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SUBMISSION

HealthConsult Discussion Paper

Review of Section 19AB and District of Workforce Shortage (DWS) Classification

The Australian Medical Association (AMA) thanks HealthConsult for the opportunity to comment on the discussion paper circulated. The issues that underpin poor access to medical professionals in rural, regional, and remote areas (RRR areas) and other geographical areas of workforce need are complex, with overlapping issues associated with the application of distribution levers, encouraging training in areas of workforce need, retention, and support of medical professionals and their networks. The AMA recommends greater investment and focus on providing opportunities and support for medical professionals wishing to undertake specialist training in RRR areas and areas of workforce needs.

The 2023 AMA rural and regional specialist training summit identified clear challenges in providing and receiving training in these areas. This includes exploring reforms to the Specialist Training Program (STP), providing greater support for International Medical Graduates and creating holistic social and community support structures. The consequences of the lack of investment in rural specialist training clearly affects the availability of non-GP specialty training and its subsequent availability of their services in RRR areas. The AMA plan for improving access to rural general practice also makes key makes key recommendations to improve access to primary care for rural communities and to address medical workforce shortages in rural areas.

The AMA believes that while Section 19AB has worked to distribute international medical graduates (IMG) to areas of workforce need, it does not meaningfully support retention and instead encourages a transient workforce, while also being unacceptably coercive to international medical graduates. In more recent times, an increasing body of evidence has also been gathered with respect to the recruitment and retention of medical professionals to areas of workforce need, particularly rural areas, with this pointing the effectiveness of recruiting medical students from rural background and encouraging high quality training opportunities in these areas. While section 19AB has played a role in supporting more equitable access to medical care, it was designed at a time when circumstances were different and the evidence around effective workforce distribution strategies was lacking. S19AB should be phased out and replaced by evidence-based policies targeting flexible incentives and support mechanisms developed as part of this review.

What impact has Section 19AB and DWS had on the distribution of the medical workforce to areas of workforce need?

Section 19AB is a blunt tool that has, in the main, seen successive governments become over reliant on its use and fail to invest in robust initiatives to support the better distribution of the medical workforce – particularly local graduates. While we acknowledge that in more recent years, more evidenced based policies are being adopted – we still have a long way to go in building a strong pipeline of graduates seeking to work in areas of workforce need. Section 19AB leads international medical graduates to be recruited to work in some of the most professionally challenging clinical environments with limited preparation and support. This is further exacerbated for international medical graduates through a lack of socio-cultural and professional support and at times limited access to supervision. This situation makes for poor workplace experience and does not support the delivery of care to the standards the Australian community has come to expect.

What impact have changes to the DWS (i.e. area designations and specialties in scope) had on distribution of the medical workforce to areas of need?

The AMA has received feedback that there are issues regarding rural towns losing their DPA/DWS classification which triggers the cessation of incentives and payments which support medical professionals to remain in area of workforce need. This has the effect of rapid workforce decline within a local area which remains non-DPA/DWA until calculations are redone. Some towns then are stuck in a cycle of being in and out of DWA/DPA status. Greater flexibility and adjustments need to be inbuilt into the system to retain workforce until certain and sustainable benchmarks are met.

How could Section 19AB be improved or supported to better meet its objectives?

The AMA argues that Section 19AB as stands is a coercive and inappropriate distribution lever and recommends the 10-year moratorium be phased out. In the interim, what is required alongside 19AB are strengthened initiatives that support IMGs both with respect to developing their clinical and professional practice while also offering greater support for their family members. It is also important to ensure that the DPA and DWS exemptions attached to s19AB operate in a way to ensure that they target areas most in need, particularly rural Australia. This could include, for example, ensuring that DWS is reformed to reflect the principle that those specialties that can be distributed are distributed. Some of the blanket rules operating currently are contrary to this goal.

Any changes to improve workforce distribution must be holistic and consider the needs and expectations of individual communities. The 2023 AMA rural and regional specialist training summit and the AMA plan for improving access to rural general practice all provide practical policy and program recommendations to improve workforce distribution in rural areas.

Which elements should be retained or reformed?

As mentioned above, the AMA supports the gradual phasing out of Section 19AB to be replaced with an innovative suite of workforce incentives and policies to recruit and retain a sustainable medical workforce in areas.

What would be the implications of removing Section 19AB?

The immediate removal of s19AB would have significant negative implications for areas of workforce need. Rather than an immediate removal Section 19AB the AMA advocates for the gradual and careful phasing out of Section 19AB with clear and innovative workforce incentives and policy alternatives in place.

What are the alternatives to Section 19AB for achieving more equitable distribution of the medical workforce?

Alternatives to improve the distribution and attraction of medical professional to rural and regional areas can include but is not limited to actions such as the development of an independent Commonwealth health workforce planning and analysis agency, funding and implementing the National Medical Workforce Strategy, and investing in rural medical training through reforming the STP to better create quality training places in rural and regional areas. AMA policy documents such as the 2023 AMA rural and regional specialist training summit and the AMA plan for improving access to rural general practice also call for:

- Support packages and policies for IMGs to provide appropriate supervision, create support networks and build fair employment and training systems.
- Shifting narratives in rural medical workforce discussions to acknowledge the rewarding and diverse work that doctors working in rural and regional areas are exposed to, and the opportunities available to create varied and flexible careers.
- Creating holistic social and community supports with all stakeholders to support both doctors and the community. This includes working with stakeholders such as states, territories, and local health networks to provide greater accessibility to early childhood care, accommodation, and social networks etc.

Has the impact of the DWS been different (positively or negatively) when compared to other distribution levers?

The use of DWS has not been properly examined for a long time, with it simply relying on a measurement of the doctor/population ratio and blanket exemptions for some specialties. In contrast, MMM and DPA are relatively more recent classifications developed through extensive consultations and more likely to support the better targeting of workforce to areas of need.

How relevant/appropriate is Section 19AB and DWS for achieving current government policy objectives?

Section 19AB cannot be considered best practice policy in the context of the current evidence base with respect to the recruitment and retention of doctors to areas of workforce need. While it is currently providing a workforce in rural, regional, and remote Australia and in areas of workforce need, it achieves this through coercion – an outdated and unfair approach that has little regard for the support that is required to drive long term improvements in access to care for patients. Further, the original objectives of Section 19AB, as established in 1996, are broadly no longer relevant. Irrelevant aims and objectives include containing the number of international medical graduates and promoting international medical graduates to take up salaried positions within the public health system to reduce Medicare costs.

DWS is an ageing measure in need of review and update, such that it leads to the better targeting of medical workforce policy

What are the benefits of s19AB in supporting access to medical professionals in areas of workforce shortage?

Section 19AB is currently providing a skilled workforce in rural, regional, and remote areas in addition to areas of workforce need. However, due to the lack of support provided to international medical

graduates this program is largely a short-term solution to medical workforce and training systems. Often international medical graduates leave their area of work after the conclusion of their 10-year moratorium or actively seek to reduce their return of service obligations.

What impact (positive or negative) has the Section 19AB/DWS had on quality of training and clinical care in areas of workforce shortage?

The AMA believes that more positive policies and programs are needed to support access to care for patients living in areas of workforce shortage. We need to continue efforts to support more locally trained graduates to work in these locations and focuses on how more training, education and support can be provided for doctors who want to live, train and work in these locations. This will foster an environment focused on excellence and work to promote improved access to care for patients.

To what extent do areas of workforce shortage rely on OTDs and FGAMS for their medical workforce?

Areas of workforce shortages do significantly rely on IMGs, OTDs, and FGAMs for medical workforce service provision. This is especially pronounced in rural and regional areas where IMGs make up 53% of the rural medical workforce and 56% of the total general practice workforce.

How appropriate are the current DWS area designations in identifying areas of workforce shortage?

The current DWS area designations are based on an approach that has not been properly reviewed or updated. Further, issues arise for Bonded Medical Program legacy participant doctors who are training in specialties and sub-specialties where information on DWS is not publicly available. For these doctors, whether their location is considered an area of DWS is not transparent.

Do you support the current assumptions that underpin the DWS? Why or why not?

The earlier comments we have made with respect to DWS already deal with this extensively. The AMA would like to see greater transparency around DWS for all Ahpra recognised specialties for BMP legacy doctors. This information should be included in publicly available DWS maps, easily accessible to all, and frequently updated. This would provide clarity to BMP legacy doctors who practice in these specialties and support them to complete their RoSO in a way that benefits access to specialist care inclusive of rural and remote communities.

How could the DWS classification be modified to better meet its objectives?

Reforms to the DWS should be determined according to objective criteria that take into account:

- the doctor to population ratio;
- the number of other doctors practising in either the same recognised speciality or providing services similar to speciality services;
- Medicare statistics and other relevant health workforce data;
- socio-economic circumstances of the proposed work locality; and
- local special needs.

It is also important that DWS benchmarks do not result in areas potentially losing DWS status only to find that this then results in reduced access to services for patients that can only be addressed when the next DWS update happens.

What would be the best geographic level at which Districts of Workforce Shortage should be classified (e.g. Statistical Area Level 3, Remoteness Areas, Local Government Areas, something else)?

The AMA has outlined the types of factors that should be used to inform future reform of the DWS and would encourage significant consultation and modelling of the impact of potential changes, including analysis of how different 'geographic levels' would impact on workforce distribution.

What changes should be considered to the DWS?

See comments provided in previous answers.

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