

WEARNE, Dr Susan, Senior Medical Advisor, Health Workforce Division, Department of Health [by video link]

WILLIAMS, Mr Matthew, First Assistant Secretary, Health Workforce Division, Department of Health [by video link]

CHAIR: Welcome. I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted.

Did you wish to make an opening statement?

Ms Shakespeare: Other than acknowledging the traditional owners of the lands we are meeting on today and paying our respects to elders past, present and emerging, we don't wish to make a further opening statement and are happy to take your questions.

CHAIR: Thanks very much. I will ask Senator Green to start off with the questions.

Senator GREEN: I want to kick off by asking a few questions about the removal of regional bulk-billing incentives. I'm referring to a change that came in in 2019. What was the justification for that removal?

Ms Shakespeare: Bulk-billing incentives do remain in place in rural areas. There were some locations that lost access to rural bulk-billing incentives at that time. They were not rural areas; they were areas in capital cities and, I think, some larger regional areas. The change in 2018-19 was due to a change in policy based on geographical classification. It utilised ABS geographic data.

Senator GREEN: This is the change for the way that GPs were paid additional incentives for children and concession card holders. How much did the government save out of that measure? What was the fiscal impact of making that change?

Ms Shakespeare: I'm sorry; we don't have that information here with us but are happy to provide that on notice. We will check budget papers from that time.

Senator GREEN: How many areas were affected by the change?

Ms Shakespeare: I will add that up for you. There were 29 areas.

Senator GREEN: Are you sure that was based on that change? That seems like a low number. We might have to come back to that in the next couple of minutes.

Ms Shakespeare: To clarify areas: the list I'm using here doesn't list suburbs as such. It does for some—for example, Belconnen or Frankston city—but in others the information I'm using has 'eastern outer Melbourne', so it's broad catchment areas rather than specific suburbs or towns.

Senator GREEN: Okay. We will come back to that one. Did the department conduct or commission any analysis on the likely impact of that decision on the financial viability of affected GP practices prior to the decision being made?

Ms Shakespeare: We will need to check back to see if we commissioned any external analysis of that nature. I imagine that the considerations were around ensuring that the rural incentives were better targeted to real rural locations. Where we had outer metropolitan areas that may have been treated as rural areas or areas that had changed under ASGS remoteness classifications at the time and were part of larger urban areas as a result, the intention of the changes would have been to make sure that the higher bulk-billing incentives were targeted to areas that are more rural and more geographically challenged.

Senator GREEN: Sure. I do have more questions. You will notice that the inquiry is dealing with rural, regional and outer metropolitan areas, so these questions are about the impact of those changes on outer

metropolitan areas. Did you undertake any analysis of the impact of GP practices in those areas? Could you take that on notice?

Ms Shakespeare: Will do.

Senator GREEN: I'd also like to understand whether the department conducted or commissioned any analysis on the likely impact of that decision on people's ability to access a GP in those affected areas. Do you need to take that on notice as well?

Ms Shakespeare: We can look through the particular locations. I am happy to have a look at the impact that that change may have had on access to services before and after the change.

Senator GREEN: I'm interested in understanding what work you did before the change.

Ms Shakespeare: We will have to take that on notice.

Senator GREEN: Since the change, has the department conducted or commissioned any analysis on the impact on GP practices in those areas and particularly the access that people have to those GPs in those areas?

Ms Shakespeare: The bulk-billing incentives are primarily intended to support Australian patients by improving their access to affordable services under Medicare. We do know that, over time, bulk-billing rates have increased, but we're happy to have a look for you on notice at the bulk-billing rates in the particular areas that may have been impacted by those changes.

Senator GREEN: This is probably a more direct question. Obviously, if that analysis exists, I would love to see it, but I want to know if you've even thought to find out. Have you had a look at whether there's been an impact in those areas? Does the analysis exist?

Ms Shakespeare: We are constantly looking at the impact of changes that we make to policies. We are constantly looking at access to services. We have teams of people that are looking at Medicare services data, access to GPs and GPFTE data. So, yes, we do spend a lot of time analysing our policies, our programs and access to the Australian health system by the community.

Senator GREEN: We don't have a lot of time today. My question was very clear: do you know what the impact has been on that decision on the access of GPs in those areas? If you don't know, I would like you to be able to say that.

Ms Shakespeare: We would know. I don't have that information with me now, and we're happy—

Senator GREEN: If you could provide it on notice—

Ms Shakespeare: as I said, to provide it on notice to you.

Senator GREEN: Thank you. I'd like to move on to some similar questions about the Medicare rebate freeze. What was the fiscal impact? What was the saving that the government got out of that Medicare rebate freeze?

Ms Shakespeare: On the Medicare pauses in indexation, I think there is a fair bit of detail set out in our written submission as it was a particular area of interest to the committee. It's some time ago, though, so indexation has been in place for several years now. It happens on 1 July every year for most services, but it's not for all services—we're not indexing pathology services. Again, I don't have specific information about the fiscal impact with me, so we'd need to take that on notice.

Senator GREEN: I'd like to know whether the department conducted any analysis of the likely impact on GP services and access to GPs before that decision, because in evidence that we've received today and in submissions we've heard that it had a significant impact on GPs in rural and regional areas.

Ms Shakespeare: Again, we'll need to take that on notice because the first pause dates back, I think, to around 2012. We'll need to look back through our records as to whether or not there was assessment of impact done at the time.

Senator GREEN: Have you conducted any analysis on the impact? We've had a lot of evidence to suggest that it has had a negative impact on GP practices. Have you looked in to whether that is the case and how many GPs were affected by those changes?

Ms Shakespeare: We have data about headcount of GPs, so GP full-time equivalent numbers per 100,000 population. From the period 2014 to the period 2020, which is data I have here with me, there have been increases across the country. It doesn't look, from the data that we have over that period, like there has been a reduction in GPs or a reduction in GP services. As I said before, bulk-billing rates have continued to increase.

Senator GREEN: Ms Shakespeare, are you referring to GPs in Australia as a whole, like the number of GPs? That's not really the question, is it? The question is: what has happened to GP services in rural and regional areas because of the Medicare rebate freeze?

Ms Shakespeare: If we look across modified Monash categories, from 2014 through to 2020 in Modified Monash 2 the GP headcount has increased from 2,072 to 2,529.6.

Senator GREEN: That's the full-time headcount, is it?

Ms Shakespeare: That's full-time equivalent.

Senator GREEN: Does that count a GP that worked one day in that area, or someone who has done a locum, or is it permanent?

Ms Shakespeare: It's full-time equivalent. My colleague Dr Wearne may be able to explain it better than I can.

Dr Wearne: The analysis that Ms Shakespeare is referring to would record any work done by somebody we have recognised to be a general practitioner, so, yes, it would include people who were permanently in the workforce and those who were coming in just temporarily.

Senator GREEN: Would it include people doing locums?

Dr Wearne: Yes, it would.

Ms Shakespeare: I can keep going—

Senator GREEN: It doesn't include—no, because I've seen the data, Ms Shakespeare. I've had a look at it, and the data you're referring to includes locums. Also, as we discussed in estimates, it doesn't give any indication in that data how many of those GPs have closed their books, does it?

Ms Shakespeare: It looks at the number of full-time equivalent practitioners providing services, non-referred attendances, under Medicare, to the community. That could be part-time doctors, full-time doctors, ongoing employed, temporarily employed—it's the full range of people providing services made into a full-time equivalent number. That's how we measure access to services, non-referred attendances, under Medicare, over time. It has increased across all modified Monash categories.

Senator GREEN: It doesn't include when a GP has closed its books, does it?

Ms Shakespeare: We did discuss this a bit last week. GPs can close their books for a number of reasons. They can decide to reopen their books. They can close their practice. They can sell their practice. Practices can change ownership. We have some doctors that join corporate practices and might close their practice at that point but provide services through a different practice. There are different models of ownership. These things are private businesses, and changes happen.

Senator GREEN: I've spent hours on the phone calling GPs who have closed their books, so I know exactly what that feels like. What I'm asking you is: does your data include full-time equivalent GPs that are only taking new patients or ones that are not taking new patients? The answer is no, isn't it?

Ms Shakespeare: It includes services.

Senator GREEN: Yes, but that's not including new patients. In terms of the Medicare rebate freeze, do you know if the financial impact was greater on outer metropolitan, regional and rural practices compared to city practices? Was there an analysis done to see whether the burden was being shared or whether it was being felt more widely by rural and regional practices? Again, that is the evidence we've received today.

Ms Shakespeare: We publish an MBS benefits page on a quarterly basis, which I understand is broken down into modified Monash categories as well as broad types of service. That analysis would have been done, and I think the results are published on a regular basis.

Senator GREEN: Can you answer that question then?

Ms Shakespeare: I would be able to go and pull the information about impact on benefits and the benefits that are going to GPs providing services in different modified Monash categories over time for you if you would like that information.

Senator GREEN: Yes, we would like that information. Thank you. We had some questions on the issue around districts of workforce shortage and distribution priority areas. We asked some questions in estimates, but I'm interested to understand what sort of analysis the department has done to understand what the impact, positive or negative, would have been for those areas where they are now a DPA. I'm talking about the change from 'district of workforce shortage' as a terminology to 'distribution priority area' as a system.

Ms Shakespeare: Understood. At the time we moved from the districts of workforce shortage, which we now just have for specialist doctors, not GP specialists—I should clarify that GPs are certainly specialists—distribution priority areas replaced the 'districts of workforce shortage' system for GP services. We consulted with a lot of rural groups in the change to the two systems. They include our working group that contributed to the

development of the DPA methodology: the College of Rural and Remote Medicine, the Australian Indigenous Doctors Association, the Australian Medical Association, the Monash University School of Rural Health, the National Rural Health Alliance, the National Rural Health Commissioner, the Royal Australian College of General Practitioners, the Royal Flying Doctor Service, the Rural Doctors Association of Australia, Rural Health Workforce Australia, the Rural Health Workforce Agency Victoria, the University of Melbourne's Melbourne Institute of Applied Economic and Social Research, the University of Newcastle Department of Rural Health, the University of Queensland Rural Clinical School, and the Antarctic Division of the Department of Agriculture, Water and the Environment. Those groups were all involved in advising us on the development of the new distribution priorities area methodology to replace the old districts of workforce shortage and were convinced that this would assist us in better targeting those areas that were experiencing shortages in GP access and GP services.

Senator GREEN: What has been the impact on areas that were considered to be district of workforce shortage areas but weren't considered to be distribution priority areas?

Ms Shakespeare: The main change, as I understand it, and my colleagues will jump in and correct me if I'm wrong, is that 'district of workforce shortage' used to compare areas to the straight average of all Medicare access across Australia, including metropolitan areas. Under the distribution priority areas, the benchmark for access to overseas trained doctor employment, so doctors who are able to get access to 19AB exemptions, is now the average of access to services in modified Monash category 2, so regional centres. In many cases there was recognition that average benchmarks in metropolitan areas were not relevant, so we've improved the system, and there were areas that—

Senator GREEN: That wasn't my question, though. My question was: what happened to the areas that were district shortage workforce areas but are not district priority areas? There were some areas that—

Ms Shakespeare: Yes.

Senator GREEN: What happened to those areas?

Ms Shakespeare: The impact on those areas is that they would not have been able to recruit overseas trained doctors. However, if they had an overseas trained doctor currently working at their practice, they could replace them. We do have exemptions to allow replacement of overseas trained doctors.

Senator GREEN: Did the number of GPs go up or did it go down?

Ms Shakespeare: Over time, the number of GPs has continued to climb.

Senator GREEN: In those areas I'm talking about?

Ms Shakespeare: We'd have to go away and have a look at that for you on notice.

Senator GREEN: You said you have some data there in front of you, and you gave me the figures for GPs in MM2, is that right?

Ms Shakespeare: That's right. Modified Monash 2, the GP full-time equivalent for MM2 from 2014 to 2020 increased from 2,072.9 to 2,529.6. I can keep going through those numbers for the other MM categories or we can provide—

Senator GREEN: If you've got them there and you can provide them today, either now or shortly after the hearing, that would be helpful. I'm interested in the MM3 to 7 figures between 2014 and 2021. I understand you only have until 2020, is that right? We're not capturing the last 12 months?

Ms Shakespeare: We're still going with 2021, so we won't have figures completed for 2021 yet, but I am giving you the most recent data we have. For MM3, in 2014 the FTE figure was 1,816.9, and in 2020 it was 2,026.9; MM4 was 1,125.1 FTE in 2014 and was 1,276.9 in 2020; MM5 in 2014 was 1,262.6, increasing to 1,419.4 in 2020; MM6 was 212.1 in 2014 going up to 220.2 in 2020. MM7 was 133.2 in 2014 increasing to 143.1 in 2020. I can also give you those numbers as a proportion of the population, so broken down per 100,000 population.

Senator GREEN: In those numbers, do you have a breakdown of the proportion of international medical graduates and locally trained doctors?

Ms Shakespeare: I don't have that number on the sheet in front of me, but I am fairly certain we can get that for you.

Senator GREEN: Okay, thanks. Do you keep data on the average waiting time to see a GP?

Ms Shakespeare: We're still looking into that for you from last week. I think our Primary Health Networks do collect information on practice opening hours and things like that, so we might be able to get some information from PHNs, but I'm still looking into that for you, Senator.

Senator GREEN: To be clear: the department doesn't keep that data; you have to ask for it from PHNs?

Ms Shakespeare: Well, it might be that somewhere else in the department holds that—the people that look at the PHN reports and manage their grants. We don't have those people—

Senator GREEN: If I asked you what the average waiting time was to see a GP in Emerald, Queensland, you don't have that information?

Ms Shakespeare: I would like to consult with my colleagues in the primary healthcare division because I know that they've also been funding Emerald practices as GP respiratory clinics with specific funding to see patients during the pandemic. So we might have some data for you about that and access to those services in Emerald under that separate contract.

Senator GREEN: But that's only if there's a PHN in place. What about the areas outside of PHNs?

Ms Shakespeare: There are PHNs—Primary Health Networks—operating right across the country.

Senator GREEN: Yes, but you're saying that you might have some information from Emerald because there's a specific area of work occurring. Is that information that all the PHNs hold for every area?

Ms Shakespeare: That was from our GP respiratory clinic contracted providers. We have one in Emerald where we've been funding access to GP services during the pandemic for people with respiratory symptoms in particular. We might have some data under that contract which is separate to the PHNs.

Senator GREEN: My question, again, is: do you have that data for all areas across the country? You said there are PHNs operating across the country. Do you know how long it takes to see a GP in Launceston, in Tasmania?

Ms Shakespeare: As I said, Senator, we're still checking as to what information the PHNs might have and might be providing to the part of the department that manages their contracts.

Senator GREEN: I have one last question on this issue of data. Does the department collect any financial data on GP practices across Australia in terms of their viability or financial circumstances? We've obviously been given some evidence today and through submissions about the viability of GP practices in rural and regional areas and how a lot of GPs are struggling at the moment.

Ms Shakespeare: There might be some information in our primary care division about the viability of practices that, again, we get through Primary Health Networks. Those are our funded organisations that are looking at the delivery of sustainable and coordinated primary care services in communities.

Senator GREEN: So, you'll have to take that on notice as well?

Ms Shakespeare: We can provide you with a lot of information about workforce programs and Medicare benefits. Those are the programs that we've got a lot of information on here today. But, if you want information about the viability of particular GP practices, yes, I think we'll need to take that on notice.

Senator GREEN: I had this conversation at estimates as well, Ms Shakespeare. I find it really hard to understand how the government can make policy decisions—and the department can be advising the government to make policy decisions—if you don't know how many GPs are in financial situations where they're under pressure, you don't know what the wait times are and you don't know how many GPs are turning away new patients. You say this is all information that you don't have at hand today, but, if it exists, could you please provide it to the committee?

Ms Shakespeare: We do have high-level data about increases in Medicare benefits that we're paying to GPs across Australia and in particular areas of Australia. We have information about how much GPs are paid by Medicare, what their reported taxable income is. But we don't look at particular business models, because there are a range of different business structures that operate across general practice. We have large corporates, and we would be able to get you information about how those large corporate practices that may report their profits are operating. But there are also a lot of small businesses, independent solo practices. We don't collect information on all of the tens of thousands of separate businesses at the department level for the purposes of Medicare or health workforce programs. We might have information about particular practice viability issues that's collected through our primary health networks. But that's the sort of information we will have to go and ask about for you.

Senator GREEN: Thanks, Chair. I'll leave it there for the moment.

Senator HUGHES: I was wondering whether you could update us on how many more doctors and nurses are working in country areas as a result of the government's Stronger Rural Health Strategy.

Mr Williams: Since the Stronger Rural Health Strategy has come online and since the significant investments the government has made in rural health, we have achieved a growth of over 750 in the number of GPs and over 1,000 in the number of nurses in regional and rural areas in Australia.

Senator PATRICK: Which MMs are you including when you put those statistics to us?

Mr Williams: That's a broad capturing from MM2 to MM7. I can go into more detail at a lower level, if you'd like.

Senator PATRICK: No, I just wanted to understand what you were saying to us. That's all. Thank you.

Senator HUGHES: Are we seeing any other outcomes from various workforce pipeline initiatives of the government?

Mr Williams: Yes. There have been some significant positive changes since the Stronger Rural Health Strategy. As I mentioned, there are over 750 additional GPs and more than 1,000 additional nurses in rural and regional areas. GP services per capita, which is a really good measure in terms of how people are receiving their services, went from 6.3 to 6.4 in 2019. We've had a reduction in the number of overseas trained doctors entering the primary health system but at the same time an increase in the number of those overseas trained doctors who go to rural and regional areas. In 2018, 35 per cent of the total number of overseas trained doctors went to rural and regional areas. That's now over 60 per cent as a result of the measures we've put in place with the Visas for GPs Program.

I can give you, on notice, an additional list of successes and achievements that have come online since the Stronger Rural Health Strategy. And obviously the government continues to invest in existing programs and the development of new programs. I think one of the important points to make is that most of the significant investments have long lead times—for example, training of the next generation of doctors in rural and regional areas, changes to the general practice training program, and the programs we have for specialists to train in regional and rural areas. They have longer lead times, and we're starting to see some of the impacts of that as well. I'd be happy to take on notice any additional benefits we have noticed.

Senator HUGHES: That would be great. The government recently announced a three-year extension to the Rural Health Multidisciplinary Training program. That program has been around since 2016. How many students have participated in that program since then?

Mr Williams: That's a really good question.

Mr Rocks: As an overview, between 2016 and 2020 we've had a total number of 14,222 medical CSP graduates coming through the Rural Health Multidisciplinary Training program, and that is a total of almost 36 per cent of all Commonwealth-supported medical places undertaking a year of clinical training and study through the RHMT program. The other component since 2016 is the total number of entering CSP students coming into the RHMT program. We had 14,493 in total. In 2020 data, the number of entering CSP students of rural origin coming in represents 35.2 per cent of the total cohort of Commonwealth-supported places. That's a rise from 30.7 per cent in 2016.

Senator HUGHES: With regard to the University Departments of Rural Health, what do these actually do? And how many students do those schools support?

Mr Rocks: The UDRH is the non-medical—allied health and nursing—component of the RHMT program. In terms of the numbers, I can get some updated 2020 data on notice, but I've got 2019 data. We had 16,500 nursing and allied health rural placements delivered in 2019 through the UDRH network, equating to 79,000 placement weeks for nursing and allied health services. It's also worth noting that, with the 2020-21 budget in October, the government has invested further in the UDRH program following the evaluation of the program. That's to provide an additional UDRH in an identified area of need following the findings from the evaluation and also to open competitive processes to universities to stretch training in more remote areas—looking at three to seven. That's also looking at projects where UDRHs can partner with aged-care providers to deliver training at aged-care facilities. Those grant opportunities have closed and are currently under assessment by the department.

Senator HUGHES: Thank you. We heard earlier today in the hearings about regional training hubs. How are those hubs supporting rural training and ensuring that we're increasing that pipeline of future rural doctors?

Mr Rocks: The hubs are also part of the RHMT program, and there are approximately 26 of those working nationally. The intent of the hubs is to provide on-the-ground networking, support and joining up of arrangements between the undergraduate and junior doctor placements and looking at strengthening and networking ties through the regions. At the moment, there's a lot of work being done particularly in the non-GP specialist training space, but we see opportunity moving forward for those in the context of GP specialties, enhancing the network

and collaboration to ensure continuous opportunities and experiences through the regional and rural training pipelines.

Senator HUGHES: On that, how many junior doctors are participating in the Rural Junior Doctor Training Innovation Fund, and what sorts of opportunities and work are participants getting to experience through that rural medical network?

Mr Rocks: We've presently got two streams to the rural junior doctor fund. We've got the original training innovation fund, and there'll be 264 rotations in 2021 as part of that. The government has also announced an extension of the Stronger Rural Health Strategy to include rural generalist junior doctor training exposure, and we've got 268 placements occurring in 2021 under that program. Moving forward—and I'm aware that some of the organisations and participants who contributed this morning spoke of the importance of expanding the junior doctor pathway—a budget announcement, which will commence from 1 January 2023, will merge these two programs and will increase the current baseline of 440 rotations to 800 by 2025.

Senator HUGHES: We've had a bit of a talk today around looking at ways to do things differently, innovatively, so it's probably an appropriate name for a program—the innovative models of care program. Are there any positive finds particularly with regard to workforce outcomes that we're seeing early on?

Mr Rocks: There are two parts to innovative models of care, but the one pertaining to training is around employment models. We have got an arrangement, the Murrumbidgee employment trial, which might have been spoken about earlier today. That's under a 19(2) exemption with the Murrumbidgee Local Health District, where we're looking at training five RGs across the region. The intent of that is for registrars coming into that program to have continuity of employment in terms of accrual of benefits and other aspects of their employment conditions by being employed through the Murrumbidgee LHD. It will look at one of the challenges for registrars going through training in coming in and out of different workplaces and different employment agreements and conditions to see what we can do to harmonise those arrangements so that there's a seamless experience and, importantly, so that registrars' training is kept within a region.

Senator HUGHES: Just so I understand it, is that also working with allied health professionals, pharmacists—bringing together all the different elements?

Mr Rocks: I might hand in relation to the innovative models. But, no, this is one is directly around working in general practice and the hospital setting in an arrangement with the Murrumbidgee health district.

Ms Shakespeare: We do have other innovative models, which are being either worked up or trialled at the moment, that are looking at how you can better connect services across a local area for aged care and disability as well as primary care and acute care. We do have a few of those trials, and the Rural Health Commissioner—I didn't hear her evidence, sorry—might have spoken about some of those, as she has a grants program to help people develop those models.

In terms of innovative approaches with pharmacists, there are also pieces of work happening through different Primary Health Networks looking at how different health professionals, including pharmacists, can be better integrated into the care team. We're happy to also provide information about some of those projects.

Senator HUGHES: Perfect.

Mr Rocks: I can provide some additional detail on those innovative models, if you'd like, but I'm happy to take it on notice as well.

Senator HUGHES: Yes, that would be great. Thank you very much.

CHAIR: Thanks. If you take it on notice, that will help us with timing now. I'll now move to Senator Patrick.

Senator PATRICK: Thank you very much, Chair. Mr Williams, you said that your statistics were for MM2 to MM7. Over what period was the increase—2014 to 2020?

Mr Williams: That was the increase over the period of the Stronger Rural Health Strategy, so it was 2018-19.

Senator PATRICK: I want to go back to a couple of questions that came up earlier in the proceedings. There was a claim that training fees that were really aimed at people going into rural, regional and remote areas were being utilised—a figure of $2 billion was quoted, and it was said that half of it was going to other metropolitan jurisdictions in the end because providers were not held to account, there was no tracking, and the Department of Health wasn't really ensuring that the money dedicated was going to rural areas. Does anyone want to comment on that if they saw that evidence?

Ms Shakespeare: Yes, I think I did see that earlier. I think it was about the specialist training program, but I could be wrong.

Senator PATRICK: Yes.

Ms Shakespeare: The department and the government are across a range of programs trying to tighten up our focus to make sure that rural areas are benefiting more from the investment that we make. The Rural Health Multidisciplinary Training Program that my colleague mentioned earlier is a very large investment—I think it's around $200 million a year. A lot of the training has been occurring in larger regional centres, but the government has made some changes and invested a little more money in the last budget—I think it was earlier this year—to make sure that we're getting more of the Rural Health Multidisciplinary Training rotations in MM 3 to 7. That was the result of quite a comprehensive evaluation we had of the RHMT.

We are also looking at reforming the specialist training program, particularly as a result of the national medical workforce strategy, which we're in the last stages of finalising—it's going through all health ministers for approval at the moment. We need to make sure that we are genuinely targeting Commonwealth funding for specialist training. Most specialist training funding is the responsibility of state and territory governments through the public hospital system, but where we do have Commonwealth funding support for specialist training, it is targeted to areas most in need. At the moment we have a grant opportunity out there for specialist colleges that want to make changes to their program delivery so that they can deliver more training in rural areas, whether that's through more flexible supervision or remote supervision. We are definitely trying to address all of these issues right across our programs. It also goes back to the discussion we had earlier around rural bulk-billing incentives. We have tightened those up so that rural bulk-billing incentives aren't going to metropolitan areas. It's an ongoing work across a lot of programs.

Senator PATRICK: In the way that you look at costs, it's clear that you're using the MBS data quite extensively to look at things like establishing GP FTEs per thousand people. Do you do that for cost? Is the standard denominator the MM divisions?

Ms Shakespeare: We have a lot of great administrative data through Medicare, and it goes back a long time—it dates back to the 1980s. We look at both services provided and benefits paid under Medicare, and we can look at those separately for different types of services, for different types of specialty, for nurses that now bill under MBS and allied health, or by modified Monash area. We don't routinely break it down into electorates, but sometimes we get asked by senators to do that. It can be done in quite a few different ways.

Senator PATRICK: What I'm wondering is what number is for someone in each of the modified Monash areas. I wonder, for example whether or not the PBS numbers are categorised by MM numbers or health workforce costs, or if primary healthcare networks are costed by that same denominator—that being a modified Monash region.

Ms Shakespeare: We are, over time, applying the modified Monash system to more and more of our health programs and approaches. I'm stretching my memory here, but I think we introduced it in 2015, based on a lot of work with rural stakeholders and experts in the factors that attracted doctors, in particular, and health workers to rural areas. So, over time—over the last five years—we have been using modified Monash as an overlay to our data as that system is being refined.

Senator PATRICK: To the extent possible, can you provide to the committee a cost per patient, noting obviously that you are using GP FTEs per thousand? You can divide that by 1,000. I just want the costs associated with each per-patient average over the modified Monash regions. You can include what data is in there, whether it's the MBS data, veterans health data or pharmaceutical data. I'm not asking you to provide anything more than what is available, but I would like to know what you might include in that.

Ms Shakespeare: Yes, we can certainly do that for you.

Senator PATRICK: Specifically for South Australia, you've got these new GP catchments, which you talked about in your submission. Again, I wonder if you could just tell me how many GPs—I'm not after specialists; I just want to stick with GPs for the moment—are in each catchment area, either as a full-time doctor or as a part-time doctor? Is it possible to provide those numbers?

Ms Shakespeare: It will be. Are you more interested in FTE or headcount?

Senator PATRICK: In some sense, most people don't relate to FTE. They relate to, 'I've got a doctor that lives in my community.' I'm not really interested in locums who fly in and fly out. I just want to really get a feel for the number of permanent doctors who are in each of the catchment areas. If someone only works four days a week but they're still effectively the town doctor, I think that qualifies, but you could simply annotate any information you provide me with the criteria that you used.

Ms Shakespeare: Are you interested in the catchments in South Australia or all of them across Australia?

Senator PATRICK: Just across South Australia. Other senators may ask for that data; my focus is on South Australia.

I thank you very much not only for the submission you gave—it was quite comprehensive—but also for the answer you eventually gave me in relation to the modified Monash areas in South Australia. The reason I was querying Mr Williams is that, if I look at the data at a national level for GP FTE per 1,000 people—and this is question on notice SQ21-000944—it's clear that around 2014-15 there was a bit of a jump. Since then things have remained relatively static. Indeed, last year we saw, generally, a decrease in the GP FTE per million people. I wonder if you could comment on that. You might have heard me asking the rural workforce agency about what's happened there and whether or not we're getting value for money. It just seems to me that it's relatively static. There are some ups and downs in there, but it's not necessarily trending upwards.

Mr Williams: Yes, you're correct. Over time in South Australia—and this belies the larger statistics and targets et cetera—there has been an increase in GP FTE for the state, but there are anomalies; that increase has not been consistent across the country or within a particular state. Some MM regions in South Australia have increased substantially, others have plateaued and some have decreased. As you mentioned before, we have a number of programs and partners on the ground to try and determine what specific factors to that area are impacting a particular town or region. Over time we hope we can bring those programs to bear to ameliorate some of the issues. But, as this entire inquiry is showing, it is very complex, and rural and regional areas have some specific challenges that are different across states. You're right in your observation that it's not consistent at the state level or at the MM level, and there are anomalies in those increases.

Senator PATRICK: Finally, it has been in the news that Dr Scott Lewis has left Wudinna. One of the difficulties he expresses is problems with the state health system. Whilst I respect issues of comity between state and federal, in the end it is the federal government that is largely funding a doctor in Wudinna. I wonder whether the department might contact Dr Lewis, to do an exit interview to try and find out what was going on that caused him to ultimately up stumps and leave. I again note it is Commonwealth funding, and I know now that in order to replace him you guys are going to have to spend a lot of money. One of the comments he made to me was, 'You will happily spend money on locums but not on potentially improving conditions for existing doctors.' I wonder if you might be willing to at least speak to Dr Lewis, because it is a significant shock in and around Wudinna to lose a longstanding doctor, knowing that it is going to be really hard to replace him.

Ms Shakespeare: We often talk to practices that have decided to close in individual areas, and, with the rural workforce agencies or PHNs, work with them to see what has happened and what we can learn from that. We've done work recently; over the last 12 months there was GP closure at Katherine, and we did some work at Bombala. I'm happy to do work there as well.

I want to let you know about the locum support. We provide funding under the Rural Locum Assistance Program. It's to let our rural doctors take leave so that they can have holidays or go and continue professional development training. There are certainly grants available through the rural workforce agency, the rural workforce program, whether it's providing grants to individual doctors that might keep them there, additional training or additional financial incentives. So there are some programs currently available.

Dr Wearne: We would be happy to speak with Dr Lewis. The issue you raised, regarding the benefits paid to locums versus the benefits paid to ongoing staff, was something we heard repeatedly when we were doing the consultations for the National Medical Workforce Strategy, and that's one of the recommendations in the strategy. Because it's a state funding issue rather than Commonwealth, we need to do that sensitively. But the concern was raised that it seems to be separate buckets of funding and, therefore, it's difficult for even those who are employing locums to know what the opposite side of it would be. So it's different people doing different things. It's a big piece of work that I suspect will produce some interesting results.

Senator PATRICK: Finally, just extending on that, Dr Lewis indicated that part of his frustration is plans being made in Adelaide by people who are not cognisant of the real issues in rural areas. Whilst Dr Lewis has raised those concerns, I'm aware that there are other doctors that feel similarly, and it would be beneficial, in my view, to talk to him not just about the locum issue but also about the frustrations that he had with the state government. Again, I respect principles of comity, but this is state money sitting alongside federal money, and maybe some difficult conversations need to be had in order to get the best outcome.

Ms Shakespeare: We are very happy to engage with our colleagues at SA Health, and I know that the Minister for Regional Health has very recently talked to his counterpart the minister for health in South Australia about the issues, too.

Senator PATRICK: And if anyone from your department needs his phone number, I'm happy to provide it through my office. I'm sure you can probably get it anyway, but there's an offer.

Senator O'NEILL: Thank you to all the officials from the Department of Health for being here today. Can I first ask for any of the data that you can provide, in the form that you are providing it to Senator Patrick for the state of South Australia, to be provided to the committee also for the state of New South Wales. I'll leave it to other senators to discern which other states this might be relevant to. But I certainly want to know the data for New South Wales, and the breakdown, and figure out where the workforce is and what you know about where the workforce is, because it seems to be a very big problem. Can I also thank you for your detailed submission. I will firstly indicate that it reads like an alternative and parallel universe in comparison with some of the evidence that I've received in my duty seat visits across New South Wales and some of the responses that I've had online during the course of the inquiry today.

This is what I was told today, and I'm interested in your response to this: 'Have you spoken to any new GPs recently about their rural placements? No time for compulsory study, endless on-call for after-hours at the local hospital. This means they can't develop any community or social life. Their appointment book is being triple-booked. No wonder they head back to the city as fast as they can.' And that's not an isolated comment, about how grossly mismatched the workforce is to the needs of rural Australia. That's my first question.

Ms Shakespeare: Senator, I'm not quite sure what the question was, but you're asking us to comment on whether or not people have good or bad experiences in their—was that a GP training rotation, or was that a junior doctor, or medical school?

Senator O'NEILL: That was a GP training rotation.

Ms Shakespeare: The Australian General Practice Training program is currently under reform. We are working with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine to make sure that that program is delivered in a way that's going to increase the primary-care workforce for the community. We've had a reduction in interest in GP training over the last few years, and we want to make sure that it's a high-quality, safe and enjoyable experience for all of our GP registrars. We've been putting in an enormous amount of work with the current training providers, and with the colleges, the supervisors association, the registrars association and other interested stakeholders, on how we can improve GP training. So it is something that we are looking at at the moment, Senator.

Senator O'NEILL: I'm sure that you are looking very carefully, and I'll take a further response as well, but I've been taking evidence in committees for health from both the House of Reps and the Senate now for nearly 11 years, and the consultation that is constantly spoken about is simply at odds with the experiences that people from regional and rural Australia continue to put on the record. It's almost like watching while Rome burns. The consultation is going on, the planning is going on, the data collection is going on, and in the meantime people are dying at a higher rate in regional Australia and rural Australia, and the small-business model that existed for GP businesses basically just collapsed in 2014, with the removal of the rebate, or the suspension of indexation around the rebate, under the leadership of Mr Abbott. The whole thing seems to be in a permanent state of crisis. I'm just wondering if this is the next effort of a rebuild after the destruction that happened with the pulling of the PGPPP. Do you have a response to that? I hope I'm conveying the level of frustration that I experience in meeting with the community as a senator.

Ms Shakespeare: The Prevocational General Practice Placements Program is aimed at a different group of doctors. The earlier example you provided us was GP registrar training. The junior doctor training which was funded under the PGPPP was a different group of doctors. I'm not sure we can link the experiences of people under the GP registrar training to the cessation of a particular program that was aimed at junior doctors who are largely based in hospitals doing their intern year mandatorily and then junior doctor training after that. But we have a new junior doctor training program in place now too, and my colleague Mr Rocks went through that in some detail earlier in our hearing.

Senator O'NEILL: Earlier today. That was the 800 versus the 4,000. With respect, Ms Shakespeare, you'll do a wonderful defence of the department and the current action of the government at this point in time, but the people who need access to GPs don't care whether you're talking about program A, B, C or delta. They don't care. They just want to have properly trained people who are committed to that community who have sufficient financial benefit and interest in bringing their high-level skills to be part of the community. They don't care what program you're talking about and they will be less inclined to be worried about connections of the impact of this program with that program. I understand that's your job, but surely the outcome of your job overall must be the provision of service access at a high-quality level, in an equitable way, across the entire country. Rural contexts

simply are not getting what they believe they have a right to. So what's new? How are you going to fix this massive problem?

Ms Shakespeare: We again need to continually look back to what the data is showing us. I've also been working in this space for a long time and I've been hearing for a long time that we have a crisis. I think the data shows that probably our crisis is a little less acute than it used to be, but that's not to say that there aren't particular issues, and we work very hard to resolve particular issues when they come up. Data at a national level or a state level or even a modified Monash category level doesn't help you, as you say, if there is a particular town that has just lost its doctor. But we have targeted programs, including the funding—which is about $27 million a year—for the rural workforce agencies to help those communities in crisis get access to a doctor that can provide Medicare services.

Senator O'NEILL: Please correct me if I'm wrong, but the provision of that service has been increasingly by very expensive locums who are flying in and flying out of communities.

Ms Shakespeare: No. What they—

Senator O'NEILL: How much is that being provided by locums?

I ask you to think about the questions that Senator Green asked you and, when you provide that data to her, to provide it with the extraction of locums, because I want to get a sense of the scale and of how many locums who are floating around in this system are being counted in FTE and/or headcount.

Ms Shakespeare: I'm sure we can have a look at whether or not we can quantify that for the Medicare billings that we use. I think a lot of the locum issues, as my colleague Dr Wearne mentioned before, are to do with state public hospital service provision. That certainly came out in our discussions about the National Medical Workforce Strategy, but locums are just one solution that can be used where a community needs help getting access to a doctor, and we will work with the rural workforce agencies and the Primary Health Networks to find other longer-term sustainable solutions. We've been able to do that in particular locations, and I'm happy to provide case studies to you on notice. We have strategies and approaches that we can take that are funded and have local, on-the-ground expert knowledge to help us, so it's not just people sitting in Canberra or Adelaide who are making the decisions about how service is going to be provided to a community. We do have strategies that can successfully resolve problems in particular communities.

Senator O'NEILL: What happens where you have been notified of the loss of a doctor or a crisis in health access in the community? Senator Green's been talking about people in Emerald waiting for three months for access to a doctor, and I live on the Central Coast, some parts of which are less than 100 kilometres from Sydney and where there are mothers with new babies who can't get into a doctor because the books are closed and who are travelling for 60 kilometres to get to a doctor. That's the scale of the problem I'm talking about. Whether it's close to the city or really remote from the city, it's problematic everywhere. So do you have a map of where the crises exist and where you have successfully replaced a doctor with a locum and then gone back to actually put in place a proper, functioning general practice that meets the local needs and is integrating well with the local hospital? All of those bits need to be connected for proper provision of health service in regional and remote Australia. So often in towns that I go to—such as Cobar, Coonabarabran, Bourke, Brewarrina, Walgett and Deniliquin—I meet with local GPs who are so frustrated. Many of them are now ageing and are desperately concerned that, for all the talk of the federal government, for all the efforts of the departments of health both state and federal and for all the announcements of money for different buckets, the entire system is so robbed of connectivity and so poorly planned and integrated that the whole country is teetering on the brink of a failure of access to GPs. I think that anxiety has only been heightened by the COVID crisis.

Ms Shakespeare: The pandemic has certainly made it harder for us to increase the number of doctors at the rate that we were seeing before the pandemic. I think the biggest impact there was that because our borders were closed—and not just because Australia's borders were closed but also because there were very few international flights, particularly into Australia—we weren't seeing the same level of overseas trained doctors, nurses and other health professionals coming to Australia. Now that the borders are open, I'm expecting that that will improve.

I think your general question, though, is: can we provide you information about how we have worked with communities to solve particular problems? We're really happy to do that. In your case, you would probably be most interested in the work that the New South Wales Rural Doctors Network, the rural workforce agency in New South Wales, does and how they've achieved particular local solutions with access to primary care services. We can also provide you with information about some of the innovative models of care that we're now funding in New South Wales communities and how those are—

Senator O'NEILL: I am interested in those, but a vignette of a particular problem that was resolved with a huge amount of effort—as much as that gives me hope for particular communities—does not give me hope for an entire structure that seems to be on its knees, in terms of access, and guaranteed access, to quality services and a GP who's not being worked to the bone in regional and rural communities. I see it everywhere I go, and I'm frustrated that the response of the department is a form of denial of the reality that I keep confronting. As a senator, I want to put it on the record, because what people are saying to me is that they cannot get a hearing of what their lived reality is. And it's not just in isolated towns—it's not just a pocket; it's across the entire system.

Ms Shakespeare: Again, I don't think that we're in denial. We can present you with the data that we have at the system level, and in New South Wales, like in other jurisdictions except the Northern Territory, there have generally been increases in GPs and GP services. But as I was just saying—

Senator O'NEILL: Do those increases include locums?

CHAIR: Senator O'Neil, we need to finish up, so let the department finish.

Ms Shakespeare: We acknowledge that there are particular issues. That's why we would need to provide you with information about how we resolve those individual issues. It is not denying that they exist; we just need to take a targeted approach, rather than a system-wide approach, to resolving those issue.

Senator O'NEILL: Do the numbers you are citing to me include locums? They are not a local GP; they're a FIFO worker with no commitment, or a tangential one, to the community. Do the numbers you are quoting to me include locums?

Ms Shakespeare: Yes. Locums provide Medicare services.

Senator O'NEILL: And they're being counted multiple times in many, many places. That is a distortion of the facts, and that means that the facts that are going on the record, in terms of numbers, do not meet the reality of people getting to a GP, and we're having this inquiry because there is a big problem trying to get in to see a GP in regional and rural Australia.

CHAIR: I think that's a good place to end our session today. Thank you very much to the department for your evidence today. The committee is requesting that answers to questions on notice be provided to the secretariat by the close of business on Thursday 18 November. That now concludes today's hearing. On behalf of the committee, I'd like to thank all of those who have made submissions to the inquiry and have made their representatives available today. I'd like to thank broadcasting, Hansard and the secretariat staff for all their assistance today. The committee now stands adjourned.

Committee adjourned at 16:02