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Dear Ms Bennett

Re: Review of Rural Health Programs issues paper

Thank you for the opportunity to comment on the Department of Health and Ageing's issues paper. The AMA is Australia's largest independent professional organisation for doctors and we represent doctors across all specialties and at all stages of their careers. As an organisation that does not rely on funding from governments, the AMA, through its Rural Medical Committee, is well placed to be an independent advocate for policies and strategies to improve the delivery of health care in regional, rural and remote Australia.

As the AMA is not engaged directly in delivering Commonwealth-funded programs to rural medical or health professionals, we have restricted our comments to the general themes raised in the issues paper. For the purposes of this submission, *rural* equates to regional, rural and remote Australia.

While the rural health programs review is welcome, we must express at the outset our disappointment that it is restricted to realigning existing programs and funding arrangements and that there is no commitment to increase funding for incentives to get doctors into rural areas. There is no doubt that existing funding could be better spent, but better targeting of funds will only help at the margin.

Ultimately, the Government has to ensure that rural communities have doctors who have the facilities to treat patients safely and the capability to train new doctors coming through the system. To this end, the AMA has called for the 2009/10 Federal Budget to include \$385 million a year for measures to get more doctors into rural and remote areas and a redistribution of funds under the National Healthcare and Partnerships Payments to improve health infrastructure for rural communities and their doctors.

Improving access to medical services

Data from a wide variety of sources confirms that people in rural and remote Australia have poorer health outcomes than their city counterparts. It also shows that they have less access to health services of all kinds than people in urban areas. An increasing number of communities are grappling with a shrinking medical workforce, fewer local health services, and the closure or downgrade of their local hospital. The AMA believes that health care in rural areas depends on a strong primary healthcare workforce and a viable public hospital system – it is not possible to have one without the other.

It is difficult to comment on the performance of DoHA's rural health workforce programs because of the lack of publicly available evaluation and performance data. Generally, DoHA's rural health programs are under-funded, complex, fragmented and too restrictive. This is the result of a band-aid approach to solving the lack of access to health services in rural Australia. There may well be scope to consolidate and refocus existing programs but in the absence of any robust evaluation materials regarding these programs, extreme care must be exercised – otherwise there is the risk that effective programs will be lost or their impact diluted.

Feedback that the AMA receives from rural doctors shows that it is difficult for doctors to maintain awareness of the various programs, despite the assistance of the rural workforce agencies. A lack of information about the programs dilutes their effectiveness. These problems were highlighted in the recent Australian National Audit Office report on the department's rural and remote health workforce programs.

To varying degrees, the Rural Retention Program, the Medical Specialist Outreach Program, scholarship programs and the rural clinical schools appear to have been the most successful programs for supporting rural healthcare delivery.

The Rural Retention Program (RRP) has been relatively successful in retaining GPs in rural and remote areas but while it helps to retain doctors, it is not attracting new ones to rural Australia. The program requires a significant overhaul, including increased funding, streamlined eligibility requirements and better administration, if it is going to encourage doctors to stay in rural areas. The program should also be extended to cover specialists working in rural areas.

As mentioned above, the AMA and the Rural Doctors Association of Australia (RDAA) believe that more financial incentives are needed and have developed a significant package of rural-specific incentives to support the rural medical workforce. This package is outlined under our discussion on workforce shortages.

The Medical Specialist Outreach Program (MSOAP) has been successful in providing funding to support the delivery of fly-in fly-out specialist services in towns where these services are normally not available. It is an effective and innovative program that has the strong support of rural communities and the medical profession alike. Extra funding would open up new opportunities for communities to access specialist services and encourage more doctors to participate in the program.

Unfortunately, many long-serving specialists are denied MSOAP opportunities as only limited funds are set aside to support existing services. This is a problem because many worthy doctors who have been providing outreach services for many years are unable to access funding support which could help to offset their significant costs of providing care to under-served communities and encourage them to continue to provide their services.

The rural clinical schools are providing an early and positive training experience in rural areas for medical students. This is potentially an effective way of encouraging more doctors to work in regional, rural and remote Australia over the long term.

Scholarship schemes such as the John Flynn scholarships have been successful but should be expanded in scope and numbers so that there are more scholarship-based medical places that encourage in a positive way more medical students to experience rural practice.

Patient Assisted Travel (PATS) arrangements have been chronically under-funded and is an area where the Commonwealth and state and territory governments can work together to improve health outcomes in rural Australia. Properly funded, expanded and nationally consistent PATS arrangements are critical to enabling cost-effective access to health care services for people in rural areas.

PATS arrangements should be expanded to cover treatments available under the MBS, including travel to access allied health professionals where a doctor coordinates the overall care. PATS services should be harmonised across jurisdictions and receive a funding boost so that patients are not disadvantaged when they must travel for treatment and that the actual cost of travel is properly reimbursed. Eligibility criteria must be flexible enough to recognise particular groups with special needs, such as Indigenous Australians.

Rural health infrastructure

In 2007, the AMA conducted a survey of rural doctors asking them to rate the importance of various policy issues. Concerns about rural hospitals featured directly in five of the top ten areas identified by rural doctors.

The closure and downgrading of rural hospitals is seriously impacting on the delivery of health care in rural areas. Decisions are normally driven by economic considerations, yet they have significant consequences for the local community and the sustainability of the medical workforce. The loss or downgrading of public hospitals facilities will often mean:

- specialist services are lost,
- there is significant travel for patients to access facilities that would normally be taken for granted, such as rural obstetric units,
- there is loss of variety in the clinical workload, which is a key attraction of rural medical practice,
- local clinicians depart because they no longer experience a broad enough clinical workload to maintain their clinical skills,
- the loss of one group of clinicians causes other clinicians to leave due to extra workload,
- there are significantly less opportunities to train rural junior doctors and less junior doctors overall, and
- there is a loss of the procedural services provided by GPs or specialists with a resultant loss of skills in rural areas and the de-skilling of staff. This also results in the loss of vital skills to train registrars, medical students, and less experienced doctors.

In other words, the loss of rural public hospitals can lead to a vicious circle that may drastically reduce local health services. This issue also highlights where federal and state and territory government policies can come into direct conflict. On the one hand, the Federal Government can put into place initiatives to encourage doctors to develop their procedural skills while state and territory decisions on hospital downgrading or closures can impact adversely on opportunities to practice and use these skills.

Doctors in rural Australia need better hospital infrastructure in order to sustain obstetric services locally and provide procedural work and anaesthetics. This is true for the rurally located GP or specialist, and for visiting doctors or specialists providing care in an area. Rural doctors on occasion also need access to specialist advice from metropolitan areas that can be enabled through the tertiary hospitals. This needs to be streamlined and easy to access.

Rural hospitals must be given a fair share of ongoing funding to help improve the delivery of health care services in rural Australia. Investing in local infrastructure that supports service provision enables the retention of a broad skills base and in turn maintain a broad range of health services for rural Australians.

The federal and state and territory governments have agreed on shared accountability and better performance reporting for public hospitals. A key objective of this accountability framework is to ensure that all Australians receive high-quality hospital and hospital-related care.

For rural Australians, this can only be achieved if the accountability framework provides specific information in relation to rural hospital funding and service delivery, and information about the support for patient transport and access to those services that cannot be delivered in a rural or remote area. This means that there must be proper accountability and monitoring of expenditure for rural public hospitals to ensure that they receive an equitable share of overall hospital funding. In addition, processes must be established to properly evaluate the available support programs for rural doctors and the impact of these programs and other investments in delivering better support for rural Australians.

Workforce shortages and strengthening workforce education and training

There are significant concerns with the long-term sustainability of the regional, rural and remote medical workforce with obvious adverse implications for the health of people living in these areas.

Rural practice has relied heavily on international medical graduates (IMGs) over the last ten years. This is not sustainable and it is essential that Australia does much more to encourage locally trained doctors to take up a career in rural practice and in doing so ensure the viability of rural health services.

The AMA believes that the current incentives to retain rural doctors, especially older doctors, in the workforce are inadequate. As outlined earlier, the RRP needs a significant funding boost and broader eligibility requirements. Current funding is not enough to attract more doctors to regional, rural and remote areas. A more sustainable approach would be to introduce rural isolation payments for all rural doctors as well as loadings to better support rural procedural doctors.

The AMA and RDAA have proposed a two-tier incentive package be introduced for rural doctors. The first tier is designed to encourage more doctors to work in rural areas including GPs, specialists and junior doctors. It takes into account the greater isolation involved with rural practice.

The second tier is aimed at boosting the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills. Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate local services including on call emergency services.

A focus on providing improved locum relief for doctors in rural Australia and coordinating this relief is also essential. Rural doctors often carry a high burden for the delivery of health care in rural Australia, and work long hours. Lack of time off for professional development, family responsibilities and recreation can be among the most negative aspects of life as a rural doctor. The risks of burnout are high and many rural doctors question if the costs are too high. While governments have in place a number of programs to provide support for locum relief, AMA research suggests that more needs to be done to ensure that rural doctors can access better work-life balance, professional development, and time to recharge the batteries.

Modern technology has made it much easier for rural doctors to access timely advice from urban-based specialists and tertiary hospitals. New technology is also creating opportunities to increase the background infrastructure for preventative medicine and chronic disease management in the rural areas where they are needed most. There is scope to design rural health programs to realise the full potential of tele-medicine services.

Rural Australia will rely on the contribution made by IMGs for the delivery of medical services for some years to come. When IMGs arrive in Australia they are often placed in highly challenging work environments with little or no orientation, while access to supervision, professional support, and training can be variable. This is not good for IMGs or their patients. These doctors need more professional and community support to enable them to improve their contribution to patient care and to encourage them to seek a permanent place in the Australian rural medical workforce.

Overseas evidence shows that providing doctors with strong training experiences in rural areas early in their career will make them more likely to stay in rural practice. There is little doubt that rural areas have the potential to offer young doctors a very good learning experience with a wide variety of clinical experiences available. There are plenty of opportunities to be part of the whole patient journey and to take on greater responsibility in the coordination and delivery of patient care.

Unfortunately, while governments have strived to put more junior doctors into rural areas they have not done enough to back this with better infrastructure, resources, and supervision. This leads to a poor training experience and is totally counterproductive. At the end of a rural term, many junior doctors will leave a rural community disenchanted with rural practice.

Excessive hours, little supervision and support, and no real training focus mean that what should have been a positive experience becomes a negative one – and these stories are then shared with their friends and colleagues.

There are strong disincentives for young doctors to work in rural areas. Under the department's Bonded Medical Places (BMP) scheme, students 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 HECS charges in full.

While recent changes have made the BMP scheme fairer and provided students with more support, it still lacks sufficient incentives. 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.

Further, the focus of the scheme on areas of workforce shortage has created some perverse anomalies with the result that potential rural doctors go instead to outer-metropolitan areas. A rural area that is well-served by doctors cannot attract bonded graduates who have come from the area and wish to return because it is not designated a district of workforce shortage. The AMA has received feedback from rural doctors that this anomaly is disrupting succession planning for some rural practices and they are being forced to rely instead on IMGs.

Some support schemes such as Rural Australian Medical Undergraduate Scholarships and John Flynn scholarships could be expanded so that more students can access scholarship-based medical places. While the AMA believes that the small-scale scholarships programs administered by DoHA are useful, medical students will only be attracted to rural areas by equitable arrangements that include HECS relief and targeted financial incentives.

Recommendations

- Introduce a two-tier package of incentives to ensure that rural areas have access to a viable medical workforce:
 - a rural isolation payment to be paid to all rural doctors (including GPs, specialists and registrars) to reflect the isolation associated with rural practice, and
 - a rural procedural and emergency/on call loading to better support rural procedural doctors (including procedural specialists) who provide obstetric, surgical, anaesthetic or primary emergency on-call service in rural communities.
- Fund two to three weeks of locum relief to between 1,000 and 1,500 regional, rural and remote doctors a year to allow these doctors to take leave and help prevent burnout.
- Encourage medical students to take up a career in regional, rural and remote areas by developing and implementing a voluntary return-of-service scheme that offers incentives such as HECS relief and scholarship payments linked to remote locality. This scheme should be available to new and existing medical students as well as junior doctors, substantially increasing the pool of potential applicants.
- Design rural health programs to enable greater utilisation of tele-medicine services.
- Design better support measures for IMGs.

Responsibilities of the Commonwealth and state and territory governments

We have touched earlier on how federal and state and territory government policies on rural healthcare can come into direct conflict and the importance of shared accountability and better performance reporting for public hospitals. The national rural and remote health strategic plan outlined in the issues paper would only be feasible if it had mechanisms to properly implement, measure and evaluate the impact of changes in healthcare delivery in rural areas.

The strategic plan would need to:

- require the states and territories to consult with communities prior to public hospital closures/downgrading and take on board their views and concerns, and
- require the states and territories to apply a public interest test before proceeding with closures/downgrading that looks at issues such as:
 - the impact on the maintenance of skills of the local medical workforce,
 - the impact on the health needs of the local community,
 - the social and employment impacts on the local community, and
 - and the availability and proximity of alternative resources and access and affordability implications for the local community.

Review of remoteness classification systems

The Rural, Remote and Metropolitan Areas (RRMA) classification system that is used by DoHA to target many of its rural workforce programs should be retained. While RRMA is by no means perfect, it is not broken. With some improvements, it would be a highly effective basis for targeting expenditure.

RRMA needs to be updated periodically and enhanced by adopting other relevant indicators. Many rural programs such as the Practice Incentives Program are based on RRMA at present. The department must be aware that any changes to the classification system could have a significant impact on the viability of many rural practices and for potential future investment in rural health services and infrastructure. Poorly designed changes will see many deserving communities lose access to existing health services.

Recommendations

The AMA proposes that:

- the RRMA classification should be updated using recent census data and then updated every five years thereafter,
- RRMA 1 should be split into inner and outer-suburban categories, and
- other relevant indicators should be used in conjunction with RRMA to determine how incentive programs are targeted.

Adequate warning of any changes to the classification system is vital so that doctors and practices can adopt transition arrangements to ensure their viability and protect their patients.

- Transitional rules should apply to ensure that existing practices and doctors who have made business decisions based on current classifications are not disadvantaged when a new classification system is adopted,
- Transitional rules should protect existing practices and doctors in the event that eligible areas change as a result of classification data updates,
- Existing doctors and practices should be given plenty of lead time to redefine and restructure their business to accommodate any changes to the classification system, and
- For localities that become eligible for an incentive program under the classification system, there should be no delays in access to assistance.

The AMA looks forward to participating in the review of rural health programs as it progresses.

Yours sincerely

A handwritten signature in cursive script that reads "Rosanna Capolingua".

Dr Rosanna Capolingua
President

A handwritten signature in cursive script that reads "David Rivett".

Dr David Rivett
Chair, AMA Rural Medical Committee

14 April 2009