



Hon Wayne Swan MP
Treasurer
Parliament House
CANBERRA ACT 2600

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Dear Treasurer

Last year you invited organisations to submit proposals to you for consideration in the 2010-2011 Budget. It will come as no surprise that the Rural Doctors Association of Australia (RDAA) continues to advocate for improvements in the access that Australians who live in the bush have to quality health services so that rural and remote communities can thrive and continue to generate the two thirds of Australia's export earnings.

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. If you choose to live in the bush you can expect to have a significantly shorter life than if you choose to live in a city.

For rural communities to attract and retain working families it is essential that they have access to good social infrastructure such as education and health services. Without this support many communities will be unable to support the workforce required to expand, or even maintain, the mining and agricultural enterprises that contribute so much to all Australians' standard of living. Investment in rural health is not just an investment in the health of individuals it is an investment in the health of our whole economy.

It is a very simple equation – to have viable rural communities, you must have the health infrastructure to support those communities; to have a good health infrastructure you must have a health workforce; to have a health workforce you must provide the educational, professional and financial supports to attract and retain that workforce. Whilst some initiatives were introduced in the last budget they were poorly targeted and there is no evidence that they will result in any real change in the current situation.

The RDAA is advocating for the following initiatives to be included in the 2010-11 Federal Budget:

- A package of incentives (Rural Rescue Package) that include increased Medicare rebates for patients who live in rural and remote Australia.

- Changes to the rural classification system - Australian Standard Geographical Classification (ASGC) so that it more appropriately classifies smaller rural communities and does not group them with large regional cities or even State capitals.
- Recognition of the contribution of doctors who are trained overseas by providing access to health care and public education for them and their families
- Implementing competitive neutrality in the National Rural and Remote Health Infrastructure Program (NRRHIP) so that it is taxed on the same basis regardless of whether a grant is made to local government, a division of general practice or a general practice.

More detail on the initiatives is included in the attachment. I would be pleased to provide any further information required about these specific new policy initiatives and can be contacted at ceo@rdaa.com.au or 02 62397730.



Steve Sant
Chief Executive Officer



Further information on the RDAA proposals

Rural Rescue Package

The government must give a clear signal that rural doctors currently working in the bush are valued and that moving to the country is an attractive career option. This can best be achieved through the payment of higher Medicare rebates for patients who live in rural and remote communities. In contrast to the incentives proposed for implementation later in 2010, a rebate based incentive provides a business incentive that supports the practice as well as a personal financial incentive for the doctor and is based on activity. The structure of the package also provides specific incentives for doctors that provide on-call procedural services such as emergency services, obstetrics, surgery and anaesthetics.

The RDAA¹ are proposing a two tier incentive package be introduced for rural doctors:

Tier One – Rural Isolation payment

- Designed to encourage more doctors to work in rural areas including GPs, other specialists and registrars. It takes into account the greater isolation, costs and complexity involved with rural and remote practice.
- This would be available to all rural doctors including GPs, locums, specialists, salaried doctors and registrars.
- Incentive payments are based on isolation and financial rewards increase with rurality. Activity based - calculated on a percentage of Medicare rebates. Special payment arrangements are to be implemented for salaried doctors including those working in Aboriginal Medical Services.

Tier two – Rural procedural and emergency/on call loading

- 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 hospital based services. In rural and remote areas there are relatively few medical specialist services available and most of the workload in hospitals is undertaken by rural GPs.
- This tier 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 with special criteria to be established for small population centres for doctors that provide regular emergency on-call services where no hospital exists.

¹ Supported by the AMA

	ASGC - RA 2 Inner Regional (Large Regional Centres)	ASGC- RA 2 Inner Regional (Rural Towns - pop'n less than 25000)	ASGC - RA 3 Outer Regional	ASGC- RA 4 Remote	ASGC- RA 5 very remote
Tier One Loading	3%	8%	11%	15%	25%
Tier Two Loading	3%	8%	11%	15%	25%

It is envisaged that the program would be implemented via the existing Medicare Service Incentive Program (SIP) and incentives would be calculated as a loading on Medicare rebates or as a special payment for salaried rural doctors (e.g. those working in Aboriginal Medical Services etc.). To ensure take up of the package, payments would need to be regular – at least quarterly.

It is expected that the costs of implementation would be offset through the rationalisation of current incentive programs paid to rural doctors and registrars.

Australian Standard Geographical Classification

The Australian Standard Geographical Classification (ASGC) remoteness indicator measures remoteness by aggregating its proximity to five hierarchical levels of service centres. It was developed to divide Australia into “broad regions for comparative statistical purposes.” This is based on the concept of remoteness defined by how far one travels to access goods and services, it does not take into account availability of health services.

Category	ASGC-RA	% of national population
Major Cities	1	68
Inner Regional	2	20
Outer Regional	3	9
Remote	4	2
Very Remote	5	1

The government has decided to introduce ASGC to replace the out-dated Rural, Remote and Metropolitan Areas (RRMA) classification system to provide the basis for a number of incentive programs as of 1 July 2010. The RDAA accepts that the ASGC is a more up to date system; however, there are a number of significant issues in implementing ASGC that will actually make it harder for some rural communities to attract a doctor. For example, the logic of putting small rural towns such as Tumut, Camperdown, Gundagai, Dalby, etc. in the same classification as cities such Hobart, Wagga Wagga and Bendigo escapes us. Royal Hobart Hospital provides cardiothoracic surgery, neurosurgery, burns, hyperbaric and diving medicine, neonatal intensive care and high risk obstetrics services whilst most of the hospitals in rural towns struggle to attract doctors to provide GP based obstetrics for low risk mothers.

Whilst there are many anomalies created by the new classification system many of these would be removed if the RA2 Inner Regional classification was overlaid with a population based filter that split the category into RA2 Inner Regional (Large Regional Centres) and RA2 Inner Regional (Rural Towns - population less than 25,000). There are other anomalies where classification borders pass through, or very close, to towns and these could be administratively adjusted on a case by case basis.

Amended ASGC Category	ASGC-RA
Major Cities	1
Inner Regional (Large Regional Centres)	2-RC
Inner Regional (Rural Towns - population less than 25,000)	2-RT
Outer Regional	3
Remote	4
Very Remote	5

← RA2 Inner Regional classification split based on population

Support for International Medical Graduates

Rural Health Services are heavily dependent on International Medical Graduates (IMGs) to provide their medical workforce. IMGs now make up almost 50% of the rural medical workforce and it has been reported that in some States, such as WA, 70% of doctors recruited to rural areas are IMGs.

Many IMGs are recruited to Australia under temporary visas (457 and 422) and, as such, they and their families are not entitled to access publically funded health or in many States public education services. Most of these doctors and their families will eventually achieve permanent resident status after achieving full medical registration and college fellowship and many will become Australian citizens.

The government should either allow these doctors and their families to access Medicare as most of their patients do or establish a 'private' health scheme to provide the same level of subsidy and support as Medicare. In addition, discussions should be undertaken in the COAG context to ensure that the children of IMGs are able to access public education in state schools free of charge.

National Rural and Remote Health Infrastructure Program (NRRHIP)

The National Rural and Remote Health Infrastructure Program (NRRHIP) provides funding to rural and remote communities where the lack of infrastructure is a barrier to the establishment of new, or the enhancement of existing health services. Funding is available for local government organisations, Divisions of General Practice; Aboriginal Corporations, private general practitioners, allied health professionals and rural private hospitals.

Where funding is provided to a rural general practice under the scheme it is regarded by the ATO as income and, as most of these practices are partnerships, it is taxed at the top marginal rate. This means that when a grant is made almost half of it is lost immediately and in many cases the partners of the practice have to borrow further funds. This is problematic as many practices already have large debts and given that many rural GPs are well past 50 years of age they are reluctant to borrow further. Many practices have told the RDAA that the taxation arrangement means that they will not access the funding and will not be able to provide education to the large number of medical and nursing students and graduates currently in the system.

Where a grant is made to one of the other eligible groups such as local government there is usually no taxation implication at all i.e. they are able to expend the full grant on health infrastructure. This arrangement is not competitively neutral and given that the grant is being given to support training facilities for medical students/registrars then it is appropriate that the government ensure that the full grant is available.