CARR, Dr Dianne, Vice President, Rural Doctors Association of South Australia [by audio link]

CONSIDINE, Dr Gerry, Vice President, Rural Doctors Association of South Australia

POOLE, Ms Lyn, Chief Executive Officer, Rural Doctors Workforce Agency [by audio link]

RISCHBIETH, Dr Peter, President, Rural Doctors Association of South Australia [by audio link]

TIDEMAN, Dr Philip, Vice President, Rural Doctors Association of South Australia

CHAIR: I now welcome representatives of the Rural Doctors Association of South Australia and the Rural Doctors Workforce Agency of South Australia. Thank you for appearing before the committee today. Do you have any comments to make on the capacity in which you appear?

Ms Poole: I'm coming to you from Kaurna land.

Dr Tideman: I'm one of the three vice presidents of the Rural Doctors Association of South Australia. I'm a consultant physician, having trained in rural general practice. I've been responsible for rural health outreach and clinical networks here in South Australia, predominantly in the area of cardiovascular medicine but also in internal medicine generally.

Dr Carr: I'm a GP/obstetrician who's been working out at Murray Bridge, in the Riverland Mallee Coorong LHN, for the last seven years. I joined the Rural Doctors Association of South Australia as vice president in late 2021.

Dr Rischbieth: I'm a rural generalist at Murray Bridge and have been for 35 years. I'm very much looking forward to sharing our experiences and some data about what's happening out in rural South Australia.

CHAIR: Thank you. I'll now ask each organisation to make a brief opening statement, if you'd like to do so, and then we'll ask you some questions.

Dr Rischbieth: Thank you for asking us to present to you. We've had some critical workforce shortages across rural South Australia ever since I've been a rural GP. However, things have become a lot worse in the last 10 years because of the lack of support from the state government in recognising the specialty training that doctors need to have. We've been propped up by locums in many of our towns. We've had proposals about funding the rural generalist training program through our state health department for a number of years. Submissions have been put forward. Unfortunately, the state health department has not agreed to that. There is an industrial process for rural generalists, which has been negated by the South Australian department of health.

We've got a lack of a training program for rural generalists, and we've got a lack of state government support for doctors who are working in rural practices and rural hospitals. There was a recent example of this, where our GP contract to work in our hospitals took over 16 months to get across the line, with six different offers from SA Health. We now have a contract which we can show to doctors and which we hope will keep doctors working in the local hospitals in their communities. But we also need to recognise that there needs to be a whole look at the structure of teaching and training in rural South Australia and that the Commonwealth and state governments need to work together.

I'd like to point out that in 2008 we went to Queensland to get advice about how to get a better-structured rural training program. We're still struggling to get that off the ground, and I think we're the only state in Australia that hasn't had that state government support. I'd like to ask Phil Tideman to provide some more information. We believe that 90 per cent of our rural practices have workforce shortages, and 25 per cent of them are not sure whether they can continue to supervise and train medical students and registrars, because of the critical workforce shortage we have in our general practices at present. Over to you, Phil.

Dr Tideman: Thank you to the committee. I want to take a slightly broad view of the situation. Although I'm Vice President of the Rural Doctors Association, which is predominantly rural GPs, I'm actually a specialist. I have practiced across all of the LHNs in country South Australia, except Yorke and Northern LHN and Barossa Hills Fleurieu LHN, and I have a detailed knowledge here on the Eyre Peninsula, having provided consulting services, as I said, across the northern Eyre Peninsula and in Whyalla for the last seven years. I've been in the health system for 37 years, about 25 of those predominantly around rural issues. For at least 30 of those years, there has been an evolving systemic imbalance in the provision of health services, which has been contributed to by policy decisions on both sides of the political spectrum. There have been attempts to deal with the situation, which have been fragmented and piecemeal.

The one thing from the Health Alliance evidence today we would disagree with is the number of medical students. We believe that problem has been largely addressed. There is not a shortage of medical students. There is some tweaking that needs to be done in the selection and provision of rurally based medical schools for

students, but the problem is not in the number of medical students; the problem arises in the allocation of those medical students, once they leave university, and the training that we can offer them in rural health.

I come back to Senator Patrick's question some time ago about what would happen to him if he hit a kangaroo on the other side of Kimba or out near Wudinna. Dean Johnson rightly pointed out that he'd be in pretty bad trouble. Acute and chronic primary care services are essential services, no different from the provision of a water supply, an electricity supply and a food supply, and they have to be treated as such. The evolving systemic imbalances over the last 30 years have now become a system failure in rural health, and I think you're seeing that from today's evidence. We are in a failure situation. We have no resident doctor between Port Augusta or Whyalla and Ceduna. As I said, I was providing consultant cardiology services to most of the northern Eyre Peninsula region, but I had to retire for health reasons in September last year and we've not been able to replace that service. That's just an example of how fragile the system was. We've lost the GP from Wudinna after 11 years of tremendous service. We had no doctor in Cowell for a long period of time. We have one resident doctor in Cleve, and this is for a population of 10,000 to 12,000 people. If you take Ceduna's problems into account, we're dealing with a population of 15,000 to 20,000 with completely inadequate services, as Mr Gill pointed out.

I would take on Mr Gill's point that the real problem here is that we can talk about all sorts of solutions but, at the end of the day, no single entity is responsible or given a KPI for actually ensuring those services. Those are funded both by the Commonwealth and by the state—and, unfortunately, by local councils; it's not their job to do that—but there's no single point of accountability in the system for the provision of services or for the provision of a teaching hospital for rural GPs in rural South Australia. And it's not only for the GP things but across the health ecosystem, which involves an extensive nursing requirement and an allied health requirement—as well as the support services, I have to say, which support all of that, like the hospitals themselves and the pathology services. This is where we need to address the problems. That's, in a nutshell, what I'm basically putting to you. We can talk about all sorts of little things and we can talk about putting young doctors back on the TV and stuff, but nothing is going to work unless someone is made responsible for the provision of the services.

CHAIR: Thanks very much, Dr Tideman. Ms Poole, do you have an opening statement?

Ms Poole: Mine is structured around the questions that were raised as part of the terms of reference. I would say that the Stronger Rural Health Strategy has been helpful because it gave us the MDRAP. That has allowed us to maintain our GP numbers in rural South Australia. We have a baseline of about 520 resident rural GPs and a fluctuating volume of registrars, depending on the success or not of the training provider in South Australia. We've done a good job of maintaining our workforce. We have a turnover of about six per cent per year, and we are replacing that six per cent. I think the really important thing to say is that what we really need in rural South Australia is about another 150 GPs over the next three years. We couldn't stand 150 if they arrived tomorrow, but we need 50 next year, 50 the year after and 50 the year after that on top of what we're retaining. And our retention rate is good. The average length of stay for our rural GPs is sitting at around 13 years. Our most recent data survey tells us that the people who responded, who were about 200, said they intended to stay another seven or eight years, so we're solid there.

The problem we have is that the construct of general practice as a small-business model is failing in small locations. I think, if there's one thing the Commonwealth could do—and I appreciate what Phil was saying—one of the fundamental things that could happen would be to recognise the absence of access to Medicare for rural communities compared to metro. I can't state that data, because it comes from the Commonwealth HeaDS UPP tool, but I can say that, if we took that money and made that money available to that small-business model, we could help them break out of this cycle of poverty, almost, where you've got none of the ingredients that are required for Medicare to be a successful business model.

For Medicare to work—bearing in mind that the national industry has gone backwards by 2½ per cent in its throughput—you need to be a seven- to 10- to 15-doctor practice with very high throughput and an ability to bulk-bill.

So, when we look at all of the communities that people are talking to you about, what's fundamentally wrong is we don't have the scaffolding in place to invest in this small business model. If we took the Medicare underutilisation to build a viable practice model in small communities, where there's no opportunity to increase the throughput or gain economies of scale, we would see a redress. Some of us who are too old have seen this done before. Many years ago we did it with funding from the Commonwealth due to the underrepresentation of Indigenous people accessing Medicare. Funds were made available inside the regional constructs to address that. If we could do something like that, it would allow the communities through northern Eyre and the Mallee—where there are small communities that are as deserving as anyone else of access to health care—to be able to have

robust practices with doctors who are well-remunerated and facilities that are supported with a mix of funding and Medicare to maintain those services and grow them. I think they're the most important things I want to say to you.

I'll quickly add—and again, it's a bit of tinkering around the edges—the changes to DPA have done us no favours. Blanketing DPA now into all of MM 3 to 7 only blunts that instrument further. It gives us no advantage in directing traffic and, of course, adding outer-metro through exception takes it further. But, again, we should not be reliant upon a system that has other countries producing our workforce.

CHAIR: Thanks very much, Ms Poole.

Senator PATRICK: Ms Poole, can you tell me how much federal funding the Rural Doctors Workforce Agency SA receives on an annual basis?

Ms Poole: I can. We received $2.8 million for our rural health workforce support program. On top of that, we're part of a consortia for the MDRAP and the scholarships program. Our share of the MDRAP is about $1.5 million. Our share of the national Health Workforce Scholarship Program is around $900,000 per year. Outside of those, we have a range of outreach programs. We are the outreach provider in South Australia for the Rural Health Outreach fund, the Indigenous outreach fund and the ears and eyes programs. That total for outreach is around $7 million per annum.

Senator PATRICK: That's a lot of Commonwealth funding. The Goyder council travelled six hours return to get here; the mayor of Streaky Bay, eight hours return; and the mayor of Kimba, three hours return. They made an effort to come here because they are desperate to get a doctor and to solve this problem. Why didn't you turn up to this inquiry in Whyalla noting that it goes to the very core of the things for which you are funded? Is there any reason why you didn't appear in person?

Ms Poole: Yes, there is, and it relates to family issues that I'm dealing with. That does not permit me to be outside of Adelaide at this point in time.

Senator PATRICK: Okay, thank you. In the last three years, how many doctors have you placed in Wudinna?

Ms Poole: None.

Senator PATRICK: How many doctors have you placed in Kimba?

Ms Poole: Inside the three years? Good question. There was a doctor there two or three years ago, when they were still operating independently—before they came into the Mid Eyre model—but it could have been longer ago than that.

Senator PATRICK: Seven years ago, we're advised. Thank you. What about Cummins?

Ms Poole: Yes, we've recruited an additional doctor in Cummins. I'm going to say it was last year, but that was in COVID, so it would have been the year before. I think she—

Senator PATRICK: That's the overseas doctor?

Ms Poole: Yes.

Senator PATRICK: Streaky Bay?

Ms Poole: Yes, we've helped facilitate the recruitment of the GP who is currently in Streaky Bay.

Senator PATRICK: The evidence we received from the mayor of Streaky Bay and from the Streaky Bay medical centre was that, in fact, they did all of the work. I go through all of the different towns—whether it be Coober Pedy, Ceduna, Elliston, Cowell; all of the townships on the Eyre Peninsula—and they are desperate for doctors. What was put to us, on the back of questions, was we should just take the money from your organisation and provide it, perhaps on a rotational basis, to various country towns who would then go about recruiting their own doctor. Once they're satisfied that they've done that, the next town should potentially get the money that you're receiving. What do you say to that proposition?

Ms Poole: I think that's one point of view. It's clearly not the Commonwealth government's view of how they want to do business.

Senator PATRICK: It could be after this committee reports!

Ms Poole: Indeed, sir! I absolutely agree that the Streaky Bay council were very involved in the recruitment, but I would equally say to you that the rural workforce agency has offered very significant support in the relocation and the retention of that GP. And the same is true in Cummins. We have just done [inaudible] in Ceduna and recently, in the last year or two, in priority locations like [inaudible] and other places. Don't think that we are standing out the front saying: 'Look at me, I'm a clever clogs. We've done this.' But it is fair to say that we've been present and helpful in the facilitation of those things. I am mindful that the communities take

ownership of their efforts, and I particularly applaud Streaky Bay, because that council [inaudible] community ownership has been a wonderful thing [inaudible].

Senator PATRICK: It's clear that they have taken ownership of the problem, but you received Commonwealth funding to assist in this regard. I'm going to give you the opportunity, on notice, to provide this committee with details of doctors—either MMM7 or MMM6—where doctors have been placed in the Eyre Peninsula, where you say you have contributed, and to provide the committee with evidence or details as to exactly what it is that you did. We'll then put that back to the various different councils. Are you able to do that?

Ms Poole: Yes.

Senator PATRICK: Thank you. I'll leave it at that, Chair. Thank you very much.

CHAIR: Thanks, Senator Patrick. Senator Grogan?

Senator GROGAN: Dr Tideman, Dr Considine: your organisation is a membership based organisations?

Unidentified speaker: yes.

Senator GROGAN: How many members.

Dr Considine: We currently have over 170 rural doctors on our books.

Senator GROGAN: So do you undertake any surveying of those members or understanding—do you have a sense of how they're feeling generally across the region, given the pressures that we've been talking about all day?

Dr Considine: I might defer to Peter Rischbieth, our president. He's got the data in front of him from our member survey.

Dr Rischbieth: Just last year, we had a meeting, a telephone hook-up, of more than 100 rural doctors expressing their concerns about the workforce and their capacity to deliver services, both in their primary practices as well as in their relationship with their local hospitals. This was the biggest ever meeting of rural doctors in South Australia; they were so worried about how they could continue to work in their general practices and in their hospitals.

Approximately 12 months before that we surveyed doctors. We got responses from over 42 towns. It was one of the saddest surveys that I've ever seen from country doctors in my 35 years. Practices were desperate. Communities were desperate for doctors to stay in their towns. Doctors were saying that they couldn't teach medical students and registrars because their clinical commitments at the hospital and their practices were so much that they couldn't then [inaudible] that mentoring and that education of junior doctors.

We have to have a workforce that can deliver the services in primary care, work at their local hospitals and also mentor, teach and train the junior doctors, which is a key part of our work. We know that, if we have an intern in a rural practice, there's a 45 per cent chance of them being a rural doctor in the long term. If they were of rural origin to start with, it's even higher. Lyn Poole and other education sources [inaudible] and the state government has put more intern places in country towns, but again they need to be supported by a longitudinal training program, supported by our state governments and our LHNs to have a proper teaching and training budget. Unless that's done, all the students will stay in Adelaide. The majority will stay in Adelaide. They have much more benefits working [inaudible] hospitals. We will not be able to get them out to the country where communities really need them.

Senator GROGAN: Would you be able to provide on notice a copy of the report on that survey, if you have one, or a summary?

Dr Rischbieth: Yes, we're happy to do so.

Senator GROGAN: Thank you. That would be appreciated.

Dr Rischbieth: I am also keen to let my colleague Dianne Carr talk about maternity services as well as the workforce issues—if she could have just a couple of minutes—and then Gerry as well. Would that be possible?

Senator GROGAN: Yes, absolutely.

Dr Carr: I am a GP obstetrician who has been working in the Riverland Mallee Coorong for the last seven years. As well I'm Vice President of RDASA, as of late last year.

In terms of our birthing services, the overwhelming message that we're getting back from women in our communities is that they want to birth locally. That was backed up with local community engagement that we did with Riverland Mallee Coorong back in November, essentially as we're looking to change to a midwifery led model.

We have been seeing numerous episodes of our maternity units being closed, either as a short-term diversion or for longer periods of time and the closure of smaller birth units. The reasons for diverts are complex. Sometimes it is the unavailability of a GP obstetrician, but it requires a whole team to be able to safely have a woman birth in her own facility, including midwifery staff and theatre staff. [inaudible] own region to be able to [inaudible] episodes where his own birthing hospitals have been closed due to a lack of theatre staff to be able to [inaudible] there be an issue.

We're finding increased centralisation of care and difficulty in both recruitment and retention of our GP obstetricians, for similar reasons to those that have been discussed already. It's not just about getting recruitment; it's also about being able to retain the doctors that you've already got. We have also seen the rising cost of indemnity insurance, which I fully understand. [inaudible] has been heavily subsidising for a number of years, and that has continued to be appreciated, but that can actually be a barrier to continued care as well.

One of the other issues [inaudible] has been the difficulty in maintaining training and credentialling for not only our doctors but our midwives and nursing staff, with difficulty in allocating time away from the ward for that education to actually occur. In regards to having a healthy obstetric rural service, it's not just about our rural GPs. Our rural GP obstetricians do need to be supported and certainly we do have capacity to be able to train our GPs as advanced GP obstetricians in the country, which is amazing. But to be able to keep this going we actually need a whole team approach. We're seeing [inaudible] at every level.

Senator GROGAN: Thank you. I want to ask a question about the legal structure and the challenges doctors face in terms of the legal pressure and professional indemnity. It was referenced earlier today that some doctors are not keen on things like practice nurses, advanced care nurses and other professionals, including pharmacists, taking on certain roles that you would say would be within their skill base, by nature of the legal implications. Do you have a view on that?

Dr Rischbieth: We have found in the COVID environment we have run out of practice nurses to vaccinate. We have nurses back from retirement. The hospital nurses, the pharmacists have all been involved in vaccinating and trying to assist in the pandemic. Rural towns have different solutions for different communities, but we recognise we have to work together, so I don't think there is a turf war when you have workforce shortages all across the communities that we live and work in. We all want to work together to support our communities. I don't think it's an issue in rural South Australia.

Senator GROGAN: I am not characterising it as a turf war or anything negative; I am actually just trying to unpack the reality of the situation. If you are the person who is fundamentally going to be held responsible then I would understand why you would be concerned about the legalities. It is just that other people have brought this up as an issue. The reason I am asking is to try and understand if there is a solution to that, not to apportion any sort of negative characterisation.

Dr Rischbieth: I don't think so. I mean, there have been some good supports for rural GPs and procedural doctors in the system from the Commonwealth and the state in last 15 years, which, if they hadn't happened, procedure work would have disappeared in rural South Australia. Indemnity is an issue for some people but, again, we have to have the proper teaching, training and upskilling to maintain our skills and our confidence and that is about having a teaching hospital system and funding our rural hospitals, which are supported by our state government, rather than the money being spent predominantly in the metropolitan areas. That is part of what Phillip is saying—building a system to support those already in the system but also to attract others to come and join us.

Dr Considine: I have been a rural doctor for 10 years—it feels like 20 sometimes!

Senator GROGAN: I was going to say you look pretty good for it.

Dr Considine: I was born two years after *A Country Practice* was first aired, so maybe some of that theme music transcended the womb. I have come from the Clare Valley today. It's a five-hour drive, but I cut across the Spencer Gulf to fly so that made it a bit quicker. I had written out some notes about some of the things that might help junior doctors and medical students choose rural practice but a lot of those have been covered by Dr Bethell and my colleagues earlier. I have been writing some notes as we go and I would like to talk to some of the things that have been mentioned in the last 10 or 15 minutes. I thank Lyn Poole for her evidence.

Unfortunately, averages of doctor numbers don't work across rural South Australia; we have a maldistribution. I come from the Clare Valley. It is a very nice region. We have 12 doctors working at a 10 FTE. Our catchment is about 4,000 to 5,000 people so we are hitting well above the Afghanistan average that we heard about before. I did my training in Wudinna with Scott Lewis, four hours from where I live now. That is a place like Kimba—I worked in Kimba with Dean Johnson—that is crying out for rural doctors, so there is a maldistribution.

Rural patients are deserving—they are actually more deserving—because they already face challenges from their geographical location, not just in access to medical services but, as Mr Dr Tideman said, to food and water as well. You guys are from the federal government. You have levers you can pull on your side. As Dr Rischbieth mentioned, we have been in state government negotiations for the last 18 months. We are looking at the levers the state government can pull for the work that we do in our country hospitals. For most of us in small country towns, that doesn't make up a huge amount of the work that we do, so we are talking about the small amount of funding and recognition for that hospital work. For places like Wudinna and even Clare, where I work, the majority is privately based general practice, so seeing patients in our clinics. That is where the federal government comes in through Medicare. It was interesting to hear about some of the ideas about rebates being either attached to a rural generalist qualifications or even location based, so looking at the Monash model as an incentivised system.

The federal member for Grey has talked about restricted provider numbers. That is probably the biggest stick you could think about. We are talking about carrots and encouraging doctors to come rural. But the premise he builds that argument on his sound—that people in rural areas pay a Medicare levy through their taxes and they should expect as good care as someone in Adelaide proper.

So let's have a look at those differences. You could argue that, for a GP, it's much easier to have your family in the middle of metropolitan Adelaide and to make a practice there than it is to set up in Wudinna. So we need to look at those differences and actually incentivise those rural areas more. Perhaps there is more of a loading for doctors that have done extra training in those rural generalist fields, noting there are some towns where you won't need an obstetrician or an anaesthetist. It would be very unsafe to do anaesthetics in a town like Wudinna. It would be unsafe to deliver babies in Kimba. But we need doctors that can do that, at a pinch, if needed. So I challenge you as a committee to look at some of those levers you can pull to support private general practice and incentivise those, whether it be geographically or by training.

We're seeing it happen now. We had a rural doctor conference for our organisation last year, and three junior medical students I spoke with were all keen to be rural doctors in Queensland. They were leaving South Australia because Queensland has a dedicated rural training pathway and they have good remuneration, and it's an aspiration for them to be rural doctors. We don't have that here in South Australia. Some of that is state based, I agree, but some of that is also federal.

CHAIR: Can I just interrupt there. With respect to good remuneration, what are we talking about in terms of differences in what that remuneration would be in South Australia compared with Queensland, for a rural doctor?

Dr Considine: I can't tell you that.

Dr Tideman: I can. For a doctor in Queensland who goes through the rural generalist pathway, as soon as they've finished that four-year pathway, they are appointed on a consultant medical salary—so the same as I get in a teaching hospital in Adelaide. That's in the order of $300,000 plus per annum, plus benefits: superannuation, sick leave, long service leave, maternity leave and various other things.

CHAIR: So even if they're working in a standalone private clinic?

Dr Tideman: No. That would be an appointment to a rural hospital. That may be fractional. It might be point 5 at that level. There are a number of different models that operate across Queensland. I've spent quite a bit of time supporting Central Queensland in trying to develop clinical networks, and I'm reasonably well apprised of what's been going on in those areas about improving remuneration.

Georgia [inaudible] was the project person who did a lot of the work for the Northern Eyre Peninsula Health Alliance. She produced a very good report, and you should ask for that to be tabled, if it hasn't been. It outlines a whole lot of the problems we've been talking about and potentially some of the solutions. What I've said to her is that we operate in an ecosystem. It's not just GPs. It's not just remuneration. It's about the career pathway that can be offered. It's about the long-term incentives to keep people in the system for five or 10 years. We don't expect people to be able to work forever in very small rural communities. It's a very demanding job. If we could get five or 10 years out of people—we got 11 years out of Scott Lewis in Wudinna, which was a tremendous effort. It's not just about the remuneration; it's about the conditions and it's about the career pathway. It's also about the support from the nurses and supporting the nurses and allied health, because we work in this ecosystem. If you take one part of the ecosystem, just like a natural ecosystem, the whole thing starts to fall apart, and we have fallen apart on the Eyre Peninsula, comprehensively, at this stage.

CHAIR: Thanks, Dr Tideman. We interrupted Dr Considine.

Dr Considine: As a final comment: we've got our placards with our names in front of us today. Someone needs to have the placard on their desk 'The buck stops here'. At the moment we're having state and federal

pointing fingers at each other. Someone needs to be accountable, and not because they're to blame but just to really run with it and take it and have the purview, 'This is my role; I'm going to fix this problem.'

Dr Tideman: For the whole ecosystem.

Dr Considine: For the whole ecosystem.

Dr Tideman: Not just GPs.

Dr Considine: Thank you for your time in coming to South Australia.

CHAIR: Senator Grogan, do you want to wrap up?

Senator GROGAN: I could ask you a dozen more questions, but we are indeed time limited. There is something I would like to ask Ms Poole. There seems to be a level of concern about what is and isn't being supported and advertised in terms of recruitment across South Australia from within your responsibilities. Maybe you could table some material that would give us a sense of that, because your story doesn't necessarily tally with what we've heard from other witnesses.

Ms Poole: Without knowing what those people have had to say—I'm not trying to be difficult; I'm just trying to understand the information you'd like. Is it how many doctors we've recruited, and where to, in the last two years, or how many vacancies we've had?

Senator GROGAN: That would be useful, to get that understanding and a sense of whether you have a prioritisation basis. Do you focus in MM7, MM6—anywhere you feel like you're going to get a result? Do you stop recruiting when you haven't had any success in a year or so? What your priorities are and how you go about your work would be useful to have as well.

Ms Poole: Okay; I've got it. I'm happy to do that.

Dr Rischbieth: One last point, which John McMahon made: the provider number allocation does not work well at the start of the changeover of new doctors around Australia in February. There are many instances where doctors turn up in town and haven't been allocated a provider number for weeks and weeks. There needs to be more workforce in the Commonwealth department allocating those provider numbers when there is that changeover every year. If doctors come to the towns and the paperwork hasn't been completed, the doctors can't bill their care—so they sit on their hands. That's one thing that must be changed. This has been happening for years and years. Please can you have some more staff in the department to do the allocation? It hasn't changed.

CHAIR: To the Rural Doctors Association: we've got the Stronger Rural Health Strategy, and the Department of Health has released the National Medical Workforce Strategy. How much do you know about these two strategies? What elements of them do you think are working and what elements of them aren't working? And how much were you involved in the development of these strategies?

Dr Rischbieth: The Rural Doctors Association of Australia, in Canberra, has been involved in a number of the discussions regarding the National Medical Workforce Strategy. I think many doctors feel that the decision about supporting HECS fees for people choosing to work in rural areas was widely supported by both nonmedical and community people, saying: 'Gee, that's a really good idea. Why don't you extend that to rural nurses and other rural health providers as well?' That would be a really clear message for the community—that the national government is keen to get people working in rural Australia. You may remember that *Blue Hills* was created after the Second World War, as a propaganda program, to attract people to come and live and work in rural Australia, after the workforce decimation of the Second World War. *Blue Hills* promoted working and living in rural Australia. We have to do the same for our junior students and people aspiring to work in rural Australia.

The other strategy, the workforce strategy, is in South Australia. We have workforce plans which have got one-, two- and five-year destination marks but there are still a lot of problems, and they haven't been delivered. A lot of those problems are regarding funding. The state government had a $20 million health plan but hasn't funded some of the basic things, including the rural generalist training program, despite the submission being on the minister's desk since January this year and Minister Gillespie meeting with our state health minister and the Rural Support Service on numerous occasions to say, 'When are you going to deliver?' These are some of the things the feds have been trying to get across the line, but our state health department, for some reason, does not want to support an industrial platform for those already working in the system, providing private care in hospitals, and a really important feature in training for our junior doctors. They are not responding to federal government pressure to start our rural generalist training program.

Dr Tideman: I had dinner with Tony Lian-Lloyd, who's been the solo general practitioner in Quorn for 35 years. He keeps himself very well abreast of these things; in fact he showed me the national rural health

workforce strategy. He has been through it in great detail and he believes it's got a lot of very good suggestions and analysis in it; I would take that as a very good endorsement of that.

The variety of South Australia rural workforce plans around general practice, allied health and Aboriginal health have been done. The problem with these is that we have no pathway to implementation. That comes back to the point I made earlier on, which is that until someone is made responsible, until the buck stops at a particular and accountable point for the delivery of services on the ground in a comprehensive rural medical ecosystem, nothing will change.

CHAIR: I thank everyone very much for appearing before us today. If there is any further information you want to provide to us or if you have any questions on notice, you can get them to us by close of business 15 March. We will be reporting to the Senate before 30 June.

Senator O'NEILL: That other report that you referred to—

Dr Tideman: The Northern Eyre Peninsula Health Alliance produced a report. I'm not sure if it has been fully endorsed by their steering committee, but Dean Johnson was representing them, I think, and Shane Gill. You can approach both of them. If that report is available then you should ask for that to be tabled.

CHAIR: We really appreciate your time.

We have been seeing numerous episodes of our maternity units being closed, either as a short-term diversion or for longer periods of time and the closure of smaller birth units. The reasons for diverts are complex. Sometimes it is the unavailability of a GP obstetrician, but it requires a whole team to be able to safely have a woman birth in her own facility, including midwifery staff and theatre staff. [inaudible] own region to be able to [inaudible] episodes where his own birthing hospitals have been closed due to a lack of theatre staff to be able to [inaudible] there be an issue.

We're finding increased centralisation of care and difficulty in both recruitment and retention of our GP obstetricians, for similar reasons to those that have been discussed already. It's not just about getting recruitment; it's also about being able to retain the doctors that you've already got. We have also seen the rising cost of indemnity insurance, which I fully understand. [inaudible] has been heavily subsidising for a number of years, and that has continued to be appreciated, but that can actually be a barrier to continued care as well.

One of the other issues [inaudible] has been the difficulty in maintaining training and credentialling for not only our doctors but our midwives and nursing staff, with difficulty in allocating time away from the ward for that education to actually occur. In regards to having a healthy obstetric rural service, it's not just about our rural GPs. Our rural GP obstetricians do need to be supported and certainly we do have capacity to be able to train our GPs as advanced GP obstetricians in the country, which is amazing. But to be able to keep this going we actually need a whole team approach. We're seeing [inaudible] at every level.

Senator GROGAN: Thank you. I want to ask a question about the legal structure and the challenges doctors face in terms of the legal pressure and professional indemnity. It was referenced earlier today that some doctors are not keen on things like practice nurses, advanced care nurses and other professionals, including pharmacists, taking on certain roles that you would say would be within their skill base, by nature of the legal implications. Do you have a view on that?

Dr Rischbieth: We have found in the COVID environment we have run out of practice nurses to vaccinate. We have nurses back from retirement. The hospital nurses, the pharmacists have all been involved in vaccinating and trying to assist in the pandemic. Rural towns have different solutions for different communities, but we recognise we have to work together, so I don't think there is a turf war when you have workforce shortages all across the communities that we live and work in. We all want to work together to support our communities. I don't think it's an issue in rural South Australia.

Senator GROGAN: I am not characterising it as a turf war or anything negative; I am actually just trying to unpack the reality of the situation. If you are the person who is fundamentally going to be held responsible then I would understand why you would be concerned about the legalities. It is just that other people have brought this up as an issue. The reason I am asking is to try and understand if there is a solution to that, not to apportion any sort of negative characterisation.

Dr Rischbieth: I don't think so. I mean, there have been some good supports for rural GPs and procedural doctors in the system from the Commonwealth and the state in last 15 years, which, if they hadn't happened, procedure work would have disappeared in rural South Australia. Indemnity is an issue for some people but, again, we have to have the proper teaching, training and upskilling to maintain our skills and our confidence and that is about having a teaching hospital system and funding our rural hospitals, which are supported by our state government, rather than the money being spent predominantly in the metropolitan areas. That is part of what Phillip is saying—building a system to support those already in the system but also to attract others to come and join us.

Dr Considine: I have been a rural doctor for 10 years—it feels like 20 sometimes!

Senator GROGAN: I was going to say you look pretty good for it.

Dr Considine: I was born two years after *A Country Practice* was first aired, so maybe some of that theme music transcended the womb. I have come from the Clare Valley today. It's a five-hour drive, but I cut across the Spencer Gulf to fly so that made it a bit quicker. I had written out some notes about some of the things that might help junior doctors and medical students choose rural practice but a lot of those have been covered by Dr Bethell and my colleagues earlier. I have been writing some notes as we go and I would like to talk to some of the things that have been mentioned in the last 10 or 15 minutes. I thank Lyn Poole for her evidence.

Unfortunately, averages of doctor numbers don't work across rural South Australia; we have a maldistribution. I come from the Clare Valley. It is a very nice region. We have 12 doctors working at a 10 FTE. Our catchment is about 4,000 to 5,000 people so we are hitting well above the Afghanistan average that we heard about before. I did my training in Wudinna with Scott Lewis, four hours from where I live now. That is a place like Kimba—I worked in Kimba with Dean Johnson—that is crying out for rural doctors, so there is a maldistribution.