16 December 2011

DIETITIANS ASSOCIATION OF AUSTRALIA
ABN 34 008 521 480
1/8 Phipps Close, Deakin ACT 2600
T: 02 6163 5200
F: 02 6282 9888
E: nationaloffice@daa.asn.au
W: www.daa.asn.au

Submission to senate inquiry:

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

The Dietitians Association of Australia welcomes the opportunity to provide input to this inquiry.

The issues associated with supply of Dietitians to rural areas are in common with those of most other allied health professions. It is fair to say that many of these issues have been canvassed previously but allied health is still at the bottom of the priority list and whilst significant steps have been made toward supporting doctors and to a lesser extent, nurses, the flow on to allied health has been minimal.

DAA appreciates federal government support of scholarships for rural students undertaking entry level programs and the introduction of the Nursing and Rural allied health Locum Scheme (NAHRLS) but these are very small considering the size and contribution of the allied health workforce and in the case of NAHRLS, not particularly well designed to meet the needs of allied health especially those working in the public health system.

These issues will be canvassed more fully under the headings below.

Response to 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;

There are sufficient graduates of dietetic programs to fill current positions in rural areas although there is a shortage of more senior dietitians in all areas. However there are significant barriers to dietitians entering these positions.

- Even if all available positions are filled it does not mean that there is an adequate supply to meet the needs of the area. The workload is heavy, diverse, demanding and significantly impacted by travelling times.

- The majority of dietitians in rural areas are relatively inexperienced often work in professional isolation and many have jobs cobbled together from more than one funding source. The stability of these funding sources can vary.
- There is little stability with few practitioners staying longer than two years with frequent gaps between the incumbent leaving and recruitment of the next. As these are often sole positions there is lack of continuity in the service.
- 94% of dietitians are female and once settled with family commitments are reluctant to move to smaller rural areas.
- Most student dietitians come from the cities and tend to want to stay in the cities. This is changing but slowly. It may be accelerated by using the model of medical education where the intent of medical students to practice in rural areas after graduation is increased with exposure during training.
- Funding models do not support allied health to work outside the public health system anywhere but this is particularly problematic in rural areas. Most rural areas have a lower socioeconomic profile therefore direct payment for allied health services is limited. Whilst a significant proportion may hold private health cover, only a limited number hold extras cover which supports treatment by private allied health practitioners. The very limited access to Medicare rebates for allied health services cannot support viable practice in rural areas. Better models than straight fee for service need to be explored to allow better access to and support for all health professionals not just select professions.
- Doctors can access Medicare rebates for telehealth services, allied health cannot. Isolated dietitians could be supported by experienced colleagues working in specialist areas in major centres but there is minimal funding to support this.
- Access to continuing professional development (CPD) and peer support is more difficult. Professional Associations do their best to provide electronic access to CPD and online resources but receive no support to do so. Some jurisdictions are better than others in providing this kind of access but it is usually confined to those employed in government funded positions.

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

- Medicare Locals should be focused much more broadly than on just providing medical services. The question should be what will be the effect on providing primary health care services of which medical services is one.
- If they work according to plan, Medicare Locals can identify gaps and look for ways to address those needs but they will be hamstrung unless the funding models for service provision are addressed.
- Medicare Locals can provide hubs for professional support and education in a multidisciplinary model but this will require strong collaboration with the Local Hospital Networks as they will likely need to share their allied health professionals.

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

- The problem is that these programs are almost entirely directed at doctors and dentists so allied health, including dietitians, is left out in the cold. If the government is serious about ensuring a good and stable supply of suitably experienced allied health practitioners who are key players in the health team then such incentives need to be directed at them also. There needs of allied health practitioners are similar to those of doctors and dentists.
- There is significant support for doctors to receive training for rural practice. There are no such supports for dietitians or other allied health.

(i) their role, structure and effectiveness,

- The scholarship program for rural allied health students appears to be effective and well subscribed but is limited
- The NAHRLS program is reasonably well designed for nurses but is highly problematic for allied health. Unlike for nurses and doctors, the public health system, especially in rural areas provides no budget for locum back fill for allied health. The NAHRLS program is based on the health service having budget to cover the salary of the locum which usually does not exist. It is also based on a very clinical model and does not take into account the diversity of roles undertaken by professions such as dietitians.

(ii) the appropriateness of the delivery model

- Unable to comment

(iii) *whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes*;

- DAA believes these should be reviewed for a number of reasons not solely related to the application of incentives.

DAA is the national association of the dietetic profession with over 4800 members, and branches in each state and territory. DAA is responsible for the professional accreditation of all university courses training dietitians in Australia, for recognition of overseas trained dietitians and for credentialing of all dietitians practising in Australia.
For further information please contact Claire Hewat either by:

Claire Hewat AdvAPD
Chief Executive Officer