“Gain, Train and Retain” : A review of Rural and Remote Workforce Programs and their potential in 2017.

CARIBBEAN GOVERNANCE TRAINING INSTITUTE

First things first – Rules of Engagement

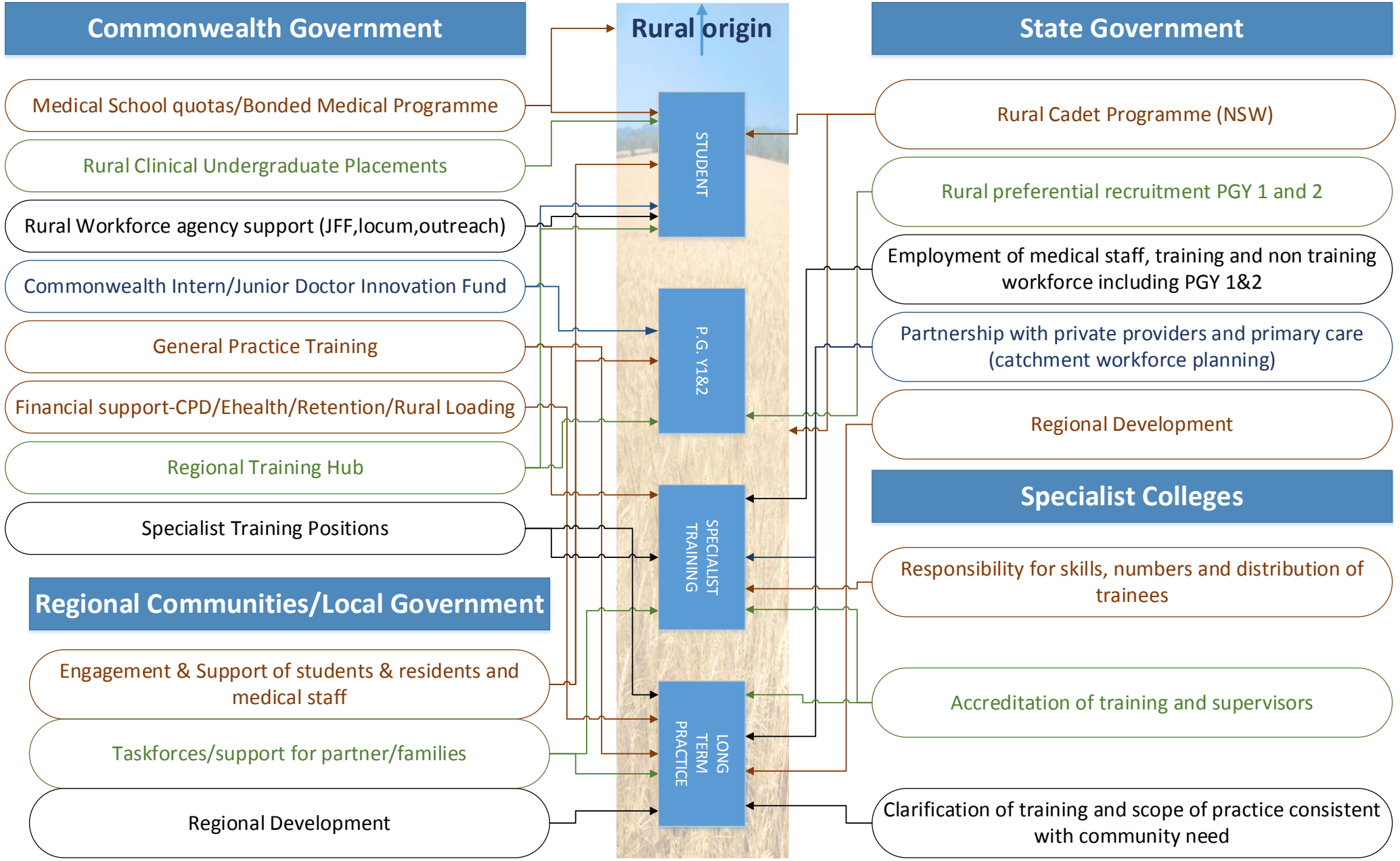
Board Governance at its Bes

- Information sharing and short sharp opinion/audience participation
- Respectful dialogue/Please don't talk over the top of anyone
- Please keep comments focused (I can be witchy if required)
- Potential for feedback to organisations/individuals

ASSUMPTIONS

- Demand and Supply assumptions (futurist qualifications also necessary!!)
- Current distributional issue in terms of total medical workforce
- Useful forum to come with a combination picture
- No one person, organisation and strategy has all the levers on distribution in an environment where individual can exercise choice
- No one size fits all
- No jurisdictional representation (not by design)

Stakeholders and their levers in the rural training pipeline



Panel Members

- **Paul Cutting –**Director of the Rural Distribution Section with the Rural Access branch Commonwealth Dept of Health
- **Megan Cahill-** CEO Rural Workforce Agency Victoria
- **Prof Lucie Walters-** Professor in Rural Medical Education Flinders University
- **David Campbell-** ACRRM Censor in Chief
- **John Hall –**Vice President RDAA
- **Louise Manning-** Intern in Regional Victoria

Australian Government
Department of Health

GAIN, TRAIN AND RETRAIN

Rural Medicine Australia 2017

Paul Cutting
Department of Health

Talk Structure

- An quick introduction to the Modified Monash Model remoteness classification
- Review on the historical growth of doctors in Australia
- Rural doctors – who and where they are
- What the future holds

Modified Monash Model – Why we changed

- The Modified Monash Model (MMM) was developed in light of criticisms of the ASGC-RA.
- Main source of criticisms related to small towns being considered as or less remote than major urban centres.
  - For instance, Hobart is considered as remote as Gundagai, and Cairns is more remote than Gundagai.
- Problem was that ASGC-RA is only a measure of relative distance, and not a good proxy for the services available in an area.

Modified Monash Model - Categories

MM 1 - Areas in RA 1;

MM 2 - Areas in RA 2&3 that are in or within 20 km road distance of a town with 50,000+ population;

MM 3 - Areas in RA 2&3 that are not in MM 2, but are in, or within 15km road distance, of a town with population between 15,000 and 50,000 people;

MM 4 - Areas in RA 2&3 that are not in MM 2 or 3, but are in, or within 10 km road distance, of a town with population between 5,000 and 15,000 people;

MM 5 - Areas in RA 2&3 that are not in MM 2, 3 or 4;

MM 6 - Areas in RA 4 that are not islands more than 5km off-shore;

MM 7 - Areas in RA 5, including islands more than 5km off-shore.

Historical GP Full-time Service Equivalent to estimated population

Financial Year	1 GP FSE to population	Growth in FSE (%)	Growth in population (%)
2006-07	1,328		
2007-08	1,278	6	2
2008-08	1,273	2	2
2009-10	1,245	4	2
2010-11	1,229	3	2
2011-12	1,220	2	1
2012-13	1,194	4	2
2013-14	1,139	6	2
2014-15	1,081	7	1
2015-16	1,051	5	1

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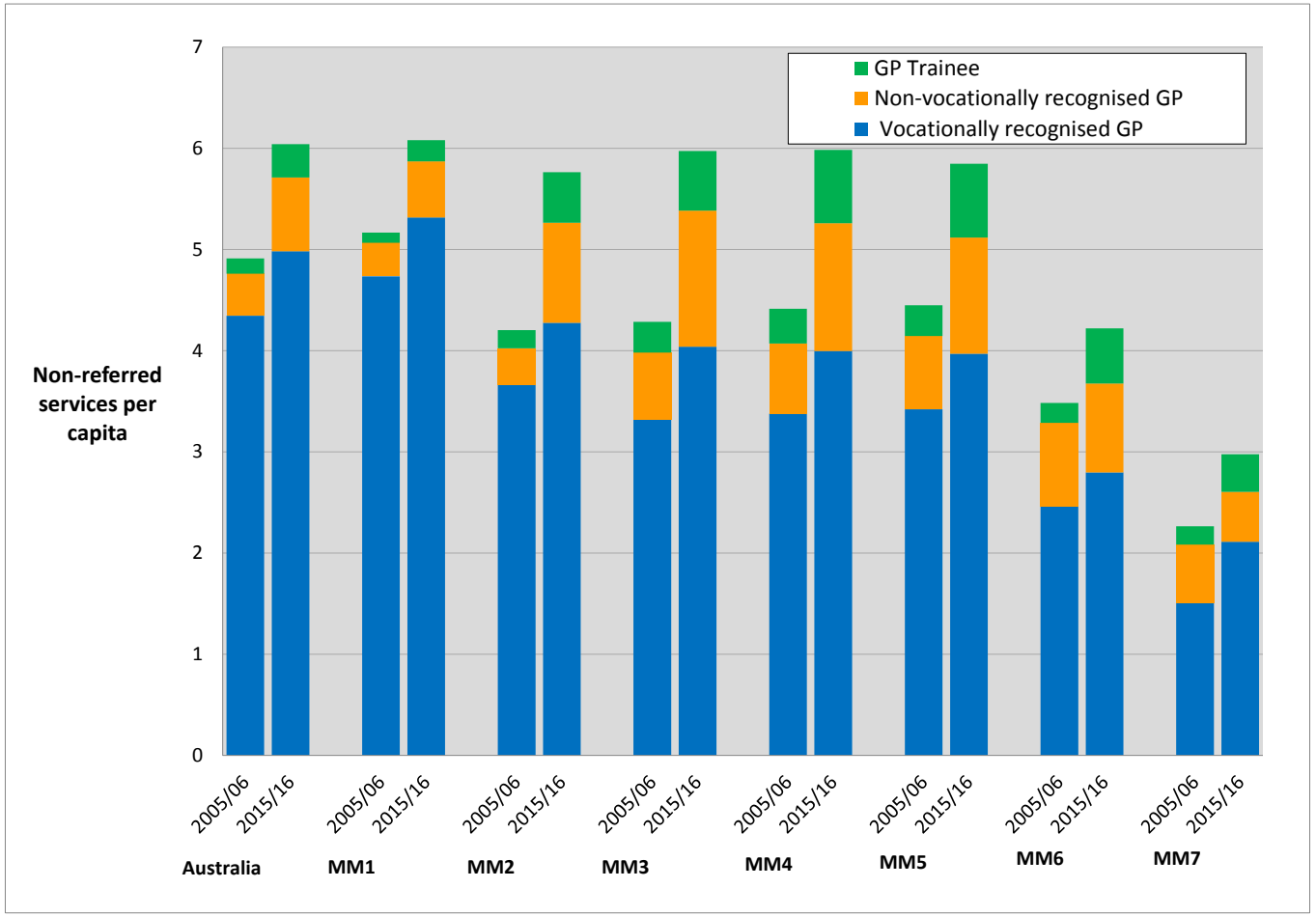
Context: Patient initiated services 2005 - 2016



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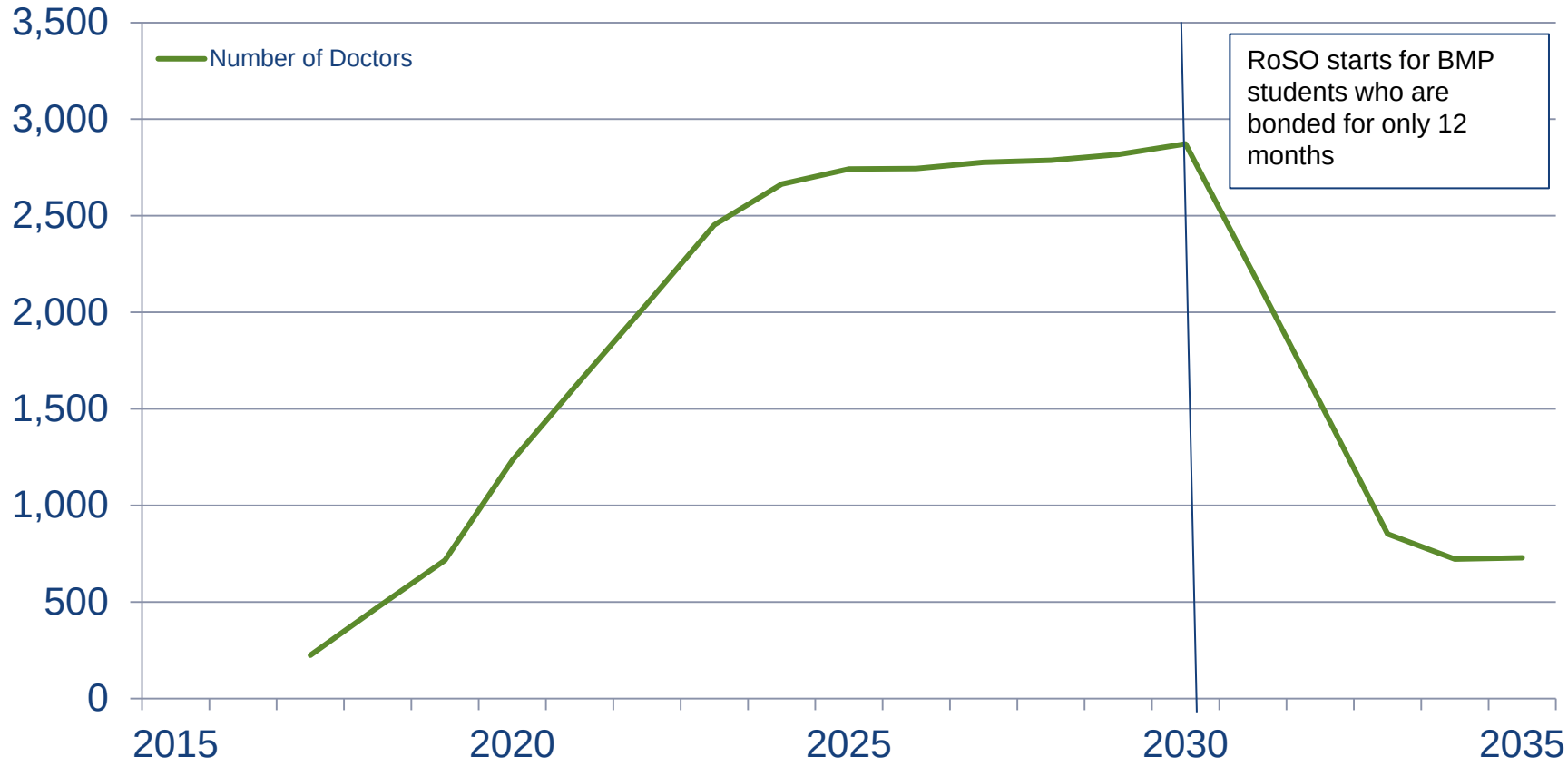
Characteristics of the GP workforce (non-trainees)

(age weighted by workload)

	MM 1			MM 2			MM 3-5			MM 6-7		
	Average Age	% Female	% Procedural	Average Age	% Female	% Procedural	Average Age	% Female	% Procedural	Average Age	% Female	% Procedural
2004-05	50	28%	4%	49	27%	5%	48	21%	3%	47	24%	1%
2005-06	51	28%	4%	49	27%	4%	49	22%	3%	48	24%	1%
2006-07	51	29%	4%	50	27%	4%	49	22%	3%	48	24%	1%
2007-08	51	29%	4%	50	28%	4%	49	24%	3%	48	26%	1%
2008-09	52	30%	4%	50	28%	4%	50	25%	3%	48	27%	1%
2009-10	52	30%	4%	50	29%	4%	50	25%	3%	48	28%	1%
2010-11	52	31%	4%	50	29%	4%	50	26%	3%	49	28%	0%
2011-12	52	32%	4%	50	31%	4%	50	27%	3%	49	29%	1%
2012-13	52	33%	4%	50	31%	4%	50	28%	3%	50	29%	1%
2013-14	52	34%	4%	50	32%	4%	50	29%	3%	49	31%	1%
2014-15	52	34%	4%	49	33%	4%	50	31%	3%	49	33%	1%
2015-16	52	35%	4%	49	34%	4%	50	32%	2%	50	34%	2%

Doctors with return of service obligations – preliminary assessment



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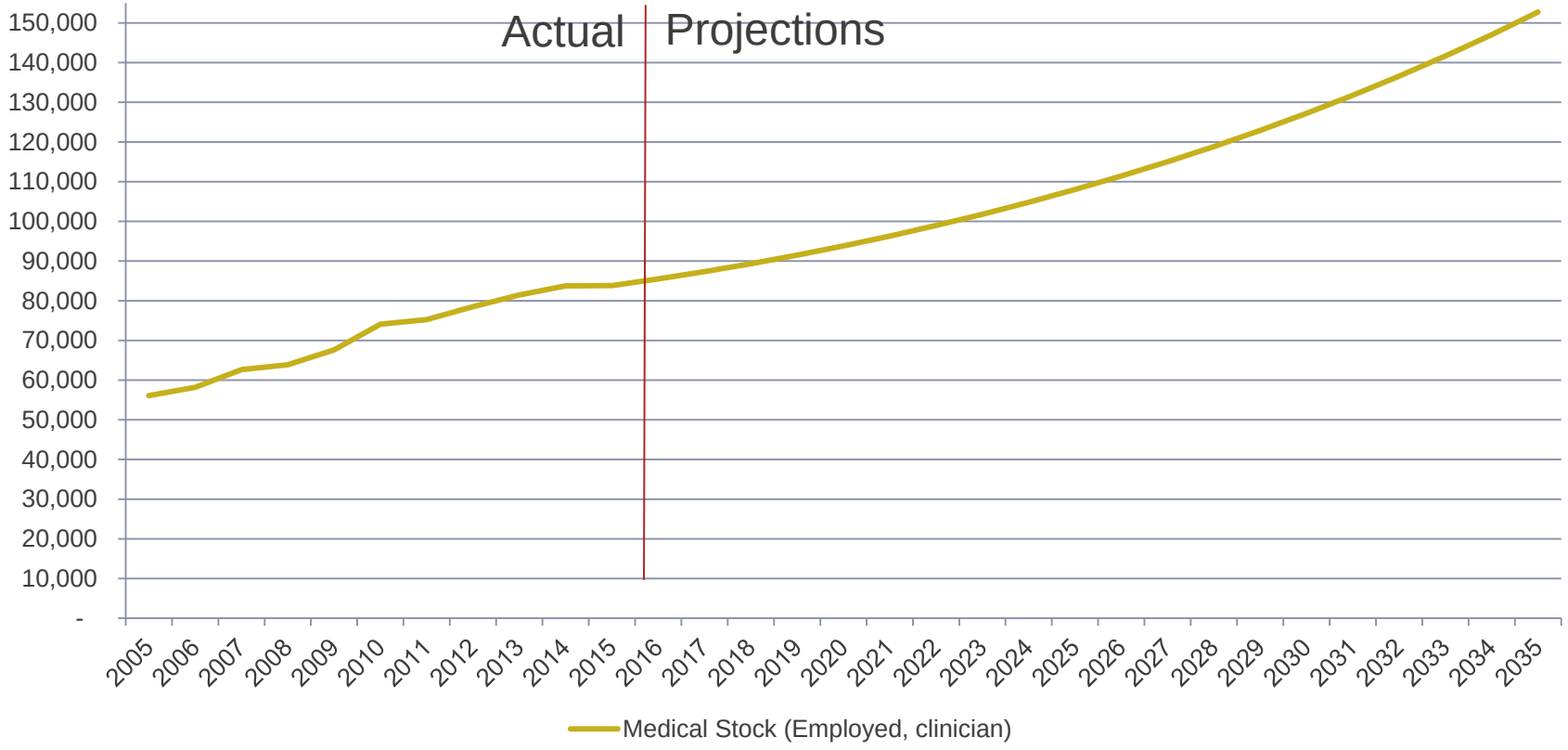
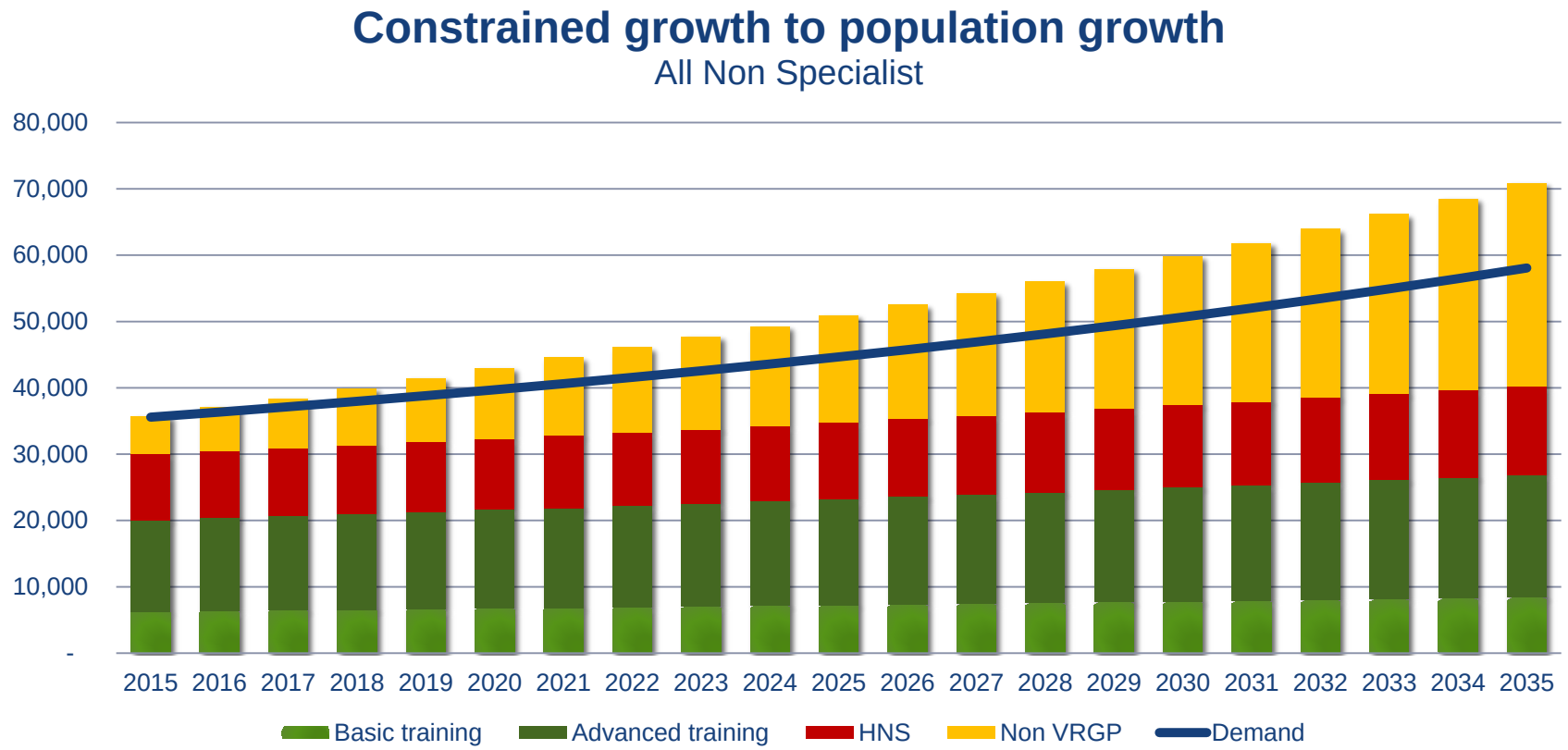
Projected growth in the medical workforce
(all doctor types)



Context - Workforce Trajectory: capped training numbers



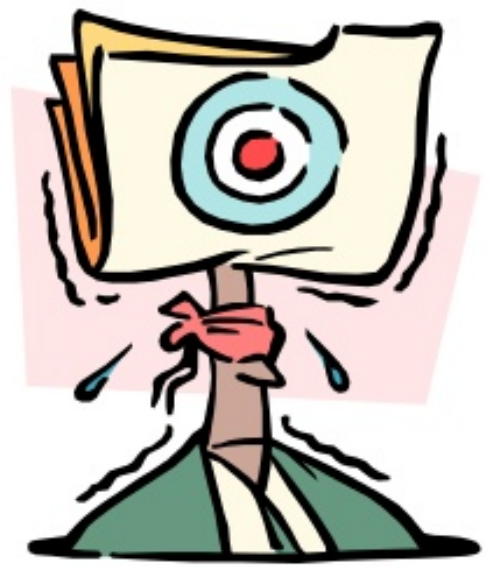
Commonwealth Workforce Strategy: Key Considerations

- Facilitate appropriate access to a quality health workforce reflecting needs identified through local level workforce planning
- Strengthen evidence base through analysis of workforce data, program monitoring and evaluation
- Rationalise and streamline workforce programs based on community need and broader reforms – supporting PHNs, HCHs, NDIS, aged care
- Work with jurisdictions and professional stakeholders on role delineation to better meet local community needs
- Demonstrate national leadership by trialling and embracing new evidence based approaches

The Hospitalists Role in Recruiting Physicians

Factors influencing physician recruitment and retention

- **Lawyers, guns, and money**
- **Diminishing returns**
  - Medicare
  - Medicaid
- **Teaching and Research**
- **Lifestyle**



Rural Clinical Schools

Attraction

	TOTAL 2011 - 2016	
Demographics	N (3341)	Mean%(SD)
Male	1389	40.9% (2.6)
Rural Origin	1438	42.9% (1.7)
Bonded	1068	31.3% (1.9)
1st Choice	1992	66.3% (2.3)

F R A M E

Rural Clinical Schools

Placement type **

	Capital or major city		Inner regional city		Smaller rural		small rural or remote community		very remote area		TOTAL
Block rotation	48	28.6%	83	49.4%	23	13.7%	9	5.4%	5	3.0%	168
Amalgamated LIC	50	43.1%	37	31.9%	22	19.0%	3	2.6%	4	3.4%	116
Blended LIC	28	36.8%	37	48.7%	9	11.8%	2	2.6%	0	0.0%	76
Comprehensive LIC	96	35.2%	79	28.9%	72	26.4%	22	8.1%	4	1.5%	273
Total	222	35.1%	236	37.3%	126	19.9%	36	5.7%	13	2.1%	633

FRAME


65
98%
120/72
4.5
14


Queensland Health
HAZCHEM
Goondiwindi Hospital Ph. 4671
EMERGENCY INFORMATION
HAZMAT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HOSPITAL
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On this site:
Community Health
IN THE INTEREST OF BETTER HEALTH SMOKING IS NOT PERMITTED ANYWHERE ON THIS SITE
WARNING
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DRIVEWAY TO HOSPITAL
PROCEED WITH CARE


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Readiness for the future

- What are the future rural and remote workforce challenges?
- What are three key issues/gaps that we could address within the national rural workforce policy environment
- What are the models of rural general practice of the future we should be imagining workforce for?
- What key non health infrastructure will be required for all of us to live in rural Australia