Regional/Rural Workforce Initiatives - 2012
February 2012

1. Preamble

The AMA has identified medical workforce shortage as a major health issue. Not only is there a nation- wide shortage of doctors, the overall distribution of doctors is skewed heavily towards the major cities such that regional, rural and remote areas shoulder a disproportionate workforce shortage burden.

Put simply, there is a strong preference amongst much of the current medical workforce to live and work in major cities - with particular preference for the inner suburbs. Given the educational background and the demographics of the current medical workforce - this should come as no surprise. Doctors are no different to any other professional group and evidence throughout the western world shows that attracting young professionals to rural locations is extremely difficult.

Table 1 below is a simple illustration of the current problem with workforce distribution. While it is possible to provide a much more complicated analysis based on other measures, this table provides a useful snapshot of the issue.

<table>
<thead>
<tr>
<th>Remoteness Area</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
<th>WA</th>
<th>TAS</th>
<th>NT</th>
<th>ACT</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major city</td>
<td>343.8</td>
<td>366.1</td>
<td>394.6</td>
<td>422.8</td>
<td>382.6</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>472.7</td>
</tr>
<tr>
<td>Inner regional</td>
<td>202.6</td>
<td>196.4</td>
<td>188.7</td>
<td>147.5</td>
<td>163.3</td>
<td>457.9</td>
<td>.</td>
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</tr>
<tr>
<td>Outer regional</td>
<td>118.8</td>
<td>106.9</td>
<td>236.6</td>
<td>127.8</td>
<td>193.4</td>
<td>178.3</td>
<td>433.8</td>
<td>.</td>
<td>.</td>
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<tr>
<td>Remote / Very remote</td>
<td>115.2</td>
<td>265.3</td>
<td>161.8</td>
<td>126.1</td>
<td>221.1</td>
<td>101.6</td>
<td>385.8</td>
<td>.</td>
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</tr>
<tr>
<td>Total</td>
<td>308.6</td>
<td>332.7</td>
<td>334.6</td>
<td>353.9</td>
<td>336.7</td>
<td>366.4</td>
<td>442.9</td>
<td>474.2</td>
<td>331.4</td>
</tr>
</tbody>
</table>

It should be noted that the distribution of the medical workforce will always be biased to the major cities and large regional towns because some specialty services can only be supplied there.

In efforts to address these imbalances, the Government has adopted a variety of measures. Evidence suggests that these are starting to have an impact, particularly in the area of increased student enrolments. In 2009, 21% of first-year domestic medical school students came from rural areas, compared to just 12% in 1997. In the medium to long term, this may deliver a much fairer distribution

of the medical workforce. However, with long lead times involved in training the medical workforce more needs to be done in the short to medium term to address the current imbalance.

The debate is not just about numbers. It is also about the right skill mix. Rural medicine, especially, requires strong procedural skills - with primary care practitioners representing the backbone of rural health care. With strong trends toward sub-specialisation, and declining numbers of rural GPs who are practicing proceduralists the problem facing regional and rural communities is even more acute than the above table would suggest.

Rural doctors are also getting older. The average age of rural doctors in Australia is nearing 55 years, while the average age of remaining rural GP proceduralists – rural GP anaesthetists, rural GP obstetricians and rural GP surgeons – is approaching 60 years4.

The Commonwealth Government has responded to the general workforce shortage problem by, amongst other things, announcing a number of new medical school places. In 2010, there were 2,264 domestic medical graduates, an increase of 72 per cent from 2005. This is projected to increase to 3,227 domestic graduates by 2015.5 While this is welcome, there is ongoing concern about the ad hoc nature of some of these announcements, the lack of any co-ordinated plan outlining how the clinical placements of these students will be accommodated in an already stretched public hospital system and whether there will be a sufficient number of quality postgraduate training positions available when these students enter the medical workforce.

The Government is still using a draconian policy of unfunded bonding of medical school places to distribute the medical workforce more equitably. Under this policy, students are bonded to work up to the equivalent length of time as their medical degree in identified workforce shortage areas. Unlike students in other professions such as teaching, medical students who take up bonded positions are offered no incentives and must repay their education fees in full unless they are also eligible for other programs. Given that the pattern of medical school enrolments has shifted dramatically, with a big increase in enrolments of students from rural areas – it is strongly arguable that this policy is highly unnecessary as existing policy settings were having a significant and positive desired effect.

While recent changes have made the Government's bonded medical places (BMP) policy fairer and provided students with more support, it still lacks incentives. It does not address the underlying causes of medical workforce shortages or make the practice of medicine in areas of workforce shortage more attractive. Regular assessment of the efficacy of the Government's various recruitment and retention schemes is important.

The Government has also introduced the HECS Reimbursement Scheme that reimburses HECS debts of medical students if they train or work in rural and remote communities. Under the scheme, doctors can reduce the period for reimbursement of the cost of their medical studies from 5 years to 2 years, depending on the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) location of their training or practice. This is a positive example of an incentive based scheme.

4 Source: Rural Doctors Association of Australia.
It should also be noted there are concerns with the new ASGC RA system, introduced in July 2010. These concerns involve anomalies identified with the RA 2 classification. The AMA considered these anomalies would make it more difficult to recruit medical staff to less attractive locations within the same classification. In light of these concerns the AMA pushed for a review of the system. The Government agreed to undertake a review and the report released in September 2011 concludes that the system is working well, however there were some “areas of uncertainty” for towns near classification boundaries and it recommends setting up a tribunal that will assess submissions for changing RA/Health Remoteness Classification (HRC) scores.

2. Opportunities to influence the overall supply and distribution of the medical workforce

The AMA supports emphatically the right of doctors to live and work where they choose and to have the freedom to exercise their clinical judgement. Nevertheless, the profession has a responsibility to ensure that there is equitable community access to a well-trained medical workforce.

There are several points where policy makers can influence both the supply and distribution of medical practitioners. These include:

- medical school intakes and selection practices;
- training curricula and program requirements;
- recruitment and retention initiatives for medical practitioners;
- flexible work arrangements allowing a better balance between work and personal/family commitments;
- development of improved work practices and the provision of appropriate resources to support medical practitioners in the delivery of health care;
- access to services, resources and amenities - community and professional alike; and
- reducing compliance costs involved in delivering healthcare and running a small business.

3. Overseas experience

To date, no country has developed a package of policy initiatives that have been shown to completely address problems in the distribution of the medical workforce. However, there seems to be several emerging lessons:

- the early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enroll in medical schools are the most likely of all initiatives to increase the workforce in these areas;
- proper medical infrastructure, a strong training experience, and access to community and professional resources, and continuing medical education are essential to the provision of a rewarding professional and personal experience;
- the opportunity to maintain and update skills is as important for rural specialists and GP proceduralists as for their city counterparts. Rural specialists and GP proceduralists must have fully funded access to centres of excellence to regularly enhance and broaden their skill base;
- consideration must be given to not only the needs of the medical practitioner, but also their family - particularly with respect to access to employment opportunities, health and education, and social amenities;
- a critical mass of doctors within a region is important in improving the viability of a practice, as well as enhancing professional development;
appropriate remuneration and incentives are essential to attract and retain medical practitioners;
• bonded students who are treated fairly and provided with appropriate incentives and support can make an invaluable contribution to the development of a sustainable rural workforce. The bonding of students without access to financial and other types of support is counterproductive and can force people to leave the medical workforce or to consider practice in other countries.

4. Why are medical workforce shortages worse in regional and rural areas?
There are a number of fundamental reasons why regional and rural areas are not getting their fair share of the medical workforce. These include:
• inadequate remuneration;
• work intensity;
• red tape;
• lifestyle factors;
• professional isolation;
• poor employment opportunities for other family members, and in particular practitioners partners;
• under-representation of students from regional/rural background (noting that this mix is changing, however, the benefits will take some time to be realised);
• continued withdrawal of services from such areas;
• lack of critical mass of similar doctors;
• hospital closures;
• downgrading of other services;
• limited educational opportunities;
• long hours/rosters; and
• inefficient administration in public hospitals.

5. Solutions
In the 2009/10 Federal Budget the Commonwealth Government introduced an overhaul of rural workforce incentives, backed by additional funding support, to help attract and retain more doctors to regional and rural areas; however, the Government’s rural health programs remain under-funded, complex, fragmented and too restrictive. Ideally, incentive payments must be tax-free.

The AMA believes that a combination of policy initiatives can be applied in order to provide regional and rural areas with a more equitable share of the medical workforce. In outlining these policy measures, it is important to recognise that the problem cannot be addressed overnight. Rather, the results will be delivered in an incremental fashion.

Going forward, the AMA has identified five key priority areas for the Government to implement that would help attract medical practitioners and students to regional and rural areas. These are:

1. provide a dedicated and quality training pathway with the right skill mix to ensure GPs are adequately trained to work in rural areas;
2. provide a realistic and sustainable work environment with flexibility, including locum relief;
3. provide family support that includes spousal opportunities/employment, educational opportunities for children’s education, subsidy for housing/relocation and/or tax relief;
4. provide financial incentives including rural loadings to ensure competitive remuneration; and
5. provide a working environment that would allow quality training and supervision.

It is worthwhile to note that some of these measures are equally relevant to the medical workforce in metropolitan areas, including improved remuneration to general practitioners, better management of hospitals and more flexible training arrangements. Even though some measures are not specific to regional/rural areas, they will still have a positive impact and have been included in this position statement on that basis.

6. Undergraduate education and training initiatives

6.1 Medical schools should have a student mix that reflects the proportion of regional/rural people in the Australian population. Subject to appropriate academic benchmarks, this should be achieved through the establishment of specific enrolment targets, the beneficial weighting of enrolment criteria in favour of regional/rural students or some combination of these. Commonwealth and state/territory Governments should cooperate to ensure that rural secondary school students are aware of the opportunities to enter medical school.

6.2 The Commonwealth should expand access on a means tested basis to existing scholarship programs (e.g. Rural Australia Medical Undergraduate Scholarship Scheme) for students from regional and rural Australia who are accepted for enrolment in medical schools in order to reduce the entry barriers they face to taking up a career in medicine.

6.3 Medical students should be encouraged to take up a career in regional, rural and remote areas by developing and implementing a voluntary return-of-service scheme that offers incentives such as higher education charges relief and scholarship payments linked to remote locality. This scheme should be available to new and existing medical students as well as junior doctors, substantially increasing the pool of potential applicants.

6.4 The AMA supports the use of programs that provide relief from HECS debts to encourage doctors to work in regional and rural areas. Such programs should reduce HECS debts based on each year of service in a regional or rural location.

6.5 The establishment of medical schools or the expansion of medical school places in rural and regional areas must be considered as part of a broader workforce planning process, which takes into account the infrastructure and resource implications for undergraduate, prevocational and vocational training.

6.6 Undergraduate education models should provide medical school students with strong early exposure to regional/rural medicine and, in particular, procedural medicine. This will foster an interest in regional/rural medicine as well as better equip graduates to face the challenges of regional/rural medicine.

6.7 Students should be provided with access to structured mentoring programs to assist them in developing an interest in rural medicine

7. Indigenous health professionals

There is a strong link between the health of Indigenous people in rural communities and their access to culturally appropriate health services. The AMA believes that:
• greater effort should be made to encourage Indigenous people to undertake medical or health professional training, and incentives provided to encourage Indigenous and non-Indigenous doctors and medical trainees to work in rural and remote Indigenous communities;
• Aboriginal Medical Services should be resourced to offer mentoring and training opportunities in rural Indigenous communities to Indigenous and non-Indigenous medical students and vocational trainees; and
• training modules, resource material and ongoing advice should be developed for, and delivered to, all medical schools and rural and remote medical practices on Indigenous health issues, Indigenous-specific health initiatives and culturally appropriate service delivery.

8. Postgraduate Medical Education

8.1 Provided it is consistent with the development of appropriate clinical skills, postgraduate medical training programs should include a regional/rural medical service component, with junior doctors having the ability to pursue more advanced training in regional/rural medicine through their relevant Medical College.

8.2 Trainees should be encouraged to undertake rotations to regional/rural areas as part of their training program. The rotation should be included in the postgraduate medical education/Medical College accreditation processes. Provided it meets the requirements of the training curriculum, trainees may elect to serve longer periods in regional/rural areas. The latter option should be available on a voluntary basis and trainees should not be compelled to serve extended periods in regional/rural areas by using de-facto workforce measures such as rural pathways.

8.3 Medical Colleges face additional challenges and costs in establishing suitable training posts in regional/rural areas. Where appropriate, Medical Colleges should be able to access specific funding to assist in meeting such costs.

8.4 Trainees are covered by a variety of employment arrangements and undertaking hospital rotations, or applying for employment at a regional/rural hospital in order to satisfy their vocational training requirements often involves the interruption/loss of employment entitlements such as sick leave and annual leave. Innovative arrangements need to be identified that allow for portability of entitlements, which ensures that trainees are not disadvantaged by undertaking regional/rural service.

8.5 Prior to appointment, trainees must be given relevant information regarding any rotations they will be required to undertake during their employment. Reasonable notice should be provided when a doctor will be required to undertake a rotation and consideration of a doctor's personal/family circumstances must be taken into account wherever possible.

8.7 Trainees should be provided with comprehensive assistance when they are required to undertake a rotation that requires them to move away from their usual place of residence. This assistance should be based on the principle that the relocation should be cost neutral to the trainee.
8.8 With increasing opportunities to deliver training in private clinical settings appropriate support for private practices should also be provided.

8.9 The Commonwealth and State/Territory Governments should co-operate in order to set aside specific funding to establish additional training positions in regional/rural areas with appropriate infrastructure and supervision.

8.10 General practice is acknowledged as one of the major planks of regional and rural healthcare. Prevocational training programs such as PGPPP, which provide trainees with greater exposure to general practice are vital for strengthening the general practice workforce.

8.11 To enable sufficient numbers of practices to be recruited to training and supervision roles, measures such as infrastructure support grants are needed to improve infrastructure in general practices, particularly to remodel existing physical space or for the additional space necessary to deliver training effectively.

8.12 In light of the changing expectations and personal circumstances of men and women entering the medical workforce, the growing participation of women in medicine and increasing numbers of post-graduate medical school graduates, Medical Colleges must ensure that access to part time and flexible training arrangements is improved, and that trainees are not unnecessarily penalised when their training is interrupted due to personal or family circumstances.

9. Continuing Medical Education

9.1 Regional/rural practice often requires doctors to treat conditions with less support than would otherwise exist in a metropolitan region. The development of appropriate CME resources and training programs, along with access to locum support is essential to the maintenance of high standards of care.

9.2 Training providers need to expand the suite of distance learning tools to assist doctors in these locations to develop their skills on an ongoing basis, and links to Rural Clinical Schools should be encouraged.

10. Generalism

There has been a decline in generalism in public and private medical practice and an increasing trend towards sub-specialisation. Insufficient numbers of generalists (general specialists) in specialities such as surgery and medicine are practising in urban and rural settings. Generalists have a vital role in the health system, as they are able to manage and treat a wide range of health conditions. The shortage of these professionals is felt acutely in rural and regional areas, and patient access to care in rural areas has decreased in line with the trend to sub-specialisation.

The reasons for the decline in generalism are many and varied, but include lower remuneration for generalists compared to sub-specialists and training models that disadvantage generalism. The decline in generalism in rural and regional areas has been exacerbated by the closure of rural hospitals and procedural units. The high workload of rural generalists and corresponding poor work-life balance also act as disincentives to generalist practice.

The following broad measures should be considered to help arrest the decline in generalism and attract and retain generalists in the medical workforce:
• elevate the status of generalism;
• facilitate greater exposure to generalist practice during undergraduate medical training;
• develop vocational training models that encourage more generalist careers;
• increase state and federal funding for rural generalist positions;
• increase state and federal funding for rural specialist infrastructure; and
• improve the level of remuneration for generalists to encourage generalist practice, including the removal of anomalies in the MBS that reward sub-specialisation over generalism.

11. Remuneration and incentives

11.1 All stakeholders should acknowledge the importance of appropriate remuneration levels, not only for doctors working in private practice but also for doctors working in the hospital sector.

11.2 A simplified structure for Medicare rebates, fully funded and appropriately indexed, should be introduced in order to more properly reflect the nature of primary care delivery, allow GPs to charge an appropriate fee for their services without the fear of leaving patients with high out of pocket costs, and improve incomes for GPs in general so as to attract more doctors into general practice. This will both benefit patients and improve the image of general practice as a career choice.

The Government should support the Rural Rescue Package developed by the AMA and the Rural Doctors Association of Australia. Implementation of the package would help to sustain the regional and rural workforce and ensure that patients in rural communities have improved access to doctors. The package encourages more doctors to work in rural and regional Australia and recognises essential obstetrics, surgical, anaesthetic and emergency skills. This funding would provide a two-tier incentive package, including further enhancements to rural isolation payments and rural procedural and emergency/on-call loading:

- a rural isolation payment to be paid to all rural doctors (including GPs, specialists and registrars) to reflect the isolation associated with rural practice; and
- a rural procedural and emergency/on call loading to better support rural procedural doctors (including procedural specialists) who provide obstetric, surgical, anaesthetic or primary emergency on-call services in rural communities.

11.3 Employers should offer competitive salary packages to doctors in order to attract them to work in regional/rural areas and depending on the location of the employer and workforce need, packages should include:

- accommodation or accommodation assistance;
- fee assistance for the education of the doctor’s children;
- return airfares to place of origin;
- home access to broadband internet services – including satellite where appropriate;
- assistance with continuing medical education, including fees, attendance at conferences, additional leave entitlements etc.;
- childcare facilities or access to subsidised assistance;
- assistance with finding suitable employment for other family members; and
- flexible, family friendly working arrangements.

11.4 Incentives to encourage doctors working part time to increase their hours should also be considered, including re-skilling where necessary.
12. Family support

12.1 The decision for a doctor to relocate or practise on a medium to long-term basis in rural areas obviously has a significant impact on their family. Where a partner works or children are at school there may be considerable direct or opportunity cost and loss of amenity from a decision to move to rural practice. Simply paying a medical practitioner more, while helpful, does not address the full dimensions of the problem and ignores significant factors in any individual's decision-making process when considering rural practice.

12.2 There should be adequate compensation, support and access to re-training if required, so that a partner or spouse can remain employed in an acceptable occupation if their partner moves to a remote area. Job seeking assistance should also be offered if required.

12.3 If the family requires assistance to maintain a child in school in a larger town or city centre, there needs to be school fee assistance, given the possible requirement for boarding and other increased services or tuition.

12.4 Where a family is fragmented by a decision for a parent or partner to take up rural practice, there should be funding for at least one return trip home for family members during the doctor's tenure.

13. Hospital work practices and infrastructure

13.1 In 2007, the AMA conducted a survey of rural doctors asking them to rate the importance of various policy issues. Concerns about rural hospitals featured directly in five of the top ten areas identified by rural doctors. The closure and downgrading of rural hospitals is seriously affecting the adequate delivery of health care in rural areas. Such decisions are normally driven by economic considerations, yet they have significant consequences for the local community and the sustainability of the medical workforce.

13.2 Governments must ensure that regional/rural hospitals are properly resourced with adequate infrastructure, information technology support and staffing to ensure that doctors work in an environment that is conducive to delivering:

- quality patient care
- a strong and relevant training experience to junior doctors, with adequate supervision
- an environment to develop their procedural skills
- opportunities for professional development
- safe working hours.

13.3 The efficient use of the skills of the medical workforce is a critical measure to enhance the delivery of healthcare services throughout the country. Doctors should not be burdened with an undue administrative workload that reduces their capacity to deliver clinical services.

13.4 Where appropriate, work practices should be reviewed in consultation with clinicians to ensure that doctors are not undertaking tasks that could be more appropriately handled by nursing or clerical staff.

13.5 Hospitals should support a broad role for Visiting Medical Officers to encourage teamwork, the sharing of information and ideas and skills development for VMOs and salaried doctors alike.
13.6 Hospitals should provide safe workplace facilities and accommodation at an appropriate quality in accordance with the AMA Position Statement – Workplace Facilities and Accommodation for Hospital Doctors.  

13.7 Hospitals must value medical staff and provide them with a good working environment. They must consult with doctors on all issues affecting patients and they should ensure that the Director of Medical Services holds appropriate clinical qualifications and is able to provide an effective point of liaison.

14. Community funded facilities

14.1 The Commonwealth Government should establish specific funding grants to allow local governments in regional/rural areas to purchase facilities to support medical practitioners such as housing/practices/equipment, so that practitioners can operate a practice on a walk-in walk out basis. The costs of establishing a practice have been nominated as one of the major disincentives to doctors who might otherwise relocate to an area of workforce shortage.

15. Outreach programs

15.1 Outreach programs to provide funding assistance for specialists visiting rural and remote areas are a valuable means to enhance the delivery of services in these areas. These programs should be adequately funded and based upon the following principles:

- services must be directed to communities where an unmet need is established by the local medical practitioners
- services must be designed to fit in with local healthcare services, and wherever possible they should include up-skilling and other measures to enhance the sustainability of local medical services
- funding must be available to existing outreach services
- there should be strong Medical College involvement in outreach programs in order to encourage greater participation
- service should not be withdrawn without consultation with the local practitioner.

16. Red Tape

16.1 Red tape placed on medical practitioners reduces the time available to consult with patients. It restricts patient access to care, with some estimates suggesting that GPs spend up to nine hours per week complying with red tape obligations. Every hour a GP spends doing paperwork equates to around four patients who are denied access to a GP.

16.2 Reducing red tape and bureaucracy, and providing more opportunities for GPs to spend face-to-face time with patients must be a key priority. It will improve the image of general practice and allow GPs to increase their patient load. The Government should address these issues by implementing the remaining recommendations from the Productivity Commission’s 2003 Review of General Practice Administrative and Compliance Costs and from the Regulation Taskforce’s 2006 review relating to general practice.

17. Nurses

17.1 The general practice nurse (GPN) is a model of collaborative care within general practice that is fully supported by the general practice community and this has improved access to care through general practice. In practical terms, this requires the Government to extend practice nurse subsidies under the Practice Incentives Program to all geographic locations and to expand MBS coverage to reflect and support the full range of work undertaken by practice nurses for and on behalf of GPs. Specific loadings for the cost of employing practice nurses in rural areas should continue.

17.2 The AMA does not support a role for independent nurse practitioners, but this does not preclude the capacity for highly skilled nurses, working as part of a collaborative primary care team led by one or more GPs to be supported in the delivery of services to remote areas where access to health care is often very difficult. These nurses should:
   - have appropriate clinical experience and training; and
   - be supported through the provision of appropriate communication technologies to ensure that treatment can be properly co-ordinated with the supervising GP(s).

18. Rosters

18.1 Doctors in regional/rural areas often face high on-call demands. This is undesirable from both the perspective of patient safety as well as effective service delivery. A core number of doctors need to be on roster to contribute to a sustainable work/life balance. The roster needs to be attractive in order to help recruit and retain doctors.

18.2 Existing competition laws prevent doctors entering into effective rostering arrangements to provide comprehensive medical services to their local community, particularly with respect to after-hours services and covering absences when doctors take leave. Registering business names in a joint venture has been shown to be an effective strategy in some situations.

18.3 The AMA believes that considerable community benefit would flow from allowing doctors to establish viable rostering arrangements, which include reasonable agreement over what fees would be charged. This would encourage doctors to co-operate in order to provide their local community with better access to round the clock healthcare - and address one of the major disincentives to regional/rural practice being a high on-call workload.

18.4 In light of the above, the Australian Competition and Consumer Commission (ACCC) should work with stakeholders to develop a simple notification process along the lines of the collective bargaining notification for small businesses recommended by the Dawson Review of the Trade Practices Act. This would significantly streamline processes and encourage medical practitioners to enter into arrangements that deliver better access to care as well as reduce the excessive hours worked by many medical practitioners in rural areas.

19. Locum Services

19.1 Locum services are also a key element to addressing the problems of high workload and little prospect of relief for rural/regional practice. Lack of time off for professional development, family responsibilities and recreation can be among the most negative aspects of life as a rural doctor. Rural Workforce Agencies and Medical College programs are an important source of
locum doctors and Commonwealth Government funding should continue to support such programs, and where appropriate be increased based on the needs of particular communities.

19.2 The AMA supports existing exemptions allowing junior doctors access to provider numbers for locum services in areas of need/district of workforce shortage, however, the process of accessing provider numbers is lengthy and involves too much red tape - which in turn discourages junior doctors from participating. Initiatives to simplify these processes need to be explored.

19.3 Doctors working in locum services should be able to access VR rebates, and the application and approval process should also be simplified in order to reduce the red tape barrier.

20. **International Medical Graduates**

International medical graduates (IMGs) form an important part of the medical workforce and regional and rural Australia will rely on the contribution made by IMGs for the delivery of medical services for some years to come. When IMGs arrive in Australia they are often placed in highly challenging work environments with little or no orientation, while access to supervision, professional support, and training can be variable. This is not good for IMGs or their patients. These doctors need more professional and community support to enable them to maximise their contribution to patient care and to encourage them to seek a permanent place in the Australian rural medical workforce. To ensure high standards of patient care in regional and rural areas, and to provide better support for IMGs in their work, the AMA believes that the following measures are necessary:

- the phasing out of the “10-year moratorium” and its replacement with a robust package of incentives and support mechanisms to encourage the increasing numbers of locally trained doctors and appropriately skilled IMGs to voluntarily consider a career in regional and rural Australia;
- consistent and transparent standards of assessment for IMGs across Australia, with the medical colleges having responsibility for assessing overseas qualifications and determining additional training or oversight required;
- introduction of streamlined processes of assessment including recognition of prior learning;
- ensuring that IMGs have access to support mechanisms including mandatory orientation, continuing medical education, bridging courses, assistance with exams, mentoring, community facilities and services;
- ensuring that IMGs have access to working conditions that are equal to comparable Australian trained doctors in like locations;
- streamlining of area of need and district of workforce shortage definitions with a requirement that an objective assessment be undertaken of the reasons for not filling a position with an Australian resident doctor before recruiting an IMG; and
- change Commonwealth and State legislation to give temporary resident IMGs and their families access to Medicare and public education.

21. **Telehealth**

21.1 The development of medical and communication technology has the potential to deliver significant benefits to regional/rural medicine. For example, faster broadband would make it

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7 For further detail, refer to the AMA 2004 position statement on overseas trained doctors.
easier for doctors in rural and regional areas to consult with city colleagues when diagnosing and treating patients. It should be noted that improved Internet services will not eliminate the need for more doctors in regional areas and for rural hospitals to be properly funded and staffed – it is a tool for doctors and hospitals to use in patient care. Governments need to work with stakeholders to encourage the innovative use of these technologies and in doing so need to consider:

- policies that promote access to relevant community infrastructure including high speed internet access
- initiatives including funding for community based facilities, or assistance with the purchase of infrastructure
- promotion of collaborative initiatives between clinicians to foster telemedicine
- raising the awareness of available technologies and providing access to training in the use of such technologies.

22. Benefits of regional/rural practice

22.1 Regional and Rural practice is a rewarding experience and does have lifestyle advantages. Stakeholders need to counter the negative perceptions surrounding regional/rural practice by highlighting the more positive aspects. Governments have committed money in the past for campaigns to encourage people to enter particular professions or training programs such as apprenticeships. Consideration should be given to running similar campaigns highlighting the advantages of regional/rural practice.

23. Access to community services

23.1 Governments have consistently withdrawn or rationalised services in regional/rural areas. This only makes it more difficult to attract doctors, and other groups to these areas. Before withdrawing such services, a public interest test should be applied to ensure that communities are not denied reasonable access to services. Consideration should also be given to imposing a moratorium on the withdrawal of Government businesses as a strategy to maintain medical services.

23.2 Governments should provide businesses with access to suitable incentives to relocate to regional/rural areas in order to encourage investment and employment and generate new economic activity, which will support improved local infrastructure and amenities.