



Rural specialist care providers are not happy that long-serving specialists are denied MSOAP benefits because only limited funds were set aside to support existing services. This is a problem because the most worthy doctors are often now not rewarded with funding to offset their substantive personal costs in providing care.

The AMA believes that funding for MSOAP should be lifted by at least 25 per cent, which is approximately \$15 million to \$20 million over four years.

5. Patient Assisted Travel Schemes

The Australian healthcare system is based on the principle that all Australians are able to have access to the same level of health care regardless of where they live. Those who live in regional, rural and remote Australia should not be disadvantaged if they must travel to larger centres to access quality health care. These patients can often suffer from serious or life-threatening illnesses that require highly specialised medical treatment, and they can often endure extended periods away from their home and family. Where health services cannot be easily accessed locally, patients should not be left out of pocket when they need to travel to obtain medical care.

In 1987, the Commonwealth relinquished responsibility to the States and Territories to provide funds to help patients with the cost of travelling to obtain medical treatment.

Australia now has separate Patient Assisted Travel Schemes (PATS) in each State and Territory, which vary significantly in terms of eligibility criteria and the level of financial support offered. Funding is inadequate, with accommodation subsidies set at around \$30 to \$35 per night and travel subsidies of around 15c per kilometre.

PATS subsidies focus on specialist treatment and do not recognise that patients may have complex and chronic conditions that require the involvement of other health professionals – within the overall supervision of their doctor.

What is needed to bridge the gap?

The reality is that in some areas it will not always be possible to deliver health services locally. Properly funded, expanded and nationally consistent PATS arrangements provide a cost-effective way to give country people better access to these services.

The AMA believes that the Commonwealth should work with the States and Territories to expand PATS to cover other treatments available under the Medical Benefits Schedule (MBS) – including access to allied health professionals where a doctor coordinates the patient's overall care.

PATS arrangements should be harmonised and funding boosted so that patients are no longer disadvantaged when they must travel for treatment. Eligibility criteria must be flexible enough to recognise particular groups with special needs, such as Indigenous Australians.

The estimated additional cost to the Commonwealth of this commitment would be \$144 million over four years, with a matching commitment from State and Territory Governments.

Conclusion - Time for action

Improving regional, rural and remote health care is not a bridge too far. Health care is a key election issue for country Australians.

The AMA believes that the standards of health care can be lifted in regional, rural and remote Australia. The communities there are already served by highly skilled doctors who often work long hours and who are totally dedicated to the needs of their community. The work is challenging and can be very rewarding. These doctors are valued by their communities and there is no doubt that many doctors enjoy the sense of community and lifestyle.

Political parties therefore ignore rural health care issues at their peril. This Federal election is an opportunity for all political parties to put forward comprehensive plans for health care in regional, rural and remote Australia, to commit to significant funding increases to bridge the gap between city and county.

No more band-aid solutions.

1. *Australia's Health 2006, Australian Institute of Health and Welfare – June 2006*
2. *Australia's Health 2006, Australian Institute of Health and Welfare - June 2006*
3. *Maternity Services for Australia, Rural Doctors Association of Australia – February 2006.*
4. *Medical Labour Force 2004, Australian Institute of Health and Welfare – December 2006*

5. *Final Report – The Registration and Training Status of Overseas Trained Doctors in Australia, Hawthorne L, Hawthorne G. and Crotty B., Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, February 2007*
6. *AMA Rural Health Issues Survey, May 2007*
7. *Australian Government Department of Health and Ageing Review of the Rural Retention Program – Final Report, Gibbon P. and Hales J., December 2006*



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Bridging the Gap

BETTER HEALTH CARE IN REGIONAL,
RURAL AND REMOTE AUSTRALIA



Regional, rural and remote Australia is undergoing massive change. Once thriving communities are being hit hard by economic rationalism. They have lost their banks, post offices and other day-to-day services that city people take for granted. Yet these same rural areas put food on Australia's tables and earn Australia valuable export dollars.

More than 6.7 million Australians live in regional, rural and remote areas.

According to the Australian Institute of Health and Welfare (AIHW), they generally do worse than people who live in major cities¹ on a wide range of health status measures.

Death rates in regional, rural and remote areas are higher than in major cities, and it is estimated that there are around 3,300 additional deaths annually in these areas than would be expected if the death rates were the same as in major cities².

People in regional, rural and remote Australia have lower life expectancy, higher rates of disability, and higher injury rates.

They deserve a fair go when it comes to health care.

The reality is, however, that many face the prospect of the closure or downgrading of their local hospital. It is estimated that more than 130 maternity units have closed across Australia since 1995, for instance³.

Country communities are finding it harder and harder to recruit and retain doctors. According to the AIHW, overall full-time equivalent medical practitioner supply increased in metropolitan regions and decreased in non-metropolitan regions⁴ between 2000 and 2004. Without the contribution made by overseas trained doctors, the situation would be even more serious.

Without government action, these problems will make quality health care services in rural and remote Australia extinct.

Rural health care is at the crossroads

Governments at both Federal and State and Territory levels have put in place a multitude of programs that attempt to improve the medical workforce in regional, rural and remote areas. While some of these programs are having a positive impact, these programs, as a whole, appear at best to be only just keeping up.

Program funding is not properly indexed, and the funding pool is simply too small.

Australia has developed an unhealthy reliance on the use of Medicare Provider number restrictions to force overseas trained doctors (OTDs) to work in rural areas. These overseas recruits will be needed in the years ahead, but their recruitment must follow nationally agreed criteria, with user-friendly selection and proper support processes. The current recruitment processes are disjointed and a recipe for poor health service delivery, as revealed in a report commissioned by the Department of Health and Ageing and released in March this year⁵.

The Commonwealth Government has embarked on a massive expansion of medical student places. The 2008 medical school intake will be more than double the intake in 2000. Importantly, around 25 per cent of students selected into medical school will be from a rural background. These students will be two to three times more likely to return to practise in a rural area.

The Commonwealth has funded rural clinical schools that provide an early and positive training experience in rural areas for medical students. Again, this is potentially a highly effective way of encouraging more doctors to work in regional, rural and remote Australia.

However, these initiatives will have no impact if services and facilities continue to be downgraded and the number of doctors in rural areas continues to dwindle. What point is there in going to practise in a rural town if you cannot give your patients access to decent facilities, or you



do not have anyone to provide you with supervision and training, or you are unable to use, maintain or improve your skills?

The AMA believes that health care in regional, rural and remote Australia deserves significant real funding increases. In the lead-up to the Federal election, the major parties must focus on measures that will make a long-term difference. They must commit to policies that focus on:

- rebuilding health infrastructure – particularly public hospitals,
- providing real incentives for recruitment and retention,
- ensuring that the currently successful outreach services are properly funded, and
- making sure that patients are well supported when they need to travel to major population centres for treatment.

The AMA is proposing fundamental building blocks for better health care in regional, rural and remote Australia. They complement other AMA work in this area, such as that outlined in the AMA Position Statement on Regional/Rural Workforce Initiatives, our call for more training and support for overseas trained doctors and, more recently, the AMA Rural Health Issues Survey⁶.

1. Rebuilding country hospital infrastructure

The closure and downgrading of rural hospitals are seriously affecting the future delivery of health care in rural areas. They are often driven by economic rationalism, without sufficient regard to the significant consequences for local communities and the sustainability of the rural medical workforce.

In the recent AMA Rural Health Issues Survey, rural doctors rated the need to lift support significantly for rural public hospitals – particularly in the area of facilities, equipment and staffing – as the highest priority to fix rural health.

The state of facilities and equipment in rural hospitals lags significantly behind that in their metropolitan counterparts and, in the worst cases, are in a state of disrepair. Outdated equipment, leaking roofs, and inadequate facilities are just some of the issues raised by the AMA over many years. AIHW statistics show that accreditation rates for hospitals in regional, rural and remote areas are much lower than in major cities. Doctors are not going to fly by the seat of their pants in poorly equipped hospitals because such rural medicine becomes dangerous, and the prophecy that rural care will become second rate becomes a self-fulfilling one.

Health care in rural areas depends on a strong primary health care workforce and a viable public hospital system. We cannot have one without the other. One of the reasons nominated by the AIHW for the poorer health status of people living in rural and remote Australia is the lack of access to facilities and services. This is a key barrier to improving the health and wellbeing of rural communities. In addition, without access to decent public hospital facilities, doctors cannot maintain their procedural skill levels and the opportunity to train new doctors in rural areas is greatly diminished.

If rural patients are to receive the same standards of care as other Australians, modern facilities and equipment are essential. Without the latest technology, rural patients cannot benefit from improved surgical techniques or improved methods of care. They may face longer recovery periods or may not have the same quality of outcome as

they would have if they lived in the city. Rural practitioners need freely available regular access to tertiary centres to improve their therapeutic and diagnostic skills so that they can provide the best possible care for the patients.

What is needed to bridge the gap?

The Commonwealth and State/Territory Governments must work together to ensure that rural hospitals have modern facilities and equipment along with the required funding to attract a sustainable health workforce.

The next round of Australian Health Care Agreements (AHCAs) should aim to secure a better funding deal for regional, rural and remote public hospitals. They must include significant and consistent funding increases for these hospitals over the life of the agreements – above and beyond the general indexation formula.

Increased funding from the Commonwealth must be matched by equal commitments from the States and Territories. Accountability mechanisms should be built into the AHCAs to ensure that regional, rural and remote communities are properly consulted on decisions affecting their hospital services and that the extra money gets to where it is needed.

The estimated additional cost to the Commonwealth of this commitment would be \$2 billion over the five-year life of the AHCAs, with a matching contribution from State/Territory Governments.

2. Rural Retention Program

Timely access to a doctor is a key problem for people living in rural areas.

Rural Australia is increasingly reliant on overseas trained doctors. Though they do an excellent job, Australia cannot continue relying on them to fill workforce gaps forever. Programs are needed to ensure that rural Australia can attract and retain doctors with recognised Australian qualifications.

The Rural Retention Program (RRP) provides grants to general practitioners based on their location and length of service in a rural area. In 2004-05, just under \$20 million was paid out under the RRP scheme, with grants ranging from \$5,000 to \$25,000 per year.

But the RRP, though it helps to retain doctors, is not attracting new ones to rural Australia.

In 2006, the Department of Health and Ageing commissioned Health Outcomes International to prepare an independent evaluation report on the effectiveness of the RRP⁷. The report revealed that current funding is seen as useful to retain doctors but is not enough to attract more doctors to regional, rural and remote areas. The message is simple – if Australia wants to encourage more doctors to work in rural areas – this program needs a significant funding boost.

Another significant shortcoming in the program, identified in the AMA Rural Health Issues Survey, is that existing RRP guidelines do not extend to the specialist workforce.

The RRP also fails to address the reality that the medical workforce in regional, rural and remote Australia is ageing. If these doctors leave the medical workforce through burnout or frustration as the rural health care environment deteriorates, significant questions will arise about how their skills and experience can be passed on to the next generation of doctors coming through.

What is needed to bridge the gap?

The RRP requires a significant overhaul. The Government should give immediate attention to implementing many of the ideas contained in its own independent report including:

- increasing the amount of payments made under RRP to a realistic level,
- introducing indexed grants,
- making RRP grants non-taxable,
- removing the waiting period eligibility criteria,
- examining the feasibility of incremental payment scales based on duration of service,
- including the range of work undertaken by rural and remote GPs – hospital work and procedural medicine – that is currently not eligible under the program, and
- extending the program to cover specialist recruitment and retention.

Importantly, awareness of incentives paid from these programs must reach doctors to have a real impact.

The Government may also wish to look at other measures to encourage doctors to live and work in rural and remote Australia. Additional superannuation contributions or specific superannuation concessions may provide long-term incentives to the ageing procedural workforce to maintain their presence as service providers and educators as we wait for increased doctor numbers to filter through in 2011-2012.

The AMA estimates that the cost of strengthening the RRP would be around \$80 million over four years.

3. Encouraging more young doctors to work in rural areas

To address workforce shortages in particular areas, the Government now offers 500 unfunded bonded medical school places (BMP) each year. Students taking up the positions are bonded to work for up to six years in workforce shortage areas.

Unlike students in other professions such as teaching, medical students who take up BMP positions are offered no incentives and must repay their Higher Education Contribution Scheme (HECS) charges in full. Recent changes have made the BMP Scheme fairer and provided students with more support, but it still lacks sufficient incentives.

Conscripting doctors to work in government-designated localities 10 or more years after starting medical school will simply create a pool of disgruntled doctors. It is unfair and inequitable, and introduces inequality of access to the higher education system. This view is based on a careful analysis of comparative OECD and US studies of the impact of student bonding on medical workforce distribution, and extensive surveys of medical students. Overseas studies have demonstrated that bonding medical students has led to serious morale and job satisfaction issues. Many students choose to buy out their bond and long-term retention rates are poor.

It does not address the underlying causes of medical workforce shortages or make the practice of medicine in areas of workforce shortage any more attractive.

It will be ineffective in improving medical services in areas of need.

What is needed to bridge the gap?

The AMA has proposed an alternative scholarship-based scheme to the Government that involves:

- selection to medical school not being conditional on accepting a contract,
- payment of a scholarship to the student,
- exemption from HECS for the medical degree course,
- a return of service period linked to the length of the medical degree course, and
- return of service from commencement of prevocational training.

In addition, the Government should consider full payment of indemnity costs for the first three years of rural service.

Easing the workforce shortage by boosting practice nurse subsidies in rural areas also needs urgent attention.

4. Giving country people better access to specialist care

The AMA recognises that, even with better infrastructure and more workforce incentives, it will still not be possible to provide full time services across all specialty areas in regional, rural and remote Australia. The reality is that specialists often need access to high cost equipment, facilities and support, and must also maintain a minimum clinical workload in order to maintain and upgrade their skills.

With this in mind, Australia must have in place robust funding programs to support specialist outreach services.

The Medical Specialist Outreach Program (MSOAP) is an existing Commonwealth program that provides funding for outreach services in rural Australia.

It allows patients to be treated locally where they have access to the support of family and friends. It can help patients avoid or minimise unnecessary travel. These are important factors in ensuring a speedy recovery from illness or injury. Provided outreach services are properly integrated with local hospital and primary care services, patients can be assured that their post-operative care will be managed effectively and will be of a high standard. MSOAP not only supports the delivery of key specialist services but, when properly integrated with existing services, it can also help build the skills of local practitioners. More than 1000 outreach services are currently funded by MSOAP.

However, despite extra funding in the 2004-2005 Federal Budget, MSOAP has already exhausted available funding through until 2008, and many worthwhile projects have been denied assistance. Fundholders under the program have identified a number of areas of need that cannot be accommodated because of budget constraints.

What is needed to bridge the gap?

MSOAP is an effective and innovative program that has the strong support of rural communities and specialists who are ready, willing and able to deliver care under the program. Extra funding would open up new opportunities for them to do so.