Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
CANBERRA ACT 2600

Dear Secretary

Inquiry into the factors affecting the supply of health services and medical professionals in rural areas.

I would like to write to the committee as a rural practitioner of 30 years standing into the supply of medical professionals in rural areas.

The supply of medical practitioners involves appropriate medical student numbers, thankfully recently increased allowing Australia to train its own doctors, instead of finding them in developing countries. These students will need to gain their experience and education outside of traditional hospitals, as there is not the capacity in many tertiary hospitals to teach the increasing numbers. This means that future students will have to obtain substantial experience in rural hospitals and rural practices, so rural health schools will need to be supported further.

Encouraging students to go rural, by encouraging universities to have 25% of students from rural areas is a good first step. There is evidence that this works but I am unsure if all universities meet this goal. The rural bonded medical scholarships also are a good incentive to get students to taste rural medicine. There are 2 schemes, the rural bonded scholarship (around $24,000 annually) in return for working 6 years in a rural and remote area, and the Bonded Medical Scheme which offers 600 places with the Commonwealth contribution paid in return for return of service. I support these being continued.

To become a practising doctor these students need to obtain appropriate post graduate training. There are currently not enough doctors with procedural skills training due to a number of reasons. “Specialist” medical colleges have first access to a number of procedural training posts in public hospitals. It has been difficult to obtain procedural training posts – surgical, obstetric, and anaesthetic for rural procedural doctors. We need to become competent in these skills to a level appropriate to rural procedural practice.

A conduit is needed to allow students and young doctors to gain these skills in a streamlined manner. I support the rural generalist pathway or conduit, model. This involves state governments resourcing the training positions in their state hospitals.

Currently there are training standards set for obstetrics and anaesthetics, but currently no standards for what is competent rural surgery. The Australian College of rural and remote medicine (ACRRM) at the moment is looking at establishing such standards.

Rural practice involves 24 hour care, as we look after standard after hours general practice patients as well as emergency attendances at our rural hospitals. In South Australia, private rural doctors provide both these services, although some states with larger populations have specific salaried emergency doctors. In South Australia after hours is one difficulty identified in attracting rural doctors. Currently PIP (Practice incentive payments) are provided as an inducement to provide such services. Medicare locals will have these funds paid to them from 1/7/2013, to use at their discretion. I can see a revolt from rural doctors if these funds are used for other purposes by Medicare Locals after that date. There is a need for innovative solutions to provide after hours care to communities without doctors or hospitals, but not at the expense of destroying what already works.

Medicare locals are an unknown quantity, but that is not necessarily bad. They are premised on finding local solutions to local problems, and as that hasn't been done before, this will obviously be contentious. However whenever centralised bureaucrats push a one item vertical health agenda (eg Diabetes OR Asthma) there is good evidence general health outcomes DECREASE. Health outcomes depend on a good primary care system that addresses all health needs. Hence I am not averse to Medicare Locals per se as they might stop Canberra thinking it knows what regional Australia needs. The quid pro quo is that Medicare locals will need to research what is needed to improve the deteriorating health outcomes in rural areas.

There has been a change in how rural incentive grants are given, due to a change in how “ruralness' is measured. The new ASGC-RA has caused unnecessary grief through making some smaller towns as rural as Hobart and Townsville . This needs to be re-looked at please.

Overseas doctors have to jump through many hoops to become registered. During this time access to Medicare is not allowed to them or their families as they don't have permanent resident status. It is double standards allowing them to work in areas of need treating Australians, but denying them access to Medicare for themselves and their families. Many have had medical services, such as delivering babies, only because doctors have foregone their fees. On the subject of competency, it would be appreciated if all states had the same process of assessment. I would suggest a minimum of 4-6 weeks supervised in an emergency department would allow competency to be assessed. Who pays the doctor to work is a moot point.

Locum schemes that allow rural doctors time off for holidays and continuing medical education are a good idea. These are currently state based, and perhaps should be a federal scheme. The old commonwealth/state dilemma again.

These are issues that concern me, and as you have read, the issues are complex and extend from medical students to procedural training.

Yours sincerely

Tim Wood
Rural GP

15th December 2011

These words are written in a private capacity, and do not reflect the ideas of any organisations I am associated with.