Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Submission No: 68

Submitted by: James Cook University

Publication: Making the submission public [redacted]

Attachments: See attachment

Submitter Comments:

Submission to the Health and Environment Committee of the Queensland Legislative Assembly

JAMES COOK UNIVERSITY AUSTRALIA

Inquiry into the provision of primary and allied health care, aged and NDIS care, the private health care system, and any impacts the availability and accessibility of these services have on the Queensland public health system.

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December 2021

James Cook University (JCU) is pleased to provide this submission on matters relating to the provision of primary and allied health care in Queensland. This submission focuses on primary care and allied health workforce in rural, remote and regional (RRR) Queensland.

Summary of the issues

1. Australia requires a coherent policy framework and outcome measures across Australian Government health workforce initiatives in general practice and rural primary care workforce.

2. Comprehensive primary care is the cornerstone of the health care system. Already under significant stress from a lack of sustainable workforce and outdated funding models, the impact of the COVID-19 pandemic on primary care in RRR Queensland has been profound. In addition to the existing barriers to accessing appropriate healthcare for people living in RRR areas, 2020 saw an overall decrease of primary care preventative health activities including chronic disease management and screening for cancers[1,2]. 46% of primary care nurses surveyed at the end of 2020 reported that the quality of care provided in their workplace was significantly or slightly worse than before the pandemic, and 80% stated that the pandemic had impacted the detection and/or management of other health issues[3]. This will play out in a number of ways in the next few years including patients presenting for care with more complex or advanced disease and, wherever patients are unable to access appropriate services within primary care, presenting to Queensland Health facilities.

3. Pre-pandemic there was an ongoing heavy reliance on international medical graduates (IMGs) and Internationally Qualified Registered Nurses (IQRNs) to supplement the nursing, GP and other medical workforce outside of the cities. International and domestic travel restrictions associated with the COVID-19 pandemic have therefore disproportionately affected the regional and remote health professional workforce and the availability of health services in these areas.

[1] https://www.mq.edu.au/__data/assets/pdf_file/0011/1173998/COVID-19-GP-snapshot-7_Cancer_Final-10-Jun-21.pdf
[2] https://www.aihw.gov.au/covid-19
[3] https://onlinelibrary.wiley.com/doi/10.1111/jan.15046

4. JCU is a national exemplar in graduating healthcare professionals who go on to pursue careers in RRR locations. According to data from the National Graduate Outcomes Survey, JCU health professional graduates accounted for 1 in 5 of all recent health professional graduates who are working in outer regional and remote locations across Australia, while comprising only 2.5% of respondents nationally. In Queensland, this figure increases to nearly 1 in 2 recent graduates working in outer regional and remote locations[4]. In order to address the ongoing shortfall in fit-for-purpose healthcare workforce in RRR, JCU requires additional support including medical program Commonwealth Supported Places (CSPs) and an increase in the number and duration of supervised clinical placements for health professional students in RRR locations.

Solutions

James Cook University

A distinctive university with a northern, regional and tropical mission

With a stated intent to 'create a brighter future for life in the tropics worldwide through graduates and discoveries that make a difference', James Cook University (JCU) occupies a unique place in the higher education sector.

In health and medicine, JCU is a recognised leader in addressing the healthcare needs of rural, remote, Indigenous and tropical communities within Australia and worldwide. The University offers a range of undergraduate and postgraduate courses in medicine, public health and tropical medicine, dentistry, nursing, midwifery, pharmacy, allied health and rehabilitation sciences, veterinary science and biomedical and molecular sciences. JCU is also a leader in place-based health research in the tropics, with a focus on diseases of high burden in the tropics, tropical health security and tropical health systems through the work of its Australian Institute for Tropical Health and Medicine.

The geographical spread of JCU's operations – serving communities local to the University from the Torres Strait in the north, west to Mt Isa and south to Mackay - covers a land area that is larger than many countries. JCU has study centres located in 16 towns covering most of regional Queensland and this is in addition to main campuses in Townsville and Cairns, the Brisbane city campus and Singapore. This 'distributed regional presence' differentiates JCU, not only in relation to the geographic spread of operations, but also in the breadth and depth of our relationships with communities and industries across Queensland and Northern Australia.

It is from this perspective that we offer the following solutions:

1. **An enabling policy framework to make comprehensive primary care the cornerstone of the health care system;**
2. **A substantial pipeline of willing domestic graduates pursuing rural and regional health careers;**
3. **Consolidate and align Commonwealth and State Health Workforce Programs under a common outcomes-oriented framework;**
4. **Review and reform nursing and midwifery programs.**

[4] https://www.qilt.edu.au/surveys/graduate-outcomes-survey-(gos)#anchor-1

Solution 1: An enabling policy framework to make comprehensive primary care the cornerstone of the health care system.

Health professional workforce planning, implementation and delivery must be situated within an overall national primary health care policy framework and be managed in the long term as a whole-of government priority.

This requires a policy framework that reshapes the Australian health care system as one integrated system, including the reorientation of secondary and tertiary systems to support primary health care. It must entail funding reform, with a change to a blend of funding for primary care that balances payment for service with value and outcomes that enable team-based care. Co-commissioning of services between state and commonwealth with an end to duplication and fragmentation is a priority for RRR locations. Health workforce planning must occur at a local and regional level, with priority given to RRR Queensland.

The recommendations of the Primary Health Reform Steering Group detail these reforms[5].

[5] https://www.health.gov.au/sites/default/files/documents/2021/08/draft-recommendations-from-the-primary-health-reform-steering-group.pdf

Solution 2: A substantial pipeline of willing domestic graduates pursuing rural and regional health careers

The single most important priority in health workforce reform is to build a substantial pipeline of domestic health professional graduates who willingly pursue RRR careers in community practice, aged care, general practice and rural generalist practice as well as regional consultant practice.

The experience of JCU demonstrates that the most cost-effective solutions for delivering a health workforce for regional, rural and remote locations is through the vertical integration of education and training that is based in and designed for the needs of regional Australia - from admission to university through to professional clinical practice and beyond. This implies a greater emphasis on regional partnerships and a formal role of the university sector in supporting fully vertically integrated regional health professional training, including specialist GP training.

The elements of the integrated regional model comprise a package of measures that includes:

- Prioritising admission of students from a non-metropolitan background
- Emphasising rural health in the undergraduate curricula
- Providing extensive positive clinical placement experience in regional, rural and remote locations
- Making rural health professionals visible across the training continuum, as academic leaders, teachers, role-models and near peers
- Ensuring that excellent clinical learning happens in quality well-supported teaching locations, including ‘teaching private practices and community pharmacies’, ‘teaching rural hospitals’, ‘teaching Aboriginal Community Controlled Health Services (ACCHSs)’ and ‘teaching remote clinics’ for students, junior doctors and newly qualified pharmacy, dentistry, nursing, midwifery and allied health professionals
- Having a local presence in towns to develop and support the health professional workforce - this means local clinical educators, professional and technical staff, Indigenous cultural educators and necessary physical infrastructure (access to accommodation, training rooms, simulation equipment,ICT etc.) to enable deep local partnerships, knowledge of people and community circumstances
- Continually evaluate outcomes and make adjustments to program design in concert with industry and community partners as required to shape desired program outcomes.

Box 1: A snapshot of success

Medical program

- JCU graduates are 6 times more likely to undertake rural clinical practice than those of other Australian medical schools.
- Two-thirds of JCU medical graduates are working outside of major cities at any point in time;
- Just under half pursue careers in General Practice or Rural Generalist Medicine;

General Practice Training

- Two-thirds of JCU-trained GPs have stayed on in the region after completing their training and 60% are working in remote and regional locations.
- Of those who graduated both from JCU with a medical degree and completed GP training with JCU, 92% go on to work in remote and regional locations.

Pharmacy

- Two-thirds of JCU's pharmacy graduates are working in regional rural and remote areas[6];
- Of the 973 JCU pharmacy graduates from 2002 to 2018, more than 65% (640) practised within Queensland in 2019[7];
- More than 84% of the 822 domestic JCU pharmacy graduates were from a regional, rural or remote area. Two-thirds of them are practising in settings similar to their hometowns[8];

Dentistry

- 75% of graduate dentists who work in Queensland Health dental facilities in rural Queensland are graduates of JCU[9].

Nursing and Midwifery

- >90% of JCU nursing and midwifery graduates remain working in regional, rural and remote Queensland post- graduation

Physiotherapy

- 48% of JCU physiotherapy graduates are working in rural and remote locations

[6] Drovandi, A, Woolley, T. Workforce supply of pharmacists in Queensland communities from James Cook University Pharmacy Graduates, Australian Journal of Rural Health, 2020-10, Vol.28 (5), p.462-468
[7] Ibid
[8] Ibid
[9] KBC Australia, 2020, Independent Evaluation of the Rural Health Multidisciplinary Training Program, Accessed 2 June 2021, https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-rhmt-evaluation

Nursing and midwifery workforce

JCU is a key provider of the nursing and midwifery workforce in Queensland's northern regions and beyond. Our programs are designed to prepare graduates to work in both metropolitan and non-metropolitan areas and thus have the skills to work anywhere in the world. We instil graduates with a solid foundation of knowledge, attributes and skills that are transferrable to a range of contexts. The continued inclusion of a professional experience placement in rural and remote facilities is critical for ensuring this preparation. Only in these contexts will they see registered nurses working to the full scope of practice. Furthermore, graduates working in regional areas will be caring for people coming from remote locations and need to have an understanding of the environments from which these individuals originate and the facilities to which they will be returning.

All nursing and midwifery students at JCU undertake regional and rural professional experience placements, including extended consolidating placements. Approximately 20% of students undertake an extended rural placement. Over 90% of JCU nursing and midwifery graduates remain working in our region after completing their undergraduate training.

Interest in the nursing and midwifery professions has increased in recent decades, particularly over the last 18 months in response to COVID-19. The profile of the profession has been raised in recognition of the extensive burden carried by the nursing profession during the pandemic. Furthermore, the greater job satisfaction and security offered by a career in nursing and/or midwifery has proven attractive as individuals re-evaluate their priorities following the extensive upheavals of the last year and a half.

What continues to be a challenge however, is the inability of the nursing profession to retain nurses beyond three years after graduation. The increasing acuity of the healthcare environment, workforce shortages, the physically and emotionally demanding nature of nursing work in RRR contexts as well as the longer working hours as compared to their city counterparts, contribute to this attrition. In addition, the nursing workforce is ageing, with the average age of nurses in RRR older than that in the cities[10]. This, combined with attrition in the early career years results in an ongoing shortage of qualified nurses for RRR locations.

A major issue facing education providers is the cost of nursing and midwifery professional experience placements. Unfortunately, many health services appear to regard placements as a revenue raising activity, rather than recognising their role in contributing to the education of the future nursing and midwifery workforce. This is reflected in the failure of regional and remote health services to titrate costs of clinical placements despite the workforce contribution made by students. This is particularly the case in their final year of study where they make a significant contribution to workforce. The lack of economies of scale in a small rural hospital, which may need to employ a facilitator even for a few students on placement, means that rural and remote clinical placements are more expensive than urban ones. This can be a disincentive for education providers and clinical services alike, but conversely, the JCU experience shows that the return on investment by clinical services in terms of future workforce is significant.

[10] https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~appendices~appendix-ii-health-workforce-2025-summary

A review of charges associated with nursing and midwifery professional experience placement is therefore urgently required, along with an increase in funding to support the cost of delivering high-quality nursing and midwifery education and a visible career pathway for nurses to pursue.
This will enable expansion of nursing training places in RRR locations, and increased support for nurses once they are qualified. Ongoing fit –for-purpose continuing professional development (CPD) support for qualified nurses working in RRR locations is critical to support their scope of practice and to recognise the barriers faced by rural health professionals (e.g. increased costs associated with travel, requirement for locum cover when they are absent from the workplace) in accessing appropriate CPD.

Case Study 1: Place-based nursing in North West Queensland – JCU's distributed place-based approach

The JCU Mount Isa Nursing program has graduated 95 nurses since 2004. These graduates are largely either still working within the region (65%), or in the Townsville and Cairns regions where patients from north west Queensland receive Tertiary Care (23%). Another 6% are in other small rural Queensland areas and 6% in metro areas. These graduates, unlike their city counterparts, would not have pursued a nursing career if it had not been locally available. They had personal carer responsibilities and other factors that influenced their decision as to where to study. This highlights the importance of ensuring distributed locally supported place-based nursing programs to develop the nursing workforce in and for the region.

The investment required from Queensland Health to enable this would be returned in the first four years with a reduction in health service costs of recruitment and staff housing. In addition, local students and graduates understand the population and geographical challenges so are more work-ready than their counterparts from outside the region.

Allied Health Workforce

JCU's rural and remote focus means that students undertake clinical placements in rural locations wherever possible and this translates into allied health workforce post-graduation. JCU graduate tracking data shows, for example, that 48% of physiotherapy graduates (10 years of data) have gone on to work in RRR locations.

This success is despite the multiple barriers that JCU faces when trying to support the education and training of a fit-for-purpose RRR allied health workforce. For example, students on clinical placement usually have to meet the costs of their accommodation and living expenses when on placement. Travel to and from RRR areas is expensive and accommodation often hard to come by, with students paying over $3000 for accommodation for a five week placement on top of their rent or mortgages in their usual residential location. This is often combined with a loss of income from casual work as the students attend clinical placements away from their usual residence.

There is a high turnover of allied health staff in many RRR locations, as well as an overall lack of positions. The high staff workload affects the capacity of services to have students on placements, and placements

can be cancelled at short notice when staff leave. Clinical placements in RRR tend to fall onto Queensland Health facilities due to the current rules around students providing services in private practice. Funding sources for private providers from, for example, private insurance, Department of Veterans Affairs, Medicare and third party compensation, means that students are unable to provide the full assessment and treatment requirements for patients seeking treatment under these schemes. Thus, either private practices and private hospitals don't offer clinical placements, or only provide placements with limited experiences for students, with many charging high fees for clinical placement (especially in physiotherapy). This results in a relative lack of involvement of the private sector in allied health clinical placements and reliance on QH facilities for placements.

The JCU experience confirms that training students in RRR locations increases the likelihood of their working in these locations after graduation. Further financial support is therefore required to enable more and longer rural undergraduate allied health clinical placements.

In addition, support for ongoing fit-for-purpose continuing professional education (CPD) for RRR allied health practitioners is required to support their scope of practice and account for the barriers that they face when accessing CPD. These barriers include the significant cost of travel from and to RRR locations as well as the requirement for locum cover when they are not practising.

Case Study 2: JCU University Department of Rural Health – a place-based approach to sustainable RRR health workforce

An important element of developing the rural and remote health workforce is the federally funded University Department of Rural Health (UDRH) program.

The Murtupuni Centre for Rural and Remote Health, in Mount Isa, was one of the first UDRHs to be established in the country and has been in operation for 25 years.

The UDRH brings an academic presence to the rural and remote areas, including resources and infrastructure that support the health services, health professionals and students as well as the communities in which they are established.

The aim of the UDRH is to:

- Deliver effective rural training experiences for medical, nursing, midwifery, dental and allied health students (prior to gaining professional registration)
- Ensure rural training experiences are of high quality
- Undertake student selection and rural student recruitment
- Engage with key partners and the local community to support the delivery of training to students
- Maintain and progress an evidence base and the rural health agenda
- Facilitate improvement of Aboriginal and Torres Strait Islander health through a range of strategies
- Provide regional leadership in developing innovative training solutions to address rural

workforce recruitment and retention.

UDRHs have the capacity to innovate, an example being the student service learning program in Mount Isa. Once the traditional student placement options are maximised, additional placements are created by structuring student led services in areas of high need supervised by UDRH staff. This additional allied health student activity is contributing to a graduate workforce for several of the North West health services.

Collaborations with Queensland Health rural Hospital and Health Services such as the North West commissioned Community Rehabilitation Service establish and provide valuable community rehabilitation service. These in turn leverage additional allied health disciplines and therapies for the benefit of the clients and the region at the same time as developing a work-ready allied health workforce.

Case Study 3: JCU Allied Health Rural Generalist Program – a place-based solution to train a fit-for-purpose rural and remote allied health workforce in Queensland[11]

Both Queensland's rural and remote hospital and health services and the non-government allied health services struggle to support and retain inexperienced newly graduated allied health professionals. A place-based approach to supporting a cohort of allied health rural generalist trainees has commenced and is expected to take several years before it translates to a stabilised and experienced workforce. It is critical that this support continues during the turbulent times that we are facing.

The Allied Health Rural Generalist Program is a professional development program, presented by JCU's internationally recognised Division of Tropical Health and Medicine and developed in collaboration with Queensland Health and Queensland University of Technology (QUT). It has two levels with level 1 being 12 modules and level two being a graduate diploma of rural generalist practice.

The level 1 program combines work-integrated training with online learning via modules designed specifically for early career allied health professionals working in rural and remote communities. It enables these health professionals to work to their full scope of practice, including clinical supervision and leadership skills, thus contributing significantly to the workforce in smaller communities.

The level 1 Program is also applicable for allied health professionals working in other under-served settings or services requiring a generalist scope of practice.

This innovative program is for Allied Health professionals working in a rural or remote health setting and who have at least an AQF Level 7 Bachelor degree in one of these nine relevant professions:

[11] https://www.jcu.edu.au/courses/graduate-diploma-of-rural-generalist-practice

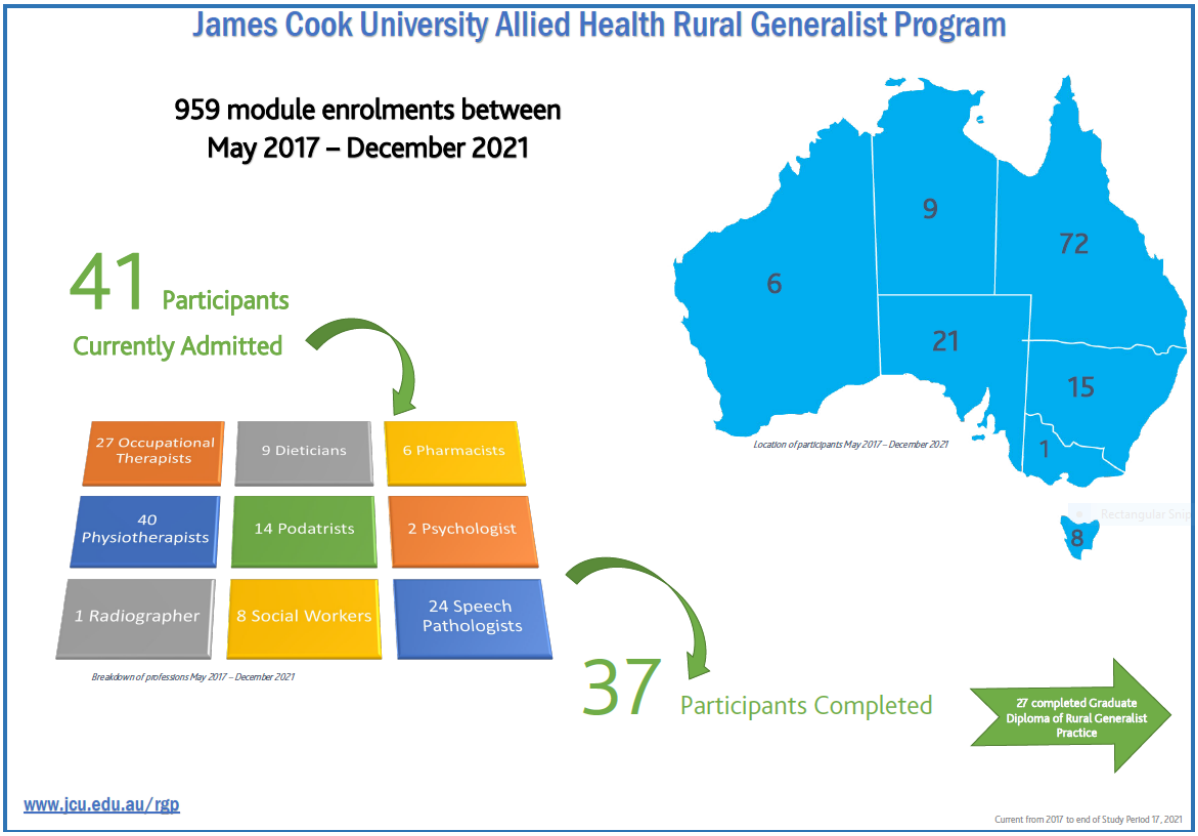
1. Dietitian/Nutritionist
2. Occupational Therapist
3. Pharmacist
4. Physiotherapist
5. Podiatrist
6. Psychologist
7. Radiographer
8. Speech Pathologist; or
9. Social Worker

On completion of the Allied Health Rural Generalist Program participants are able to:

- Apply rural and remote generalist knowledge and skills to practice in the workplace context
- Contribute to identification of local service needs relevant to profession and work-based multi-disciplinary team
- Facilitate quality improvement initiatives to optimise access, efficiency and effectiveness of the local service
- Extend and reframe early career knowledge and skills to match the local service strategic intent.

Level 1 Program outline

- 12 modules in total
- 6 core service delivery-based modules; and
- 6 clinically-based modules (from a choice of up to 24 modules, dependent upon profession)
- Can be completed in 1 year



The **Level 2 Graduate Diploma of Rural Generalist Practice** has had an increasing number of enrolments since 2019, and to date 27 students have completed the Graduate Diploma.

Evaluation of the program has confirmed that it is an effective education program that provides benefits for rural and remote communities, employing organisations and the program participants12.
Strong ongoing support from Queensland Health is required to ensure that as many allied health practitioners as possible access the course and thus work to their full scope of practice.

Medical workforce

Given the ongoing demand for medical labour in major cities, and to reduce the current reliance on international doctors, creating a substantial pipeline of domestic medical graduates who are willing to pursue careers in rural and regional Queensland will require a significant increase in the number of Commonwealth Supported Places (CSPs) in medical schools.

It is critical that such an investment applies evidence for how to deliver a regional, rural and GP workforce and not merely expand the supply of graduates pursuing metropolitan consultant specialist medical careers. Support from the Queensland Government for these additional CSPs is crucial. Additional CSPs will allow JCU to offer its full medical program in three regional locations, thus increasing access to medical training for students from RRR Queensland. This investment will increase the number of medical

[12] https://pubmed.ncbi.nlm.nih.gov/33982849/

graduates working in RRR locations.

JCU is an exemplar of an effective regionally integrated model that takes in students from the regions, providing positive rural curriculum and placement experiences throughout medical school, connects through to pre-vocational training of junior doctors and on to vocational training to a GP Fellowship or other specialty.

Case Study 4: James Cook University is the nation's leading producer of rural doctors and GPs

Uniquely amongst Australian universities, JCU has the only medical program that delivers fully integrated medical training from entry to medical school through to Fellowship as a specialist General Practitioner (GP). JCU's medical programs were designed from the outset to create a fit-for-purpose medical workforce for regional, rural and underserved communities[13].

The establishment of the JCU medical course in 2000 was a landmark - the first in Australia to be entirely located in a regional area and to be based in the tropical north[14]. Around 70% of students admitted to the JCU medical program are of non-metropolitan origin and selection into the course prioritises those whose interests align with the JCU mission. The medical course provides extensive rural clinical placement in an inspiring regionally based education and training experience.

As a result of this program design, the majority of JCU medical graduates (around 75%) go on to work outside of major cities and around half pursue training and careers as GPs or Rural Generalists (RGs)[15, 16, 17]. This is a very different profile of graduate outcomes compared to other Australian medical schools.

In 2016, JCU became the only university in Australia to also deliver the Australian Government funded AGPT program. The area served by JCU for this program covers 90% of the state of Queensland and is home to a population of over 1.6 million people, including two-thirds of the state's Aboriginal and Torres Strait Islander population. The proportion of people living in a location classified as a 'major city' in this region is 17%, with the remaining 83% of people living in locations classified as regional or remote[18]

JCU training offices are based in 14 towns across regional Queensland. This reflects an emphasis on local deployment of clinical teachers and professional support staff, who are thereby deeply engaged

[13] https://www.youtube.com/watch?v=k8SsAAYBf38
[14] Hays RB. A new medical school for regional Australia. Medical Journal of Australia 2000; 172(8): 362-363
[15] Sen Gupta T, Woolley T, Murray R, Hays R, McCloskey T. Positive impacts on rural and regional workforce from the first seven cohorts of James Cook University medical graduates. Rural and Remote Health 14: 2657. 2014.
[16] [3]Sen Gupta T, Murray R, Hays R, Woolley T. Rural medical education promotes rural medical career intentions and internship choices:a comparative outcome survey of a regional Australian medical school. Rural and Remote Health 13: 2313. 2013.
[17] Ray R, Woolley T, Sen Gupta T (2015). James Cook University's rurally orientated medical school selection process: quality graduates and positive workforce outcomes Rural and Remote Health 15: 3424. (Online) 2015
[18] JCU GP Training program. Available at: www.jcugp.edu.au

with local communities, GP practices and hospitals. The majority of GP training sites integrate seamlessly with other JCU health professional education activities, including undergraduate medicine. By combining staff, infrastructure and relationships across JCU's GP training, Rural Clinical School, University Department of Rural Health and Regional Training Hub programs, JCU is able to take gain efficiencies that enable a local presence in smaller regional, rural and remote towns. Since 2016, JCU has, to date, produced 696 qualified GP Fellows in the North Western Queensland GP training region, an area that covers 90% of the state of Queensland.

JCU's graduate tracking research shows that:

- Two thirds of JCU-trained GP Fellows have stayed on in the North Western Queensland region after completing their training
- 60% of JCU-trained GP Fellows are working in remote and regional locations
- Of those who both graduated with a medical degree from JCU and who also completed GP training with JCU, 92% go on to work in remote and regional locations after Fellowship.

JCU's local presence fosters strong community partnerships and a contextual understanding of the health workforce needs of different communities and regions. The integration of training locally also provides a seamless training experience from undergraduate education through to prevocational training and then to postgraduate vocational training in General Practice.

The current state of outer metropolitan, rural, and regional GPs and related services: the case for increased domestic medical graduates

Australia has seen profound changes in the medical workforce over the last 20 years. On the face of it, Australia might now seem to have an ample supply of doctors in comparison to similar OECD countries. In 2019, there were 3.9 doctors in clinical practice per 1,000 population in Australia, 79% of whom were located in major cities.[19] This is a dramatic jump from 2008, a time when there were 2.8. clinicians per 1,000 population. Interestingly, the 2008 Australian figure is closer to current numbers in the USA (2.6/1,000), Canada (2.7/1,000), the UK (2.8/1,000)[20].

In spite of this, Australian doctor numbers continue to grow at an average annual rate of 3.9% - more than twice the rate of growth of the Australian population[21]. This relates to a high level of demand for medical labour in major cities and a continuing dependence on what is in effect a revolving door of foreign doctor recruitment to meet regional workforce gaps. The fundamental issues driving this are geographic maldistribution and unbalanced specialty mix in domestic medical labour. This is illustrated by distribution of medical practitioners by geographic location and country of graduation (Figure 1).

[19] Health Workforce Data Tool. Available at: hwd.health.gov.au/datatool/. The data quoted here and referenced elsewhere is an analysis ofthe Australian Government's Health Workforce Dataset. Further information available on request

[20] OECD Health Statistics 2020 - Frequently Requested Data. Available at: www.oecd.org/sdd/oecdfrequentlyrequestedstatistics.htm

[21] Health Workforce Data Tool

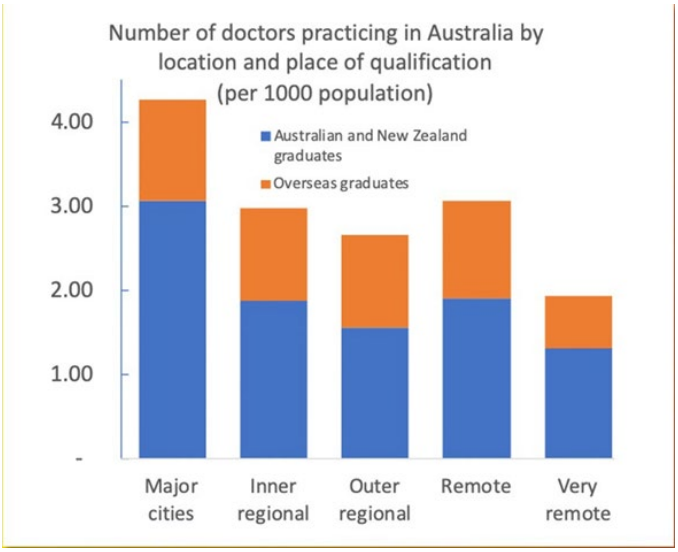


Figure 1. Practising doctors per 1000 population by geographic location and country of primary medical qualification (2019)[22]

Domestic medical labour supply accounts for only two-thirds of the growth in Australia's doctor numbers. Approximately 3,600 new doctors graduate from Australian medical schools every year, comprising around 3,000 domestic medical graduates and 600 international fee-paying graduates. The majority of newly qualified doctors (around 75%) come from a metropolitan background and, for most, their education and clinical training also occurs in capital cities and predominantly in large tertiary hospitals [23]. The remaining one-third of the growth in stock of Australia's medical workforce - in both the city and the regions - is made up of doctors who were trained overseas. Prior to the COVID-19 pandemic, around 3,000 IMGs were entering the country every year. Australia is among the highest importers of foreign-trained doctors in the OECD[24].

International labour recruitment is, in effect, Australia's longstanding 'temporary fix' for regional medical workforce shortage. At entry, many IMG doctors have limited registration and are obliged to work in areas of need for a period, mostly in a 'supervised' capacity in regional General Practice or in service jobs in regional and outer metropolitan public hospitals.

Even though the continued importation of IMGs is predicated on regional workforce shortage, the reality is that two decades of heavy reliance on IMGs as a regional workforce supplement has ended up mostly contributing to burgeoning metropolitan workforce growth.

Meanwhile, the high level of domestic and international medical labour supply that goes into major cities is itself a powerful driver for subspecialisation in the Australian healthcare system that is mostly financed according to the medical services that are provided (be that the activity-based funding of public hospitals, Medicare rebates for clinical services, private health insurance or out-of-pocket payments by patients). This drives up overall health care expenditure by both governments and individuals and contributes to fragmentation of care. It also tends to undermine general practice, clinical generalism and rural medical workforce supply.

[22] Health Workforce Data Tool

[23] Medical Deans Australia and New Zealand. Student Statistics Report 2021. Available at: medicaldeans.org.au/md/2021/10/MDANZ-Student-Statistics-Snapshot-2021.pdf

[24] OECD Stat. Foreign-trained doctors – annual inflow. Available at: stats.oecd.org/Index.aspx?QueryId=68

Australia's heavy reliance on IMG workforce for the regions is plainly poor public policy. It is important to emphasise however that Australia is nonetheless indebted to the many individual IMGs who have played and continue to play a crucial role in sustaining medical services in remote and regional areas. International medical graduates are valued colleagues.

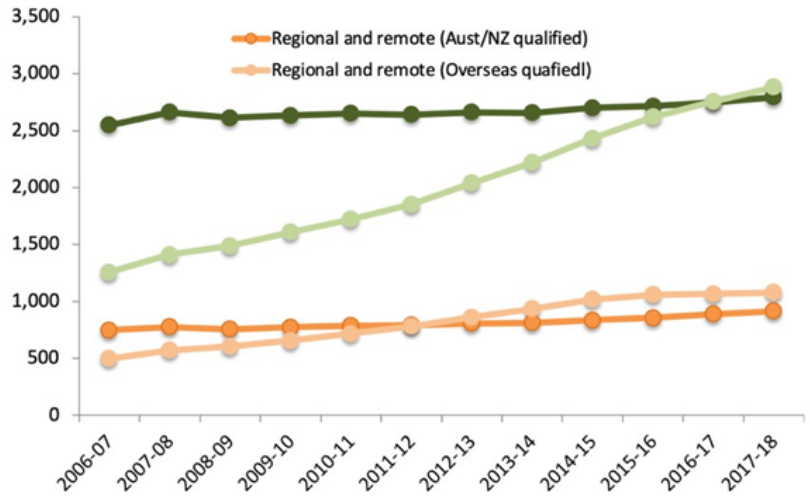
The change in the profile of the GP workforce is particularly striking with respect to IMGs. At present, around 60% of qualified GPs are graduates of Australian medical schools and 40% are IMGs. However, the point-in-time proportion of IMGs or domestic medical graduates in the total GP numbers does not give an accurate picture. To understand the impact of current policies on General Practice workforce, both the dynamics of change in numbers over time as well as the scope of practice and location of services provided need to be considered.

From 2015 to 2019, the average annual growth in the stock of qualified specialist GPs in Australia was around 665 per year. Two-thirds of the increase in numbers was in major cities and nine out of 10 of those were international medical graduates[25]. This reflects the general move to the cities by IMGs once visa and Medicare moratorium restrictions are lifted. At 2.6% per annum, the rate of growth of GP stock in major cities is almost twice the rate of population growth.

This pattern is also reflected in Medicare expenditure data. In regional Australia, Medicare billing for non-referred GP services that were attributable to IMGs eclipsed those of domestic medical graduates in 2011/12 which, given the reliance on labour importation in the regions, is not particularly surprising. What is more surprising, however, is that IMG Medicare billings in major cities outstripped those of domestic graduates in 2016/17 and continue to grow sharply. This is again because it is in the cities where the 'rurally-trained' IMG GPs generally end up.

Figure 2 (below) illustrates this change in non-referred GP Medicare billings from 2006/7 to 2017/18.

Medicare spend on non-referred GP attendances ($m) – constant 2017/18 prices



[25] https://www.aihw.gov.au/reports/australias-health/health-workforce

Figure 2. Total Medicare expenditure on GP non-referred services by practitioner location and country of qualification (constant prices) 2006/07-2017/18 [26]

Australia's continued reliance on international labour to prop up medical services in the regions and the intersection of this with Australian Government GP training arrangements means that taxpayers are in effect funding IMGs to complete GP fellowship training in regional Australia and then who usually go on to work in major cities. Meanwhile, interest in a GP career among domestic graduates is at a historical low - 16% among final year medical students[27] and 16% among junior doctors in their first or second year after graduation[28]. General Practice in Australia is steadily becoming a career that is taken up by IMGs working in the cities.

The only positive in the GP growth figures is that of the modest 187 average annual increase in the stock of domestic graduates who are qualified GP Fellows, around two-thirds are working regionally and only one-third in major cities. JCU makes a substantial contribution to that growth.

Of particular interest to this inquiry is the contribution that JCU graduates make to the QH Rural Generalist Program. Despite being Queensland's smallest publicly-funded medical school, JCU medical graduates comprise more than 50% of the QH Rural Generalist Program.

An increase in Commonwealth Supported Places for JCUs medical program will therefore strengthen the positive outcomes for rural medical workforce for Queensland.

[26] JCU analysis of Australian Government Statistics Under Medicare. Available at: www1.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1
[27] Medical Deans Australia and New Zealand. Medical Schools Outcomes Data Report 2021. Available at: medicaldeans.org.au/data/medical-schools-outcomes-database-reports/
[28] Medical Board of Australia. Medical Training Survey 2020 Annual Report. Available at: medicaltrainingsurvey.gov.au/Results/Reports-and-results

Solution 3: Consolidate and align Commonwealth and State Health Workforce Programs in medicine and allied health, and especially in General Practice, under a common outcomes-oriented framework.

Substantial reform is required across the suite of Commonwealth and State Health Workforce programs as they apply to primary care and community practice, including General Practice, and rural health workforce. This reform must address the entire training continuum from undergraduate through to ongoing professional development once health practitioners are fully qualified.

The confusing array of overlapping programs aimed at addressing workforce challenges in RRR locations needs to be consolidated and aligned and a clear joint commonwealth and state outcomes frameworks developed.

The Australian General Practice Training program (AGPT) is no longer fit-for-purpose and would benefit from a comprehensive review as part of this broader examination.

Solution 4: Review and reform the nursing and midwifery programs

Almost all entry to practice nursing and midwifery programs in Australia are of three years duration, This is an inadequate duration for a program that aims to graduate competent health professionals. Furthermore, it is completely out of step with nursing preparatory programs across the globe and other health professions in Australia. Contracting academic semesters do not provide sufficient time to ensure the preparation of graduates for the enormous complexity of the contemporary healthcare environment.

A minimum four-year program is required, which would also allow significantly more hours of supervised clinical placements. The JCU program requires 880 hours of supervised clinical practice, substantially above the Australian standard of 800 hours of professional experience placement. This is, however, well below the global average, with similar courses in the UK, for example, requiring twice this amount of supervised hours. While midwifery programs have a greater allocation of clinical time, pressure placed on students to complete the requirements in the time available is problematic. Furthermore, where graduate programs are available, they are not compulsory, leaving some graduates to transition to their profession in an unstructured and unsupported manner.

All these factors contribute to the attrition in nursing workforce that we see around three years after graduation, and require a comprehensive review with changes in policy. This includes structured early graduate support and fit-for-purpose continuing professional development programs.

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Glossary of Terms

(ACCHSs) Aboriginal Community Controlled Health Services

(AGPT) Australian General Practice Training

(AGPT) Australian General Practice Training program

(APHCRI) Australian Primary Health Care Institute

(CSPs) Commonwealth Supported Places

(GP) General practitioner

(GPET Ltd) General Practice Education and Training Ltd

(GPFTE) GP full-time equivalent

(GPs) General Practitioners

(GPwSI) GP with Special (or Specific) Interest'

(IMGs) International medical graduates

(JCU) James Cook University

(PGPPP) Prevocational General Practice Placement Program

(PHCRED) Primary Health Care Research, Evaluation and Development

(RACGP) Royal Australian College of General Practitioners

(RDAA) Rural Doctors Association of Australia

(RGs) Rural Generalists

(RHMT) Rural Health Multidisciplinary Training program

(RTH) Regional Training Hub

(RTOs) Registered Training Organisations

(UDRHs) University Departments of Rural Health