RURAL DOCTORS ASSOCIATION OF AUSTRALIA

SUBMISSION TO TREASURY

Pre-Budget 2023-24

About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and their patients and communities.

RDAA believes that all Australians have the right to excellent medical care regardless of their postcode.

The health needs of people living and working in rural and remote communities, and the provision of health services, varies considerably from community to community. However, access to all health professionals and services is generally worse than in cities. This is a significant factor contributing to poorer health outcomes in rural and remote areas, including life expectancy.

It is essential that health services be provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their own communities to redress rural and remote health inequities.

RDAA uses the term 'rural' to encompass all locations described by Modified Monash Model (MMM) levels 3-7 [1], acknowledging that this includes remote and very remote places where the health needs are often greater and health service delivery challenges most difficult.

Introduction

Inadequate access to health professionals and services is a key contributor to the poorer health outcomes experienced by rural Australians as compared to those in cities. Variables contributing to this include geographic isolation and a range of other socio-economic, technological, demographic, cultural, climatic, and environmental factors. These circumstances also contribute to the greater scope and complexity of rural medical practise.

The difficulties in recruiting and retaining medical professionals in rural areas over decades have resulted in a maldistribution of the medical workforce across the country. This has been exacerbated by the impact of the COVID-19 pandemic and consequent policy responses – for example, the decision to broaden the Distribution Priority Area (DPA) program to include outer metropolitan areas – and by the impact of severe climate-related events on rural communities, such as flooding which decimates physical and technological infrastructure and cuts off regular access to essential supplies including medicines, equipment and personnel.

RDAA welcomes the work of the Strengthening Medicare Taskforce that recognises that the Medicare Benefits Schedule (Medicare) as a funding model is not necessarily fit-for-purpose in rural general practice. Bulk-billing rates in rural general practice have surpassed the limits that can be accommodated in rural general practice to maintain a viable small business, to cover significant overheads related to staffing, infrastructure, equipment and supplies.

[1] The Modified Monash Model (MMM) is a scaled classification system measuring geographical remoteness and population size with MMM 1 being a major city and MMM 7 being very remote. Rural doctors are rural GPs, Rural Generalists and/or consultant specialists (resident and visiting) who provide ongoing medical services in MMM 3-7.

Support must be provided for funding models that reflect rural communities' need for multidisciplinary team care with general practice at the core to prevent further fragmentation of patient care (already challenged by the necessity to travel to access services not locally available), and the cost of providing that care. It is also imperative that the time frames for the development and implementation of new funding models reflect the need for immediate action to enable rural people to access the health care they need.

There is a clear threat to the viability and sustainability of rural and remote primary health services. If these services are closed, there will be a cascade effect that will negatively impact rural hospitals and rural consultant specialist services. New initiatives, and the strengthening of existing initiatives, to improve the attractiveness of rural medical careers and support rural medical service viability and sustainability must be immediately developed and implemented to prevent the collapse of the rural health sector.

While limitations on the Federal Budget and inflationary pressures on the economy must be acknowledged, RDAA notes the reported improvement to Australia's economic outlook because of global political and economic circumstances that have resulted in a strong trade surplus of $12.4 billion (fifth highest result on record)[2], Gross Domestic Product (GDP) at higher than pre-pandemic levels, and a ranking as the world's twelfth largest economy[3,4].

RDAA strongly urges the Australian Government to invest in medical workforce solutions that may have short term financial implications but that will provide significant return on investment in the future, including by delaying the onset of chronic diseases and preventing avoidable hospital admissions, as well as ensuring that rural Australians are able to fully participate in economic and social activity.

Summary of Recommendations

New investment is critically needed in MMM 3-7 areas to prevent rural health services becoming unviable and unsustainable.

RDAA calls on the Australian Government to:

- Provide 150 more Full Time Equivalent (FTE) prevocational medical positions in rural areas.
- Establish a national e-credentialing infrastructure to streamline bureaucratic processes, and mobilise the medical workforce.
- Index rural incentives to support the viability and sustainability of rural medical practices.

[2] Ronald Mizen (2022). Australia's 'nice problem from the Ukraine war'. Financial Review. 3 November 2022. https://www.afr.com/policy/economy/australia-s-nice-problem-from-the-ukraine-war-20221103-p5bvcf. Viewed 25 January 2023.
[3] Austrade (2022) Why Australia Benchmark Report. https://www.austrade.gov.au/benchmark-report/resilient-economy. Viewed 25 January 2023.
[4] Australian Bureau of Statistics (September 2022). Australian National Accounts: National Income, Expenditure and Product. https://www.abs.gov.au/statistics/economy/national-accounts/australian-national-accounts-national-income-expenditure-and-product/latest-release#key-statistics. Viewed 25 January 2023.

- Implement rural priorities under the National Medical Workforce Strategy 2021-2031:
    - full roll out of the National Rural Generalist Pathway[5]
    - expansion of the single employer models for Rural Generalist trainees
    - investment in rural supervision across all medical specialties
    - investment in doctor wellbeing strategies.
- Expand the Workforce Incentive Program (WIP) to support rural consultant specialists to enhance viability of specialist services in rural and remote communities.
- Establish a housing program to support critical workforce recruitment and retention in rural and remote communities.

There are also opportunities to redistribute existing funds where there has been an underspend, as, for example, in the Australian General Practice Training (AGPT) program, into other rural medical initiatives.

RDAA has previously noted that government investment needs to align with intended outcomes, and incentives must encourage service provision above baseline standards, drawing attention to the after-hours Practice (PIP) incentive payment as an example of a program that could be streamlined to achieve savings that could be redirected to support other measures. All practices for accreditation purposes, must have an after-hours arrangement in place. City-based GPs receive a PIP for providing a minimal level of after-hours service to their patients. The PIP pays these practices $1 per Standardised Whole Patient Equivalent (SWPE) to put a message on their voicemail and a sign on the door directing patients to contact an alternate after-hours service. This is a significant amount of money that could be reinvested to support incentives for rural and remote GPs, or genuine after-hours services.

Context

Rural Australians continue to have poorer health outcomes than people in cities with higher rates of morbidity and mortality. Rural patients often have more complex care needs. They experience higher rates of many chronic diseases; risky health behaviours; accidents and injury and suicide.

Current and former policy settings have had limited success in addressing the health inequities that exist for rural people – including poorer access to medical and other health professionals. Maldistribution of the medical workforce remains a concerning issue.

The continuing impacts of COVID 19 pandemic, and the increased mental and physical health issues being experienced by rural Australians related to adverse weather events and climate change, have also placed increased demands on medical and other health professionals, and health infrastructure

[5] The Collingrove Agreement: 'A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and/or community settings as part of a rural healthcare team.' National Rural Health Commissioner (2018). National Rural Generalist Taskforce Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway. p5. https://www.health.gov.au/sites/default/files/documents/2021/05/advice-to-the-national-rural-health-commissioner-on-the-development-of-the-national-rural-generalist-pathway_0.pdf. Viewed 27 January 2023.

in rural areas. This has contributed to increased mental and physical stress and burnout among these professionals.

Detailed Recommendations

Investment in medical workforce programs is urgently needed to attract, support and retain doctors in rural communities and redress rural health inequities. As a matter of priority this investment should:

Provide 150 more Full Time Equivalent (FTE) prevocational medical positions in rural areas.

Providing junior doctors in rural communities by rolling out planned increases in the John Flynn Prevocational Doctor Program (JFPDP) to 250 Full Time Equivalent (FTE) positions – currently to be phased in by 2027 – and by funding an additional 150 FTE positions (to a total of 400 FTE equating to 1600 rotations) as soon as possible would:

- Enable approximately fifty percent of Commonwealth Supported Place (CSP) medical graduates to undertake a rural rotation during their internship and post-graduate years (PGY 2-5) when they are making key decisions about their future training and career pathways. If junior doctors have quality training experiences in rural areas (positive rural exposure) they are more likely to undertake further training in these areas.
- Rapidly boost the medical workforce in rural general practice and small hospitals to support Rural Generalists, rural GPs and resident or visiting consultant specialists.

Establish a national e-credentialing infrastructure to streamline bureaucratic processes and mobilise the medical workforce.

Currently, each District and/or State or Territory have established independent systems to collect and retain documents for the credentialing of doctors. This means that doctors are required to submit the same documentation for individual hospitals or districts where they wish to work. The onerous administrative requirements that credentialing entails are a deterrent to medical practitioners, including locums, who are keen to provide services in communities where they are needed. Many of the processes are still paper-based and duplicative and a straight-forward application would have a minimum of 30 pages of required documentation.

Establishing a secure central repository to enable medical practitioner documentation to be shared with defined permitted access arrangements for medical colleges and credentialing bodies would:

- Assist to mobilise the medical workforce, including locums, consultant specialist outreach service providers and any needed surge medical teams.
- Significantly reduce the administrative burden on busy clinicians.

- Be of benefit to credentialing committees and health services by streamlining recruitment and onboarding processes for new doctors and Visiting Medical Officers.

Index rural incentives to support the viability and sustainability of rural medical practices.

Indexation of incentives and grants for rural doctors – including, but not limited to, the Rural Procedural Grants Program, the Workforce Incentive Payment (WIP medical stream), and Australian General Practice Training (AGPT) related payments – is needed to redress the decreased value in real terms of these payments. The incentives are now not as attractive to potential new rural doctors as they once were. Many have not been indexed for over 10 years. This has meant that, in effect, rural doctors have taken a pay cut year on year which, similarly to the 'Medicare freeze', is affecting the financial viability and sustainability of rural general practice.

To prevent further erosion of value, RDAA suggests that it will be necessary to index payments at a rate of 5 percent initially, and then at a rate tied to the Consumer Price Index (CPI) in subsequent years.

If payments are not indexed it will add to the increasingly difficult task of maintaining an operational income that is faced by rural general practices. If these practices become unviable and are forced to close there will be significant consequent negative impacts on all health services in their areas.

Implement rural priorities under the National Medical Workforce Strategy 2021-2031:

- **full roll out of the National Rural Generalist Pathway**
- **expansion of the single employer models for Rural Generalist trainees**
- **investment in rural supervision across all medical specialties**
- **investment in doctor wellbeing strategies.**

The National Medical Workforce Strategy 2021-2013[6] identifies key priorities to address medical workforce issues in Australia. Those relating to the training, supply and distribution of all medical practitioners in rural Australia must be a priority to mitigate the poorer access to doctors that has been the experience of rural Australians for decades which has contributed to significantly worse health outcomes. Investment is needed to:

- **Fully implement the National Rural Generalist Pathway to streamline blockages in the training pipeline and career progression and support.** This includes ensuring that Medicare rebates for

[6] Australian Government Department of Health (2021). National Medical Workforce Strategy 2021-2013. https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf. Downloaded 26 January 2023.

consultant specialist items are also available to Rural Generalists with an accredited advanced skill working as part of an integrated team with consultant specialist engagement.

- **Expand the single employer models for Rural Generalist trainees**. The single employer model is a key component of the National Rural Generalist Pathway. It is recognised that the current employment arrangements for GP registrars are a barrier for potential junior doctors electing to take up GP or Rural Generalist training. Currently there are two operational single employer model sites (Murrumbidgee LHD, New South Wales and the Riverland Mallee Coorong LHN, South Australia) with a further ten sites underway. Further expansion of this initiative nationally would derive considerable benefit by preventing potential general practice trainees being disadvantaged by entitlement loss should they choose to undertake general practice training. A coordinated application process for individual districts or communities that choose to apply should be instituted, with each application being assessed on its merit.
- **Support rural supervision of trainees in all medical specialties.** A critical training issue in rural areas is the inadequate funding for the supervision of trainee doctors. Increasing supervision payments to allow a rural GP or Rural Generalist to supervise multiple junior doctors at one time, and including a 19(2) exemption[7] for the program if necessary would support the expansion of the JFPDP. Supervision by rural consultant specialists must also be supported.
- **Develop and implement doctor wellbeing strategies.** The psychological distress and burnout experienced by doctors has been highlighted during the COVID-19 pandemic and the spate of natural disasters that have impacted heavily in rural areas. Doctors have higher rates of suicide [than other professions] and a stigma surrounding seeking medical care for oneself [8]. It is also difficult for a rural doctor to seek help as they experience lack of access to local care (other doctors may be in the same practice or known socially) and must travel for care further afield which is not always practicable. Rural doctors must be supported seek help to maintain their own health and wellbeing to prevent any serious personal or professional consequences of ill health.

Expand the Workforce Incentive Program (WIP) to support rural consultant specialists to enhance viability of specialist services in rural and remote communities.

Expansion of the WIP Medical Stream to consultant specialists who provide in-person care in rural areas where the individual practitioner undertakes some private practice work would enhance the viability and sustainability of private consultant practice in rural areas. In particular, this initiative would support the provision of private obstetric services in small regional and rural communities, as well as access to private psychiatric and physician (for example, cardiology) services.

[7] Under a governing Memorandum of Understanding with the Commonwealth Government, a section 19(2), Health Insurance Act 1973 https://www.legislation.gov.au/Details/C2018C00319) Ministerial exemption allows eligible sites to claim against the Medicare Benefits Schedule (MBS) for permitted services https://www1.health.gov.au/internet/main/publishing.nsf/Content/COAG%20s19(2)%20Exemptions%20Initiative. Viewed 27 January 2023.

[8] Australian Government Department of Health (2021). National Medical Workforce Strategy 2021-2013. https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf. p 25. Downloaded 26 January 2023.

Establish a housing program to support critical workforce recruitment and retention in rural and remote communities.

There is often limited access to suitable accommodation for doctors and their families in rural areas. A housing program which supports critical workforce such as doctors, nurses, teachers, and other professionals, to make capital investments in the community has the potential to bolster recruitment and retention of these workers through increasing their connection to that community. Such an initiative could also generate broader economic activity within the local community. RDAA is proposing a pilot program for rural doctors utilising underspent funds from AGPT and/or the HELP debt initiative.

Conclusion

It is vitally important that Federal budgetary measures support the consolidation and refinement of existing rural medical and health policy and programs, as well as the development and establishment of innovative new initiatives, if rural medical services are to remain viable and sustainable and the health of rural people is to be measurably improved.