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Mr Ian Holland
Committee Secretary
Community Affairs References Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Holland

Re: Submission to the Senate Community Affairs References Committee Inquiry into the Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas

The AMA welcomes the Senate Community Affairs References Committee Inquiry into the factors affecting the supply of health services and medical professionals in rural areas. This submission is directed at the following aspects of the Terms of Reference:

(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;
(b) The effect of the introduction of Medicare Locals on the provision of medical services in rural areas;
(c) Current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:
    i. Their role, structure and effectiveness,
    ii. The appropriateness of the delivery model, and
    iii. Whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes; and
(d) Any other related matters.

In particular, this submission will focus on the shortages and factors affecting the supply of the medical workforce in rural areas.

1. Background

The AMA has identified the medical workforce shortage as a major health issue. Not only is there a nation-wide shortage of doctors, the overall distribution of doctors is skewed heavily towards the major cities such that regional, rural and remote areas shoulder a disproportionate workforce shortage burden. Put simply, there is a strong preference amongst much of the current medical workforce to live and work in major cities, with particular preference for the inner suburbs. Doctors are no different to any

other professional group and evidence throughout the western world shows that attracting young professionals to rural locations is extremely difficult.

The shortage of medical practitioners in rural and remote Australia has been a problem for a long time. Governments at state and federal level have implemented various programs to tackle this situation although the effect of these has been limited. The reality is that there is now an unhealthy reliance on international medical graduate (IMG) doctors to prop up medical workforce numbers. The shortages are not only in medicine, but these are some of the most critical shortages. Limited access to medical practitioners contributes to the lower health status and life expectancy of Australia's non-metropolitan population.

There are also significant concerns over the sustainability of the rural medical workforce, with obvious adverse implications for the health of rural people. The AMA contends that urgent intervention is required to attract Australian-trained doctors to rural areas. Despite extensive measures over many years, the rural medical workforce crisis persists.

Rural medical practice especially requires strong procedural skills with primary care practitioners representing the backbone of rural health care. In this regard, the debate should not just be about numbers, it should also be about the right skill mix. With strong trends toward sub-specialisation, and declining numbers of rural GPs who are practising proceduralists, the problem facing regional and rural communities is even more acute.

Rural doctors are getting older. The average age of rural doctors in Australia is nearing 55 years, while the average age of remaining rural GP proceduralists – rural GP anaesthetists, rural GP obstetricians and rural GP surgeons – is approaching 60 years[1]. This means that the ageing of the health workforce has serious implications for sustainable health service delivery and for the supervision and mentoring of trainees and new graduates into the future[2]. These issues impact on the health workforce nationally and in all settings, but are even more pressing in regional, rural and remote areas.

Furthermore, it is estimated that about 50 per cent of the rural medical workforce have been recruited from other countries. These practitioners have provided an essential and appreciated contribution to the health needs of rural communities but it is not a sustainable situation in the long run. We need to attract Australian-trained doctors interested in a career in rural medicine. Given that most medical specialties are not viable in smaller communities, we need rural generalist doctors with advanced skills training to meet the health needs of these communities.

In 2005 the AMA prepared the Rural and Regional Workforce Initiatives Position Statement, a copy of which is attached (Attachment 1). This sets out a suite of initiatives that would support a more sustainable and accessible medical workforce in these areas. While some aspects of these initiatives have been addressed to varying extents since it

[1] Source: Rural Doctors Association of Australia.
[2] Productivity Commission (2005) *Australia's Health Workforce*. Productivity Commission Research Report AIHW 2010b.

was released, it is still a very relevant document and we would urge the Committee to give it full consideration. This submission, however, attempts to discuss some of the higher priority areas and put forward recommendations that would have immediate impact.

2. The factors limiting the supply of medical workforce to small regional communities

Up until very recently, Government policies and low numbers of medical school places have ensured that Australia's own locally trained medical workforce has been in shortfall. While there have been a number of measures taken to address this undersupply in recent years, the fact remains that an undersupply of medical practitioners has been experienced in many parts of Australia and no where more so than in rural and remote areas.

There are a number of fundamental reasons why rural and remote areas are not getting their fair share of the medical workforce. These include:

- inadequate remuneration;
- work intensity including long hours and demanding rosters;
- red tape – many practitioners are working on their own so they have full responsibility for all the red tape associated with their practice in addition to the additional red tape which is often required to set up services in multiple locations and to access locum relief;
- lifestyle factors;
- professional isolation;
- poor employment opportunities for other family members, and in particular practitioners' partners;
- continued withdrawal of general services from rural areas;
- lack of critical mass of similar doctors;
- hospital closures and inefficient administration in public hospitals;
- exposure to medico-legal issues;
- limited educational opportunities for family members;
- reduced access to professional development and peer support; and
- inadequate locum relief.

More broadly however, the factors affecting the supply of medical workforce in rural Australia should be viewed in the context of generalism; remuneration and incentives; hospitals and infrastructure; compensation and family support; costs of establishing a practice and access to community services; high on-call demands and the need for rosters and locum services; and recruitment of international medical graduate (IMG) doctors.

2.1 Generalism

There has been a decline in generalism in public and private medical practice and an increasing trend towards sub-specialisation. Insufficient numbers of generalists (general specialists) in specialities such as surgery and medicine are practising in rural settings. Generalists have a vital role in the Australian health system, as they are able to manage

and treat a wide range of health conditions. The shortage of these professionals is felt acutely in rural and regional areas, and patient access to care in rural areas has decreased in line with the trend to sub-specialisation.

The reasons for the decline in generalism are many and varied, but include lower remuneration for generalists compared to sub-specialists and training models that do not encourage generalism. The decline in generalism in rural and regional areas has been exacerbated by the closure of hospitals and procedural units. The high workload of rural generalists and corresponding poor work-life balance also act as disincentives to generalist practice.

Recommendation

The AMA recommends that the following broad measures be considered to help arrest the decline in generalism and attract and retain generalists in the medical workforce:

- elevate the status of generalism;
- facilitate greater exposure to generalist practice during undergraduate medical training;
- develop vocational training models that encourage more generalist careers;
- increase state and federal funding for rural generalist positions;
- increase state and federal funding for rural specialist infrastructure; and
- improve the level of remuneration for generalists to encourage generalist practice, including the removal of anomalies in the MBS that reward sub-specialisation over generalism.

2.2 Remuneration and incentives

All stakeholders should acknowledge the importance of appropriate remuneration levels, not only for doctors working in private practice but also for doctors working in the hospital sector.

A simplified structure for Medicare GP consultation rebates, fully funded and appropriately indexed, should be introduced in order to more appropriately reflect the nature of primary care delivery, so as to ensure that patients are supported to spend time with their GP without the fear of high out-of-pocket costs, and to attract more doctors into general practice. This will both benefit patients and improve the image of general practice as a career choice.

The Government should support the Rural Rescue Package developed by the AMA and the Rural Doctors Association of Australia (Attachment 2). Implementation of the package would help to sustain the regional and rural workforce and ensure that patients in rural communities have improved access to doctors. The package encourages more doctors to work in rural and regional Australia and recognises essential obstetrics, surgical, anaesthetic and emergency skills. This funding would provide a two-tier incentive package, including further enhancements to rural isolation payments and rural procedural and emergency/on-call loading.

It includes:

- 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 services in rural communities.

Recommendation

The AMA recommends that the Government:

- simplifies the structure of Medicare GP consultation items and improve funding for these, backed by appropriate indexation arrangements; and
- implements the Rural Rescue Package developed by the AMA and the Rural Doctors Association of Australia.

2.3 Hospitals and 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 in five of the top ten areas identified by rural doctors. The closure and downgrading of rural hospitals is seriously affecting the adequate delivery of health care in rural areas. Such 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 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 a loss of variety in the clinical workload, which is the 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 the extra workload; and
- there are significantly less opportunities to train junior doctors and less junior doctors overall.

Before withdrawing such services, a public interest test should be applied to ensure that communities are not denied reasonable access to services. Consideration should also be given to imposing a moratorium on the withdrawal of Government businesses as a strategy to maintain medical services.

The funding for enhancements of existing general practices that is being provided through the Primary Care Infrastructure Grants (PCIG) initiative and National Rural and Remote Health Infrastructure Programs Funding (NRRHIPF) is welcome but existing funding is too limited. Appropriate infrastructure enables and supports integrated services

and improved training opportunities for GPs, nurses and allied health care professionals. More funding for PCIG and NRRHIPF should be made available as the current programs are oversubscribed. This over-subscription is a signal to the Government that more can be done to enhance the infrastructure of existing general practices increasing their capacity to deliver a broad range of medical services and quality patient care.

Recommendation

That AMA recommends that:

- the Commonwealth Government makes available more funding for PCIG and NRRHIPF to enhance the infrastructure of existing general practices and their capacity to deliver a broad range of medical services and quality patient care; and
- before withdrawing or rationing public hospital services, all layers of Government should conduct a public interest test to ensure that communities are not denied reasonable access to services.

2.4 Compensation and family support

The decision for a doctor to relocate or practice on a medium to long-term basis in regional and rural areas obviously has a significant impact on their family. Where a partner works or children are at school there may be considerable direct or opportunity costs and loss of amenity from a decision to move to rural practice. Simply paying a medical practitioner more, while helpful, does not address the full dimensions of the problem and ignores significant factors in any individual's decision-making process when considering rural practice.

There should be adequate compensation, support and access to re-training if required, so that a partner or spouse can remain employed in an acceptable occupation if their partner moves to a remote area. Job seeking assistance should also be offered if required. If the family requires assistance to maintain a child in school in a larger town or city centre, there needs to be school fee assistance, given the possible requirement for boarding and other increased services or tuition. Where a family is fragmented by a decision for a parent or partner to take up rural practice, there should be funding for at least one annual return trip home for family members during the doctor's tenure.

Recommendation

The AMA recommends that the Government funds initiatives to support:

- adequate compensation, support and access to re-training for spouses;
- spouse job seeking assistance;
- school fee assistance to maintain a child in a larger town or city centre; and
- where a family is fragmented by a decision for a parent or partner to take up rural practice, funding for at least one annual return trip home for family members during the doctor's tenure.

2.5 Costs of establishing a practice and access to community services

The costs of establishing a practice have been nominated as one of the major disincentives to doctors who might otherwise relocate to an area of workforce shortage. The AMA supports existing specific funding grants that enable local governments and other appropriate organisations in regional and rural areas to purchase facilities such as housing, practices, and equipment so medical practitioners can operate a practice on a "walk-in walk-out" basis.

2.6 High on-call demands and the need for rosters and locum services

Rosters

Doctors in regional and rural areas often face high on-call demands. This is undesirable from both the perspective of patient safety as well as effective service delivery. A core number of doctors need to be on roster to contribute to a sustainable work/life balance. The roster needs to be attractive in order to help recruit and retain doctors.

Existing competition laws are perceived as preventing doctors entering into effective rostering arrangements to provide comprehensive medical services to their local community, particularly with respect to after-hours services and covering absences when doctors take leave.

The AMA believes that considerable community benefit would flow from allowing doctors to establish viable rostering arrangements, which include reasonable agreement about what fees should be charged. This would encourage doctors to cooperate in order to provide their local community with better access to round the clock healthcare and address one of the major disincentives to regional and rural practice, which is a high on-call workload.

Recommendation

The AMA recommends that the Government works with stakeholders to develop an improved legal framework to underpin more viable rostering arrangements, which include reasonable agreement about what fees should be charged to encourage doctors to cooperate in order to provide their local community with better access to round the clock healthcare.

Locum services

Locum services are also a key element to addressing the problems of high workload and little prospect of relief for rural/regional practice. Lack of time off for professional development, family responsibilities and recreation can be among the most negative aspects of life as a rural doctor. Rural workforce agencies and medical college programs are an important source of locum doctors as well as locum placements funded under a national scheme. The Commonwealth Government funding should continue to support such programs, and where appropriate be increased based on the needs of particular communities.

Further, under the current rules governing access to Medicare, doctors are required to apply for, and obtain a separate provider number for each practice location at which they work. This has a major impact for doctors who provide locum assistance in several locations and the bureaucracy involved would inhibit many doctors from taking on locum positions.

It is important that locum services are used for their proper purpose and not as long-term solutions for doctor shortages where other solutions should be found. Ensuring appropriate industrial and remuneration arrangements for incumbent doctors is critical and locum services should not be used as a means to avoid addressing the underlying reasons why some locations need long-term locum services.

Recommendation

The AMA recommends that the Government:

- expands existing funding for locum services; and
- establishes a new Medicare provider system under which medical practitioners retain a single provider number and each practice location in Australia receives a location specific number.

2.7 International Medical Graduates

International medical graduate (IMG) doctors form an important part of the medical workforce and regional and rural Australia will rely on the contribution made by IMG doctors for the delivery of medical services for some years to come.

When IMG doctors 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 IMG doctors or their patients. IMG doctors need more professional and community support to enable them to maximise their contribution to patient care and to encourage them to seek a permanent place in the Australian rural medical workforce.

Recommendation

To ensure high standards of patient care in regional and rural areas, and to provide better support for IMG doctors in their work, the AMA recommends:

- the abolition of the "10-year moratorium" and its replacement with a robust package of incentives and support mechanisms to encourage the increasing numbers of locally trained doctors and appropriately skilled IMG doctors to voluntarily consider a career in regional and rural Australia;
- improving support mechanism for IMGs that include orientation, continuing medical education, bridging courses, assistance with exams, mentoring, community facilities and services;

- improving area of need and district of workforce shortage definitions with a requirement that an objective assessment be undertaken of the reasons for not filling a position with an Australian resident doctor before recruiting an IMG doctor; and
- changing Commonwealth and State legislation to give temporary resident IMG doctors and their families access to Medicare and public education.

3. The effect of the introduction of Medical Locals on the provision of medical services in rural areas

The tasks of integrating and coordinating the range of organisations and service providers operating within primary care together with linking primary health care with other sectors can be done well or badly, efficiently or inefficiently and in a manner supportive or unsupportive of GPs . At one extreme, if done well, it could provide great benefits to GPs and patients and at the other extreme, it could waste a lot of valuable resources and demotivate the GP workforce.

The AMA acknowledges the potential reach of Medicare Locals. Medicare Locals have the potential to impact on aged care services, mental health outcomes, chronic disease management, Indigenous health services and services to the disadvantaged. However, Medicare Locals need to be introduced in a way that is respectful of the existing role of GPs and other community based Specialists and in a fashion that seeks to maximise positive relationships and partnerships at all levels.

GPs are the highest trained practitioners in the primary health care setting and have a key role in the coordination and management of care for patients, providing over 120 million services each year. Medicare Locals can be useful to GPs by supporting them in carrying out their role and assisting them in accessing allied health services in the community. Given the potential for Medicare Locals to consume precious health resources, they need to be organised in an efficient manner with contestability and transparency as key considerations.

The AMA has a number of concerns about the introduction of Medicare Locals and how they might impact on the provision of medical services in rural areas. In particular the AMA has concerns about the governance structure of Medicare Locals and the lack of GP involvement in these governance arrangements, the size of their boundaries, the potential for Medicare Locals becoming fund-holding organisations for medical services, and the looming loss of after hours Practice Incentive Payments (PIP).

3.1 Governance structure

The AMA remains concerned that the introduction of Medicare Locals in their current form will not meet stated policy objectives. This will be because the role of GPs in the current Medicare Local governance structures will be greatly diminished when compared to existing divisions of general practice. With delivery of primary health care services being the central plank of the operations of Medicare Locals, the AMA supports a

governance structure that ensures a significant presence of local GPs on Medicare Local Boards and all key committees established by the Boards.

The AMA notes that overseas experience (UK, NZ etc) suggests that any primary health care organisation should be GP led and that local doctors must be strongly represented on the boards of primary health care organisations. This ensures that the task of integrating and coordinating the range of organisations and service providers operating within primary care is achieved. It would also ensure a better link between primary health care and other sectors in a manner that is supportive of general practice and in accordance with local needs.

The current Medicare Local model being implemented by the Commonwealth does not encourage/prioritise strong GP involvement and to that extent the AMA believes that they will result in poorly targeted services and the diversion of resources away from patient care. Should this eventuate, Medicare Locals rather than filling the gaps will have exacerbated the fragmentation of patient care. This will be further exacerbated in rural Australia where GPs are often the linchpin linking primary care and secondary care services.

3.2 Medicare Locals boundaries

The boundaries established for Medicare Locals are for the purpose of funding and administration only and should not be used to restrict access to clinical services or as an effective barbed wire fence against historical or natural referral patterns. The boundaries should be flexible and adaptable to reflect local considerations and patient flows, and must follow and improve patient flows that already exist (of particular note are border towns and locations where people often move across State borders to access care). In this regard, the AMA is concerned about the size of the current Medicare Local boundaries and the potential for decisions to be made that ignore local needs and knowledge.

3.3 Fund holding

A key foundation of Medicare, supported by both sides of politics, is universal access to patient rebates for the provision of medical services initiated by patients as needed. The AMA supports the continuation of these arrangements and rejects any move to divert rebate entitlements as bundled payments to GPs or to Medicare Locals to fund the provision of GP or Specialist medical services (the same applies to PBS entitlements).

In this regard, the AMA has concerns about the potential for Medicare Locals to develop in ways that are inimical to good health provision. Examples of such developments would include Medicare Locals evolving into powerful fund holding bodies purchasing GP services directly for a population group, interference in the GP clinical care role as opposed to support, interference in the fee for service aspect of general practice, rationing, proliferation of bureaucracy etc.

The Government should review the operations of Medicare Locals within three years after their implementation and at regular intervals thereafter to ensure they are

performing in a manner that is consistent with their broad objectives. This review should have strong representation from the medical profession

3.4 Practice Incentive Payments (PIP) and after hours care

Medicare Locals will be funded to manage provision of after hours services. The AMA has concerns about the impact of the new funding arrangements, a key component of which includes the withdrawal in 2013 of the After Hours Practice Incentive Payments (PIP). There is concern that general practices, particularly rural practices that currently provide after hours services may cease to do so following withdrawal of the PIP as it may become unviable to do so.

Recommendation

The AMA recommends that:

- the Senate conducts an inquiry into the implementation of Medicare Locals and their impact on primary health care service delivery; and
- the Government retains after-hours PIP payments in their current form.

4. Current incentive programs for recruitment and retention of doctors, particularly in smaller rural communities

4.1 Their role, structure and effectiveness

While the AMA recognises that a number of measures have been put in place in recent years to help in the recruitment and retention of doctors in rural communities, in general terms, the AMA believes that the Department of Health and Ageing's rural health programs are under-funded, complex, fragmented and too restrictive. This is the result of a patchwork approach over many years to solving the lack of access to health services in rural Australia.

The Government has responded to the shortage of doctors in rural and remote areas by implementing a number of initiatives that include an increase in the number of new medical school places; Bonded Medical Places; the HECS Reimbursement Scheme; and the General Practice Rural Incentives Program.

Of the current initiatives encouraging rural medical practice, one area that is welcome and where a positive impact is being felt is increased medical student enrolments. The Commonwealth Government has responded to the general workforce shortage problem by, amongst other things, announcing a number of new medical school places.

In 2010, there were 2,264 domestic medical graduates, an increase of 72 per cent from 2005. This is projected to increase to 3,227 domestic graduates in 2015.[3] While this is welcome, the AMA does have an ongoing concern as to how the clinical training

[3] *Medical Training Review Panel: Fourteenth Report*, Canberra: Australian Government, 2011

placements of these students will be accommodated in an already stretched public hospital system and whether there will be a sufficient number of quality post graduate training positions available when these students enter the medical workforce.

Not only is it important that medical student numbers have increased but the number of students coming from rural and regional locations is also increasing. It has long been known that students who come from rural and regional locations are more likely to want to return to such areas when they start practicing medicine. In 2009, 21% of the first-year domestic medical school students came from rural areas, compared to just 12% in 1997.[4,5] In the medium to long term, this may deliver a much fairer distribution of the medical workforce. However, with long lead times involved in training the medical workforce, more needs to be done in the short to medium term to address the current imbalance.

The Government is still using a draconian policy of unfunded bonding of medical school places to distribute the medical workforce more equitably. Under this policy, students are bonded to work up to the equivalent length of time as their medical degree in identified workforce shortage areas.

Unlike students in other professions such as teaching, medical students who take up bonded positions are offered no financial incentives and must repay their education fees in full unless they are also eligible for other programs. Given that the pattern of medical school enrolments has shifted dramatically, with a big increase in enrolments of students from rural areas – it is strongly arguable that this policy is highly unnecessary as existing policy settings were having a significant and positive desired effect.

The AMA has opposed the Bonded Medical Places (BMP) Scheme since its inception and has consistently lobbied the Government to relax the heavy-handed conditions of the Scheme. The AMA believes that the existing Medical Rural Bonded Scholarship Scheme and HECS Reimbursement arrangements should be enhanced and expanded so as to replace the BMP scheme.

The General Practice Rural Incentives Program that commenced in 2010 has been generally welcomed as an initiative to support GPs wanting to work in rural and remote locations. One problem that has been identified by AMA members is the restriction that to be eligible for a relocation grant a practitioner must relocate to a Remoteness Area (RA) location more remote than any practice locations they have worked in the previous 12 months. In some cases, GPs do locum work in rural areas and then decide that they would like to make a more permanent move to that same location or a more remote location. The 12-month restriction rule disadvantages them if they want to make the move quickly.

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[4] *Medical Training Review Panel: Thirteenth Report*, Canberra: Australian Government, 2010

[5] New Zealand and Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1997), *The Characteristics of Students Entering Australian Medical Schools 1989 to 1997, AMWAC Report 1997*, Sydney

Queensland's Rural Generalist Pathway (QRGP) has experienced some early success in delivering procedurally trained doctors to rural locations across the State. The QRGP offers a career pathway for junior doctors wishing to pursue a vocationally recognised career in rural generalist medicine. However, there is some concern that this program is too hospital focused. A broad advanced skills pathway could be developed utilising the existing GP training program, linked to the achievement of the relevant GP qualifications awarded by the Royal Australian College of General Practice (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

The AMA also notes that the Rural Clinical Training and Support Program (merging the previous Rural Clinical School Program and the Rural Undergraduate Support and Coordination Program) is a good model for increasing the number of medical graduates who reach specialty status and contribute significantly to the rural medical workforce.

The AMA recognises that the Federal Government has recently established a new agency "Rural and Regional Health Australia". The impact of Rural and Regional Health Australia is yet to be seen and we hope, unlike the former Office of Rural Health, that it becomes an effective advocate for rural health issues so that rural health issues are recognised within the federal health bureaucracy leading to meaningful policy initiatives.

Recommendation

The AMA recommends that the Government:

- enhances existing Medical Rural Bonded Scholarship Scheme and HECS Reimbursement arrangements so as to replace the BMP scheme;
- modifies the eligibility criteria for access to relocation grants; and
- supports the development of a broad advanced skills pathway utilising the existing GP training program, linked to the achievement of the relevant GP qualifications awarded by the Royal Australian College of General Practice (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

4.2 The appropriateness of the delivery model

The AMA supports team based care arrangements that are led by medical practitioners. The AMA supports task delegation by doctors to other health care practitioners – it does not support task substitution. The AMA approach delivers well-coordinated care from the most appropriately trained health profession – the core of which is a medical diagnosis.

GPs are the highest trained general health professional with a minimum of 10 to 15 years training and as the population ages and chronic conditions become more widespread, the role of the GP becomes more important in the lives of their patients. GPs have generally embraced team-based care to give their patients better access to other primary health care services after diagnosis and assessment and the consideration of an appropriate management plan.

In rural and remote areas, the nature of smaller communities often means GPs work even more closely with their colleague health professionals. However, it is important to note that while other health professionals may be able to make a limited diagnosis of a specific illness or injury, they are not trained in the total health care of the whole person in the way a GP is. In the GP-led model of primary health care delivery, a patient's care is then organised around these needs. The specialised training of GPs is vital to the evolving primary care system.

The evidence clearly indicates that a GP-led primary health care team delivers the best outcomes and care for patients. Nurses and allied health professionals have a key role to play in primary health care but they do not substitute for the skills of a GP. Rural and remote people deserve the same care and health outcomes as people in metropolitan areas and therefore any policy for rural and remote health care must place the local GP as the lead primary care team member.

Recommendation

The AMA recommends that the Government states clearly in any policy on rural and remote health care that Australians must be able to access the care and services of a GP and that wherever possible a primary health team must be led by a GP.

5. Whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes

From July 2010, the Federal Government adopted the ASGC-RA system of classification as the prime system for determining the allocation of funding under a variety of rural health programs including various rural medical workforce incentive programs. ASGC-RA replaced the much older RRMA classification system.

The ASGC-RA system is based, in turn, on the Accessibility/Remoteness Index (ARIA) of Australia. ARIA is a purely geographical measure of remoteness. Governments and private sector groups use the generic ARIA system for a variety of purposes. The Federal Government's former Rural Retention Program was based on a special version of ARIA known as GP-ARIA.

The ASGC-RA system groups localities into five essentially arbitrary categories (compared with seven categories under the old RRMA system). Remoteness is calculated using the road distance to the nearest Urban Centre in each of five classes based on population size. ARIA+ scores are first calculated for each Urban Centre, in 1km square grids. These are then added together, covering the whole geography of Australia. Each grid square carries a score of remoteness from an index of scores ranging from zero through to 15.

For the initial ARIA system:

Category	Description of category	ARIA score range
RA1	Highly accessible	0 to 1.84
RA2	Accessible	>1.84 to 3.51
RA3	Moderately accessible	>3.51 to 5.80
RA4	Remote	>5.80 to 9.08
RA5	Very remote	>9.08 to 12

For the subsequent (ARIA+) system (introduced in 2003), the bands and categories became:

Category	Description of category	ARIA score range
RA1	Major cities of Australia	0 to 0.20
RA2	Inner Regional Australia	>0.20 to 2.40
RA3	Outer Regional Australia	>2.40 to 5.92
RA4	Remote Australia	>5.92 to 10.53
RA5	Very remote Australia	>10.53 to 15

The purpose of the ASGC-RA system is to scale a range of financial and other incentives designed to recruit and retain doctors in rural areas, with the aim of ensuring that the biggest payments are made to doctors in the most remote or needy towns. The AMA has concerns about anomalies identified particularly with the RA2 and RA3 classifications.

The AMA considers these anomalies will make it more difficult to recruit medical staff to less attractive locations within the same classification. The major problem is that, because many small rural towns are now classified the same as major regional cities, doctors receive the same relocation and retention payments regardless of whether they choose to practice in the small towns or large cities. This issue together with other issues is further discussed in the following sections.

5.1 Stakeholder discontent with ASGC-RA

Rural doctors have legitimate concerns about the anomalies that have arisen since the implementation of ASGC-RA. It is important to note that there were also anomalies under RRMA. However, there are now many stakeholders who feel that the anomalies are greater under ASGC-RA than under RRMA. RRMA was more "granular" (with seven bands as opposed to five under ASGC-RA). Also, the third band under ASGC-RA is a relatively wide band. Both factors contribute to a groundswell of stakeholder discontent with ASGC-RA.

The AMA contends that there are three key issues that are the source of all the controversy surrounding ASGC-RA which are the arbitrary effect of bands; relative prices; and reliance on a purely geographical indicator.

The arbitrary effect of bands

For purposes of funding arrangements, geographical areas (for the most part, towns and/or cities) are classified as falling into one of five ASGC-RA bands. Although it is claimed that the boundaries reflect "natural break points", the remoteness of communities is a continuum. The choice to have five bands (as opposed to seven under RRMA) is arbitrary and the band boundaries are also essentially arbitrary.

The effect of arbitrary boundaries is that:

- people in quite different situations are treated as though they were the same (even though they may be at opposite extremities of a band and face quite different issues); and
- people in quite similar situations are treated as though they were different (when they sit close to, but either side, of a band boundary).

The relatively wide third band under ASGC-RA (the "Outer Regional" category) has thrown up a number of anomalies, although it must be said that there are also anomalies with the other bands especially the RA2 (Inner Regional) band.

For example, the NSW rural towns of Cootamundra, Tumut, Young and Cowra are classified as RA2, the same as the Hobart suburb of Sandy Bay. Similarly a RA3 classification was given to the central Queensland mining town of Moranbah, population 8000 and 200km southwest of Mackay, and Townsville, home to 170,000 (with same classification). It means doctors will receive no extra incentives by relocating to Moranbah.

Relative prices

ASGC-RA is not a relative price or costs structure. Sets of prices are superimposed over RA bands. In some cases, the RA band is the sole parameter determining the scale of payment. In other programs RA is one of several parameters (e.g. length of continuous service in the case of the rural retention program). In the AMA's view, the use of such composite parameters is not controversial. What we see, however, is a lack of transparency as to how the Government determines the scales of payment and the payments related to each band or category.

Reliance on a purely geographical indicator

As noted above, ARIA (which is the "engine" under ASGC-RA) is a purely geographical measure of remoteness. Remoteness carries with it a range of social, professional and economic outcomes. The issue is whether or not a purely geographical measure is adequate as a basis for assessing the relative needs that accompany particular degrees of remoteness.

Of particular concern is that ASGC-RA measures distance from the State capital by road as the measurement tool disregarding factors such as the quality of transport links and the ease of travel along these routes. This is seen by many rural doctors as the major problem with ASGC-RA. It is the reason why an area like Townsville or Cairns is regarded as rural.

5.2 GISCA review of ASGC-RA classification

Late in 2010, the Department of Health and Ageing engaged the National Centre for Social Applications of Geographical Information Systems (GISCA) to investigate concerns raised by stakeholders. GISCA was asked to:

1. Review the current Remoteness Area (RA) Classification and ARIA;
2. Examine the identified "area of concern" (localities); and
3. Suggest potential refinements to the RA/ARIA model.

GISCA concluded and recommended that:

- ARIA and the associated RA classification developed by the ABS is now widely accepted as the standard measure of remoteness for Australia (the implication being that the system should be retained as the main "workhorse" for dealing with rural funding issues);
- By far the major issue for the identified areas of concern is that these towns lie close to the breakpoints of the RA classification;
- More RA classes would create more boundaries and would only increase the number of towns that lie close to a boundary; and
- For areas of "uncertainty" (involving towns with ARIA scores close to the break points or with a geographical location close to RA boundaries) there be a new classification system, the Health Remoteness Classification (HRC) utilising the services of a panel of experts comprising representatives from the Department, health professionals and academia.

With regard to the GISCA conclusion and recommendations, the AMA is of the view that:

a. GISCA has tried to defend the "purity" of ARIA. We support that. An objective, spatial measure of remoteness is needed as part of the mix, understanding that it is not the answer to everything. However, the AMA does question the independence of the review conducted by GISCA as they had a vested interest in defending the system.
b. GISCA has correctly identified the ASGC-RA category boundaries as a source of much of stakeholder discontent.
c. GISCA argues against more categories because more categories mean more boundaries. We note, conversely, that more categories would reduce the concerns that the bands are too wide (treating situations as they are the same when they are not) and would lower the financial stakes for those claimants hovering near a

boundary. A strong case could be made for splitting the existing RA2 and RA3 into two categories each.

d. We judge their preferred solution (an alternative way of categorising "areas of concern") as complex and cumbersome. We contend that the solution to the boundaries problem is to do away with them and make a wider use of seamless ASGC-RA scores.
e. While the GISCA review deals in depth with the narrow terms of reference, the issues don't stop at that line. Satisfaction with the implementation of ASGC-RA would be increased were the Government more forthcoming in explaining the science underlying the relative pricing systems (if there is any) and far more willing to engage with stakeholders when reviewing those scales.

5.3 A way forward

The AMA judges that most concerns with ASGC-RA arise from the way the bands are applied and from the scales of payments.

Removing/widening the bands

ASGC-RA is based on ARIA. As noted, ARIA is a continuous variable. The AMA is of the view that consideration should be given to:

- not having bands at all. This would require new formulae where the amount of payment would vary with the ARIA score for the relevant geographical area which may be the suburb or town itself or, in some cases more appropriately, the area served (e.g. the catchment area for services provided from a town); otherwise
- having a more granular structure (more bands with narrower spans so as to reduce the anomalies now due to wide banding).

Given that an ARIA score can be obtained for any spatial unit in Australia, it would be a relatively easy matter to establish new payment formulae that related to level of payment to the ARIA score for each claimant. It would also be relatively easy to implement the change so it was on a revenue neutral basis (if that were required by budgetary circumstances). This would treat like with like and directly address much of the discontent arising from the use of bands.

The second option (a more granular structure with more steps in the scale) would represent a smaller change from current arrangements. We note that in their review of ASGC-RA, GISCA contended that more steps means more disputes. The AMA is inclined to the contrary view. More steps means less disparity in the way claimants are treated (the claimants falling within each band would be more uniform than currently). Also, there would be smaller differences in rates of payment where a claimant is teetering on the boundary of a band (smaller stakes).

We suggest that the preferred option is to not have bands at all. This does require a change of thinking. That said, it is not difficult to do and there is already one successful example of a no bands classification system (e.g. GPET new "facgeo" framework for

funding of rural training providers). The no bands system is intrinsically a more equitable system.

Greater stakeholder engagement around price scales

The relationship between the ASGC-RA bands and the scales of payment related to them is currently quite opaque. The AMA believes that satisfaction with the system would increase if there were more stakeholder engagement around the pricing systems. We note that:

- there needs to be more discussion around the relativities between the various steps in the scale. For example, some scales are effectively linear. The AMA questions whether this is appropriate;
- there needs to be a regular process of reviewing scales of payment especially where the objectives of the program are not being met or where the outcomes are uneven; and
- the payment scales need to be appropriately indexed with inflation and earnings so that they are not etched away over time.
- It would be worthwhile to have a truly independent review of the ASGC-RA by an organisation that does not have vested interest in defending the model.

Introducing non-geographic parameters

The purely geographic measure (ASGC-RA) has the advantage of being relatively objective. That said, it does not capture all the issues around remoteness (which we note include social, professional and economic issues associated with more sparsely populated areas). A geographic measure will always be required as part of the mix. However, the jury is still out as to whether ASGC-RA needs to be supplemented by measures that take account of factors other than geographic remoteness from service centres particularly noting the AMA's concerns that road distance alone (and not accounting for factors such as the quality of the road) from a Capital city does not provide the full picture about how patients and medical practitioners travel in rural locations to access and provide services respectively.

We suggest that the question posed here should be deferred for consideration once progress has been made on the other, more immediately troublesome, fronts:

- eliminating or reducing the anomalies created by the current bands; and
- eliminating or reducing the anomalies created by sub-optimal scales of payment.

Recommendation

The AMA recommends that:

1) consideration be given to implementing ARIA scores as a continuous variable instead of grouping localities into ASGC-RA bands;
2) failing the adoption of recommendation 1), the fall-back option is to adopt a more granular band structure (more bands, narrower bands);

3) there be a great deal more stakeholder engagement in relation to the scales of payment that attach to the ASGC-RA bands (if bands are retained);
4) the scales of payment be the subject of regular review and indexation;
5) the ASGC-RA system should be retained as the geographic indicator; and
6) The Government work with stakeholders to ascertain whether ASGC-RA should be supplemented by other indicators, which capture some of the social, professional and economic aspects of remoteness.
7) The Government commission a fully independent review of the impact of ASGC-RA

6. Any other related matters

6.1 Telehealth

Modern technology (telehealth) 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 telehealth services.

The Medicare rebates for video consultations have the potential to improve access to quality medical services for people in rural, remote, and outer metropolitan areas over time. The AMA welcomed the Government's decision to fund video consultations for referred specialist consultations, and the funding to encourage medical practices to set up facilities to provide video consultations. The initiative could considerably enhance access to GP services for specific patient groups.

The delivery of health services to Indigenous populations in remote Australia is almost exclusively through health centres that are exempt under subsection 19(2) of the Health Insurance Act 1973. These remote health centres access medical care via specialised general practitioners who reside in urban centres such as Darwin or Alice Springs. These practitioners could enhance their face-to-face care of Indigenous populations with video consultations from urban centres to remote health centres.

Busy rural and remote medical practitioners can find it challenging to provide medical care to residents of aged care facilities. Similarly, there are patients who have difficulty attending rural general practices because of mobility problems or because of distance.

Extending the MBS video consultation items to GP consultations for remote Indigenous Australians, aged care residents, people with mobility problems and rural people who live some distance from GPs will considerably improve access to medical care for these groups and improve health outcomes.

Recommendation

The AMA recommends that the Government extends the MBS video consultation items to GP consultations for remote Indigenous Australians, aged care residents, people with mobility problems and rural people who live some distance from GPs.

The AMA appreciates the opportunity to provide input into this Inquiry and would be happy to answer any further questions that Committee may have.

Yours sincerely

Dr Steve Hambleton
President

21 December 2011

D11/7846