Dr John M Boully

December 10, 2011.

The Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600. Australia.

Submission

The factors affecting the supply of health services and medical professionals in rural areas

Summary

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Dear Secretary and Senators,

I write with reference to the following:

The factors affecting the supply of health services and medical professionals in rural areas

Terms of Reference

The factors affecting the supply and distribution of health services and medical professionals in rural areas, with particular reference to:

(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.

As a general medical practitioner who has worked consistently in the arenas of rural and semi-rural health, I can only speak for myself.

Following my experience of living in a remote Aboriginal community for 3 months in 1973 as a medical student, I decided that a positive impact on health status would be best achieved by involving local people in all aspects of their health care. As a consequence, I was motivated to work for the establishment and development of Aboriginal Medical Services in localised Aboriginal communities, usually beginning on 'reserves' that were positioned adjacent to country towns.

However, in the 1970's, 1980's and early 1990's, work with and for Aboriginal Medical Services was considered unconventional and was not well supported. As my early working years were so formative, the decisions I made back then shaped my subsequent career path and led to me working in many different rural and urban communities, often those with low economic status, indigenous and non-indigenous, over several decades.

I have provided general medical practitioner services since 1976 in a wide variety of medical practices in the following rural and semi-rural locations:

In South Australia – Yalata, Davenport, Port Augusta, Leigh Creek, Port Pirie, Coober Pedy, Moonta, Mount Pleasant, Mount Gambier, Renmark, Barmera, Salisbury, Whyalla, Berri, Port Lincoln, Balhannah and Mount Barker.

In New South Wales – Airds (in Campbelltown), Kempsey, Wilcannia, Walgett, Armidale, Mount Druitt, Broken Hill, Narromine, Molong, Bingara, Cobar, Forster, Taree, Purfleet, Condobolin and Griffith.

In Victoria – Mildura.

In the Northern Territory – Bagot (in Darwin), Alice Springs (includes related outback communities), Berrimah and Katherine (includes related East Arnhem Aboriginal communities).

As I am a doctor, I write from a doctor's perspective. This paper demonstrates that, yet I wonder if nursing staff and allied health workers might also relate to some of the issues I will raise here.

With respect to:

(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;

As your inquiry wishes to consider "the factors limiting the supply of health services and professionals to small regional communities" I can state the following:

1. In my early working years, GPs had lower status and significantly less remuneration than specialists. There was **insufficient recognition of the importance of 'generalists'**. As a result, there was not much back-up for GPs like me who threw themselves into the challenging arena of Aboriginal health.

2. In my case, my full concentration on medical care at the local community level meant that I lost the **skills required to be a competent emergency or hospital doctor**. These were not my main interests anyway, but this led to my further alienation from possible GP support agencies that evolved later.

3. The role of 'doctor' places real responsibilities and burdens on GPs in smaller communities. **Burn-out can be a real danger**, and the constant demand for medical services can stifle other interests. In my case, my **broader professional interests in service development, planning and education were not supported time-wise or financially,** and so I moved on.

4. There seems to be a **hotch-potch of different models** for health service provision to small regional communities. Has anyone recorded and analysed the different funding models for health professionals, I wonder? Here, I am talking about consideration of the **tensions between public/private, Commonwealth/ State, local and regional etc**. When do doctors (for instance, as in my case) ever get a chance to know how things are structured management-wise and/or financially? All too often we are expected to concentrate on patient service provision, and that alone. In contemplating going to work in the bush, however, **some of us might like to know more about the system we are asked to work for, and what the requirements and expectations of that system are.**

5. The establishment of Aboriginal Medical Services as locally based and locally run services were often resisted by the authorities. These days, it is difficult to know which of these services are to be supported and enhanced as community-controlled organisations and which of them are being managed under a system of regional management answerable to a variety of State and Commonwealth funding agencies and structures.

   The **tension between these different approaches can cause philosophical and practical impediments to progressive development** of on-the ground services.

For those with a commitment to the field of Aboriginal health, the issue of tension between the community-control philosophy and the State and Commonwealth health system 'partnership' approach to addressing indigenous health issues (and all systems have their limitations) may cause many professionals to stay away or opt for more conventional positions.

5. **Systems of (truly) open dialogue are lacking.** I know of no agency that is set up to seriously address this deficiency. Colleges want to teach, agencies want to utilise our labour, and services want to employ us, but who is there to assist us in the process of reflecting on our experiences, review our approaches, or mentor us? Where do professionals gain any form of career counselling? How do we make our career decisions? In my case, all key career decisions have been made in isolation.

So these are some of the factors that have limited the supply of health services and personnel to staff such services.

With respect to:

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

I wouldn't have a clue !

I have no contact with Medicare Locals. I don't know who they are or where they are. If they are taking up the slack and addressing the needs of rural communities I haven't heard of anything they are doing.

As I have suggested, although I often work in rural areas I rarely meet other doctors and virtually never see staff from the related 'support' agencies. I just do what I do, as I have done for 35 years now.

With respect to:

(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;

I don't wish to comment much on these. To this day, I remain largely ignorant of the details of these incentive programs.

Incentive programs came at a time in my career when there was little recognition of my preferred service model, that being for me to provide medical, educational and planning services to a variety of Aboriginal communities and their emerging medical services.

The early forms of incentive programs did not understand what I was on about, and did not attempt to understand what was professionally important to me. As a consequence, I did not involve myself with them.

With respect to:

(d) any other related matters.

Since hearing about your Inquiry I have been reflecting on certain matters.

As the Senate's Committee is looking into

The factors affecting the supply of health services and medical professionals in rural areas

I have been thinking about the following:

1. **What is the nature of the current system (if there is one) that determines the supply of health services and medical professionals to rural areas? Who gets to make the important decisions about service provision?**

It seems that assumptions have been made that private sector practitioners will independently go to rural areas and establish, maintain and develop their practices. Importantly, though, the public sector calls upon these same practitioners to provide services to hospitals. So we depend upon a mixture of public and private sector activities for the provision of adequate services.

In current circumstances of doctor shortages (for instance), it is clear that times have changed. Doctors are no longer quite so willing to locate to and remain working in isolated rural settings.

Public sector officials may have concentrated on the staffing of hospitals for essential hospital services, but this concentration on hospitals has meant that the

wider field of primary medical care has been largely ignored. Now we have a real crisis.

So who is thinking about the bigger picture?

Where is the interface dialogue (if there is any) between private and public sectors? If the system of dialogue is limited to the provision of hospital services only, as I suspect it is, what about the rest of the rural health workforce?

If there is a system of broader dialogue, is the dialogue ongoing or only occasional and intermittent? What can be done to ensure not just ongoing dialogue but further cooperation and service development?

2. Who is to be regarded as a medical professional?

It seems that to be seriously regarded as a rural GP, a doctor needs to be permanently resident in a rural area and providing services to the local hospital.

These doctors are sometimes referred to as ‘cradle to the grave’ medical practitioners.

However, even these ‘permanent’ doctors need support. Medical support is likely to be obtained from city-based colleagues, if only such a support system could be further encouraged and developed.

Some doctors have returned again and again to work in rural areas, even though their efforts are intermittent. Even if these doctors (such as myself) do not provide hospital services they should, in my view, be regarded as part of the rural GP workforce, and recognised as such.

In my case, I have worked across a wide geographical area covering three states. This may be somewhat unusual but the work achieved is a demonstration of my commitment to the needs of rural and isolated patients and my attempts to reach out to these people.

To continually ignore city-based doctors who do work or might be willing to work in rural areas will not assist the process of providing medical support to the rural medical workforce.

As a non-procedural GP it has been my experience that I have not been afforded any real consideration as a rural GP, even though much or most of my working life has been conducted in rural areas. I have worked largely alone and unsupported, except by my immediate employers and the locum agencies. As a result, my periods of enthusiasm, initiative and significant motivation have

eventually given way to resignation to the fact that my experiences and my views are not recognised and have not been valued by health authorities.

If my experience is typical of doctors who have worked in a similar fashion, it should be no surprise that their willingness to 'go bush' has waned.

3. Where are we with regard to the touted 'health reform' process?

Whilst the State manages the hospital system, it is the Commonwealth that supports the services of most doctors. Medicare and the Pharmaceutical Benefits Scheme are Commonwealth initiatives that underpin the practice of medicine in most areas.

Some doctors are employed by the State, and some State monies flow to other doctors on a contractual basis.

Most GPs lie outside the State health system, even though many of them work in close relationship with it (providing services to hospitals).

Some of these GPs bulk-bill and, these days, many of them charge fee-for service. The complexities of employing staff and running a viable business create significant challenges in themselves.

So where are we these days with regard to 'health reforms, and what does this mean for rural GP and other services?

Or is this still a work in progress? I suspect that this is so, that the ongoing uncertainties inherent in the system that is still evolving but continually 'not quite yet' clear is another factor that makes health professionals hesitate to commit themselves to the rural health task.

4. Who, actually, is in a position to decide what are to be the appropriate arrangements for the encouragement and engagement of the GP workforce, especially in rural, remote and indigenous settings?

In the process of planning and implementation, I like to consider not just WHO, but also HOW, WHEN, WHERE and WHAT is to be done.

So who has the authority and the responsibility here?

Are practitioners meant to decide these things for themselves, in relative isolation?

Do agencies of government have a role? If so, who are these agencies and what is their role? Importantly, do these agencies reach out to the potential workforce or do they simply perform work sufficient only unto themselves?

Do existing Commonwealth/State partnership arrangements allow for consideration of the needs and persuasions of different doctors when important decisions about the provision of health and medical services are made? Are doctors (for instance) just to be slotted in to pre-determined roles (as I suspect), or **might there be some consideration of involving medical professionals in decision-making processes**, so that potential staff may have some say in determining how their various skills may best be employed?

It has been my experience that it is usually only my medically-skilled labour that is required, not any of my ideas or opinions, or of my other skills (such as planning and education). But if doctors are not involved in decision-making about their own lives and careers, is there any wonder that they choose to go elsewhere?

5. What about Aboriginal Health Services ? Where are the important decisions being made with respect for the provision of GP services for indigenous communities?

As Aboriginal health services are funded by a variable mix of Commonwealth and State monies, it is difficult to know what arrangements apply to doctors in different locations.

When I contemplate work as a GP, it is foremost in my mind to try to understand what I might be getting myself into. It is often difficult to know the nature of the system I might be working for, and under what arrangements. Nevertheless, I think and feel that such considerations are important.

What, for instance, is the future of the so-called community-controlled sector? Is this a favoured model or is it under threat? What is the government's preferred model for GP service provision to Aboriginal communities, or are we to remain with the current mix? How are the various models of service provision to be funded, and what implications do these funding models have on the nature of the work expected?

Some remote area work experiences have exposed me to the pressure of expectation that I will be performing Care Plans and other specific higher income generating Medicare items as a matter of course. As a locum doctor, I have raised objections to this, as I consider that Medicare claims need to be legitimate, not utilised principally as a means of generating income.

So where does this leave doctors who might be interested or encouraged to work in the field of indigenous health? Where do we get our guidance? Who can we talk to?

6. The changing nature of general practice.

Another factor that has concerned me is the steady stream of multiple new Medicare items that specify certain behaviours in order to make extra financial claims.

It appears that the nature of general practice has been re-designed by bureaucrats with the expectation that doctors will pick up and run with these new requirements and 'incentives'. The system has become very complicated and, in my case, a 'turn-off'.

As a visiting locum it is not appropriate for me to be doing Care Plans as routine. These items are intended for doctors with a permanent presence.

Recently I saw a patient with early stage Multiple Sclerosis who had suffered severe and disabling toothache for several months. She brought with her a letter from the local GP Plus Health Centre requesting that I create a GP Management Plan for her and then proceed to generate the extra plan (and Medicare claim) based on deciding Team Care Arrangements. If these two plans were created the dental team at GP Plus might then be able to assist with her teeth.

I established that the patient was suffering from upper as well as lower jaw pain and, looking up some past documents, realised she had previously been referred to the Dental Hospital for a Marcaine nerve-block injection to the upper jaw.

As I was not the usual GP, and there was no team (!), it was not for me to create the two sets of plans requested. Instead, in view of the patient's distress, I referred her that day to the same specialist who had seen her previously at the Dental Hospital. Hopefully, she had her teeth and her myalgia attended to. What a farce ! How come the GP Plus centre didn't do the required work themselves. (Maybe they didn't have the GP ??). This is an example of visionary ideas that fall short on practical application.

I studied medicine in order to assist people. I do this in my work, in whatever way I find appropriate. In a sense, every single consultation involves the creation of a care plan, in conjunction with the patient. In my case, I like to spend adequate time in history-taking, examination, diagnosis, deciding upon and reviewing investigations and management approaches, patient education, counselling, referrals, record-keeping and the completion of required certificates and medical reports. This is my normal work. It is enough.

The imposition of all these extra schemes, all linked to more complicated Medicare claim expectations, new technologies, soft-ware programs and www. websites often strikes me as another burden, one that I wish to avoid. It is for reasons such as these that many baby-boomer doctors are giving up the practice of medicine.

7. Barriers

There are significant barriers to progressive development and real reform. I could describe instances of laziness, nepotism, medical territorialism, greed, waste, passive inertia and resistance to change, fraud, self-interest and corruption. I have seen instances of all of these.

These realities can be very difficult to change but, in my opinion, the naming of barriers and the further analysis of these as challenges and contradictions can open the way for the development of positive responses and the development of strategic priorities as part of the more comprehensive planning processes that are needed.

Workforce planning has clearly not been comprehensive enough. Planning of all types is certainly necessary, I just wonder who is doing it and how useful and effective the plans are. In my opinion, too much planning is superficial, too full of jargon, often irrelevant, and too far removed from the people who are meant to benefit from it.

8. How are we to enable the new services that are needed?

I recently worked in a rural SA town in a private practice that will soon close. The owner and the current doctor have already made their contribution but are unable to continue.

I have wondered about how such a practice might be enabled to continue, and have wondered who, if anyone, might be in any way knowledgeable or concerned about this.

So how are we to build the new services that are needed? What sort of adaptations of the health system are to be developed for the growing number of communities now experiencing shortages?

There is nothing new in stating that GPs have an essential primary health care (PHC) role to play. They are in the front line of primary health care and provide direct care at the first point of contact for clients. They can utilize the rest of the health system by referral. They work to try to reduce the impact on hospitals, and are also pivotal in providing client access to the welfare system (Centrelink). Without doctors, the community really suffers.

Where is there a mechanism for doctors themselves to give consideration to workforce issues across the country and in the States? If someone has an interest, how can that be encouraged?

What are the various models for the engagement of GPs (for instance), and how can such models be developed and analysed, and their various implications considered?

Without answers to these questions GPs will be left to fend and decide for themselves. I think that the results speak for themselves.

Conclusion

In conclusion, I would like to request that a 'map' be created, a summary diagram, listing and recording all the different agencies (with contact details) that are willing to welcome open-ended dialogue and exchange with medical and allied health professionals so that these same professionals will be offered opportunities to explore the many issues related to their interests, seek out information relevant to their own needs, and be listened to.

Whilst there may be lots of emphasis placed on rural health in undergraduate and early postgraduate training, doctors who were trained years ago don't have the same supports. They are also expected to shoulder the extra burdens and expectations laid out by layers of health-related government and other agencies.

In the current context of professional shortages, much of the current system tends to operate in crisis-management mode, pleading with potential staff to take up known vacancies in a well-established and somewhat inflexible system. I suspect that many government-funded agencies are required to adhere to, and are, as a result, hamstrung by 'detailed programmatic specificity'. As a result, there is a sense of inflexibility, even rigidity, to what is expected or required. I have found this to be alienating.

For anyone reading this, I am arguing for a cultural shift in the way organisations project themselves, and a policy-shift that enables more flexibility and creativity at the local level.

In the current climate, there seems to be little opportunity for new participants to engage in genuine open-ended dialogue. Without dialogue, there is little scope for the building of trust and the development of new and functioning relationships. Without supportive and encouraging relationships, there is little chance of enabling and developing inter-dependent and cooperative arrangements.

Navigating a complex system to find useful information and explore practical possibilities is a most important first step for those contemplating work in rural and remote geographical locations. Enquiries from professionals that are handled with respect and a demonstated willingness to explore new ideas and potentials may enable more professionals to take up a working role.

I wish the Senate and any readers well in your endeavours to address the many serious issues inherent in the field of health for our rural and remote citizens.

Yours Sincerely,

Dr John M Boully.