SUBMISSION TO THE COMMITTEE RE: FACTORS AFFECTING SUPPLY OF HEALTH SERVICES AND MEDICAL PROFESSIONALS IN RURAL AREAS

Australia is large with a diverse population, many of whom are clustered around major cities. As one moves further away from cities, population densities decline and it can be hard to recruit and retain doctors to work in these areas. The rural retention incentive scheme has done much to encourage doctors to both move to rural areas and to stay there. This grant is not necessarily 'cash in the doctors pocket' but is usually absorbed into the higher business costs of running a practice in the bush or operating as a doctor.

The recent change in the RRAMA classification to the ARIA scheme saw several perverse anomalies, not least the same incentives applied to cities like Hobart as to small towns like Gundagai

When doctors are making decisions about where to live and work, they will likely gravitate towards places like Hobart where there is no requirement to be oncall, they can enjoy a cosmopolitan city lifestyle...and yet receive the same 'incentive' as the doctor who works in a small rural town, is oncall for the local hospital and has to travel many hundreds of miles to enjoy the amenity that the metropolitan doctor can achieve by walking a few hundred metres.

The old scheme worked.

The ARIA scheme acts as a positive DISINCENTIVE to recruitment and retention of medical professional sin rural areas and should be scrapped.

It really is that simple. Perhaps the committee could and should take advice form the RDAA on thisi issue, as I am sure they can articulate matters far clearer than I can.

It is not complex. It just needs to be reversed.

Second, the abolition of PIP funding for after hours medical services and the roll out of Medicare Locals is causing much angst. Within my region, many doctors are planning to withdraw from providing after hours services as the structure for support to provide this service (Medicare Locals) is not established, and hence the remuneration previously obtained through PIP.

This is a double tragedy - not only will patients not be able to access local after hours services, but they may be forced to travel many hundreds of km to access services they previously had locally. Some Medicare Locals schemes encompass vast areas of land - this centrist model, whilst convenient for bureaucrats, is the deathknell for many rural communities who currently enjoy local health services.

However, there are not many votes in rural areas. Perhaps if the Committee could commit to the need for a 'rural health obligation', this would serve as a framework for Govts to comply with meeting the health needs of rural populations. Again, I would refer the Committee to the Rural Doctors Association of Australia who are far more articulate and politically-savvy than this country doctor.