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RURAL DOCTORS ASSOCIATION OF AUSTRALIA

BUILDING A SUSTAINABLE FUTURE FOR RURAL PRACTICE: THE RURAL RESCUE PACKAGE

AMA/RDAA JOINT POLICY STATEMENT

Introduction

Rural medicine is a challenging and rewarding career that is different from metropolitan practice in terms of isolation, costs, content, context and complexity.

A rural doctor seeing patients in the general practice setting by day, may also provide on-call and after hours emergency services during the night and/or perform procedures at the local hospital on a regular basis. These highly skilled rural doctors are important in rural and remote medicine because of the lack of population to support sub-specialties.

Over the past two decades, many rural and remote communities have found it increasingly difficult to attract and retain doctors with the right mix of skills to meet their health needs, including GPs with advanced skills training who can provide acute services in the hospital setting. Medical graduates are demonstrating a preference for specialisation and subspecialisation, resulting in fewer generalist doctors available to become rural doctors.

Successive Federal Governments have introduced a range of initiatives in a bid to attract and retain doctors in rural and remote areas. While some gains have been made, the geographical maldistribution of doctors persists[1] and the sustainability of some rural health services remains under threat.

Targeted and evidence-based supports are urgently required to build an adequate rural medical workforce with the right mix of skills for rural and remote communities. These supports should facilitate high quality rural and regionally-based training, particularly rural generalist training, and provide appropriate financial and non-financial incentives for doctors with the skills for rural practice to live and work in rural and remote areas.

[1] In 2013-14, while the number of full time workload equivalent GPs per 100,000 population in major cities was 102, there were 91 in outer regional areas, 70 in remote areas, and only 57 in very remote areas. Australian Government Productivity Commission, *Report on Government Services 2015*, Table 10A.23 *Availability of GPs by region, 2013-14.*

It is noted that the rural medical workforce is dynamic and should be monitored to ensure any measures to address workforce shortages address current needs.

Incentives and Grants

Incentives and grants play an important role in improving rural medical workforce recruitment and retention:

Non-Financial Incentives

Workforce policies and programs can deliver non-financial incentives to increase the attractiveness of living and working in rural and remote communities.

These include:

- providing locum relief so doctors can leave their communities to undertake professional development or take a holiday;
- providing professional development and teaching opportunities;
- supporting flexibility of working hours;
- providing professional support; and
- providing well staffed and equipped work places.

Financial Incentives

There are three specifically rural programs offering financial incentives and support to rural doctors and rural practices: the General Practice Rural Incentives Program (GPRIP); Rural Locum Education Assistance Program; and Rural Procedural Grants Program.

Support for quality initiatives in general practice is provided through the Practice Incentive Program (PIP). A rural loading provides an additional rural incentive.

Public investments in rural practice infrastructure are another important initiative for supporting rural practice. These types of investments are typically provided through a grants program and deliver social and economic benefits by improving access to primary care and supporting the teaching of doctors-in-training.

The Government has introduced a new rural classification system, the Modified Monash Model (MMM), for the purposes of determining incentives under its health workforce programs, including the GPRIP. The MMM classification system categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and town size and was developed to recognise the challenges in attracting health workers to more remote and smaller communities.

A Rural Remuneration Framework

Research indicates that the most effective way to achieve fairer remuneration for rural doctors is to improve remuneration through an explicit payment that recognises and rewards rural doctors for the complexity of the work they perform in an isolated setting.[2]

The Rural Rescue Package

The RDAA and AMA are proposing that a two tier incentive package be introduced for rural

[2] Monash (2003)

doctors. The first tier is designed to encourage more GPs, other specialists and registrars to work in rural areas. 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 advanced skills training in a range of areas such as obstetrics, surgery, anaesthesia, acute mental health or emergency medicine. Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate acute services locally, including on call emergency services.

It is envisaged that the program would be implemented via the existing Service Incentive Program (SIP) and incentives would be calculated as a loading on rural doctors' Medicare billings or as a special payment for salaried rural doctors. The loading would increase with rurality.

Tier One - Rural Isolation payment

The rural isolation payment would be available to all rural doctors including GPs, locums, other specialists, salaried doctors and registrars. Incentive payments would be based on isolation with the level of support provided increasing with rurality.

The payment would be activity based and calculated on a percentage of Medicare billings, with special payment arrangements for salaried doctors.

Tier Two - Rural procedural and emergency/on call loading

The second tier is aimed at boosting the number of doctors in rural areas with essential advanced skills in a range of areas such as obstetrics, surgery, anaesthesia, acute mental health, or emergency medicine[3] who provide on-call services to their communities.

Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate local hospital based services. In rural and remote areas there are relatively few medical specialist services available and most of the workload in hospitals is undertaken by rural GPs.

To be eligible for this payment, a doctor would need to be credentialed by their hospital to undertake the advanced skills, and be providing meaningful on-call services for the local hospital.

Special criteria would need to be established for small population centres for doctors that provide regular emergency on-call services where no hospital exists.

This payment would also be activity based and calculated on a percentage of Medicare billings, based on the structure below:

MMM*	**3**	**4**	**5**	**6**	**7**
Tier One	10%	15%	20%	30%	50%
Tier Two	10%	15%	20%	30%	50%

**Incentives paid through SIP would be calculated by the above percentage loadings to Medicare billings*.

[3] Other areas of skills need may be added as required, for example palliative care, paediatrics, or indigenous health, to ensure that community needs are met.

These incentives would be promoted through a variety of available mechanisms including a special section in the Medicare Benefits Schedule. To ensure take up of the package, payments would need to be regular – at least quarterly.

Conclusion

People living in rural and remote Australia deserve to have access to high quality health services and experience better health outcomes.

To improve this access and achieve better health outcomes, a holistic approach must be taken to training, attracting and retaining a rural medical workforce and supporting rural practice. Targeted, rural specific incentives should form an important prong of this approach and recognise the chronic underspend of Medicare (including radiology and pathology) and Pharmaceutical Benefits Scheme funding that some estimates put at more than $2 billion.[4]

The economic and social costs associated with the failure to take action to build a sustainable rural medical workforce are substantial and must not be ignored.

Want more information?

See the websites of the AMA and RDAA for more information about rural health issues.

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[4] National Rural Health Alliance *(2011) Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas*. http://ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/position/pos-full-complementary-report-27-feb-11.pdf