RURAL DOCTORS ASSOCIATION OF AUSTRALIA

PRE BUDGET SUBMISSION

2024-2025 Commonwealth Budget recommendations

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 the patients and communities they serve.

Introduction

The Rural Doctors Association of Australia (RDAA) welcomes this opportunity to provide a submission for the 2024-2025 Federal Budget.

RDAA's priority areas for Budget consideration are:

Continued expansion of the John Flynn Prevocational Program

Exposure to rural generalist practice during the prevocational training period is a key priority within the National Rural Generalist Pathway Advice Paper. The John Flynn Prevocational Program provides rotations to rural general practice at a critical period of a junior doctor's training journey. Prevocational doctors are at a crucial decision-making point, making final decisions on their future training and career pathways at a time when the majority of their training experience has been hospital-based. This program provides exposure to rural general practice (GP) and rural generalist (RG) practice, enabling these junior doctors to experience the opportunities available in rural and remote practice, and to see and understand the type of medicine practised in rural and remote general practices and, for RGs, hospitals.

With intern and resident medical officer positions mainly based in capital cities or the largest regional centres, these rural rotations are essential. The 1,000 rotations currently funded, enable this experience for less than half of the Commonwealth Supported Program medical student places. There is an intake of 850 rural GP or RG training positions each year. Limiting the program to only 1,000 rotations means that there is minimal scope for attrition.

Since the inception of the John Flynn Prevocational Program, RDAA has maintained that 1,600 rotations are needed. This would facilitate the opportunity for around 50 per cent of domestic graduates to undertake a rural placement during their prevocational training years.

RDAA recommends funding an additional 150 John Flynn positions, along with some minor amendments to the program guidelines, which will significantly enhance the recruitment opportunities into rural GP and RG practice, as well as the regionally based Commonwealth funded Specialist Training Program positions.

Additional 150 John Flynn Prevocational Program positions:

Cost E$30 million, based on each position funded at $200,000, including remuneration package, supervision and accreditation requirements.

Rural Generalist Expanded Access to PBS and MBS

RDAA has commenced work on a project to review the Medicare Benefits Schedule to assess item numbers which are within the scope of practice of a rural generalist (RG) with a particular advanced clinical skill (for example, psychiatry items for an RG with an advanced skill in mental health). RDAA notes any recommendations as a result of this project will be progressed through the Medicare Review Committee. It has been identified that the RG scope of practice also needs to be considered in relation to access to the Pharmaceutical Benefits Scheme and any limitations on prescribing.

RDAA recognises that there are mechanisms through the Scope of Practice Review and ongoing Medicare review work under which a funding proposal will be considered. This must be a priority for allocation of funding in the next 12 to 18 months.

Expansion of MBS and PBS item eligibility to Rural Generalists with relevant advance skills.

To be determined within next 12 months.

Expansion of Workforce Incentive Program – medical stream to non-GP specialists

The medical workforce maldistribution is real. Access to general practitioner services is a challenge for patients in rural and remote communities, but access to consultant specialist services is near impossible.

Communities such as Broome and Alice Springs demonstrate that regional models can be established in isolated areas of Australia but they are reliant on full time public hospital work. This then limits the headcount for the practitioners to be employed and can result in burn-out.

More needs to be done to encourage these specialists to provide a combination of private and public work to support an increase in actual doctors on the ground and access to consultant specialist services closer to home for rural patients. It is noted there is often limited scope of private practice work in these communities, and therefore additional financial support is required to ensure viability and sustainability.

Expanding the WIP medical stream to non-GP specialists will assist in retaining trainees (who have completed part of their training through the Commonwealth funded Specialist Training Program) beyond Fellowship in rural and regional areas. RDAA anticipates this would result in additional program spend through increased utilisation.

RDAA proposes that the criteria in relation to working in Modified Monash Model (MMM) 3-7 locations, as per the current guidelines, is retained, and that providing evidence of community-based consultant specialist level service delivery (i.e. outside of the public patient hospital services) should be a requirement.

Anecdotally, there appears to have been a small number of consultant specialists deemed eligible for the payment under the current system. RDAA has been unable to obtain clear advice on eligibility criteria for non-GP specialists to access this incentive. Clearer guidelines and promotion of the incentive is required.

Expansion of WIP payments to non-GP Specialists

Cost: E$29,203,200 per annum

General Practice Supervision Support

It is essential, for succession planning, that general practices are supported (and incentivised) to provide a training experience across the continuum of a future GP's training period from medical student, prevocational doctor to registrar. Additional investment in supervisor work is urgently needed to remunerate them fairly and ensure training in general practice is of the highest quality.

There are two parts to this proposal:

Simplification of supervisor payments

There are at least six different sources of Commonwealth funding (Practice Incentives Program medical student support, direct university payments, More Doctors for Rural Australia Program supervision, John Flynn program supervision, Ausstralian General Practice Training program supervision, Rural Generalist Training Scheme supervision), to provide supervision to medical students, prevocational doctors and GP or RG registrars.

Re-designing the supervisor funding arrangements would also ensure general practice is better prepared for potential changes to employment arrangements, such as Single Employer Model arrangements, into the future. It is important to note, that continued expansion of the Single Employer Model remains a key priority for RDAA.

Additional investment in GP supervisors

Under the fee for service model in general practice, supervision demands have a direct impact on the salary of the GP supervisor. The variation in payment levels and time burden make supervision of students more lucrative than of other trainees, such as prevocational doctors.

The John Flynn Prevocational Program does not provide easily accessible information on supervision payment levels, but it is understood there is a small allocation of funding for this. It should be noted that the participants in this program are not billing Medicare, so it will only be when the GP supervisor then participates in the consultation that a fee will be raised which will cover that consultation only. It must be further noted that due to the time demands of supervising prevocational doctors, there is a significant reduction in the productivity of the GP Supervisor when they are teaching. The minimal financial support for supervision in this program has been identified as a barrier to some practices, or having more than one John Flynn participant in a practice even if the practice infrastructure such as a consultation room and supervisor capacity is available.

Within Australian General Practice Training (AGPT) clinical supervision is not funded. Under the current fee for service model this means that the system relies on supervisors to work unpaid for many hours throughout a GP registrars' training time. This is unacceptable. Consultants working in the hospital system would all resign if the time they spent supervising their registrars was unpaid.

Supervisor payments range from around $23,400 for a GP registrar in a capital city for a full year to $48,000 for a medical student placement of two sessions per day for 48 weeks. For a More Doctors for Rural Australia Program (MDRAP) supervisor, payments are capped at $30,000 per annum, yet the teaching and supervision is very intensive with significant time focused on additional elements not needed by domestic graduate doctors. Examples of this include teaching to develop an understanding of the Australian health care system, context of Australian general practice and, in some cases, the context of Australian rural medicine.

Under the new intern accreditation framework, there is significant potential to increase training in general practice to meet the health care needs of Australian communities, but this can only be done if we increase supervision capacity.

To increase training capacity in general practice supervisors must be paid fairly for the work they do.

Consolidation of GP Supervisor payments. Cost-neutral.

Additional investment in GP supervisors. E$50,000,000

Childcare for Rural Health Care Workers

There is increasing focus on broader community-based infrastructure and service issues which are impacting on recruitment and retention of healthcare workers in rural and remote settings[1].

Rather than finances, there is a genuine access to childcare issue that needs to be addressed in order to make rural practice an option for training and employment, and maximise the number of hours staff are available to work.

Some pertinent statistics include:

- 54.3% of medical students commencing in 2021 were female (2)
- The female to male ratio in health professions is 2.9:1 in 2020 (3)

Childcare centres exist in many city hospitals[4] and while on a smaller scale, there is potential for setting up centres in rural locations

These centres would have additional benefits including providing further local employment opportunities and supporting a broader economic benefit by enabling partners of health professionals to have greater employment opportunities – one which is currently often restricted by a lack of access to child care.

[1] https://www.ruralhealth.org.au/sites/default/files/publications/evidence-base-additional-investment-rural-health-australia-june-2023.pdf
[2] https://medicaldeans.org.au/md/2021/11/MDANZ-Student-Statistics-Report-2021.pdf
[3] https://www.aihw.gov.au/reports/workforce/health-workforce
[4] For example: South East Sydney Local Health District; Royal North Shore; Royal Women's hospital Melbourne; PA Hospital Brisbane.

RDAA proposes an initial 10 site program to establish rural childcare centres in the grounds of rural or remote hospitals in places which are accessible to health care workers (state and privately employed) or other critical community workers such as police. Under this proposal:

- State hospital services provide the land on site for construction (this may or may not include buildings to be repurposed)
- Commonwealth allocates up to $2million for construction and refurbishment to each site. Tender process for community-based application
- Operational costs will be the responsibility of the successful service manager application.

Location on the hospital grounds is key as, similarly to the child care centre at Parliament House or at metropolitan hospitals, it helps manage community expectations as to who has priority access to child care places in the facility. If the pilot is successful and expansion of the program is supported, in rural and remote communities where there is insufficient land available on hospital grounds, consideration must be given to the purchase of appropriate land or buildings, for example adjacent to a general practice.

10 Rural Hospital on-site Child Care Centres

Cost: $20 million for the pilot 10 sites.

Rural Incentive Calculator

RDAA has recently developed a calculator for doctors which calculates the total of the financial incentives they may be eligible for, if they complete the requirements under specific programs. RDAA members have indicated a need for this tool to assist in promoting accurate remuneration projections and increasing awareness of the various financial support payments available to rural doctors.

The calculator includes the following incentive payments:

- HELP Debt reduction
- Procedural Grants – procedural, mental health and emergency
- Workforce Incentive Payment Medical Stream
- Workforce Incentive Payment – Advance skills
- AGPT Registrar payments under the Nationally Consistent Framework
- RGTS Registrar payments for ACRRM

This tool was developed by RDAA and within the current RDAA budget; no additional funding was requested. The calculator is currently in its final testing stages with the Department of Health and Aged Care and will soon be launched on the RDAA website, with links to each of the programs, as well as additional information on various financial supports that are based on reimbursement of specific amounts (which are variable to each individual applicant).

Following a demonstration of the tool to Commonwealth Department of Health and Aged Care staff, RDAA has been asked about the potential of including the various state incentives. This would involve expanding the calculator to include many more state-based programs and incentives, which RDAA does not currently have the resources to undertake.

With additional funding to invest, RDAA could complete this expansion of the current Commonwealth Incentive Calculator to include state-based funding with work to be completed over the next two years. With the current review of the incentives, indexation of some payment and new policy always in scope, RDAA is seeking some additional funding to maintain the currently of the incentive calculator.

Expansion of Federal Rural Incentive Calculator to include State-based incentives

Cost: $220,000 per financial year for 2024/25 and 2025/26 plus $22,000 per annum for maintenance of calculator