



3 August 2005

**GPPHCNT Submission**  
to the  
**PRODUCTIVITY COMMISSION HEALTH WORKFORCE STUDY**

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## **1. Introduction**

This statement has been prepared in response to the Productivity Commission's request for input into the development of a Health Workforce Study aimed at identifying and examining the critical factors that impact on the health workforce, and identifying solutions to ensure the continued delivery of health services. It sets out the position of General Practice and Primary Health Care Northern Territory (GPPHCNT) in relation to questions raised by the May 2005 Productivity Commission's Issues Paper 'The Health Workforce', and in particular the primary health care workforce in the NT.

GPPHCNT is the peak body for the general practice and primary health care sector in the Northern Territory, providing a range of workforce programs as well as support for GP Divisional programs, policy and advocacy.

## **2. Productivity Commission's Issues Paper - General Comments**

GPPHCNT supports the overall thrust of the Issues Paper and the concerns it raises. We welcome the holistic approach to the health workforce team and are pleased it acknowledges the need to address the health workforce team on a multidisciplinary level, defining the 'health workforce professional' to include the entire health workforce.

The NT is greatly affected by chronic shortages of health workforce professionals. Being made up solely of remote, rural and isolated urban areas, it has always experienced difficulty in attracting an adequate number of health professionals, including medical practitioners, nurses, allied health professionals and Aboriginal health workers (AHWs).

We acknowledge that the Australian Government has funded a significant number of initiatives addressing the medical workforce shortage, especially in rural and remote areas, including: the GP Rural Incentives Program; Rural Workforce Agencies, Rural Divisions of General Practice; Bonded Scholarships; Bonded Medical School Places; the 5 year Overseas-Trained Doctor scheme; Rural Clinical Schools; University Departments of Rural Health; Regional GP Training Programs; student placement programs and various other initiatives. Nevertheless, there is a continuing undersupply of the health workforce personnel in the NT, in particular rural and remote areas, with the worst access available to the Indigenous population of the Territory.

### **3. Contextual Issues relating to the NT health workforce**

#### Geographical Factors

Low overall population, low population density, and high proportion of Indigenous people in the NT, are key issues affecting the delivery of all health care services and programs.

The estimated resident population of the NT at September 2004 was 200,449, representing about 1% of Australia's total population, dispersed across 17% of Australia's land mass. The population density for the NT is approximately 0.1 persons per square kilometre - the lowest of all jurisdictions and significantly lower than the national average of 2.6 persons per square kilometre<sup>1</sup>. All of NT outside of Darwin and surrounding areas is classified as remote (RRMA 6 and 7) under the Rural, Remote and Metropolitan Areas Classification System.

The Top End (Darwin urban, Darwin rural, Katherine and East Arnhem regions) covers an area of over 614,000 square kilometres and a population of approximately 155,000 people, 110,000 of whom are concentrated in the greater Darwin region (including Palmerston, located some 10km outside of the Darwin city boundaries). The tropical climate of the Top End limits access to many smaller communities during the wet season due to heavy periods of rain and thunderstorm activities.

The Central Australian Region (Alice Springs, Tennant Creek and remote communities) cover an area of over 830,000 square kilometres and a population of approximately 46,000 people, approximately 17,000 of whom are Indigenous. About 31,000 people live in Alice Springs and Tennant Creek, with the remainder scattered throughout 45 remote communities and outstations. Both the long distances and Central Australia's desert climate frequently hamper or prevents travel to the remote communities.

#### Aboriginal and Torres Strait Islander Population

It is estimated that as at June 2001, Aboriginal and Torres Strait Islander peoples made up around 29% of the NT population, compared with about 2% nationally, with four fifths of the NT's Indigenous population living in the remote (RRMA 6 and 7) areas<sup>2</sup>. The Indigenous population is younger on average than the general population, and accounts for 40% of the NT population aged 14 and under<sup>3</sup>.

Aboriginal and Torres Strait Islander peoples suffer greater ill health, are more likely to experience disability and reduced quality of life, and die at significantly younger ages (about 20 years younger) than other Australians.

The underlying determinants of their ill health include extreme socio-economic disadvantage, low incomes, high unemployment, and poorer educational outcomes, as well as environmental factors such as poor housing and the linked higher rates of health risks such as smoking, obesity and alcohol misuse<sup>4</sup>. Poor health outcomes amongst Australia's Indigenous population are a direct result of colonisation, dispossession, social disruption, and political disempowerment.

Due to the relatively high numbers of Aboriginal and Torres Strait Islander peoples in the NT as well as their high morbidity and mortality rates, Aboriginal and Torres Strait Islander peoples' health issues need to be addressed as a key factor in the implementation of all general practice and primary health care initiatives and programs in the Territory.

#### **4. Primary Health Care Service Providers in the NT**

Due to the specific demographic, climatic and cultural factors, the models in which many (approximately 50%) of Territory's GPs work are atypical of the private general practice model prevalent across Australia. In general, primary medical care in the NT is mainly provided through the following service providers:

- Private General Practice operates mainly in Darwin and the remote regional centres, namely: Alice Springs, Katherine, Tennant Creek, and Gove, and services non-Aboriginal and some Aboriginal clients. In addition, a small number of nominally privately practicing GPs work in "mixed models" of service delivery set in Aboriginal communities in remote areas (RRMA 7) whereby services are provided by both the private sector GPs and the NT-government employed health team;
- Aboriginal community controlled health services, also known as Aboriginal Medical Services (AMSs), provide culturally appropriate, autonomous primary health care services to the Territory's Indigenous population. AMSs are initiated, planned, and governed by local Aboriginal communities through their elected Aboriginal board of directors. Relatively large services operate in Darwin and in each of the remote centres and provide outreach to some other remote areas of the NT. A number of smaller services, usually employing a salaried resident GP to work as part of a multidisciplinary team comprising of AHWs and nurses, service very remote areas. Income from those services is directed to the AMSs.
- Northern Territory Department of Health and Community Services (NTDHCS) provides a visiting District Medical Officer (DMO) Community service to a number of remote Aboriginal communities as well as care through hospital-based emergency departments and community clinics.

In addition to the above models, Remote Area Nurses (RANs) and AHWs provide a significant amount of primary care in remote NT settings where there are few resident GPs. These staff may be employed by the NT Government or by an AMS; they often work alongside visiting DMOs and, in some cases, the NT-government employed staff may work in clinics alongside GPs in private practice.

Along with the ongoing development of new primary health care services based on pooled Commonwealth and NT Governments funding, Co-ordinated Care Trials and/or the Aboriginal Primary Health Care Access Program employ GPs and other health workers under an Aboriginal community controlled model.

#### **5. Health Workforce Issues in the NT**

The NT experiences significant health workforce shortages and high levels of turnover, particularly, but not only, in remote areas.

In much of remote NT primary health care services are extremely limited. In communities where there is a health clinic but no resident GP, services are delivered by resident RANs and AHWs. Emergency support is provided by NTDHCS remote health services including telephone on-call support and emergency aerial evacuations. General practice services are provided by visiting DMOs but in many communities these visits are infrequent and brief. During the wet season, residents of some extremely remote communities rely on the expertise of nurses and AHWs for most of their primary health care and even emergency care.

## General Practitioners

A 2002 study of the GP workforce<sup>5</sup> indicates that the NT has a significant shortfall of GPs, including an indicative shortfall for Darwin of more than 10%, and for the remainder of the NT of more than 20%. Part of the shortfall is due to high turnover rates: current estimates of GP and primary health care practitioner turnover in the NT range from 25% to 35% per annum.

The Remote General Practice Workforce Plan for the NT was produced in November 2003 and assesses the adequacy of the GP workforce in remote areas of the NT. The study found the current total GP workforce in Central Australia to be 38.4 full-time equivalent (FTE) doctors, compared with a requirement based on accepted ratios of 55.3 FTE GPs, leaving a shortfall of approximately 17 FTE GPs. The GP workforce in remote Top End (excluding Darwin) was found to be almost 30 FTE, compared with a total requirement of over 65 FTE, leaving a shortfall of 35.5 FTE<sup>6</sup>. Darwin also suffers from significant but less well enumerated medical workforce shortages.

A recent AIHW report<sup>7</sup> states that, in 2001, there was just one FTE Medicare-billing GP for every 2,131 people in the NT, about half the national average of one GP for every 1,154 people. In 2002-2003 Territorians visited their GP an average of 2.6 times per person per year, half the rate of other Australians (4.9 visits per person in a single year). It also states that the NT has the highest proportion of older GPs nearing retirement and the GPs are increasingly female, overseas trained and more likely to work part time. This is further compounded by the already mentioned special health care needs of the NT based on the high burden of disease amongst the Indigenous population.

The above mentioned workforce shortages and high levels of turnover have significant implications for implementation of general practice and primary health care programs including those rolled out through Divisions, including immediate and practical capacity issues which can make it difficult for practitioners to take on new initiatives which require time away from direct service provision. On the other hand, the strong emphasis on multidisciplinary primary health care which is evident in the NT setting, particularly in Aboriginal health, creates opportunities for general practice programs to take a broader approach engaging the whole primary health care team rather than being GP-centric.

## Nurses

Along with the growing chronic disease burden and medical workforce shortages in Australia, the role of nurses in patient and practice management has been significant in the past and the nurses continue to be the main health provider. The health promotion and education roles are expanding rapidly and Remote Area Nurses (RANs) play a crucial part in a multidisciplinary approach to comprehensive primary health care.

According to a new AIHW report<sup>8</sup>, Australia's nursing supply increased from 1,031 FTE nurses per 100,000 population in 2001 to 1,106 FTE nurses in 2003. This rise is believed to be associated with an increase in average hours worked, from 30.7 hours in 2001 to 32.5 hours in 2003. Between 2001 and 2003, there was a 5.1% increase in the total number of registered and enrolled nurses. However, the aging profile of the nursing workforce has continued to rise from 40% of nurses aged 45 years in 1986 to 46% in 2003. The average age of the nursing workforce rose from 40.3 years in 1997 to 43.1 years in 2003. The aging profile of the nursing workforce has been more prominent in regional and remote areas, indicating nursing workforce shortages in the future.

The role of the nursing workforce has been vital in the NT setting, especially in remote areas. Whilst the general trend in Australia has been for a majority of the nursing workforce employed in the aged care and hospital settings, the NT has an increased need for nurses in community health centres in remote and very remote areas.

GPPHCNT acknowledges the Australian Government's initiatives to address general nursing shortages outside the metropolitan areas through its 1998 Rural and Remote Nurse Scholarship Program, which aims to assist professional development and skill training for registered and enrolled nurses working in remote and rural areas, as well as those wishing to train and practice in these areas. Nevertheless, given that only about 2% of the total nursing workforce is employed in remote and very remote areas, more incentives targeting training, recruitment and retention of nurses are required. Innovative scholarship schemes, such as the John Flynn scholarship for student doctors must be developed to sustain and nurture the remote nursing workforce.

Commencing in May 2005, GPPHCNT has been managing a Nursing in General Practice Program, whereby a Practice Nurse Program Coordinator is employed to ensure that the NT responds to the needs and priorities of local general practices and nurses and tailors programs to these needs. The Practice Nurse Program supports the primary health team approach as a way to promote sustainable general practice, promoting flexibility and understanding the constantly changing needs of practices. It is hoped that the project funding will be extended beyond its current end date of December 2005 to enable long term visions for this project to be realised. The Nursing in General Practice Program is an example of an initiative which addresses the issue of health workforce shortages in a geographically and culturally sensitive manner, tailoring its outcome objectives to the specific needs of the NT population – a key factor when addressing health workforce incentives and reforms.

Training, education and support for RANs are crucial in developing a sustainable remote medical workforce. The Council for Remote Area Nurses of Australia (CRANA) conducts critical hands on training for remote practitioners, equipping them with skills required to perform competently. In addition, it also provides educational support and development through the Remote Health Practice Program which the participants can enter at a graduate certificate level and exit with a Masters Degree in Remote Health. CRANA also runs the 'Bush Crisis Line' – a 24 hour telephone counselling and debriefing service for remote practitioners, which aims to help create sustainable methods for practitioners and their families to deal with work related and other stressors.

All the above training, education and support services are multidisciplinary in nature and are accessed by all health professionals, including GPs, DMOs, ambulance officers and allied and other health professionals. It is crucial that this approach is maintained in all future government incentives and programs.

### Aboriginal Health Workers

AHWs have had a key role in the delivery of primary health care in Indigenous Australia since the early 70's, when the importance of appropriate health services for Indigenous population of Australia and the lack thereof was first recognised. Due to the high demand for local qualified AHWs in the NT, their role has been formalised and the NT now requires AHWs to be registered for clinical practice. The clinical role of the AHWs in the NT is therefore well defined and underpinned by the NT Customised Aboriginal and Torres Strait Islander Health Worker Competency Standards, registration, a career path and a salary structure.

Apart from their clinical role, AHWs play a key role in cultural brokerage between Western medical systems and Indigenous communities. AHWs roles and responsibilities include treatment of wounds, administration of medicine, management of chronic disease, prevention programs such as immunisation, cultural brokerage, translation and many more functions and duties.

A significant health disadvantage to Indigenous peoples in accessing general practice in Australia is that their health needs require different style and quality of practice. According to a study which compared clinical consultations in an Aboriginal Community Controlled Health Services (ACCHS) with those in mainstream general practice, ACCHS consultations were said to be “more complex, with more young patients, more new patients, more home visits, more problems managed, more new problems and more consultations leading to emergency hospital admission”<sup>9</sup>. In addition, the study showed that nearly all patients used Aboriginal health workers as their first point of contact, and nearly half the consultations were with Aboriginal health workers alone<sup>10</sup>.

The high need for AHWs’ involvement in primary health care teams is confirmed in the agreement under the NT Aboriginal Health Forum (NTAHF) that there should be a much higher proportion of AHWs than registered nurses in the NT. A recent update to the Territory’s two Aboriginal Primary Health Care Workforce plans indicates that AHW numbers have collapsed, particularly in Central Australia, and there are almost as many registered nurses in the NT as AHWs<sup>11</sup>. The NT Primary Health Care Workforce Update of the Top End Aboriginal Health Planning Study (2000) and Central Australian Aboriginal Health Planning Study (1997) undertaken under instruction from the NTAHF in February 2004 provides the ratios for of AHWs in the Top End to be 1:1370 per head of population (27% of ideal percentage) and in Central Australia 1:1340 (22% of ideal percentage). The study further concludes that the support of AHWs training comes primarily from the community sector as opposed to the NT Department of Health and Community Services and that the main obstacles in employing and training more AHWs come from low literacy levels, too much “humbug”, competency requirements, expenses and the requirement of attending formal AHW education through the Batchelor College<sup>12</sup>.

### Allied Health Professionals

The allied health workforce is an important component of the primary health care system, especially in rural and remote primary health care settings where allied health has particularly important role of supporting and complementing services provided by GPs. Maintaining and expanding an allied health workforce in rural and remote Australia is also an important strategy in the recruitment and retention of general practitioners to these areas to improve access to general practice services.

The National Rural and Remote Allied Health Advisory Service (NRRHAS), defines rural and remote allied health professionals (AHPs) to include: physiotherapists, occupational therapists, speech pathologists, podiatrists, psychologists, orthoptists, social workers, radiographers, audiologists, dieticians, prosthetists/ orthotists and hospital pharmacists.

Overall, rural and remote communities have a lower level of access to AHPs with the particular impact on the care needs of aged and disabled people, those needing rehabilitation and people with chronic diseases in those areas. It is estimated that around 25% of AHPs service rural areas where 32% of Australia’s population lives.

Access to allied health services in the NT, which is predominantly remote, is more restricted than in the rest of Australia. This is reflected in the following Australian Institute of Health and Welfare (AIHW) statistics (based on Medicare data, 2001 ABS National Health Survey and 1998 Physiotherapy Labour Force Report):

- In 2001-02 the number of optometrists rendering at least one service under Medicare in the NT was 20 in comparison to 3,099 nationwide – this is only 0.6% per head population despite the NT constituting 2% of the Australian population. The NT had the lowest rate of employment with FTE of 10.0 per 100,000 population, in comparison to the nationwide average of 15.7. Furthermore, the 2001-02 figures in the NT fell by 9.1% from 1998-99 whilst, at the same time, the ACT recorded an increase of 21.1%.
- In 1998, the NT had the lowest rate of physiotherapists – 82 out of 11,304 nationwide. This is only 0.7% per head population. The NT has the lowest FTE of 43.3 per 100,000 population, in comparison to the highest FTE of 74.6 in SA.

Access to allied health services in the NT is even more restricted in the Indigenous setting as a result of low numbers of Indigenous AHPs and the lack of culturally appropriate services.

## **6. Other Health Workforce Issues Relevant to the NT**

### Overseas-Trained Doctors (OTDs)

OTDs are an important and growing part of the Australian medical workforce. As at June 2004, OTDs constituted 30% of the GP workforce in the rural and remote areas of the NT, and by 2003 OTDs made up over 20% of the total national medical workforce.

GPPHCNT welcomes the Australian Government's initiative under Strengthening Medicare to recruit an additional 725 OTDs to Australia by 2007, but we believe that a number of policy initiatives are required to attract, train and support OTD GPs working in under-serviced areas of the NT. GPPHCNT has been unable to consider or place OTDs in many of the vacant positions in the NT because of the level of supervision required by the Medical Board of the Northern Territory. Most of the OTD applicants for positions in the NT have not completed the requirements of the Australian Medical Council (AMC) or obtained Fellowship of the RACGP and subsequently do not meet the standards required for unsupervised general practice.

The provision of supervision for those OTDs that may be granted conditional registration is also problematic because of the nature of GP practice in the NT and the high unit cost of providing supervision and support in remote areas.

GPPHCNT supports the ethical principle that Australia has a responsibility to produce a sufficient number of domestic medical graduates to satisfy the health needs of its population and it advocates for reforms in Australia's approach to recruitment of OTDs. This has been encapsulated in the GPPHCNT's position paper available at [www.gpphcnt.org.au](http://www.gpphcnt.org.au). OTD recruitment should be considered as a short measure term only and the Government should closely monitor OTD workforce patterns to ensure that the placement of doctors on the Skilled Occupation List does not undermine the measures and programs currently in place to attract GPs to rural and remote practice.

Furthermore, it is important that the assessment of OTDs' general skill and knowledge levels includes indicators measuring capabilities and understanding required for working in particular rural or remote context. Such requirement is essential for successful recruitment of health workforce in the NT's remote areas and Indigenous communities. One short term measure would be to allow OTDs to sit their Australian Medical Council (AMC) exam from overseas and then apply for positions in the rural stream of the GP training program as part of the 5 year OTD scheme. As noted above, initiatives which rely on OTDs to fill gaps should be seen as short term solutions only.

Finally, it is essential that further incentives are introduced to target recruitment and retention of GPs in the NT. It must be recognised that practicing in rural, remote and isolated parts of Australia is in itself a disincentive and a hardship for many OTDs. Living conditions, the availability of employment and education options for family members, and the availability of services generally, tend to be far more limited in the NT (and particularly its remote areas) than in the outer areas of major Australian cities.

With incentives also being introduced for both outer metropolitan and rural and remote areas, we are concerned that our ability to recruit and retain OTDs (and other doctors) may be compromised. Increased commonwealth support should be provided to OTDs providing essential services to rural and remote Australia, such as access to Medicare, public education system, personal loans etc.

Funding arrangements need to also recognise the high unit cost of providing training and support in remote areas. The qualitative reasons why NT remote practice differs from rural and remote practice in other states are numerous, and result in considerably higher costs in providing training, support services and assistance to OTDs. Key factors include significant cultural dislocation and social isolation, the duration and cost of travel to remote locations, limited specialist GP trainers, minimal provision of training outside urban centres and limited opportunities for pre-exam experience in mainstream General Practice. Training requirements in the NT include not only those of the FRACGP examination, but those of rural and remote practice, including primary health care, cross-cultural and language skills and multidisciplinary practice.

### Bonded scholarships and medical school places

GPPHCNT welcomes the Australian Government's actions aiming to increase the number of medical school places and GP training positions and the funding of new medical school bonded places. We support incentive based bonding of medical graduates to districts of workforce shortage. We further advocate following refinements to the current bonding scheme:

- The bonded places should be offered on a HECS-free basis, offering a financial incentive as well as delivering equity to students vis-a-vis other students;
- The period of the bond should be limited to 6 years, regardless of whether a doctor works full-time or part-time so as not to disadvantage doctors with families;
- The period of the bond should commence as soon as the doctor begins working in a district of workforce shortage so as to promote establishing professional and personal relationships and forming connections to the community;
- The penalties for breaching the bond should be clear and limited to a ban on obtaining a Medicare provider number for the portion of the unfulfilled bonded period;



- Students should not be allowed to “buy their way out” of the bonding requirement, as this has the potential to convert the bonded places into de-facto fee-paying places.
- Additional incentives should be introduced to ensure a reasonable quota of graduates from bonded places commences practice in rural and remote districts of workforce shortage.

## **7. Future Directions**

A number of government initiatives over recent years have made a considerable contribution to supporting recruitment and retention of GPs in Aboriginal health in remote settings. However, there is still a strong need for enhanced recruitment and retention programs which target all levels – school students, medical undergraduates, prevocational graduates, registrars, post graduates, OTDs and experienced GPs – with both financial and non-financial incentives to live and work in rural and remote areas.

GPPHCNT seeks Australian Government action in the following areas:

### Financial incentives

The government must, as a priority, address the need to reduce the gap between GP incomes and the incomes of other specialists. At a broad level, the gap between GP incomes and that of all other specialists is too large. This is a major reason why medical graduates are not choosing to enter the GP training program compared with other specialties. The NT has been unable to fill all of its training places in an environment where there is a shortage nationally. Means to reduce the gap include retaining the Rural Retention Payments scheme and introducing measures such as the proposed restructure of Medicare attendance items, which is supported by all major GP groups. Such measures will help to increase the overall pool of GPs, so that remote areas are not competing with more “attractive” locations for a workforce which is in short supply.

There needs to be increased support for specific financial incentives for GPs to work in rural and remote areas, particularly in a context where incentives are introduced for Outer Metropolitan Area practice. Remote regions of the NT are exceptionally difficult to recruit to, and sufficiently differential incentives are required to attract doctors who are also being offered incentives to work in rura/regional and outer metropolitan areas.

### Improved funding for Aboriginal Primary Health Care Services

The majority of GPPHCNT’s work under the RRGPP is related to attracting, recruiting, and retaining GPs in Aboriginal primary health care services. One barrier is the varying ability of these services to adequately fund GP positions so as to be in a position to offer competitive packages to GPs. Australian Government initiatives to improve funding for medical services through the AMSs they fund (eg through the Primary Health Care Access Program, PHCAP; and through improved AMS access to Medicare, including new MBS items for Aboriginal health), are welcomed. However, there still appears to be inequity in funding between AMSs, which needs to be addressed. A funding formula for OATSIH-funded services, related to community numbers and community need, and linked to accepted workforce ratios, is well overdue.

It is well known that the NT has the lowest per capita access to Medicare funding of any jurisdiction. The Medicare system is designed for private general practice with high patient throughput and short consultations; it does not work well in remote NT where there are insufficient GPs to meet community needs; where the majority of patients have high and complex needs and require longer consultations; and where GP travel time between clinics and patients can be considerable. While higher MBS rebates, items for Aboriginal health, and items for practice nurses, are all improvements, more fundamental changes are needed to ensure the Australian Government contributes appropriate funding to address primary health care needs in the remote NT.

### Non-financial incentives

Non financial incentives are needed to attract Australian GPs into areas of need. Although these are not expected to produce new doctors for another 6-12 years, current policies such as bonded medical school places and bonded scholarships are moves in the right direction<sup>13</sup>. GPs who work in areas of need should also be given preferential access to further training, including subsequent specialist training programs, training in general practice fields, and university and other educational appointments; as well as preferential access to sought-after practice locations. In order to achieve the latter it would be necessary to introduce some form of regulation of the sale of provider numbers (including, possibly, consideration of geographic provider numbers).

### Support for multi-disciplinary primary health care teams

Healthy, well elaborated and well supported multi-disciplinary primary health care teams are a key factor in attracting and retaining medical staff. As well as delivering comprehensive, holistic care, a functioning PHC team capable of dealing with the challenges at hand can also help to prevent stress, isolation, and overwork on the part of the GP. Initiatives to address GP recruitment and retention need to be complemented by initiatives to promote and support the Aboriginal health worker, nursing, and allied health professions. These professions need to be upgraded and elaborated to meet PHC needs across such areas as environmental and hearing health, aged and disability care, mental health, and chronic disease prevention and management. As mentioned earlier, scholarship schemes such as the John Flynn Scholarship which support the multidisciplinary team are vital for long-term sustainability.

## **7. Conclusion**

GPPHCNT, with its broad constituency, brings together workforce issues for general practice and primary health care, with quality, integration, and population health issues. Like other remote parts of Australia, the Northern Territory has unique needs which require specific programs to address the current serious workforce issues.

The Australia wide medical workforce shortage is particularly felt in the NT where access to health care is also hindered by extreme isolation, large distances and high burden of disease amongst the Indigenous population of the Territory. In many settings in the NT, general practitioners, Aboriginal health workers, nurses and allied health professionals work together in multidisciplinary teams, often using standard treatment protocols in mainstream urban general practice, Aboriginal community controlled health service sector and small remote health clinics which often lack resident GPs.

It is necessary that any future incentives and programs to be introduced by the Australian Government target the whole multidisciplinary health workforce team, by applying financial and non financial incentives towards their recruitment and retention, with particular emphasis on recruitment and retention of health care workers in the Territory and the remainder of the remote Australia.

There are external factors beyond the control of organisation such as ours, which impact on how effectively we can attract, recruit and retain doctors. These include:

- a worldwide shortage of doctors, so that we are competing not only with other parts of Australia, but with other countries, for GP workforce;
- inadequate numbers of Australian medical graduates – this is now being addressed through new medical school places across Australia, but these will take a decade to have an impact on the workforce shortage;
- inadequate financial and non-financial incentives to attract sufficient GPs to remote practice – this is largely a matter of national government policy;
- “on the ground” issues relating to the conditions under which remote GPs in the NT work – these can include clinic governance and management issues, housing issues, issues relating to the primary health care team, lifestyle issues, etc – GPPHCNT has little or no control over these factors and they can work for or against attraction, recruitment and retention of GPs to particular locations.

Government policy at national and state/territory level is needed to address such issues.

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<sup>1</sup> Australian Bureau of Statistics. *Regional Statistics: Northern Territory*, Canberra, ABS 2004:44.

<sup>2</sup> Australian Bureau of Statistics. *Australian Social Trends*, ABS 2005:4102.0.

<sup>3</sup> ABS, 2004: 48.

<sup>4</sup> Australian Bureau of Statistics/Australian Institute of Health and Welfare. *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*. Canberra, ABS/AIHW 2003: 129

<sup>5</sup> Access Economics, for the Australian Medical Association, 2002. *Primary Health care for All Australians*. Canberra, AMA.

<sup>6</sup> General Practice and Primary Health Care Northern Territory, 2003. *Remote General Practice Workforce Plan for the Northern Territory*. GPPHCNT, Darwin, 2003: 54-64.

<sup>7</sup> Australian Institute of Health and Welfare. *General Practice Activity in the states and territories of Australia 1998-2003*, AIHW Cat No GEP-15 (5 October 2004).

<sup>8</sup> Australian Institute of Health and Welfare. *Nursing and midwifery labour force 2003*, AIHW, (12 July 2005).

<sup>9</sup> Thomas DP, Heller RF and Hund JM. “Clinical Consultations in an Aboriginal Community-Controlled Health Service: a Comparison with General Practice”, *Aust NZ J Public Health*; 1998 Feb; 22(1): 86-91.

<sup>10</sup> *Ibid*.

<sup>11</sup> NT Primary Health Care Workforce Update, February 2004 of the Top End Aboriginal Health planning Study (2000) and the Central Australian Aboriginal Health Planning Study (1997) undertaken under instruction from the NT Aboriginal Health Forum through their regional planning structures (TERIHPC & CARIHPC).

<sup>12</sup> *Ibid*

<sup>13</sup> While this is the position of GPPHCNT, Top End Division of General Practice, a GPPHCNT member organisation, does not support bonded medical school places or bonded scholarships.