Assessment of the Distribution of Medical Places and Training.

February 2017

CENTRAL NSW COUNCILS

Centroc's Mission is to be recognised as the lead organisation advocating on agreed regional positions and priorities for Central NSW whilst providing a forum for facilitating regional co-operation and sharing of knowledge, expertise and resources; effectively nurturing sustainable investment and infrastructure development.

www.centroc.com.au

CENTRAL NSW COUNCILS

Centroc
PO Box 333
Forbes NSW 2871
Phone: 0428 690 935
Email: jennifer.bennett@centroc.com.au

Chairman: Cr Gary Rush, Mayor, Bathurst Regional Council

6 February 2017

Reference gr:jb 021706
Enquiries: Ms J Bennett: 0428 690 935

The Hon Dr David Gillespie MP
Assistant Minister for Rural Health
Parliament House
Canberra ACT 2600

Dear Dr Gillespie,

Re: Assessment of the Distribution of Medical Places and Training

Central NSW Councils (Centroc) represents over 243,000 people covering an area of more than 72,500sq kms comprising the Local Government Areas of Bathurst, Blayney, Cabonne, Cowra, Forbes, Hilltops, Lachlan, Lithgow, Oberon, Orange, Parkes, Upper Lachlan, Weddin, and Central Tablelands Water.

It is about the same size as Tasmania with half the population and a similar GDP.

Centroc's vision is to be recognised as vital to the sustainable future of NSW and Australia.

Its mission is to be recognised as the lead organisation advocating on agreed regional positions and priorities for Central NSW whilst providing a forum for facilitating regional cooperation and sharing of knowledge, expertise and resources.

Fit for the Future

Centroc was selected as one of five regional pilot Joint Organisations to assist the NSW Government strengthen and reform local government.

Centroc has two core objectives:

1. Regional Sustainability - Encourage and nurture suitable investment and infrastructure development throughout the region and support members in their action to seek from Governments financial assistance, legislative and/or policy changes and additional resources required by the Region.
2. Regional Cooperation and Resource Sharing – Contribute to measurable improvement in the operational efficiency and effectiveness of Member Councils through facilitation of the sharing of knowledge, expertise and resources and, where appropriate, the aggregation of demand and buying power.

The Centroc Board is made up of the 28 Mayors and General Managers of its member Councils who determine priority for the region. These priorities are then progressed via sponsoring Councils. For more advice on Centroc programming and priorities, please go to our website http://www.centroc.com.au

Health and particularly health workforce is a key priority for the Centroc Board. Centroc has a series of policies and supports a program in attracting and retaining health workforce, for example the Beyond the Range Program. Key to this region is getting improved policy and legislation as well as support for the region's "grow our own" philosophy to bring more medical workforce training, including doctor training, to the region.

In the national funding framework, Local Government does not have responsibility for health infrastructure or workforce. It does have a statutory role in health protection such as food safety and delivering secure quality water. However, health is identified in 100% of Community Strategic Plans as being a priority of the people of Central NSW. Under the Local Government Act, 1993, Local Government develops programming to meet community need. Therefore Centroc members increasingly find themselves providing health infrastructure and incentives to attract and retain health workforce.

Our communities have higher rates of chronic disease, unnecessary hospitalisation and preventable deaths compared to major cities. We also have fewer doctors. After 20 years of hearing about a tsunami of health workforce, particularly doctors, there is now an oversupply of doctors in major cities, while chronic shortages continue in rural and regional areas.

According to NSW Health Statistics, the average man in Western NSW dies almost three years earlier than NSW counterpart, and women almost two years earlier. Australian Bureau of Statistics numbers confirm the trend. A key contributor to this statistic is the under-supply of health services and workforce and the tyranny of distance

According to Charles Sturt University, the proportion of GP proceduralists has halved from 24% in 2002 to 12% in 2011, and in rural and regional communities have access to around 1/6 of the specialists compared to major cities. All indications are that this will not improve unless action is taken. The NSW Rural Doctors Network suggests at least two doctors will have to replace each one doctor who retires over the coming years.

In some areas, GP proceduralists are required – doctors with specific skills in obstetrics or anaesthetics for example. Generally, larger towns like Forbes, Parkes, and Cowra can support proceduralists as well as generalists. The smaller towns can't support a proceduralist load, so require strong GP generalist support.

Looking into the future, one way that we can measure whether Australian medical graduates are likely to move to rural practice in future is by looking at the proportion of medical graduates who want to work in rural or regional areas when the finish their postgraduate training.

According to the latest data from the Medical Schools Outcomes Database Survey conducted by the Medical Deans of Australia and New Zealand, in 2014 only 17.8% of city medical graduates expressed a preference to work regionally. Of this, only 6% wanted to work smaller rural towns and remote centres where doctor shortages are greatest. These towns comprise 10.1% of the Australian population. Even if every one of the 17.8% decided to work rurally, this is still half the proportion needed to address current shortages, expected rural GP retirements and ensure a sustainable supply of doctors to meet the medical care needs of 33% of the Australian population who live in rural and regional areas.

According to other research, fewer than 10% of medical graduates from typical metropolitan medical schools will actually go on to work in a rural area after completing their postgraduate training.

As Health Workforce Australian concluded in 2012, current policies are unlikely to fix the geographic maldistribution of doctors in Australia.

It has been claimed by city medical lobbyists that the problem is simply a lack of postgraduate training places in rural and regional areas. They argue that medical graduates are forced to do their training in the cities, resulting in them forming lifelong relationships with people in the city that ties them to metropolitan life. But this ignores the fact that these medical students have already spent many of their formative years living in the cities while at university.

According to the latest data from the Medical Deans, 49% of medical graduates already have a partner by their final year of study. Because over 80% of their fellow medical students (and up to 95% of their fellow university students) are from the city, the likelihood is that most medical graduates have already formed relationships that will tie them to the city regardless of where they train.

There is no comprehensive evidence that more rural postgraduate training will result in more graduates working rurally. But there is comprehensive evidence that rural medical schools deliver more rural doctors.

Australia only has one medical school that is fully located in a rural area, and has a core mission to address rural doctor shortages – James Cook University (JCU). Centroc is currently investigating the James Cook University model in North Queensland. Charles Sturt University, in partnership with La Trobe University, has proposed a similar model be established – the Murray Darling Medical School. Centroc supports the development of a medical school based in regional NSW.

At JCU, medical students are selected based on their commitment to working rurally from day one. These students are educated alongside other rural students throughout their degree, forming relationships with other rural people that will be with them for the rest of their lives. They train in rural and regional hospitals and health services. And at the end of their degree, 76% intend to work rurally (with 46% in smaller rural towns).

We also know that it works for other health disciplines. At Charles Sturt University and La Trobe University, more than 75% of their on-campus health students at their regional campuses are from a rural or regional area, and more than 70% of these go on to work in regional employment after graduation.

At best, metropolitan medical schools have only been able to deliver 17.8% of graduates interested in rural practice, and fewer than 10% in rural practice after completion of their training.

Rural based medical and health programs are delivering 3-4 times these numbers.

The mathematics is simple. Rural medical schools deliver more opportunities for rural students; more doctors and health professionals to rural practice; better health outcomes for our communities; more jobs into our regions; and, more economic growth. This is why we support the development of the Murray Darling Medical School.

We urge the Federal Government to be part of the solution to this wicked problem and as a Joint Organisation Councils we are keen to work to ensure that the distributed model of the Murray Darling Basin Medical School will be optimised across our varying sized communities.

Yours sincerely,

Cr Gary Rush
Chair
Central NSW Councils (Centroc)