RURAL DOCTORS ASSOCIATION OF AUSTRALIA

The Hon Josh Frydenberg MP

29 January 2021

Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

The Rural Doctors Association of Australia (RDAA) welcomes this opportunity to provide a submission for the forthcoming 2021-2022 Federal Budget.

RDAA is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.

RDAA commends the Australian Government's efforts to address rural health issues through its Stronger Rural Health Strategy and the opportunity provided by Ministers Hunt and Coulton's for RDAA to provide the Government with a proposal for a Rural Medical Workforce Strategy/Plan.

The Plan has been developed in consultation with the National Rural Health Commissioner Prof Ruth Stewart. Engagement and requests for feedback has also been undertaken with the key medical bodies including RACGP, AMA, ACRRM, GPRA and GPSA.

RDAA has, throughout the development of the Plan, been in regular contact with the Commonwealth Department of Health to ensure the specific actions and broader strategies align with the National Medical Workforce Strategy, and Primary Health Care Reform.

Key elements of the Strategy design are:

- No additional funding, but to achieve better outcomes from the current investment through streamlining of systems and processes, realignment of Commonwealth programs and investment, reduce duplication, removal of unnecessary bureaucratic processes, and greater accountability with funding to be aligned to outcomes.
- Focus on genuine rural and remote locations, ensuring the deliverables are aligned with a Program's intent.
- Support innovative solutions, and multidisciplinary team-based care.

The strategy also works across the continuum of a medical practitioners' training and career. It also incorporates strategies for general practice, rural generalist and consultant specialist workforce challenges.

Priority areas for budget consideration are:

- Redefining rural as Modified Monash Model (MMM) 3-7. The Government must start to differentiate between large regional centres (MMM2) and rural and remote if there is to be real action on the maldistribution of the medical workforce. MMM2 locations has 427.1 FTE medical practitioners per 100,000 population while MMM 4 sit at 236.9 FTE per 100,000[i]. RDAA acknowledges there are some unique MMM 2 communities that face workforce challenges, however applying the rural initiatives to all MMM 2, undermines the intent of the rural programs. Some MMM 2 locations would benefit from targeted and innovative workforce solutions designed to address their specific needs.

- Significant expansion to the current Rural Junior Doctor Innovation Fund. The first 2-3 post graduate years for junior doctors (intern year included) have been consistently identified as period where potential future trainees and workforce are lost to rural medical practice, across all disciplines of medicine. This period of a doctors' career is predominantly based in city and large regional centre hospitals, working alongside Consultant specialists, with minimal to no exposure to rural clinical practice. Former Commonwealth funded programs that provided a large number of junior doctors with a rural placement also provided an opportunity for rural practitioners to influence junior doctors in their training and career choices and has been often identified as a key recruitment opportunity.

  This program needs to be renamed, have some small modifications to maximise the workforce available for the rotations, and the total number of positions needs to be increased to 400FTE, over three years (currently 110 FTE are funded).

- Full implementation of the National Rural Generalist Pathway. The Government has progressed the first stage of implementation but if the program is to reach its full potential, there is still a large number of recommendations to be progressed and finalised, such as single employer models, and reform of the Workforce Incentive Program (former GPRIPS).

- Review of the Specialist Training Program including audit of existing positions, establishing new eligibility criteria and matrix for prioritisation of allocation, evaluation of the placements and linking the funding to achieve updated outcomes of the program. The Commonwealth Department of Health needs to ensure greater accountability for the outcomes of the program.

- National e-credentialing infrastructure. Western Australia and Tasmania have introduced this system and having national infrastructure to support the credentialling process would be of significant benefit. Credentialling is undertaken by individual local health districts with a small number of Districts willing to use one process for all their hospital services. This will facilitate much greater mobilisation of the workforce

and support private practice clinicians working in the hospital system, amongst many other benefits.

In addition to our Rural Medical Workforce Plan initiatives, RDAA continues to call on the Government to commit to investing in telehealth for GP to patient post COVID. RDAA for many years has advocated for telehealth services that are provided by the patient's regular GP.

RDAA also supports the Australian Medical Association's position on reform for the employment arrangements of GP registrars.

RDAA looks forward to working with the Australian Government to achieve better health outcomes for rural and remote Australians.

If you have any further questions in relation to the RDAA submission please contact Peta Rutherford, Chief Executive Officer via email ceo@rdaa.com.au or telephone 0427 638 374.

Yours sincerely

Dr John Hall
President

[i] https://hwd.health.gov.au/assets/Medical%20Workforce%20factsheet%202018.pdf