RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

Inquiry into the Council of Australian Governments reforms relating to health and hospitals

RDAA submission to the Standing Committee on Finance and Public Administration (SCFPA)

The RDAA is pleased to provide this submission to the SCFPA's Inquiry into the Council of Australian Governments (COAG) reforms relating to health and hospitals.

The submission includes some introductory comments on the reform agenda, as well as some more specific comments on the following aspects of the COAG reforms:

- the impact of National Call Centre and Medicare Locals on afterhours health care in rural and remote areas;
- governance arrangements for Medicare Locals and Local Hospital Networks (LHNs) in rural and remote areas;
- the number and size of LHNs;
- the Voluntary Diabetes Enrolment and Capitation Program; and
- the allocation of financial support for nurses in general practice.

1. INTRODUCTION

The RDAA recognises the need for significant reform in the area of health care funding. For far too long, successive Federal and State governments have shifted blame for the shortcomings of the Australian hospital and health care systems, and side stepped taking responsibility for developing a national reform agenda.

While the details of how the COAG reforms are to be implemented are yet to be seen, a key concern for the RDAA is that the design of the forthcoming changes recognises and accommodates the often unique circumstances and challenges associated with delivering hospital and health care services in rural and remote Australia.

In the RDAA's view, the critical issue that needs to be addressed in order to deliver better health outcomes for Australian families living in rural and remote areas is the establishment of a sustainable rural health workforce. Funding reform and the roll-out of new programs will only redress the health disadvantage experienced by people living in the bush if doctors, nurses and other health professionals are available on the ground to deliver the health care.

While the RDAA welcomes the announcement of funding for many new more GP training and prevocational places across Australia, we consider that this is merely the first step in the process. The logical next step has been largely ignored - the introduction of realistic measures to actually entice these and other doctors to move to the bush once they have graduated.

The RDAA is disappointed that the most significant health reforms of recent times do not involve the funding of the much-needed Rural Rescue Package called for by RDAA, the Australian Medical Association and the Australian Medical Students Association. The Rural Rescue Package is specifically designed to entice more doctors to the bush, and to better support rural practices as the small businesses that they are.

Rural doctors are multi-skilled professionals that provide a diverse range of health care services from the cradle to the grave. They usually earn less than their urban counterparts but are more likely to work longer hours (around 40% work over 60 hours per week compared to 26% of metropolitan doctors working over 60 hours per week). They are an ageing population, with the average age of rural doctors in Australia nearing 55 years and the average age of rural GP proceduralists (i.e. rural GP anaesthetists, rural GP obstetricians and rural GP surgeons) nearing 60 years.

At least 1800 doctors are needed immediately in rural and remote Australia to ensure even basic medical coverage in the bush. The influx of overseas trained doctors is the only reason that medical workforce numbers in rural areas are not in complete free fall. Close to 50% of rural doctors are overseas trained and in many areas 100% of services are being provided by overseas trained doctors, well above the national average of 25%.

The RDAA has serious concerns that some of the forthcoming health care reforms will undermine the future of rural health by making the option of a career in rural medicine even less attractive to medical graduates. General practices operate in the bush as small businesses and struggle to remain economically viable. Any reform proposals that are likely to diminish the income of rural practices are of particular concern.

The RDAA considers that the health reform agenda has yet to demonstrate that the Government comprehends the enormity of the challenge involved in attracting doctors to work in the bush, and understands the dynamics of how rural health care is delivered. Long term strategies that invest in the future of rural health are urgently required. The sustainability of rural communities is put in jeopardy when rural health services fail - no one wants to live and work in a community where you are unable to see a GP, receive emergency care or access local services to give birth. Rural communities will find it increasingly difficult to attract young working families and professionals such as teachers and police and support local businesses, farming, mining and tourism activities unless these people can be assured they can access basic infrastructure in their community including health care services.

3. SPECIFIC COMMENTS ON ASPECTS OF THE COAG REFORMS

3.1 Impact of the National After Hours Access Service on existing arrangements

The RDAA has concerns that the proposals for better access to after hours care, supported by Medicare Locals, will interfere with existing arrangements for accessing after hours care in rural and remote areas that are operating effectively.

Arrangements for accessing after hours care in rural and remote areas are currently tailored to suit local circumstances. In some rural areas, GPs will provide health care services through a general

practice, as well as after hours emergency care at the local hospital. This commonly occurs where the local hospital does not employ a staff specialist within the Emergency Department.

To access an after hours GP, a patient in a rural area will call the local hospital and be triaged by nursing staff within the Emergency Department. The nursing staff will know which GP is on call, and his or her movements, and can advise the patient accordingly. Where the patient's condition does not require the immediate attention of the GP, nursing staff will be able to refer the patient to the local medical practice or manage the patient until the GP can see them.

It is difficult to envisage how the National After Hours Access Service and Medicare Locals can improve on these local arrangements. The key issue for accessing after hours services in rural areas does not centre on identifying who is providing after hours services and where those services are located. Rather it is centred on the availability of workforce (i.e. the number of rural doctors available in the community to provide after hours care).

The RDAA also has concerns about the cessation of after hours incentives for GPs under the current Practice Incentives Program, which will be phased out in 2012 and 2013. Once these incentives have been removed, after hours GP services in smaller rural communities may be reduced or jeopardised if Medicare Locals do not step up and provide the necessary support for rural practices.

3.2 Governance arrangements for Medicare Locals and LHNs in rural and remote areas

The RDAA considers that, in smaller rural communities, there will need to be at least an alignment of boundaries between Medicare Locals and LHNs.

In many rural communities, there is no line drawn between primary care and secondary care. This is particularly the case in smaller communities where GPs provide coverage for obstetrics and anaesthetics, or perform specialist procedures, at the local hospital and provide after hours medical care through the local hospital's Emergency Department. For these communities, it may be appropriate for the Medicare Local and the LHN to form a single entity that provides for the overall health of the community. Where this is the case, it will be critical that accountability and performance indicators are at such a level that they measure the health of the community rather than just throughput of the hospital.

Where Medical Locals and LHNs are separate entities, the RDAA urges the Government to ensure governance arrangements are in place that ensure collaboration between the Medicare Locals and LHNs work to provide for the health of the community, and discourage blame shifting across the primary and secondary health sectors. The RDAA also urges the Federal Government to ensure local clinicians have the promised input into the proposed LHNs.

3.3 Number and size of LHNs

The RDAA notes that the size of LHNs in terms of population is a secondary issue in rural and remote Australia. The key concern is that the boundaries of the LHN reflect the community of interest – that is, the locality where there are synergies between patient flows and communities.

Such synergies may exist between rural towns that are relatively close together, but which are located in different states. For example, the NSW towns of Mildura and Broken Hill, and the Riverland region of South Australia, generally all refer patients to Adelaide for hospital care.

State boundaries should not prevent the creation of the most appropriate configuration for a LHN. If LHNs are unable to span State boundaries, disputes will arise between States over the funding of patient care where patients are referred across State boundaries for hospital-related care.

3.4 National minimum standards for hospital services

The COAG National Health and Hospitals Network Agreement sets national minimum standards for hospital services, including the length of waiting lists and access times for Emergency Departments.

For rural Australians, there are additional dimensions to the length of waiting lists and access times for Emergency Departments. These additional dimensions relate to the availability of medical care and the distance that needs to be travelled to access GP, specialist and emergency care. To access specialists for elective procedures, many have to travel to a major regional or capital city - often many hours drive or a flight away. In the case of emergency care, with the downgrading of many hospitals many rural Australians are unable to access this care in their town or they may live hundreds of kilometres from their nearest hospital. If it takes four hours for a person living in a rural area to reach their local hospital, a four hour cap on Emergency Department waiting times provides little comfort.

The RDAA also notes that prompt treatment on arrival to the Emergency Department or once a patient is placed on a waiting list is premised on the availability of an appropriately trained and skilled health workforce. In the absence of such a workforce, hospitals in many parts of rural and remote Australia will be unable to meet the national minimum standards.

With the closure of more than 50% of rural maternity units over the last 15 years, access to obstetrics services within a reasonable timeframe is also a critical issue for rural communities. For many women in rural communities, the nearest obstetrics service can be located hundreds of kilometres away.

3.5 Voluntary diabetes enrolment program

The RDAA has a number of concerns about the proposed voluntary diabetes enrolment program announced by the Minister for Health in March 2010.

While the RDAA agrees with the Minister's contention that diabetes patients who enroll with a medical practice - that is, identify and form an ongoing relationship with a primary healthcare provider for their diabetes treatment—will likely achieve better health outcomes, it does not support the use of a pure capitation model to fund the program. A key concern is that a pure capitation model of funding may result in fewer visits by diabetic patients to their GP, less

continuity of care and lower levels of compliance with the recommended best practice treatment régimes for patients with diabetes.[1]

If a pure capitation model is adopted for the scheme, enrolled general practices will be asked to underwrite the financial risks associated with variations in demand for health care from enrolled patients. Such variations may often be attributable to factors outside of the medical practitioner's control (for example, patient non-compliance or traumatic injury).

The management of these financial risks by general practices is problematic, particularly if the pool of enrolled patients for the general practice is not representative of the population average in terms of health care needs (for example, where the general practice has a concentration of diabetic patients with complex needs). In metropolitan areas, participating general practices will be able to manage some of this demand variation risk by referring complex patients to a specialist service from the outset, or once the cost of providing care begins to exceed the quantum of the capitation payment. This option is not likely to be available for general practices in rural and remote areas.

Rural doctors face many challenges in building and sustaining a medical practice that is economically viable.[2] In view of this, rural doctors are unlikely to choose to participate in a voluntary diabetes enrolment program where there is a risk that they may be underpaid for providing quality care to patient with complex or unpredictable health care needs.

While the Government is still working on the details of the program, RDAA believes a 'blended funding model' of fee-for-service Medicare payments supplemented by specific support payments for diabetes-related treatments, with a rural loading, would provide the best health outcomes for patients with diabetes and better support general practice to provide the comprehensive care these patients need. This type of blended funding model would better accommodate the economic and clinical elements of general practice, not to mention rural general practice, and establish a more appropriate and sustainable framework for improving the care of patients with diabetes and reducing hospital admissions for diabetes and diabetes-related conditions.

3.6 Allocation of financial support for nurses in general practice

While the RDAA welcomes initiatives to support the use of practice nurses in a primary care setting, the long-term financial impact of the new Practice Nurse Incentive Program (PNIP) on rural practices is likely to be problematic for rural doctors in larger practices.

Under current arrangements, general practices in rural areas receive funding for practice nurses through three streams:

- the Practice Nurse Incentive Program (PNIP);
- the Medical Benefits Schedule (MBS) practice nurse items, including rural bulk billing incentives; and

[1] See Gosden T, Forland F, Kristiansen I, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behaviour of primary care physicians. Cochrane Database of Systematic Reviews 2000, Issue 3. Art. No.: CD002215. DOI: 10.1002/14651858.CD002215

[2] RDAA, *Viable Models of Rural and Remote Practice Project* (2003). The report of the project is available online at http://www.rdaa.com.au/uploaded_documents/SUMMARY_VIABLE_MODELS_S1&S2_REPORT__2pagespreads

- rural loading (based on RRMA).

The collective value of these funding streams can be substantial in larger rural practices, particularly where the practice has efficiently used the practice nurse to provide services to their patients and the volume of MBS practice nurse items is high.

Under the new PNIP, incentives will be capped at five incentives, meaning that practices will be eligible to receive up to $125,000 from a single funding stream to support the employment of practice nurses. A rural loading of between 20%-50% will continue to apply to this funding (based on ASGC-RA).

The RDAA has conducted some initial modeling of the new PNIP in relation to a sample of rural general practices. The outcomes of this modeling raise some serious concerns. While some smaller practices may financially benefit from the new PNIP, the modeling indicates that some larger practices may experience substantial revenue losses. One practice modeled may lose up to $100,000 per year in revenue. While the Government has indicated that general practices will not lose money as a result of the restructuring of the new PNIP, this guarantee against financial loss is limited to three years. As such, it is unlikely to encourage those practices to continue to use nurses to the same extent in the longer term, thereby reducing the access of their local community to care.

The RDAA urges the Federal Government to undertake financial modeling across a range of general practices in rural and remote Australia to gauge the true financial impact of the new PNIP. Such modeling will give the Government a clearer picture of the impact of the new PNIP on rural practices beyond 2015 once the grandfathering arrangements cease.

Any future decline in income for rural GPs is a major concern, as it will exacerbate the rural medical workforce shortage. The RDAA encourages the Government to retain the funding advantage that rural practices have enjoyed under this program that have assisted these practices to continue to offer access to health care to their communities.

The RDAA also has concerns about the accounting costs associated with funding arrangements under the new PNIP, as funding will be provided to the general practice, rather than individual GPs, as was previously the case. This may result in a decline in income for many GPs and act as a disincentive to remain in rural practice.

Finally, the RDAA considers there is tension between the Government's encouragement of GP "super clinics", and the creation of a new PNIP that caps incentives for practice nurses to five GPs. If a rural area has two general practices, each with five GPs, the new PNIP will act as a disincentive for the two general practices to merge and provide affordable, high quality, comprehensive and integrated primary care services which are convenient and more accessible.

The RDAA believes access to nursing care should not be dependent on the structural arrangements of medical practices and incentives for practice nurses arbitrarily capped to five.