

CORRECTED VERSION

RURAL AND REGIONAL SERVICES AND DEVELOPMENT COMMITTEE

Inquiry into retaining young people in rural towns and communities

Halls Gap — 16 May 2006

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Witness

Dr G. Bertuch, principal director, Ararat Medical Centre (sworn).

The CHAIR — Welcome. I have a brief statement to read before we begin. Under the powers conferred on this committee by the Constitution Act and the Parliamentary Committees Act this committee is empowered to take all evidence of these hearings on oath or affirmation. I wish to advise all present at these hearings that all evidence taken by this committee, including submissions, is, under the provisions of the Constitution Act and the Parliamentary Committees, granted immunity from judicial review. I also wish to advise that any comments made by witnesses outside the committee's hearings are not protected by parliamentary privilege.

We are an all-party parliamentary committee, including an Independent, hearing evidence today on the inquiry into retaining young people in rural towns and communities. Before we begin, if you could please state your full name and address, the organisation you represent today and your position within that organisation.

Dr BERTUCH — Graeme Bertuch from Ararat —[ADDRESS REMOVED] medical centre and my address is [ADDRESS REMOVED]Warrak, 3377.

The CHAIR — Thank you very much. If you could please provide us with your evidence, perhaps for about 10 minutes or so, and then we will have some time for questions following that.

Dr BERTUCH — What I have done today is provided you with a folder which outlines the arguments. What we are looking at with these terms of reference is identifying the factors that influence young people to decide whether to remain in or leave communities. This is in particular reference to doctors in rural communities. It is one of the very difficult things at the moment. It is very popular in the press; even today coming in there was something about overseas-trained doctors hitting the headlines again.

As a background to what is happening at the moment, for instance, 60 per cent of graduates are young females. This places a stress on areas like this, I believe. Fifty per cent of graduates are of non-European origin. Working hours are coming down at a fairly great rate, and I think there is some evidence in there to show you that. Young doctors are willing to take less and less responsibility.

With this background, we have problems of attracting and retaining young people. That equally goes, as we will mention later, for more senior doctors as well, and particularly young people, because we need them coming through to relate to younger parts of the population — like teaching; with some of the teachers I notice that the general age group is going up.

What I have done here is to set out a program — and I can lead you through this. The contents refer both to my notes and also to the references.

When we are looking at Ararat, if we go to the current positive factors for country towns — this is a background to give you an idea of what the current situation is and then we can go on to what we could see as positive and negative factors for young people — in Ararat we have a very good quality medical centre. It is well known right around through western division and everywhere else because of its quality — we have made sure of that. We have a new hospital that has just gone up — we spent \$8.5 million — and a new nursing home going up.

We have access to visiting specialists and also good access to Ballarat specialists. At the moment we have a good number of doctors, and that means less hours of after-hours duty and more support for young doctors. We have good facilities at Ararat — heated pool and things like that — and we have a proximity to Ballarat and Melbourne. They are all positive factors. Some of those can also be negative factors because you will find a lot of people in Ballarat do not know what is out past the arch, and certainly people in Melbourne say, 'Where is Ararat?'

Other negative factors include inducements given by other states. If you go to page 4 there, you will see that there is interstate competition that is directly impeding on country practice and other areas of need. You can get inducements like \$100 000 to go and sit on a seat in Cairns. The Queensland government is spending \$6.4 billion on a health package over 18 months to attract over 300 doctors. That is competitive. Likewise in South Australia there are inducements. There are no such inducements in Victoria. I have spoken with Mr Helper here, and he rightly says we really should not be competing with these people, but unfortunately it is a competitive world and unless we do something to get people, we are going to be in a lot of trouble.

Overseas trained graduates — the OTDs that I refer to here — are drying up because of competition from overseas. On top of that we have red tape at government and medical board level that is causing trouble. I had a talk with the young doctors in our group. We are a training organisation. We have three overseas trained doctors. We have

registrars. There are a few things on page 5 that give you some perspective from these young doctors. Given that 60 to 70 per cent of graduates are female, it is very difficult to attract them because, if they have got a spouse who cannot get a job in country areas, who is a professional in some other way, it is very hard.

Professional contacts — ongoing professional education, especially in remote areas, is difficult, and it is difficult to get relief. High doctor to patient ratios in country towns often mean long after-hours duty, and young families do not want that any more. They want what they call quality time.

Children's education becomes a problem as the families age. When they get to secondary school, they start asking whether they should go to a private school, and this often means shifting away from the town.

Social interaction is one thing. I think it is a problem of living in Melbourne. They do not know that socialising in a country town is second to none after a while. You really have far more socialisation than you need sometimes. Another thing is access to medical care. If specialist care is required for children, there is a lot of travelling, particularly if they are single mums, as some are likely to be with the high percentage of female graduates, so it makes it difficult for them. They find difficulty in running homes, child care access, maternity leave, sick leave and other things. It can cause trouble if they are looking at joining a partnership or modifying their partnership, and they often have to take a cut in income if they have a family member who is sick.

With regard to overseas trained graduates who are not Australian citizens, until they are Australian citizens they have to pay all their medical expenses, and that makes it hard, particularly if they do not have access and they have to take time off work. Likewise, it is hard for these people to get credit ratings if they want to settle down in a country area and buy a house; it is very difficult.

There are a few other considerations here that probably go across the broader aspect of the medical community. There is a rural retention program for doctors that cuts in after five years. It is probably to most of us worth about \$10 000 a year to be included if we stay in the community after five years. Unfortunately, when you are comparing that with a 'sit down on a seat in Cairns' of \$100 000, it does not seem to go very far.

One of the big things — and I will pass this around to my colleagues as well — is retention of experienced doctors. If you do not have experienced doctors in a community, you are less likely to attract young doctors. I think they feel they need the support these days, and it is getting harder and harder, as people get to retirement, to maintain them. We had a locum through recently who had retired from his community. He was travelling around Australia just doing locums. He was taking home as much as people who are taking responsibility for running medical practices, and more in some cases. If we at the Ararat Medical Centre try to induce someone to stay, it costs us between \$20 000 and \$70 000. That is by the time of relocation. We have been paying this. There is often a spotter fee for the organisation that has introduced the doctor to us.

I have been in touch with the Ararat council about putting this back and seeing how it could be involved as a community because I think it becomes a community issue. As more senior doctors, we can sit on our seats seeing people and let it run down and just say we cannot see any more, but that is not the idea of serving a country area. It becomes a problem for the community to address as well these days. There is an ageing population, and that is going to shortfall our doctor numbers over the next few years.

Lastly, one of the things that impedes a lot of changes — and I think you will find that coming up with the Minister for Health's suggestions, including other people — is politicisation. The colleges are very strong, and they will not happily accept other people stepping into their areas.

The *Medical Journal of Australia* article, that talks about more doctors but not enough Australian medical work force supply, suggested that no matter what we do there is going to be a deficit of doctors across the board until at least 2012. That is now showing up for specialists as well. I heard something on the radio in the last couple of days about surgeons.

In summary, the government is aware of the doctor deficit. Professional colleges, universities and organisations such as RWAV have done research and are active in setting conditions for future recruitment, especially in areas of special needs. This research in the *Medical Journal of Australia* concluded that the general practice work force is likely to face chronic shortages necessitating innovative policy responses to ensure the community's needs of primary medical care are met.

The rural retention program which rewards retention is inadequate compared with inducements being offered by individual states. The overseas trained doctor supply is drying up because of competition from other countries in similar positions, and I believe that optimum numbers of doctors need to be maintained in towns so that there is a quality of life for young doctors and families. The percentage of women and non-European graduates, together with current lifestyle expectations, have dramatically change our doctor demographics.

These are just some ideas that I present, along with many. If you read some of the articles there, there is a reply from David Hawker and from his Parliamentary Secretary to the Minister for Health and Ageing, Christopher Pyne, giving government initiatives and what they are doing. Once again these will not cut in for quite some time.

My suggestions will be seen perhaps by some as fairly dramatic — such things as a tender process for provider numbers. That would ensure that areas of need would have more access to doctors, because in very popular areas you would get a higher tender price, a higher cost, and certainly in country areas it would be a lower tender price, and you might also get community involvement in promoting that doctor.

HECS fee minimisation would attract young doctors; minimisation or abolition in return for a period in areas of need. I think you have to maintain the senior doctors as long as you can, and something like significant superannuation contributions to those doctors would help. Once again we were looking at, say, \$10 000 rural retention, but this is not a lot compared with inducements, as people get more senior, to go elsewhere and be locums and so on. There are no responsibilities and they can have the lifestyle they want and travel around Australia. I think communities must offer assistance to make the conditions more conducive, such as the introduction to facilities in the town, perhaps letting go of fees for a year or two. We need home help particularly for young female doctors, child care et cetera.

In summary, I have presented you with my view of what is happening. I think it is fairly comprehensive and I welcome any questions.

The CHAIR — Thank you very much for going to all that effort.

Mr WALSH — Your idea of a tender process for Medicare provider numbers — have you run that past the AMA?

Dr BERTUCH — No. I just thought of that yesterday.

Mr WALSH — Do you think they would go for it?

Dr BERTUCH — I do not know. You would have to do a SWOT analysis of the benefits and negatives. From a country doctor's point of view, I cannot see any great problems. Certainly it would tend to redistribute the doctors that are coming in. I am not saying that to the ones who are already there. It is a fairly unique way of looking at it. It creates in some ways a form of goodwill as well.

Mr WALSH — One of my personal theories is that we should have Medicare provider numbers tied to postcodes so that we get an even distribution around Australia; would you consider that?

Dr BERTUCH — This would do the same. One of the ways to overcome this problem, which will happen, is that the pendulum will swing the other way. You will have more graduates than you need and then you will have tied up the provider numbers, and then you can nominate what provider numbers you will have in each area. That would make something like this tender process worthwhile too.

Mr WALSH — The market will decide.

Dr BERTUCH — The market will sort it out.

Mr WALSH — Good idea.

Mr INGRAM — One of the things that has come through evidence to the inquiry is that there is, if you like, a barrier to young people to go to university. There are a lot of young students in country areas who are getting the grades to go into fairly high-skilled areas like medicine and other courses, but because of the costs to get to university, the increased cost of accommodation and other things for those students to study in a metropolitan university, they are either deferring for a year or not going to university. Do you see any solutions to resolving that?

We have also heard that if you get a link, if you like, for students who once they qualify, whether it be back to a rural community or a rural university, they are more than likely to stay in practice in country areas.

Dr BERTUCH — I certainly think country students are more likely to come back to the country. They know the social factors that operate in country towns; they often have family. It is amazing how many country people come back to country towns even if they have been away for a while. I think there are already initiatives like John Flynn scholarships and other inducements to get them to come to country areas. I am actually mentoring a couple at the moment on that basis. They will cut in eventually, probably in 2012. I think there should be some HECS fee relief for young doctors coming to areas in need. It might be a more significant inducement than anything else.

I have also suggested to our local community hospital that perhaps it could look at even just supporting students who are doing medicine or something else which is important for the town. There could be mini scholarships, or pay for their books and so on. You might not get them back, but they would be more likely to come back.

Mr McQUILTEN — On that point, what about the perceived view — or my perceived view — that medical schools were a bit biased against country students, and I have personal knowledge of a number of them where the kids had the marks, but they would not tutored like the Melbourne kids were to actually enter the courses. Therefore, we had country kids who probably did not get in when they should have got in.

Dr BERTUCH — I cannot comment directly on that. I know at the next level up, once they are training they are told that if they leave their city training areas, it is harder to get back into the mainstream. That is a negative inducement for young people to come to the country. I would like to see more rotations through country areas. In the early days, say 20 years ago, we had residents on rotation from Ballarat and we had family medicine program trainees. They actually filled our places over those early years and stayed some time. Once they become exposed to country areas they can see it is not so bad.

The other thing I suppose is the entry level at universities for medicine — you have to almost be an Einstein to get in. It might be that looking at some differential in marks for country students would help. I do not think you necessarily need 99.9 on your tertiary score to do medicine.

The CHAIR — Thank you very much for your presentation today. You will get a copy of the transcript in a couple of weeks. You may correct any errors but you cannot change matters of substance.

Witness withdrew.