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**RURAL DOCTORS
ASSOCIATION
OF AUSTRALIA**

Caring for the Country

AMA/RDAA RURAL WORKFORCE RESCUE PACKAGE FACT SHEET

Background

There are significant concerns over the sustainability of the rural medical workforce with obvious adverse implications for the health of rural Australians. The AMA and RDAA believe that a rural medical workforce crisis now exists and that an urgent intervention is required to attract Australian trained doctors to rural Australia.

According to the Australian Institute of Health and Welfare (AIHW) rural people generally do worse than people who live in major cities on a wide range of health status measures. For example, death rates in regional, rural and remote areas are significantly higher than urban areas.

Health services in rural areas are also being rationalised, which is making access to health care more difficult for rural patients. Since 1995 around 50% of maternity units alone have been closed across the country.

Funding levels are lower with the under-spend for Medicare funded GP services being estimated at \$157m in 2004/05. Private health services are more widely available in urban areas so the benefit of the private health insurance rebate is not as significant in rural Australia. This short changes rural Australia by around \$100m per annum.

Rural communities are finding it harder and harder to recruit and retain doctors. According to the latest AIHW statistics overall medical practitioner supply has increased in metropolitan regions and decreased in non-metropolitan regions. The decreases in the rates of supply in the three non-metropolitan regions were: (per 100,000 population) from 147 to 143 FTE in Outer regional areas, from 152 to 133 FTE in Remote areas and from 138 to 95 FTE in Very remote areas.

The influx of overseas trained doctors is the only reason that medical workforce numbers in rural areas are not in complete free fall. Up to 50% of doctors in some parts of rural Australia are now overseas trained – well above the 25% average across the country. Even with the contribution of overseas trained doctors at least 1000 additional doctors are needed to fill current vacancies.

It is a grim statistic that in the last 15 years less than 5% of graduates from Qld and NSW universities have taken on rural practice and there is no sign that this percentage is increasing.

How can we turn this situation around and restore health services in rural Australia?

The AMA and RDAA have proposed a range of policy initiatives that will directly benefit rural patients. These include more funding for rural hospitals, a rural health obligation, more support for patient transport schemes, expanded specialist outreach services, and training strategies. These are important, but they are not enough to fix the problems in rural Australia once and for all.

The Government needs to commit to a significant initiative that is simple to understand and implement. It must give a clear signal that doctors currently working in the bush are valued and that moving to the bush is an attractive option.

The RDAA and AMA are proposing that a two tier incentive package be introduced for rural doctors. The first tier is designed to encourage more doctors to work in rural areas including GPs, other specialists and registrars. It takes into account the greater isolation involved with rural practice.

The second tier is aimed at boosting the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills. Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate local services including on call emergency services.

The proposed loadings would be based on the existing rurality loadings in the Practice Incentives Program – split into two tiers. It is envisaged that the program would be implemented via the existing Service Incentive Program (SIP) and incentives would be calculated as a loading on rural doctors’ Medicare billings or as a special payment for salaried rural doctors. The loading would increase with the rurality - based on the Rural, Remote and Metropolitan Areas (RRMA) classification system.

The RDAA/AMA model can be summarised as follows:

Tier One – Rural Isolation payment

- This would be available to all rural doctors including GPs, locums, other specialists, salaried doctors and registrars
- Incentive payment based on isolation. Support increases with rurality
- Activity based - calculated on a percentage of Medicare billings
- Special payment arrangements for salaried doctors

Tier two – Rural procedural and emergency/on call loading

- This would be targeted at procedural and emergency skills and would include specialists
- To be eligible a doctor would need to be credentialed by their hospital to undertake obstetrics, surgery, anaesthetics or primary on-call emergency services
- Eligible doctors must be providing meaningful on-call services for the local hospital
- Special criteria to be established for small population centres for doctors that provide regular emergency on-call services where no hospital exists
- Activity based - calculated on a percentage of Medicare billings

The final incentive structure is subject to further discussion and agreement, with one possible loadings structure* outlined below.

RRMA	3	4	5	6	7
Tier One	7.5%	10%	20%	12.5%	25%
Tier Two	7.5%	10%	20%	12.5%	25%

* *Incentives paid through SIP would be calculated by the above percentage loadings to Medicare billings*

These incentives would be promoted through a variety of available mechanisms including a special section in the Medicare Benefits Schedule. To ensure take up of the package, payments would need to be regular – at least quarterly.

How much will this rescue package cost?

It is estimated that this investment in rural health care would of the order of \$300m to \$400m annually. Given the extent of rural workforce shortages, this is not an unrealistic or excessive amount.

Summary

The RDAA and AMA believe that unless immediate action is taken to address the rural workforce crisis that access to health services in the bush will be further reduced and that many rural communities will be significantly disadvantaged. A key part of addressing rural workforce shortages must include appropriate rural specific incentives to attract and retain doctors along with other measures outlines in the AMA and RDAA Election documents. The cost of implementing the rural specific incentives will be significantly outweighed by the cost of not implementing them as rural communities are unable to access health services and as a consequence will be unable to retain and attract families to their communities.