RURAL DOCTORS ASSOCIATION OF AUSTRALIA

SUBMISSION TO THE NATIONAL HEALTH REFORM AGREEMENT ADDENDUM 2020-2025 MID TERM REVIEW

RDAA Submission

Due 2 June 2023

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 healthcare services, varies considerably from community to community. However, access to all health professionals and healthcare 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 healthcare 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 healthcare service delivery challenges most difficult.

Summary of Recommendations

- There must be KPIs/measures specifically for rural and remote hospital service provision as well as broader workforce measures.
- Infrastructure investment must align with clinical capability framework service provision and accreditation standards.
- All rural hospital emergency services (or services providing emergency care by another name, such as Victorian Rural Hospital Urgent Care Centres/Services and South Australian rural hospital emergency departments) must be staffed by doctors being paid by the State, and not through private patient billings, or Medicare bulk billing.
- All rural hospitals have a budget line item with an allocation of funding for education, training and research.
- For Commonwealth funded positions that are allocated based on rotation to a rural hospital, the rural hospital should have a budget line item for that position salary, as well as HR records to align with the staff providing services in that hospital.
- Establish a fund for rural hospitals to access innovative workforce solution funding to support grow their own initiatives.
- Establish a central repository for credentialing documentation or a mechanism for Districts to access documentation from other health services.

[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.

- Develop a national framework for rural maternity services in relation to scaling up or down on service level provision, that includes mandatory engagement with community and peak body organisations.

Elements to be examined under the review:

a) Implementation of the long-term reforms on the objectives and funding arrangements, and whether practice and policy in place delivers o the objectives of the NHRA and the Addendum

The NHRA has failed small rural hospitals and has had serious impacts on investment and support in the primary care sector, particularly in relation to workforce.

RDAA believes that, through this agreement, there is opportunity to increase the accountability of the States in relation access to services for rural and remote patients. Access should be based on the principle of equitable access, as close to home as possible.

In establishing base year service provision on which Activity Based Funding would be initially allocated, many large hospitals appeared to increase activity to ensure ongoing indexation was based on a high activity foundation. Continued growth in hospital activity has drawn the increased number of domestic graduates into the hospital sector, creating a significant shortfall in the general practice workforce, in particular rural general practice, and as a result the rural hospital medical workforce. The state hospital approach to sub-specialisation of the workforce has also reduced efficiency and increased costs within the system.

Recommendation:
There must be KPIs/measures specifically for rural and remote hospital service provision as well as broader workforce measures.

b) The impact of external factors on the demand for hospital services and the flow on effects on Addendum parameters

Rural maternity services need protection under this agreement. There must be greater community engagement and transparency on decisions to close or downgrade rural maternity services. There needs to be clear direction in relation to the actions that must be taken in an effort to prevent the closure of a rural maternity service. While demand may appear to be declining this is often as a result of periods of bypass and a revolving door of locum staff creating uncertainty about the service. RDAA recognises that rural hospitals are generally birthing women with a lower risk profile.

Recommendation:
Develop a national framework for rural maternity services in relation to scaling up or down on service level provision, that includes mandatory engagement with community and peak body organisations.

Infrastructure investment needs to align with clinical capability to ensure equivalent quality of care and service in comparison to mothers who birth at public hospitals in regional and city centres. This is particularly important to ensure continued compliance with accreditation standards. Rural maternity services are impacted when an operating theatre requires an upgrade to align with standards in relation to ACORN, Infection Control etc.

Recommendation:
Infrastructure investment must align with clinical capability framework service provision and accreditation standards.

Impact of COVID and its flow on impacts to the medical workforce supply has resulted in the withdrawal or reduction of many visiting specialist services to rural communities. These services remain in great demand, therefore planning needs to recognise an increased need as opposed to the reduced supply level as an indicator of rural community requirements.

c) For rural and small regional hospitals, whether they continue to meet the block funding criteria determined by the Independent Health and Aged Care Pricing Authority

Block funding in its current design for small rural hospitals is a barrier to innovation and service reform, and is also a barrier to recruitment and retention of health workforce.

The block funding model applied to most small rural hospitals does not include teaching or research funding which currently is only applicable to tertiary and large regional hospitals. The block funding model fails to recognise the significant contribution to education and training across all health professions facilitated in small regional and rural hospitals. Rural hospitals provide teaching and training to medical students, increasingly prevocational doctors and registrars, particularly the rural generalist workforce but increasingly across other streams of medicine as well.

In rural hospitals where teaching is carried out there are additional issues created by GP Visiting Medical Officer (GP VMO) arrangements. For example, in New South Wales and Victoria, where hospital inpatient services are provided through contracts with GP VMOs, if a registrar is on-call, and the supervisor is called into provide assistance, or utilises the presentation as a teaching

opportunity, only one fee is paid for the service, significantly reducing the remuneration when teaching or supervising a registrar. This not only reduces any incentive to maximise the teaching opportunities, it has the potential to create an environment where a registrar does not seek assistance when they should.

Supervision of registrars should also be budgeted as a separate line item, and be separate from any fee for service arrangement, to ensure a supportive environment which maximises teaching opportunities in rural hospitals. Investment in supervision has significant flow on impacts to retention of these doctors beyond their training years.

Recommendation:
All rural hospitals have a budget line item with an allocation of funding for education, training and research.

There are many Commonwealth funded programs, such as John Flynn Prevocational Program and the Specialist Training Program, where funding is allocated to the supplying hospital, rather than the rural hospital where the doctor-in-training is allocated under the program. This means that if the supplying hospital recalls or does not provide the doctor for that rotation/term, as often happens, the rural hospital has no mechanism to negotiate with another service to provide that doctor in the future. Despite not supplying the position, the hospital that holds the funds also may retain the funding, or a portion of it, and therefore the investment has not been utilised for the true intent of the program.

Recommendation:
For Commonwealth funded positions that are allocated based on rotation to a rural hospital, the rural hospital should have a budget line item for that position salary, as well as HR records to align with the staff providing services in that hospital.

In Block funded hospitals there is very limited ability to invest in innovative workforce solutions as funding is often very limited to a minimal staffing roster, for example 24/7 nursing coverage one RN and one EN/AIN.

Rural health services have the greatest need to invest in innovative workforce solutions, and in particular “Grow Your Own” initiatives. This is particularly important to nursing and midwifery staff.

The new prevocational framework for junior doctors presents a new opportunity and there is significant potential to expand rural training in these years. The years immediately following on from

university are highly influential in determining long term training and career direction. The limitation will be funding availability for rural hospitals to develop the rotations or full-time positions.

Recommendation:
Establish a fund for rural hospitals to access innovative workforce solution funding to support grow your own initiatives.

d) Whether any unintended consequences such as cost shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial and other arrangements in the Addendum

Arrangements for Victorian and South Australian small rural hospital emergency departments with a private billing arrangement, subsidised by Medicare, must be ceased.

These services are, for all intents and purposes, small hospital emergency departments, which are funded through bulk or private billing. The reality is that due to the type of presentations (ie. emergency) the medical practitioners must bulk bill. The Medicare rebate is significantly less than the remuneration a senior medical officer in a regional hospital would receive on salary and is an unfair rate of pay for services that can be provided in unsociable hours (11pm to 7am) for extended periods of time. This disparity has resulted in a continued trend of local GPs no longer providing 24/7 emergency coverage at the local hospital. This is a cost shift that has resulted in rural patients having a reduced level of emergency care locally available.

The following link provides a map of Urgent Care Services where Medicare Billing occurs in Victorian small rural hospitals:

https://www.health.vic.gov.au/rural-health/urgent-care-in-regional-and-rural-areas

These small rural hospitals' urgent care services operate as a small rural hospital emergency department or service. The local community treat it as one, with even ambulance services, while advised they are not an emergency service, have been known to attend if they know a doctor is on call. These services are located in the hospital building, use hospital nursing staff, and clinical supplies. The doctors staffing the services are also expected to have emergency skills and undertake the appropriate continuing medical education to maintain their skills. Correspondence was sent to the former Commonwealth Minister for Health Greg Hunt, and former Victorian Minister for Health Jenny Mikakos, raising concerns about this model, provided as Attachment A and B.

Recommendation:
All rural hospital emergency services (or services providing emergency care by another name, such as Victorian Rural Hospital Urgent Care Centres/Services and South Australian rural hospital emergency departments) must be staffed by doctors being paid by the State, and not through private patient billings, or Medicare bulk billing.

Note – many of these sites would be eligible under COAG 19(2), so there is potential of some Commonwealth offset of the doctors' salary.

A significant inefficiency within the hospital sector is the administration and bureaucratic burden and level of duplication associated with the credentialing of senior medical staffing. RDAA has long held a position that there would be great benefit to the system to have a central repository of documentation or a mechanism where information could be accessed by the credentialing teams in each of the health districts.

The repeated requests for the same documentation has a significant impact on rural services, creating a barrier to facilitate increased visiting specialist services into rural communities that would enable patients to access services closer to home.

Locum members of RDAA have repeatedly advised that they limit the practices they support due to the level of documentation and the time required for each credentialing process. Straightforward documentation for an Australian trained and Fellow GP anaesthetist for a South Australian credentialing process had in excess of 40 pages.

The documentation requests, due to the time limitation on certified copies, limits the mobilisation of the medical workforce and results in greater patient travel for rural patients to access services.

Recommendation:
Establish a central repository for credentialing documentation or a mechanism for Districts to access documentation from other health services.

It should be noted this would be a first step to enabling a process to facilitate transferring of credentials between services, and this should be a consideration to be progressed for the next agreement.

e) The performance of the national bodies against their functions, roles and responsibilities

The National Pricing Authority needs to evolve and develop new funding models for hospitals, particularly for rural hospitals.

f) Arrangements for approval and funding of high-cost therapies in public hospitals, as outlined in the Addendum Schedule C and Appendix B

For rural patients (located in MMM 3-7), there should always be provision for prescribing by a General Practitioner or Rural Generalist, where they have liaised and received advice from the appropriate Consultant Specialist.