Victorian Healthcare Association

SUBMISSION

Australian Senate Community Affairs Committees' Inquiry on the factors affecting the supply of health services and medical professionals in rural areas.

16 December 2011

1. Introduction

This submission outlines the Victorian Healthcare Association (VHA) response to the Australian Senate Community Affairs Committees' Inquiry into the factors affecting the supply of health services and medical professionals in rural areas.

The VHA agrees to this submission being treated as a public document.

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The Victorian Healthcare Association

The VHA is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians, from the perspective of its members.

Prefacing comments

The VHA welcomes the opportunity to contribute to the Senate Community Affairs Committees' Inquiry as the current, or potential, workforce shortage is a pressing issue facing our rural health service members. A number of issues, as outlined below, affect the supply of a rural workforce. The VHA particularly appreciates the opportunity to comment on the classification system currently used to provide incentives for rural practice. There have been concerns that previous decisions on the classification systems used for rural areas have not adequately taken into account the rural context, making it difficult for rural services to plan for their futures and leading to maldistribution of the rural workforce.

The viability of many rural communities is strongly correlated to the level of healthcare available within that community. The inability of rural communities to recruit or retain a permanent health workforce has the potential to diminish available services and place further stress on the remaining workforce. This can lead to lower health outcomes for the community and undermine the sustainability of these important rural communities.

2. The VHA's Response

(a) The factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres.

Rural practice offers a number of professional challenges to those who undertake it. There is a feeling, and often a reality, of professional isolation. There is an absence of professional support services in rural areas. The lack of diagnostic testing and specialists to which patients can be referred makes many doctors feel unsupported. Some doctors, for example, find it difficult to make clinical decisions without the ability to undertake blood tests, ultrasound or x-ray – services that are significantly limited in rural health services. GPs often believe that they need to be a 'rural super doctor', but struggle to find

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the training or expertise necessary to do so. Improved access to mentoring and support networks would help to allay these rural practitioners' fears. Better use of telehealth and web-based support, as well as developing networks between regionally-based rural clinical schools and rural health services, would provide much-needed support to rural GPs, nurses and allied health workers.

Doctors in rural areas often perform additional functions to those in metropolitan areas, for example GPs often undertake after-hours on-call work, and have to be responsible for emergency medicine. The role of the rural doctor often becomes a 24/7 job, having to run their own private practice and provide on call support. Health workers are often well-known community figures and are approached with questions and for advice by locals, even when they are off-duty. This makes it difficult to create a work/life balance, and increasing numbers of doctors want to work shorter hours to reduce stress on their own health.

The existing workforce shortage compounds this by making it harder for doctors to leave the local area to attend professional development and training due to the difficulty in finding locum coverage. Doctors are then often forced to make decisions regarding holidays and training opportunities based on the availability of locum cover, meaning opportunities are often missed. This can lead to a resentful workforce, and the risk that practitioners leave the rural area permanently. Improved locum cover would make doctors happier and better trained, creating an attractive working environment. Other barriers to continuing professional development, such as accommodation, travel and childcare costs, should be lowered for rural healthcare professionals, so that they are not forced to permanently move to metropolitan areas to access career opportunities. In-place training could be improved to help rural practitioners maintain their skills by using tools such as teleconferencing, e-health, mobile units and simulations.

Many rural areas suffer from a lack of succession planning, particularly for GPs, who operate on a private practice basis making coordination more challenging. The problem of succession planning will increase as the rural GP workforce ages. The loss of a stable, permanent GP in a rural health service also means the loss of any opportunity to supervise a registrar or overseas trained doctor, losing any potential to attract these future doctors. It can also lead to instability in the range of services offered as health services may be tempted to employ someone with a different skill set to the person they are replacing simply to have someone in place. As this replacement works to their particular skills, the profile of the service offered can change, often away from the genuine needs of the community.

Rural areas currently suffer from a perception problem. Metropolitan-based workers are unwilling to move to rural areas because they fear that they will miss out on many of the benefits attributed to living and working in the city. Rural areas lack comparative opportunities for arts and cultural activities, shopping and restaurants, and educational choices for practitioners' children. Moving to a rural area often separates workers from their extended family and friendship networks. Poor availability of public transport or information technology, such as broadband, compounds the feeling of physical isolation.

High costs are often a deterrent to moving into rural practice. Relocation and travel costs to and from metropolitan centres, both in money and time, can be prohibitive. Moreover, the costs of operating in a rural area can discourage practitioners from moving there. Rural areas often have low socioeconomic status meaning the potential income that can be derived from private practice is significantly lower, or non-existent, in comparison to a metropolitan area. This is a significant barrier to the relocation of allied health professionals to rural areas.

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Even when practitioners are funded by public monies the potential income can be affected. GPs rely on the Medicare Benefits Schedule, which is less financially attractive in sparsely populated areas than in a metropolitan area, particularly with the added costs of establishing their practice. Grant and incentive funding is often done on a per-person basis which creates significant extra costs and administration for practices with only one health professional. The impact that Activity Based Funding will have on rural areas remains to be seen as the prices set by the Independent Hospital Pricing Authority need to be calculated with consideration of the costs of operating in a rural environment.

The need to attract people to work in rural areas indicates a failure to keep people who have grown up rural areas working there. The root of this lies in the difficulty to provide the necessary educational support for young people to pursue a career in healthcare. Parents and students in rural areas often have the perception that university education is difficult to attain, and struggle to reconcile the financial and emotional burdens of leaving home to attend university in the city. Often there is inadequate core science teaching at secondary level, which means the passion and proficiency for subjects necessary to become a health professional is underdeveloped. Evidence shows that people who have grown up in rural areas understand and appreciate those areas and return to work successfully as rural medical practitioners. To help address the workforce shortage, secondary school students need to be supported and given rural health workforce role models.

Rural undergraduate and postgraduate placements would help medical students to understand the benefits of rural practice and dispel some of the myths that surround working outside the city. Small rural health services which host placements also need support, as there is often little short term benefit to the health service, except for the hope that placements will act as a long term recruiting mechanism.

Systems should be established that help rural people to stay and train in rural areas. Rural Clinical Schools and University Schools of Rural Health are helping to address these issues, but more could be done to offer core first and second year applied sciences to rural students. Some health services have found that rural people are pursuing careers in health, such as nursing, later in life when training and education needs to be flexible to accommodate a family life.

Pathways to rural practice are far from clear, and funding is complex. People who want to live and work in rural areas need to be identified and given clear training pathways to facilitate them to stay in rural practice, such as the GP - Rural Generalist training pathway currently being developed in Victoria. The specialisation of the medical workforce has made it difficult to foster rural generalists, and the current lack of a clear pathway makes training difficult to navigate for those who do want a generalist career.

(b) The effect of the introduction of Medicare Locals on the provision of medical services in rural areas.

The Federal Government urgently needs to provide more details on the role Medicare Locals will play in identifying and resolving workforce shortages. Much of the work so far on Medicare Locals has been on the technicalities of their establishment. It is of concern that the lack of clarity surrounding the establishment of Medicare Locals means that some opportunities may be missed. This has led to some frustration and cynicism towards their implementation, which may undermine their potential.

The Commonwealth Government has made a firm commitment that Medicare Locals will improve access to after-hours care. Action is required to stop the workforce shortage preventing this - a shortage that has so far not been addressed through existing incentive

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programs. Some rural services that are already funded to provide full after-hours services are concerned that they will lose their existing funding when the decision to fund after-hours falls to Medicare Locals.

(c) Current incentive programs for the recruitment and retention of doctors and dentists, particularly in smaller, rural communities:

At the moment, there appears to be little coherence across the state and federal levels in regards to incentive programs for rural workforce. It is often unclear to both health professionals and health services what incentives exist and who is eligible for them. A simple schematic description of the pathways would be appreciated.

Current postgraduate incentive programs for rural general practice consist almost exclusively of financial incentive payments for moving to a rural area (relocation grants) and ongoing incremental payments for retention in rural communities (retention grants). The effectiveness of these can be judged by their limited success. As explained above, money alone is not what drives someone into rural practice. The National Nursing and Allied Health Rural Locum Scheme and the Rural GP Locum Program have helped to ease the burden of attaining locum cover. However, package incentive deals could be developed that include built-in holiday locum relief, continuing medical education locum relief or fringe benefits taxation benefits. It is important that these benefits be retained for rural health services even when working in consortia with larger, regional hospitals.

The purely geographical measure of the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) classification scheme, takes diverse regions and labels them homogenously and has exacerbated the difficulty of recruiting health professionals. Geographic distance to metropolitan areas alone cannot be taken as a simple proxy for the availability of services and the attractiveness of rural services to health practitioners.

The ASGC-RA was designed to be easy to update, improving the accuracy and reliability of the data used to inform the Department of Health and Ageing. The VHA applauds this aim, but a classification system needs to be adopted that is both flexible and sensitive to the differences within a region.

A number of our members felt that they had not been adequately consulted on previous changes to the classification system and, as a result, the current system is problematic. Some small rural health services are on the same classification as areas of outer Melbourne. Other services, for example Ararat, have to compete on the same payment level as large regional hospitals, such as Ballarat. Moreover, there are differences between towns of a similar size and remoteness that may have a significant impact on the quality of life of doctors who choose to work there. As one doctor has commented, "If you had the opportunity to go and work in Apollo Bay or Birchip, which would you choose?" For many doctors, the existing classification system has created an incentive system that makes it very easy to choose to work in areas that may not be suffering from an acute workforce shortage.

A geographic definition of remoteness must take into account where most of the health service catchment population lives, for example Orbost Regional Health serves the remote area of northern Gippsland and across the New South Wales border, but as their office is based in an Outer Regional classification area they do not receive incentives that adequately represent their need. The ASGC-RA classification scheme exists to compensate for the added expense of running health services in rural and remote areas, but is undermined if it fails to take into account the genuine catchment area of a rural health service. Flaws in the ASGC-RA classification scheme can be seen in the decision by many incentive programs to continue to state that 'former RAMA 7 agencies can apply' believing

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that this more adequately represents remoteness, but there is no guarantee that incentive schemes will continue to include this more sensitive definition in their criteria.

A more sensitive classification system would also take into account other criteria for incentive payments. The first of these is population density, as the population distribution within a certain area will have a high impact upon the financial viability of a GP practice or health service. Rochester, a town of fewer than 2000 people, is classed as RA 2, the same as Bendigo, a town of almost 100,000 people. The larger towns have more amenities, a larger professional network and a greater potential for private practice to attract health professionals. The current ASGC-RA classification also does not recognise the dual role that rural GPs often play, providing services to the public hospitals in addition to primary care services.

Another key factor currently missing from the ASGC-RA classification scheme is the existing health services and workforce supply, and the burden of disease. Some areas suffer a more acute shortage than others for particular workforce specialities, which should be taken into account when incentivising workers to come to the area. There is no point providing incentive payments to move to a rural town that is already well provided for. In order to reach this conclusion, it is important to take into account the burden of disease in a community to help determine the number of doctors necessary, and the specialities needed. For example, a town with a high Aboriginal population may require additional and culturally-specific workers to address the higher prevalence of chronic disease in this community.

It is important to take into account the socioeconomic status of an area when determining its classification. As mentioned above, private practice is often an additional lure to work in an area, something which tends to be minimal in areas of low socioeconomic status. A GP often invests heavily to set up a practice in a town and so it will be the smaller, lower socioeconomic status towns who lose out when a business is more viable in a larger, richer town. Towns with a higher socioeconomic status often provide more amenities such as shops, restaurants and safe, attractive public spaces which draw people to live there.

As mentioned above, many factors provide obstacles to living and working in rural towns, and this needs to be reflected in the incentive payments offered. It is no surprise that a medical professional would prefer to live in a larger population centre with a more developed health service where they can gain professional support from others who work there, a population that can provide them with a more reliable income, and an environment that maximises their quality of life. The classification system on which incentives are currently based does not always address this.

The incentive schemes currently on offer are particularly medically-focused. While there is a limited supply of GPs in rural areas, the workforce shortage is particularly acute among oral and allied health professionals. There currently exists no federal financial incentive to recruit dentists to rural areas. Work is being done to attract people to work as dentists in rural areas. The establishment of rural oral health and dental schools, such as that at La Trobe University's Bendigo campus, help to attract students, but not enough is being done to help these oral health graduates to stay in rural areas. Government needs to develop incentives for dental clinicians to work in rural and regional areas, and with disadvantaged populations. Public dental agencies, particularly in rural and regional areas, must compete with the private sector, which allows dentists to determine their own work hours, fees and remuneration often within a central business district or upper/middle-class suburb of a major population centre.

Currently, rural health services are forced to shoulder the costs of attracting nurses and allied health professional. The only federal incentive program to attract nurses to rural

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areas is the Practice Nurse Incentive Program, which offers a 50 per cent rural loading. However, this incentive program is only open to nurses who work in an RACGP accredited general practice. Additionally, Victoria offers no statewide rural nursing or allied health incentive programs. Services are forced to provide significantly higher salaries than would be paid in metropolitan areas, and salary packaging that includes benefits, such as subsidised housing. The VHA would welcome a more substantial incentive scheme to help shift some of these costs away from small rural health services.

3. Conclusions

As noted, several factors affect the supply of health professionals in rural areas: lack of professional support; lack of amenities and educational opportunities for health workers and their families; and limited opportunities for private practice. Measures can be taken to address these issues, such as improved support networks for rural health professionals and better systems for attracting young rural people to stay and work in healthcare. However, some of the perceived downsides of rural working, such as the distance to metropolitan areas, cannot be easily overcome and so sensitive incentive schemes are required to ensure an adequate supply of health professionals to rural areas.

Current incentive schemes offered in rural Australia are flawed and this compounds the lack of supply of health services. They are focused too narrowly on providing financial incentives, which fails to address the lack of professional support experienced in rural areas. For example, incentive packages that provide locum cover would enable rural practitioners to develop their skills to better serve their community and stay for the long-term. Incentives are also too narrowly directed towards medical services, particularly general practice. A reviewed classification system should be used to expand incentives to ensure that people, no matter where they live, have reasonable access to health professionals.

The ASGC-RA classification scheme that is currently used by the Department of Health and Ageing to determine benefits is highly problematic. A flexible and up-to-date classification system is needed that takes into account the important issues that impact upon a doctor's decision to live and work in an area: remoteness, population density, the existing services and health burden, and socioeconomic status.

The VHA welcomes the opportunity to provide further information to the Senate Community Affairs Committees on this or any other issues relating to health in Victoria.

Please contact me on to clarify any information in this submission.

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