



Federal Budget Submission 2007/08

Rural Service Obligation

The Rural Doctors Association of Australia (RDAA) calls on the Australian government to put in place a Rural Service Obligation in relation to rural health services and urges that this obligation be the centrepiece of the next Australian Health Care Agreements with the State and Territory governments.

Community service obligations for rural and remote Australia should not be restricted to telephones—rural communities also need a minimum service obligation to ensure they have better access to rural doctors, local hospitals and rural health services. People living in rural Australia should be guaranteed that when they have a heart attack, are injured in a farming or road accident, or have a baby they can access health services locally. The Australian government is the major funder of health services through Medicare and the Australian Health Care Agreements with the States and has a responsibility to ensure that rural Australians have access to basic health services. It is not expected that major tertiary referral hospitals will be built in every country town but it is reasonable to expect that country towns will have access to a rural generalist doctor, accident and emergency services, maternity services and essential medical and surgical facilities at their local hospital.

To ensure the Rural Service Obligation is met across rural Australia the Government needs to address the following areas:

- **Building capacity to support and teach undergraduates, junior doctors and supervised international medical graduates in rural practice**

With the significant increase in university medical places, attention must be focused on supporting rural doctors to increase their capacity to host and teach medical students and junior doctors. Rural doctors recognise their professional responsibility to assist in teaching but are often hamstrung by workload, infrastructure and business pressures that make it difficult for them to support the clinical education of medical students and junior doctors. With a current heavy reliance on international medical graduates we also need to ensure that rural doctors are supported and encouraged to mentor and supervise these doctors to ensure that they are able to provide a safe and high quality service to their communities.

- **Attracting more doctors to the bush**

There has been almost no success in attracting graduates of Australian universities to take up rural practice. Recent figures indicate that less than 5% of medical graduates over the past 15 years are in rural practice. Even with the larger numbers of medical graduates it is unlikely that they will even be able to replace the current members of the medical workforce who will leave rural practice in the next 5 years. Additional initiatives need to be put in place to ensure that rural communities retain access to medical services. Both procedural and non procedural doctors need to be recruited; however specific incentives for doctors to undertake procedural training need to be put in place.

- **Retaining and supporting rural doctors**

Getting doctors into rural practice is one thing but retaining them for significant periods of time is quite another. Rural medical practice has many challenges such as higher complexity of clinical practice and isolation. In comparison to their metropolitan colleagues, rural doctors have to deal with every medical condition that comes through their door or presents at the local hospital, often without support from their specialist colleagues. They rarely have support from deputising services, they have to provide 24 hour medical cover to their communities and major tertiary hospitals can be many hours away, even by air.

Families of rural doctors also require support to assist them to adapt and thrive in locations that are often quite distant from their usual social and family support mechanisms.

- **Maintaining and enhancing rural health capacity**

The RDAA is aware that approximately 50% of small maternity units have closed in rural towns over the past 10 years. Risk adjusted data indicates that these small units are safe and can produce obstetric outcomes at least as good as large metropolitan hospitals. It is fair for the government to be concerned about the low birth rate in Australia but it is unreasonable to expect rural families to be forced to have their babies hundreds of kilometres from their homes. The closure of these small maternity units has increased the risks associated with birth and the costs that rural families must incur in relation to childbirth. Small rural maternity services must be supported and reopened where possible to ensure that access to these basic but important services is available to rural families.

Access to other services provided by small rural hospitals is also essential if rural communities are to survive. These hospitals are often the largest employers in the town and are an essential part of the local economies. The closure or downgrading of rural hospitals will also often result in the closure of medical practices in the town as the procedural doctor no longer has access to hospital facilities. Small rural hospitals are under pressure with problems in recruiting staff and maintaining their infrastructure. The Australian Government must, through the negotiation of the next round of Australian Health Care Agreements, quarantine the funding for hospitals in RRMA 4-7 centres and ensure appropriate incentives are put in place to ensure small rural hospitals continue to provide high quality health care services to their local communities.

- **Supporting communities in drought**

Many rural communities have been declared as exceptional circumstances areas and are suffering through the effects of one of the most severe droughts on record. Many of these communities are also suffering a health care drought and are unable to access appropriate health care services and, in particular, mental health care. The government should take action to both support communities now through the provision of additional health care resources but should also ensure in the longer

term that an adequate health workforce is available to support communities no matter what the rainfall is.

- **Improving Indigenous health**

Despite some welcome signs of improvement in some health outcomes these improvements are still well behind the non-Indigenous population. Indigenous Australians born in the period 1996-2001 are expected to live nearly 20 years less than the rest of the population. Indigenous Australians also face a higher burden of disease particularly in chronic and lifestyle related disease. For example, cardiovascular disease was the leading cause of death for Indigenous males and females living in Qld, WA, SA and the NT, with rates at least 3.2 and 2.8 times those of males and females of the total population. This sort of pattern is reflected across all the major chronic disease groups with the incidence in some disease groups at more than seven times the rate that they occur in the general population.

The Detail

Building capacity to support and teach undergraduates, junior doctors and supervised international medical graduates in rural practice

1. Support for clinical infrastructure for teaching

Most rural practices have not been designed with teaching of students and junior doctors in mind. Additional consulting accommodation/facilities are required if quality teaching is to be undertaken. Practices can incur significant costs in providing consulting accommodation for teaching with little or no return on their business investment. Small grants for practices will assist in providing additional teaching/consulting areas which may include fit out and in some cases additional accommodation space. These grants would be in addition to grants from training programs that do not usually cover capital works. Grants of up to \$50,000 for practices in RRMA 4-7. Estimated cost of 300 grants - \$15m pa

2. Support for junior doctors accommodation/facilities

For junior doctors and students to undertake placements in rural locations there needs to be suitable accommodation available. Some accommodation is currently provided through programs such as the Prevocational General Practice Placements Program; however with the large increase in medical graduates over the next 5 years many rural communities will be unable to host junior doctors and students. This ultimately means that a lower number of doctors will be attracted to rural practice as they cannot get meaningful rural experience during their training. The provision of additional support to towns, rural hospitals, local community organizations or Divisions of General Practice to assist in accommodation of doctors and students undertaking placements in rural general practices will mean that more graduates will get experience in rural and remote practices. A grant of up to \$50,000 to assist in the provision of accommodation in RRMA 4-7 should be made available. Estimated cost of 100 grants - \$5m pa

3. Reimbursement for teaching

The current Practice Incentives Program (PIP) payment per session for teaching is totally inadequate to compensate the costs associated with teaching. In the context of increasing numbers of medical students there is a growing discomfort among rural doctors about the amount of teaching they are being asked to undertake. The pressure of time, particularly in rural areas where there is a shortage of doctors, is beginning to become an even greater concern. To be a good teacher requires time and commitment and doctors need to decrease their consulting to supervise and support students and to undertake additional work to prepare for teaching sessions. The Government should increase payments to doctors for teaching students to \$250 per session in recognition that teaching students reduces their patient throughput by

at least 4-5 patients per session and there is significant administration and organisational costs and preparation time involved in teaching.

Eligibility for this payment should not be limited to practices that have decided to sign on for the PIP but should instead be related to the practices that are accredited by the university medical schools or the Regional Training Providers to teach students/registrars. Estimated additional cost of \$12m pa is based on 80,000 sessions pa

4. Support for supervision of International Medical Graduates

With the increasing reliance on international medical graduates (IMGs) in rural and remote areas it is appropriate to provide them with support, supervision and mentoring so that they can work effectively in their communities. GPs and practices can incur large costs in providing support, supervision and mentoring to IMGs. Many IMGs require this support and supervision so that they can provide safe medical care to their patients. The following support for GPs and practices should be made available:

- a. indemnify the GP supervisor against any vicarious liability in respect of a doctor with conditional registration who is being supervised or mentored,
- b. payment of \$750 per day where the GP supervisor takes direct and principal responsibility for patients who are being treated by a doctor with conditional registration (i.e. supervision level 1),
- c. payment of \$3000 per week where the GP supervisor shares responsibility for patients who are being treated by a doctor with conditional registration (i.e. supervision level 2),
- d. mentor support payment of \$3000 per 3 month period to the GP supervisor for mentoring and support to IMGs who have primary or full responsibility for their patients (i.e. supervision levels 3 & 4),
- e. payment for any days or part days that the GP supervisor is out of their own practice at \$1500 per day (pro rata for part days).

5. Additional rural clinical school places

The most significant drivers of rural medical recruitment are selecting medical students from rural origins and providing undergraduate and post-graduate rural training opportunities for all students regardless of origin. Rural clinical schools are the cornerstone of providing appropriate rural opportunities for medical students. Given the evidence supporting the effectiveness of rural clinical schools, additional places should be made available and opportunities for funding the establishment of new clinical schools associated with new medical schools should be taken.

Attracting more doctors to the bush

6. Increase the number of medical scholarships

Undergraduate medical places will almost double by 2012. There is an expectation by some that this will translate to more doctors working in rural and remote areas. Unfortunately the RDAA does not share this expectation and believes that further

initiatives need to be put in place to ensure that a reasonable number of these new graduates are attracted to rural medicine. For this reason it is proposed that the number of John Flynn Scholarships and Rural Australia Medical Undergraduate Scholarships be increased in proportion to the increased number of medical undergraduate places. There should be no increase in unfunded bonded scholarships as there is little, if any, evidence that these lead to long term increases in the rural medical workforce. All scholarships should also be fully indexed to the CPI to ensure they continue to be attractive to medical students.

7. HECS reimbursement scheme

The current HECS reimbursement scheme provides for a doctor who undertakes training or provides medical services in designated rural and remote areas of Australia, to have one fifth of their HECS fees reimbursed for each year of service. The designated areas are RRMA 3-7. The RDAA proposes that where a doctor works in RRMA areas 6/7 that the rate of reimbursement is accelerated to one quarter of their HECS fees for each year of service.

8. Better targeting of PIP payments

There is a need to review the PIP payments system so that it better targets improvements in workforce and primary health care outcomes. In particular, there is a need to examine how payments can be targeted to employed doctors, international medical graduates and new medical graduates to provide incentives to undertake rural practice.

9. Improved targeting of rural retention payments

The current arrangements for the payment of rural retention payments probably do little to attract new doctors to rural practice. It is unlikely that many doctors would see a payment that takes 6 years (Category A areas) to achieve as a real incentive whereas 3 years is a period that many doctors would see as reasonable. For Category E locations it is reasonable that payments also start much earlier and the RDAA considers that this will provide a much greater incentive when doctors are being recruited into all rural areas. There is a need to reduce the qualifying period for rural retention payments to 3 years in category 'A' locations and to 6 months in category 'E' locations. These payments should also be increased so that they maintain their 'real value' in relation to earnings.

10. Incentives for procedural training

The numbers of rural doctors who have procedural skills continues to decline. Procedural skills include obstetrics, surgery and anaesthetics. These procedural doctors, who currently make up approximately 22% of the rural medical workforce, are essential to ensuring that rural Australians have access to quality care in rural hospitals. The Registrars Rural Incentive Payments Scheme provides financial incentives for general practice registrars who undertake the majority of their general practice training in rural and remote locations. However, there is no specific incentive for registrars to undertake procedural training. In most cases procedural training extends the time taken to complete their vocational training. Registrars

should have access to additional incentive payments of up to an additional \$60,000 to compensate them for loss of income related to undertaking procedural training. This additional incentive funding should also be made available to established rural doctors who wish to gain procedural skills.

11. Commonwealth to fund procedural training places

Access to procedural training places is essential if we are to maintain a skilled procedural workforce in rural areas and ensure that rural hospitals can continue to provide procedural services to their local communities. State governments currently have responsibility for procedural training, however the number of places and training arrangements vary dramatically and are generally considered inadequate to maintain the rural procedural workforce. The Commonwealth should take responsibility for funding procedural training places and ensure that all training places, where possible, are located in regional and rural centres where rural proceduralists are most needed. It is also appropriate that procedural training places be funded on a supernumerary basis so that training can be undertaken where the emphasis is on skills attainment and the adoption of training places is more attractive to hospitals. In addition to transferring procedural training places from the States to the Commonwealth, an additional 50 places should be made available. Estimated costs of additional training places @ \$200K ea is \$10m

12. Research into decision making processes for doctors considering rural practice

Despite some work being done in Australia and overseas on when and how doctors make decisions about entering rural practice, there is very little information available on practical policy initiatives that can be put in place to encourage doctors to take up rural practice and the effective points of intervention. This project would develop a synthesis of the available literature, undertake focus groups with recent medical graduates (PGY1-3) and develop and test a number of policy initiatives that would inform government decision making in this area. This submission seeks funding for a one year research project to investigate the critical points of intervention in the decision to become a rural doctor and the processes and motivators in the choice of career and location. Estimated cost \$0.28m

Retaining and supporting rural doctors

13. Support for rural medical families

It is not only doctors who need support in rural and remote areas but also their families. Where the doctor's family feels supported and happy in their rural location it is much more likely that the doctor will continue to practise in that area. To ensure that rural families are provided with support, project officers should be provided to support the Rural Medical Family Network in each State and the Northern Territory. Additional funding should also be made available to assist in running functions and training for members of the Rural Medical Family Network. Estimated cost of 6 FTE project officers @ 100K ea (including on costs) is \$0.6m. Estimated cost of supporting events and training for the Rural Medical Family Network is \$0.6m

14. Incentives in recognition of the isolation and complexity of rural practice

RDAA supports the immediate implementation of fee for service (FFS) incentive items for medical practitioners working in rural and remote communities to act as systemic incentives to recruit and retain practitioners and to compensate them for the professional and family isolation, and the increased skills and responsibility, of rural and remote practice.

Isolation fee for service payments

An Isolation FFS incentive payable to all practices through the Practice Incentives Program for all consultations undertaken in practices in RRMA 3–7.

Rural Practice fee for service payments

A Rural Practice FFS incentive payable, in addition to Medicare A1 rebates, for consultations undertaken in RRMA 3–7 for all practitioners who meet defined service obligations including the provision of a minimum level of obstetric, surgical or anaesthetic (procedural) services and/or primary accident and emergency on-call services.

15. Training support for Temporary Resident Overseas Trained Doctors

Better support for Temporary Resident Overseas Trained Doctors, including immediate access to training/fellowship programs (\$2.1m pa) and support for health and education expenses for them and their families (\$2.75m pa), is essential if these doctors are to be encouraged to remain in Australian rural practice.

16. Access to emergency care items

Rural doctors who are rostered by their hospital to provide emergency care provide high quality care on par with that available in any emergency department having regard to the facilities and resources available. These doctors have undertaken training and developed extended skills in emergency care, and they are often responsible for the stabilisation and the provision of advanced life support to accident victims before they are evacuated to larger emergency facilities. There is currently no recognition in the MBS for these emergency care doctors who cannot access the MBS emergency care items. Doctors credentialed by their local hospital to provide emergency care should be able to access the MBS item numbers 501 through to 536.

17. Support for specialist and GP obstetricians

Continuation of SOLS pilot program

In 2005 the Australian Government funded a scoping study to investigate the feasibility of a national rural Specialist Obstetricians Locum Scheme (SOLS) to support the dwindling rural obstetric workforce. The study recommended a pilot be conducted prior to the introduction of SOLS nationwide. The pilot commenced in July 2006 and will run for 15 months. External evaluation begins in July 2007 which

means it will not be available in time for inclusion in the 2007 budget process. Even in its initial stages, the pilot has shown very positive trends, e.g. that good locums can be recruited under the aegis of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and that there is a high demand for quality locum relief. Although designed as a retention strategy, SOLS has the potential to support recruitment by guaranteeing some annual relief. The pilot also demonstrates that this service should be available to all rural obstetricians. It is proposed that SOLS be extended to provide 14 days of subsidised locum relief to all rural specialist obstetricians with priority given to those in greatest need of relief.

Estimated cost: \$1.71m pa

Extension of pilot program to include GP obstetricians

Experience and feedback during both the scoping study and the current pilot indicate that the positive impact of SOLS will be enhanced by parallel support for GP obstetricians and that an extension to include this will create synergies between and maximize the investment in two very well received initiatives: SOLS and the Strengthening Medicare Training for Rural and Remote Procedural GPs Program (TRRPGPP). This expansion will involve increased collaboration with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. The SOLS pilot demonstrates that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists is able, through its professional databases, to recruit locums when other agencies cannot. It will provide recruitment and administrative support for GPs providing obstetric services in RRMA 3-7 who require locum relief and whose uptake of the TRRPGPP is constrained by lack of suitably qualified locums.

Estimated cost: \$0.1m pa

Maintaining and enhancing rural health capacity

18. Ensuring small hospitals thrive, and supporting small maternity units

Incentives should be made available directly by the Commonwealth to small rural hospitals for the maintenance of procedural services, and to provide those hospitals that may have reduced or ceased providing the full range of procedural services with support to again provide these services to their local community. It is proposed that these incentives would be for:

Small maternity units – payment of incentives for small rural maternity units to assist with the cost of recruitment of skilled midwives and procedural doctors, onsite team training, and other costs associated with maintaining a viable unit and workforce.

Estimated cost: 150 units @ \$0.2m - \$30m pa

Surgery and anaesthetics – payment of incentives to small rural hospitals recognising the additional costs in continuing to provide or enhancing these services. There are approximately 390 public hospitals in around 700 towns (of 1000 - 20,000 people) in Australia. These hospitals play a large role in not only ensuring access to

health services but in local economies where rural hospitals are often the largest employer. The maintenance of procedural services is essential to ensuring that rural hospitals remain viable and continue to support the health care needs of local communities.

The government should also ensure that the next round of Australian Health Care Agreements has appropriate incentives for the maintenance of small maternity units in place. In particular, the government needs to put into place arrangements to monitor the funding of, and access to, services in small rural hospitals and to quarantine small rural hospital funding in the next round of the Agreements. Community impact statements should also be required before there is any reduction in services or closure of a small maternity unit. This impact statement should include the impact of the costs to the community of the closure, the effect on other health care services, and the effect on the social capital of the town.

19. Access to MRI

GPs are currently unable to directly refer patients for MRI scans. Many rural patients are unable to access specialist referral for MRI scans at all or may have to travel many kilometres to a major centre where specialist referrals are available. In most cases this means that the rural patient has to make at least 2-3 long distance trips to obtain the referral, then have the MRI and then present for additional specialist consultations that may be required after the MRI. There are many patients who are not able - for financial, employment or family reasons - to undertake this additional travel and therefore are not able to access appropriate diagnostic services. This may ultimately lead to poorer health outcomes and increased costs of treating later stage disease. The government should enable GPs in rural locations to refer patients for MRI scans without the need for a specialist consult. It is expected that minimal if any additional costs would be involved as other less appropriate diagnostic modalities (e.g. CT scans, plain films) would not be used. There would also be savings in specialist consultations as many of the conditions diagnosed can be adequately managed in rural medical practices, and the community would incur significant savings in travel, accommodation and lost productivity.

Supporting communities in drought

20. Encouraging rural Australians to access mental health services

There is a substantial body of evidence that rural people, particularly male farm workers, are reluctant to seek help for mental health conditions including depression. The RDAA seeks funding to assist with a campaign in the rural press, local radio and TV to get the message across that it is okay to access help. Costs are less than \$0.05m for a wide-reaching community service announcement.

The government has recently allocated \$51m over 4 years towards the enhancement of rural mental health services. This initial investment is welcome, however the task is enormous and further funding is likely to be needed to address the relative disadvantage that rural communities have in relation to accessing mental health services compared to metropolitan areas.

Improving Indigenous health

21. Access to specialist services

Approximately 20 specialists provide care to predominately Indigenous communities in remote areas through fly in fly out clinic arrangements. The travel costs associated with these clinics may be supported under various programmes but the doctors are expected to bill patients. Many of the patients who attend these clinics have not provided, or are unable to provide, appropriate referral information to allow the specialist to claim appropriate specialist items through Medicare. In many cases, because there is no doctor at all on site, a specialist may be asked to provide assistance to a remote area nurse or Aboriginal Health Worker, or a patient may just turn up for treatment. The only option in these cases is for the specialist to either not charge for the care or bill items from *Group A2 - Other non-referred attendances to which no other item applies* which are significantly lower than their usual items. There is a significant risk that these clinics will become financially unviable if specialists are unable to bill specialist items.

The government should put in place arrangements that allow these specialists to bill their usual rates when a GP referral cannot reasonably be expected or provided. It would be a proviso of any arrangement that the specialist concerned would provide advice to the patient's usual GP on any treatment provided. Estimated cost: \$0.2m

Background

The Rural Doctors Association of Australia (RDAA) is the national body representing the interests of rural medical practitioners right around Australia. Our vision is for excellent medical care for rural and remote communities. RDAA is committed to building and maintaining a workforce of highly skilled and motivated rural medical practitioners.

Approximately 34% (6.7m) of Australians live outside of major cities in regional, rural and remote areas. The proportion of the population who are Indigenous is much larger in the rural and remote parts of Australia, with 70% of the total Indigenous population of Australia living outside of major cities. Australians who live in rural and remote areas have the same right to quality health services as their counterparts who live in metropolitan centres. However, this is not the reality and Australians who live in country areas access health services at very much lower rates than metropolitan residents and have significantly worse health outcomes. All Australians are facing a health crisis caused by increasing rates of serious chronic diseases such as diabetes and by the increase in health conditions that accompany an ageing of the population; however, Australians living in rural and remote locations are more likely to be smokers; to drink alcohol in hazardous quantities; to be overweight or obese; to be physically inactive; to have lower levels of education; and to have poorer access to work, particularly skilled work which adversely affects their health status and health outcomes.

Over the past 5 years the Australian government has put in place a number of initiatives to assist in building and maintaining a viable rural medical workforce. Many of these initiatives have been proposed and supported by the RDAA; however, there remains much work to be done in ensuring that the rural population of Australia has reasonable access to quality health care. The rural health workforce shortage remains the main area of concern to the RDAA and despite significant increases in the numbers of medical and other health graduates that will be produced by universities over the next 5 years, the RDAA has yet to see any real evidence that this will be effective in rebuilding a severely depleted rural medical workforce. Rural medicine, in particular, requires strong procedural skills - with primary care practitioners representing the backbone of rural health care. The bottom-line is that much more needs to be done to recruit doctors to the bush and to encourage and support them to remain in rural practice. Gone are the days when we can expect our rural doctors to work 14-16 hours per day, 7 days a week - we need to ensure that they can effectively balance their workloads with their family and social lives. For this reason, this budget submission focuses on workforce issues as a key foundation for the provision of accessible quality health care for rural Australians.

Costings

Where possible, costings have been provided in this submission. All costings are indicative only and are provided to give an indication of the magnitude of costs or savings that may accrue if the initiative is implemented. Costings have been undertaken where possible

using information available from government data. For some of the proposals, detailed costings have not been developed due to lack of applicable financial information.

Further Information

Further information on the items in this submission can be obtained from Steve Sant, CEO Rural Doctors Association of Australia, on tel: 02 6273 9303 or email: ceo@rdaa.com.au.