RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

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

22 December 2011

Dear Secretary

INQUIRY INTO THE FACTORS AFFECTING THE SUPPLY OF HEALTH SERVICES AND MEDICAL PROFESSIONALS IN RURAL AREAS

The Rural Doctors Association of Australia (RDAA) welcomes the Senate Standing Committee on Community Affairs' *Inquiry into the Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas*.

I enclose a detailed submission to the Inquiry from RDAA at Attachment A.

RDAA's key priority is to ensure that effective policies exist to assist rural and remote communities to attract and retain medical practitioners with the qualifications, skills and commitment to meet the needs of people in those communities. Research has clearly shown that in order to address this aim the policy framework must take account of three key domains:

1. Professional aspects including appropriate training for rural practice and strategies to manage practitioner workloads;
2. Economic aspects including system based remuneration structures and incentives that recognise the increased skills, responsibilities and training of rural practitioners and support practices to build workforce capacity to meet the continuing and comprehensive health care needs of their communities in a sustainable manner;
3. Structural issues including the need to provide adequate infrastructure for vertical and horizontal integration and maintenance of secondary level care as well as general systems support.

The current health policy framework is failing to meet the needs of rural and remote communities. This failure is reflected in the health status of people in these communities, the considerable underspend in Medicare in comparison to metropolitan areas, and the ongoing difficulty in attracting doctors and other health workers to these communities.

Patients in rural and remote areas deserve equitable access to high quality patient care across the primary and secondary (hospital-based) care continuum.

To secure this access, a stable, sustainable, and appropriately skilled rural health workforce is critical. To improve the health outcomes of patients in rural and remote areas, we must encourage doctors with the skills for rural practice to live and work within rural communities so that they can provide continuity of care and longitudinal care.

Rural medical practice is different to urban medical practice. Rural doctors work in a range of communities and practice settings across a broad scope of professional activities. They practise 'cradle to the grave' medicine, delivering babies, resuscitating severely injured patients, administering anaesthetics, providing palliative care, and treating chronic disease and mental illness. The smaller the rural community, the longer hours the local GP is likely to work when the demands of private practice, hospital work and on call duties are taken into account1.

Rural communities deserve sustainable, viable rural medical practices. Rural practice viability is dependent primarily on a number of factors, including sufficient numbers of appropriately trained GPs to share the workload, adequate rewards for the skills and responsibility of rural and remote doctors, and the availability of quality infrastructure and management. To build a sustainable rural medical workforce, Government policies and programs must address each of these factors.

If you have any questions about RDAA's submission, please do not hesitate to contact me.

I would also welcome the opportunity to appear before the Committee.

Yours sincerely

Dr Paul Mara
President

ATTACHMENT A

RURAL DOCTORS
ASSOCIATION
OF AUSTRALIA
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INQUIRY INTO THE FACTORS AFFECTING THE SUPPLY OF HEALTH SERVICES AND MEDICAL PROFESSIONALS IN RURAL AREAS

SUBMISSION

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

22 DECEMBER 2011

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PART 1: BACKGROUND

1.1 THE STATE OF RURAL HEALTH

Australians who live in rural and remote areas have the same right to quality health services as their counterparts in metropolitan centres.

However, this is not the reality. The key to achieving accessible and quality health services for rural Australians to provide a medical workforce which is numerically adequate, which is located within the community it serves, and which comprises doctors and other health professionals who have the necessary training and skills to be able to deliver the services required.

Australians living in rural and remote areas have much poorer access to local health services, significantly worse health outcomes and a significantly shorter life expectancy than Australians living in metropolitan areas.

The numbers speak for themselves:

- life expectancy in rural and remote areas is up to 7 years less than the city[1]
- Indigenous life expectancy in rural and remote areas is between 12-17 years less than the rest of Australia[2]
- rural mortality rates are up to 3 times higher than city rates[3]
- there is a higher prevalence of mental health problems in rural and remote areas[4]
- people living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities,[5] and
- people with cancer in regional areas are 35% more likely to die within 5 years of diagnosis than patients in the city.[6]

Many people living in rural and remote areas are unable to access even the most basic primary care medical services in their local communities, and have to travel significant distances just to see a GP for a basic consultation, or have to wait many weeks to be seen close to where they live.

In many States, there is an increasing centralisation of services, with rural hospitals and specialist units either being closed or downgraded. This means that

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[1] http://www.aihw.gov.au/ruralhealth/healthstatus/lifeexpect.cfm
[2] Ibid.
[3] Australian Institute of Health and Welfare (AIHW), 2010, *Australia's Health 2010,* AIHW, Canberra, at 248.
[4] Ibid, at 249.
[5] Ibid, at xi.
[6] Jong KE, Smith DP, Yu XQ, et al. *Remoteness of residence and survival from cancer in New South Wales*. Med J Aust 2004; 180: 618-622.

rural patients can no longer access the services they require in or close to their local communities.

While recent investments by the Federal Government in regional health infrastructure, training for health professionals and programs such as the telehealth initiative have been welcomed, this investment will only redress the health disadvantage experienced by people living in rural and remote areas if doctors, nurses and other health professionals are available on the ground to deliver the health care.

More targeted strategies for attracting and retaining a sufficient rural health workforce are long overdue.

1.2 THE RURAL MEDICAL WORKFORCE SHORTAGE

The Commonwealth has invested heavily in general practice training in Australia and, in recent years, has increased prevocational and vocational training places.

In providing this support for general practice training, the Commonwealth has implicitly and explicitly recognised:

- the value of a strong generalist model of primary care
- the requirement for a strong focus on rural and regional health workforce development, and
- the need to ensure that the health needs of rural, remote and regional populations are met through the development of locally relevant educational programs.

Commonwealth initiatives to attempt to support the development of a robust rural and regional health workforce have resulted in increased GP training places in rural and regional Australia. However, some goals have been more difficult to achieve. Retention remains a key issue. In January 2008, just over a quarter (27%) of previous rural pathway registrars were still working in rural practice[7]. In other words, many doctors taking the rural stream do not remain in rural practice. New strategies which focus on retention are required.

The attrition rate for rural doctors with the necessary skills for rural practice over the past two decades has been far in excess of replacement, resulting in the closure of many small services and, more recently, some medium and even larger services. The trend has been initially to close the procedural-based services of the hospital (for example, anaesthetics, obstetrics and surgical services) but now many hospitals are unable to provide afterhours and emergency medicine services on a full time basis.

[7] Ibid, at S71.

The medical workforce in Australia is increasingly being characterised by a preference for specialisation and subspecialisation, with a continued drift of specialty colleges towards subspecialisation.[8] That means there are fewer doctors available to become GPs or rural doctors with advanced training skills. There is a concern that many doctors who have an inclination for rural practice are now moving towards the specialties of anaesthetics and emergency medicine instead.

Initiatives that increase GP training places in rural and regional Australia, and expand the GP workforce in those locations, have simply not kept pace with the increasing demand for rural medical services. In addition, rural training programs often fail to distinguish between doctors with a sincere interest in rural practice and doctors who undertake training in rural areas because they have little or no choice.

A particular concern for rural and remote communities is the steady disappearance of doctors with advanced skills training from the rural landscape. This unique group of doctors provide highly skilled services across a number of disciplines that traditionally include obstetrics, emergency medicine, surgery and anaesthetics. However, there is a growing recognition that doctors working in rural and remote areas also require advanced skills in emergency medicine, surgery, paediatrics, acute mental health and Indigenous health.

People living in rural and remote areas rely on the availability of these doctors to ensure procedural and other advanced and acute medical services are available within their local community, helping to avoid delays in diagnosis and treatment, mortality and long term morbidity and the financial and emotional hardships associated with the need to travel long distances for diagnosis and treatment.

Rural doctors with advanced training skills are important in rural and remote medicine because of the lack of population to support sub-specialties, yet their numbers are declining.[9] In the period from 2002 to 2008, the proportion of rural doctors providing procedural services decreased from 24% to 20%.[10] In 2010, there were only 56 GP registrars undertaking advanced skills training in anaesthetics or obstetrics and/or gynaecology.[11] This compares with 73 in 2006 and 82 in 2008.[12]

The declining numbers of rural doctors providing procedural services impact on the health of a community and the workloads of those remaining in this field. It

[8] Medical Training Review Panel (February 2009), 12th Report, Australian Government.
[9] Rural Health Workforce Australia, *Medical Practice in Rural & Remote Australia: National Minimum Data Set (MDS) Report* as at 30th November 2009, at 15.
[10] Campbell, DG, Greacen, JH, Giddings, PH and Skinner LP, *Regionalisation of general practice training – are we meeting the needs of rural Australia?* MJA, Volume 194 No. 11; at S72.
[11] Ibid, at S72.
[12] Ibid, at S72.

also has an adverse impact on the viability of rural general practices and the sustainability of smaller rural hospitals, and places increased pressure on retrieval and procedural services in larger regional and metropolitan hospitals.

Changes are required to secure a rural pipeline of medical graduates for the future with the skills required for rural practice.[13] This must include medical graduates with advanced skills training who can provide the services needed in rural and remote communities.

1.3 THE NATURE OF RURAL PRACTICE

Rural practice is an often demanding and specialised medical discipline that requires advanced training and skills beyond those required of urban GPs. Traditionally these advanced skills have been categorised as procedural skills undertaken in small rural hospitals. However, increasingly there is recognition that there are broader challenges in rural practice than simply those imposed by the content of each patient presentation. Higher-level clinical decisions need to be made and greater responsibility has to be taken when working in isolation.

The increased training and skills requirements are recognised academically through the establishment of the advanced curricula and certification of ACRRM through the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) and the RACGP through the Fellowship of the Royal Australian College of General Practitioners (FRACGP)/Fellowship of Advanced Rural General Practice (FARGP).

The management of seemingly simple clinical presentations and conditions can be complex in rural areas due to isolation from professional supports and major centres, and limited local availability of diagnostic and other health facilities.

Addressing medical workforce shortages in rural and remote areas is therefore not just about finding a doctor – any doctor – to work in rural and remote communities. It is about finding the right doctor with the necessary skills, qualifications and experience for rural practice.

There is also a clear, but not fully or generally appreciated, difference in the nature of the medical workforce problem in rural and remote areas. The key challenge for recruiting a rural medical workforce is that doctors in smaller rural towns in particular are expected to provide full-time primary (practice-based) and secondary (hospital-based) level services. This imposes significant demands on practitioners and their families, impacting on workload, professional responsibilities and lifestyle, and can act as a deterrent to recruitment and retention of doctors to rural areas.

[13] Ibid, at S72.

A recent study provides evidence that a GP's total hours worked per week consistently increases as community size decreases.[14] These differences are linked to the work rural GPs undertake in public hospitals. The study also concluded that GPs working in smaller rural communities also have a higher on call workload, with the likelihood of a GP attending more than one call out a week ranging from 9% for urban GPs up to 48-58% for rural GPs in small communities.[15]

The personal costs associated with working longer hours and having an on-call workload, particularly in the absence of adequate rewards and supports, impact on the professional satisfaction of rural doctors. We simply must do more to build rural practices that are professionally and financially viable and sustainable.

1.4 RURAL PRACTICE VIABILITY

In 2003, RDAA received funding from the Australian Government for a landmark study – The Viable Models of Rural and Remote Practice Project (the Viable Models Project).[16] The project analysed the content, context, complexity and costs associated with rural and remote practice as a basis for developing a framework for viability and benchmarks that can be applied locally.

A copy of the report of the Viable Models Project is available online at: http://www.rdaa.com.au/policies-submissions/papers.

For the purposes of the project, the concept of a viable practice refers to one "which meets the particular medical needs of the community by providing appropriate services in a way that takes account of the financial and personal costs to both the practitioner and the community at large."[17]

The project clearly showed that rural practice is different from metropolitan practice in terms of isolation, costs, content, context and complexity of practice. These challenges and differences are far more multifaceted than simply the additional responsibilities associated with providing hospital-based care and relate even to day-to-day practice requirements.

The most common threat to practice viability was seen to be inadequate workforce numbers followed by economic or financial issues. The most important factor for improving workforce recruitment and retention was perceived to be better remuneration followed by improved afterhours arrangements.

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[14] McGrail, MR, Humphreys, JS, Joyce, CM, Scott, A, and Kalb, G. *How do rural GPs's workloads and work activities differ with community size compared to metropolitan practice*? Australian Journal of Primary Health, November 2011, published online at www.publish.csiro.au/journals/py.
[15] Ibid, at x.
[16] Monash University School of Rural Health and the Rural Doctors Association of Australia (2003) Viable Models of Rural and Remote Practice. Stage 1 and Stage 2 Report.
[17] Ibid, at xvi.

The evidence gathered under the study clearly identified three interconnected domains for viability:

1. the economics of practice, including income, expenses and remuneration structures
2. professional issues, including education and training and workloads, and
3. structural issues, including practice management and other systems and infrastructure.

Improved remuneration through an explicit and transparent Medicare rebate that provides a financial incentive to rural doctors was seen as the most effective way to achieve better remuneration. Grants and other incentives ranked well down the list of factors for improving workforce recruitment and retention.

The findings of the study were used to identify the crucial factors that affect viability and sustainability of practice and to develop benchmarks in these areas. These benchmarks included:

- an on-call rate of no more than one night in four and one weekend in four
- at least six weeks annual leave with extra compensation for on call load and provision for study leave and long service leave
- an average patient daily load of 25 patient encounters per day in the surgery, based on findings of an average patient contact time of 12-14 minutes and up to two hours per day in non patient contact time (for administration and teaching), and
- a maximum number of hours worked per day of 10 hours.

The economic model proposed through the Viable Models Project identified four key components necessary for practice viability. These were:

- core remuneration for private and salaried practitioners (remuneration received during normal working hours, including income from Medicare and other fee-for-service payments, including private billings and gap fees, workers compensation and third party fees, and the non-rural incentives components of the Practice Incentive Program (PIP)
- grants and incentives, including rural incentive payments through the PIP, retention grants, procedural grants, State incentives, and remote incentives for special circumstances
- hospital awards and agreements (usually state-based), and
- infrastructure support to encourage practice and community development, and provide facilities for teaching, integrated care models and succession planning.

The Project clearly showed that adequate numbers of appropriately trained and qualified doctors with the skills to meet the needs of the community was the most important determinant of practice viability and that improved remuneration through Medicare was the best perceived way to meet this workforce need.

1.5 THE POLICY OF EMPLOYING OVERSEAS TRAINED DOCTORS

Medical workforce shortages began to appear more generally across Australia in in the 1990s, and were exacerbated by policies that limited the number of training places for medical students in Australia.[18] In some parts of Australia, there has been a permanent under supply of doctors for more than four decades[19].

To fill this shortage, Australia has actively pursued a "short term" policy of recruiting doctors from overseas.

While a large number of doctors have come to Australia in the past 15-20 years, the rural medical workforce crisis persists. The influx of OTDs is the only reason that medical workforce numbers in rural areas are not in complete free fall. Around 50% of rural doctors are overseas trained and, in many areas, 100% of services are being provided by OTDs.

OTDs arrive in Australia with significant variability in the level of their training, experience, clinical skills and communication skills. Due to current workforce policies, they are often sent to areas where they are personally, professionally and culturally isolated. Many have limited access to the support, supervision and mentoring they need to orientate themselves to the Australian health care system and to enable them to provide the highest quality of service that meets the needs of their communities.

Any doctor seeking to practise in rural and remote communities, wherever they have trained, should be given priority access to the basic and advanced training required to meet the needs of these communities, prior to unsupervised practise. Currently, the only qualifications that reflect these requirements are the FACRRM and FRACGP with its associated FARGP.

All doctors also have a right to adequate supervision and support during this training. Yet in the recent Senate Inquiry into Registration Processes and Support for Overseas Trained Doctors, Chair of the Medical Board of Australia, Dr Joanna Flynn, said on current supervision requirements for OTDs: "I think it would be fair to say that it is patchy." She went on to say that, in the absence of "an ideal situation" where OTDs would spend more time under supervision in teaching hospitals and then in group settings, "…we have some alternative [supervision] arrangements which we believe provide access at a level of reasonable safety."

In our view, a level of 'reasonable safety' is not good enough for rural Australians.

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[18] Van Der Weyden, MB, and Chew, M (2004) Arriving in Australia: overseas trained doctors, MJA: 181 (11/12): 633-634

[19] Rural Workforce Australia (2008*) Will more medical places result in more rural GPs?* RHWA, Melbourne.

RDAA believes there is a strong and urgent need for a coordinated, national approach to providing appropriate initial and ongoing assessment, training, support, and supervision to OTDs.

PART 2: FACTORS LIMITING THE SUPPLY OF MEDICAL PROFESSIONALS TO SMALL REGIONAL COMMUNITIES

The reasons why some rural and remote communities cannot attract and retain doctors are multifaceted and interrelated. Any strategy to address rural medical workforce shortages should therefore keep sight of the bigger picture, rather than isolate issues and seek to address these issues without considering other causal factors. It needs to be integrated and be informed by the reality of the delivery of medical services in rural and remote areas, including the day-to-day activities and challenges facing rural doctors and rural practices.

As identified in the Viable Models Project, the nature of the medical workforce problem in rural and remote Australia is not one that can be explained simply in terms of the ratio of doctors to population.

A large number of rural and remote practices are small practices dispersed across geographically isolated areas. They are vulnerable because they are "inherently unstable and have little internal stability or redundancy for support".[20] It also costs more to run a rural practice and there is a reduced capital gain on any investment by rural doctors in practice infrastructure compared with urban practice.

Small rural practices also find it difficult to provide cover internally when one doctor is on leave. Where these small practices provide afterhours and emergency care at the local hospital, the on call rates are very high, and can result in "burn out" if the doctors do not have access to additional time off and adequate financial compensation.

In RDAA's view, the fundamental building blocks for sustainable rural practice are financial viability, professional supports, work/life balance, and good infrastructure. Without these building blocks, the rural medical workforce crisis will persist and the health disadvantage experienced by people living in rural and remote Australia will continue.

[20] Monash University School of Rural Health and the Rural Doctors Association of Australia (2003) *Viable Models of Rural and Remote Practice*. Stage 1 and Stage 2 Report; at page XVII.

2.1 FINANCIAL VIABILITY

Incentives and grants

There are a number of incentives and grants programs available for general practice. These include the Practice Incentive Program (PIP) and the rural program. These incentives and grants are important alternative sources of income for rural practices, as the level of MBS rebates has not kept pace with the actual costs incurred to deliver general practice services.

The PIP is made up of 13 incentives. Practices can apply for as many incentives as they are eligible for. Only one of the PIP incentives is specifically a rural incentive. This is the rural loading. Practices participating in the PIP with a main practice location situated outside capital cities and other major metropolitan centres are automatically paid a rural loading incentive. The rural loading recognises the difficulties of providing care, often with little professional support, in rural and remote areas.

These loadings are based on the RRMA geographical classification system. This classification system lists communities according to their local government area within each category[21].

There are some categories of the PIP that have greater application for rural practice such as the Procedural GP Payment. The Procedural GP Payment aims to encourage GPs in rural and remote areas to continue to provide surgical, anaesthetic and obstetric services locally in their communities.

A procedural GP provides non-referred services, normally in a hospital theatre, maternity care setting or appropriately equipped facility, which in urban areas are typically the province of a specific referral-based specialty. These services are provided in obstetrics, surgery and anaesthetics.

Another category of the PIP grant that has greater application for rural doctors and rural practices is the afterhours incentive payment. While this incentive does not specifically relate to rural practice it would apply more often to doctors working in small rural communities where doctors typically provide more hospital-based inpatient, outpatient and afterhours services than in urban areas. As such, this incentive payment can be a significant driver for rural doctors to maintain afterhours services.

From 1 July 2013, the incentive payments available through the PIP afterhours incentive payment will be discontinued. The funding previously made available through these programs, together with additional funding from the

[21] The loadings do not apply to Service Incentive Program grants.

Commonwealth, will be redirected through Medicare Locals. Medicare Locals will be tasked with administering this funding to further improve access to after hours care within their region. RDAA strongly opposes this change.[22]

There are four specifically rural programs offering financial incentives and support to rural doctors and rural practices. These are:

- the General Practice Rural Incentives Program
- the Rural Locum Education Assistance Program
- the Rural Procedural Grants Program, and
- the HECS Reimbursement Scheme.

The extent of the financial benefit provided to rural doctors and rural practices under these four rural programs depends, in part, on where the doctor or the practice is located, and the remoteness of that location. While these rural programs are welcome, the classification system used to determine the remoteness of a location is flawed as it classifies small rural communities as being equally remote as larger regional centres, impacting on the ability of some rural communities to attract and retain doctors.

Classifying levels of remoteness - the ASGC-RA

The Australian Standard Geographic Classification - Remoteness Area (ASGC-RA) classification system is the current system used for determining the allocation of rural health incentives and subsidies across Australia. The ASGC-RA essentially divides Australia into five regions - major cities, inner regional, outer regional, remote and very remote - for comparative statistical purposes. It measures remoteness based on geography – that is, the physical road distance to the nearest urban centre and how far one has to travel to access goods and services.

For RDAA, the key problem with the ASGC-RA is that it gives a large weighting to physical road distance from a capital city and relatively small weighting to population size. It is purely a geographic measure of remoteness, which excludes any consideration of socio-economic status, availability of health services, rurality and populations size factors (other than the use of natural breaks in the population distribution of urban centres to define the service centre categories). As such, the ASGC-RA can fail to represent the extent of health disadvantage experienced in some rural and remote areas. This has serious implications for smaller rural communities, which are simply finding it harder and harder to attract and retain doctors.

Under the ASGC-RA, some larger regional cities (for example Townsville and Cairns) - and even some wealthy suburban centres (for example, Sandy Bay,

[22] See Part 3 for RDAA's comments on Medicare Locals and financial support for afterhours services.

Hobart) - will attract the same incentive and support payments as small rural communities where the GPs provide general practice services as well as on-call afterhours care to their patients, including all public holidays, and inpatient care to insured patients at the local hospital.

The classification of large provincial cities as outer regional, and indeed cities such as Hobart as inner regional, under the ASGC-RA is a product of measuring remoteness based on geography alone and is a fundamental flaw of the ASGC-RA. It significantly reduces the differential between the financial incentives offered for working in an "outer regional" city (RA3) with theatres, restaurants, a choice of schools, shopping centres, specialist support and a major hospital and those offered for working in an inland "remote" rural town (RA4) with more basic facilities where the doctor is expected to work across the primary and secondary care continuum, including after hours.

The classification of cities such as Hobart, Townsville and Cairns as more "rural" under the ASGC-RA than under the Rural, Remote and Metropolitan Areas (RRMA) classification system distorts the reporting of the numbers of doctors working in "rural" areas. Doctors who are working in urban centres where there are an abundance of doctors are now being counted as working in inner regional and outer regional areas, allowing the Government to report that the rural medical workforce shortage is easing.

Unless major changes are made to increase the classification differential between these cities and small rural towns, the small rural towns will continue to be discriminated against and lose out to the major regional cities in attracting much-needed doctors. Precious health dollars will also continue to be spent on incentives that are going to doctors and practices located in cities where there are no or few workforce shortages.

A recent technical review of ARIA conducted by the National Centre for Social Applications of Geographical Information Systems (GISCA) acknowledges that there are issues surrounding where the boundary between the different ASGC-RA categories should be drawn, including problems of similar places finding themselves either side of a boundary. However, the GISCA report glosses over the fundamental flaw of how the ASGC-RA classifies large provincial cities and even capital cities as "rural".

RDAA considers that the recommendation in the GISCA report to establish a tribunal to assess submissions for changing RA/HRC scores would be cumbersome and costly, and of a limited benefit for some affected rural communities depending upon the composition of the tribunal, the factors the tribunal is obliged to consider and the criteria to be applied in the decision-making process. Such a process would divert attention away from addressing

the fundamental problems in those communities that are not located in “areas of uncertainty”, creating a two-tiered system under which some rural communities disadvantaged by anomalies in the ASGC-RA can appeal their classification, and others cannot.

RDAA is somewhat skeptical about the proposal for a tribunal given that the GISCA report indicates that such a process was used in the original development of GPARIA to assess formally submissions for changing RA/HRC scores and “rejected the great majority of objections”.

In RDAA’s view, the GISCA report does not address the major problems that smaller (mainly inland) towns face competing with the attractions and services available in large regional cities. Unless major changes are made to increase the classification differential between these towns and cities, the small towns will continue to lose out to the major regional cities in attracting much-needed doctors.

RDAA also notes the budgetary impact of classifying capital cities such as Hobart as “rural” and large provincial cities as more “rural” under the ASGC-RA.

RDAA regards the problems with the ASGC-RA as a significant issue that is impacting across a range of policy areas designed to address medical workforce maldistribution and urges changes to ensure the system better reflects the relative needs of different communities.

We call for an independent review of the ASGC-RA so that a classification system can be implemented that:

- is evidence-based and has face validity;
- is flexible enough to change as individual community circumstances change;
- is developed in consultation with rural and remote communities across Australia
- acknowledges the other factors that can influence access to health care, and
- is capable of making a real difference to the health outcomes of the people who live in rural and remote areas.

The need for an economic framework for sustainable rural practices

Rural doctors surveyed as part of the Viable Models Project clearly identified fee-for-service incentives as being the most appropriate way to support improved remuneration for rural practice as a means to attract workforce.

These rural doctors considered that explicit financial rewards that are attached to each service they provided would be a strong incentive to remain in rural practice.

RDAA believes a new remuneration and incentives framework is required to explicitly recognise and reward rural practices and individual rural doctors practicing outside major cities for the work they do during normal working hours and afterhours. This framework should:

1. ensure that communities as far as possible are able to receive treatment for common and serious conditions locally
2. encourage doctors to acquire the training and skills required to meet the needs of local communities
3. compensate for added responsibility and skills intrinsic to rural practice
4. support, wherever possible, commitment in practice infrastructure development, and
5. establish a basis for a sustainable practice load.

The framework should involve retaining existing remuneration mechanisms and incentives (ie Medicare fee-for-service, private billing, hospital based-income, and Commonwealth and State incentive grants) and establishing additional fee-for-service incentives that were identified in the Viable Models Project as the most effective way to improve remuneration for rural doctors.

The new fee-for-service incentives would operate under the MBS in the same way that the bulk-billing incentive operates under the MBS. It would provide eligible rural doctors with an explicit financial incentive that would be attached to every service provided to patients in their general practice.

The new incentive would specifically recognise and reward rural doctors with advanced skills training who utilise these skills in rural and remote settings through incentives that take into account the greater costs and complexity involved with rural and remote medical practice (the complexity payment). This complexity payment would be complemented by a rural isolation payment for rural doctors made under the GPRIP, but based on a valid rural classification system that appropriately classifies smaller rural communities.

The $1 billion underspend each year in Medicare services to those living in rural and remote areas of Australia[23] indicates that there is the capacity to provide this incentive framework.

[23] Compiled from information provided by the Prime Minister's Office in November 2009 on Medicare spend per head by ASGC classification.

The complexity payment

The new complexity payment incentive would recognise and compensate rural doctors with advanced skills training (credentialed through the award of a FRACGP/FARGP and/or FACRRM) who provide both primary and secondary level (hospital-based) care.

Eligible doctors would need to provide:

- primary care services
- meaningful on-call services, and
- services the local hospital that involve utilising advanced skills training.

Special criteria would also need to be established for doctors who provide regular emergency on-call services in small population centres where no hospital exists. Minimum levels of involvement would apply as measured by workload, call-backs and afterhours activity for accidents and emergencies.

Where eligible rural doctors are employees, appropriate salary arrangements would apply that incorporate the quantum of these incentives.

This incentive would support those rural doctors providing primary care/general practice services through an accredited general practice, together with secondary care at the local hospital. A rural doctor who only provides a subspecialty practice within a hospital setting would not be eligible for the incentive.

The isolation payment

The isolation payment would compensate rural doctors for the greater isolation, costs involved with rural practice.

The rural isolation payments would provide more targeted payments to rural doctors, and be structured as a loading that would be provided for each service provided.

While there is already the GPRIP incentive program in place, the anomalies inherent with the ASGC-RA classification system, which underpins how incentives available under the GPRIP are allocated, prevent the GPRIP from providing effective and transparent rewards for doctors who go to work in rural and remote areas and stay there.

To ensure rural isolation incentives such are those available under the GPRIP are capable of attracting and retaining doctors to smaller communities, the incentives must be based on a realistic rural classification system that

appropriately classifies smaller rural communities. This means that smaller rural communities should not be included in the same classification as larger communities, which unfortunately is currently the case under the ASGC-RA.

There must also be an adequate incentive differential between communities in different ASGC-RA categories. For example, the incentive differential for living, working and establishing a practice in the inland town of Cloncurry (RA4) as opposed to the coastal city of Townsville (RA3) must be significant enough to act as an incentive.

It is therefore proposed that the difference in incentive grants be adjusted to ensure that there is at least a significant loading for smaller communities and more remote communities.

Incentives for specialists to live and work in regional Australia

Rural communities have the right to specialist[24] medical care provided by a sustainable specialist workforce in order to maintain their health at the same level as those living in metropolitan areas. Local access to cardiology services improves survival from heart attack. Local accident and emergency, surgical, anaesthetic and intensive care facilities increase the likelihood of surviving trauma and acute illness. Local medical, oncology, radiology and radiotherapy services reduce the need to travel long distances for care.

Easily accessible obstetric and paediatric services mean young parents living and working in rural communities can have babies and raise their families with confidence that appropriate healthcare is available when they need it.

The rural specialist workforce is ageing. Service gaps that are increasingly difficult to fill are appearing. The potential for a significantly better income in private practice in urban areas is a major disincentive for new Fellows to consider regional practice, particularly as some regional centres will not have the population mass to support sub-specialties.

Specialists who have spent years caring for their communities are increasingly frustrated by hospital systems that respond to medical workforce shortages by short-term strategies, employing expensive locums or sourcing specialists trained overseas, rather than working with the specialists themselves to seek long-term practical solutions.

[24] For the purposes of this discussion, a "specialist" encompasses medical practitioners other than specialist General Practitioners.

Ultimately, rural and regional centres that offer good facilities and reasonable remuneration are required to attract newly qualified specialists to regional and rural.

RDAA believes the Government should do more to invest in regional specialist services. This should investment should include:

- extending the Specialist Obstetrician Locum Scheme (SOLS) program to other craft groups, particularly paediatrics, and expanding it to include all appropriately qualified GP proceduralists
- providing financial support for specialist colleges to develop training programs, including mentorships and scholarships, to encourage rural specialists to train the next generation of rural specialists
- extending the General Practice Rural Incentives Program to specialists
- enhancing the provision of educational resources, infrastructure and accommodation for rural registrars and post-fellowship trainees, including the development and support of community-sponsored programs to encourage the retention of rural specialists, and
- expanding the Support Scheme for Rural Specialists.

For more information, see RDAA's Rural Specialist Group information papers:

1. *A sustainable specialist workforce for rural Australia*, and
2. *Value of local specialists medical services to rural Australia.*

These papers are available online at http://www.rdaa.com.au/policies-submissions/papers.

2.2 PROFESSIONAL SUPPORTS

Small rural communities require sufficient numbers of appropriately skilled doctors to share the workload of meeting their primary and secondary (hospital-based) health care needs. In many rural communities, any doctor will simply not do – it must be a critical mass of doctors with the skills, training, experience and inclination to provide services across the primary and secondary care continuum, including a willingness to share the load of providing afterhours and emergency care. Where a critical mass is not feasible, adequate relief must be available to allow rural doctors to take time-off. This should include leave to participate in continuing professional development.

Changes are required to secure a rural pipeline of medical graduates for the future with the skills required for rural practice.[25] This must include medical graduates with advanced skills training who can provide procedural and other services to rural and remote communities.

[25] Ibid, at S72.

Delivering appropriately skilled doctors to rural Australia

Queensland's Rural Generalist Pathway (QRGP) has experienced some early success in delivering procedurally-trained doctors to rural locations across the State. The QRGP offers a fully supported career pathway for junior doctors wishing to pursue a vocationally recognised career as a "rural generalist". The pathway has proven to be popular and is now over subscribed.

The apparent early success of the QRGP in drawing the next generation of doctors into rural practice has prompted calls for a national approach to the delivery of advanced rural training specific to meet the needs of rural communities. These calls are underpinned by recognition that, while the specific design of the QRGP has been influenced by circumstances unique to Queensland, the key pillars of the QRGP model are potentially transferable across all Australian jurisdictions.

RDAA is working on the proposal for a National Advanced Rural Training Program (NARTP) in consultation with the Australian College of Rural and Remote Medicine, Australian Medical Association, General Practice Education and Training, General Practice Registrars Australia, and Royal Australian College of General Practitioners.

The proposed NARTP represents one of the most promising ways to ensure that patients in rural and remote areas gain the access they need and deserve to high quality patient care in the primary care and hospital setting. The NARTP would offer a fully supported and coordinated training pathway and appropriate recognition and incentives for pathway graduates to practise in rural areas, and would involve a reworking of how existing GP training pathways and processes can provide support to junior doctors seeking a career in rural practice.

Evidence suggests that the opportunity to perform procedural and higher level clinical work increases the attractiveness of general practice as a career choice.[26] This is clearly demonstrated in a recent study that concluded that the probability of a junior doctor choosing to become a GP (which is around 39%) rises by 16% with an increase in procedural work.[27] The study also concluded that increasing GP earnings by one third (or $50,000) would lead to a 12% rise in the probability of a junior doctor choosing to become a GP.[28]

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[26] *Sivey, P, Scott, A, Witt, J, Joyce, C and Humphreys, J, Why Junior Doctors Don't Want to Become General Practitioners: A Discrete Choice Experiment from the MABEL Longitudinal Study of Doctors (2010) Melbourne Institute Working Paper Series. Working Paper No. 17/10, University of Melbourne.*
[27] Ibid, at 20.
[28] Ibid, at 20.

These findings suggest that an advanced rural training program that offers a mix of general practice and hospital work and the introduction of financial rewards for rural doctors with advanced skills training are likely to attract more junior doctors into a career in rural practice. [29]

These findings also suggest that the time has come to rethink how we use existing training programs, infrastructure and resources to train and retain doctors for rural practice.

Investing in the regional training of doctors

Commonwealth initiatives to support the development of a robust rural and regional health workforce have already produced some very positive outcomes, including increased GP training places in rural and regional Australia. There has also been an increase in the number of places for undergraduate medical students, a cohort who are already starting to graduate and enter prevocational training.

The increasing number of medical graduates provides a real opportunity to invest in a range of initiatives to ensure that students and junior doctors with a commitment to rural training and rural practice can access clear pathways through medical school and, following graduation, to rural practice. To achieve this, greater numbers of training placements in rural and remote areas and appropriately skilled clinical supervisors are required, along with adequate infrastructure and support and remuneration for supervisors.

There are a number of barriers to teaching junior doctors and registrars in general practice. These include a lack of practice infrastructure and teaching space, insufficient funding for teaching, loss of income for supervisors, an increase in liability, and pressures on time.[30] These barriers are often exacerbated in rural and remote areas where there is an undersupply of doctors and where it costs more to build practice infrastructure. Many rural practices are finding it harder and harder to balance clinical service provision and teaching roles, as teaching and supervision takes GPs away from patient care and creates additional work for other practice staff.

Securing affordable, temporary accommodation for medical students, junior doctors and registrars in rural and remote areas is also a challenge, particularly in mining communities where vacancy rates for rental accommodation are low and rental prices are high.

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[29] Doctors who graduate from the NARTP, go to work in a rural area, and provide primary care services and meaningful on-call and procedural services for in the local hospital would be eligible for the proposed explicit complexity and isolation payments proposed under Section 2.1.

[30] Thomson J, Allan, Belinda, and Anderson, Katrina. *GP interest in teaching junior doctors. Does practice location, size and infrastructure matter?* Australian Family Physician Vol. 38, No. 12, December 2009.

Positive rural experiences at the undergraduate, junior doctor and postgraduate level are important, as they increase the odds of medical students, junior doctors and registrars choosing to become a rural doctor. A greater investment in medical training infrastructure and supports is required to ensure rural practices and rural hospitals are able to offer meaningful training opportunities to a larger number of trainees in the full range of rural settings. This investment should recognise the true costs and benefits of teaching and revise remuneration for teaching practices accordingly. Additional resources should be provided to fund appropriate infrastructure to accommodate junior doctors and registrars in rural and remote primary care settings.

2.3 PRACTICE INFRASTRUCTURE

Infrastructure grants

The capital cost of premises and infrastructure in rural areas and the negative impact this has in relation to recruiting doctors and on incomes was seen under the Viable Models project as having a significant negative impact on viability.

In view of this, RDAA has welcomed the funding of rural medical practice infrastructure by the Federal Government through the Primary Care Infrastructure Grants program.

The program provides grants to assist rural and urban practices to increase consulting rooms, expand treatment areas, provide additional space for allied health services, and make more space within the practices to train medical students and young doctors.

The Federal Government recently announced a second round of grants under this program. About $21 million in grants in this round has been shortlisted for general practices in regional and rural Australia.

One of the biggest challenges in rural practice is affording the expansion of the infrastructure itself to accommodate enough doctors, nurses and other health professionals. The cost of developing additional practice infrastructure is significant, and as a result many rural practices remain restricted in the range of services they can provide, in part because they can't afford to expand their practice space.

In view of this, these grants under the Primary Care Infrastructure Grants program are extremely important to the rural practices that receive them. They are also a great investment in the future rural doctor workforce, given expanded infrastructure can make it easier for rural practices to train additional medical students and young doctors.

RDAA believes that infrastructure grants should be more targeted and be accompanied by funding agreements that include service requirements that reflect the needs of the local community. For example, if a small rural community has no afterhours services, an infrastructure grant to the local practice to expand its service could include a requirement that the practice agrees to provide an afterhours service for a minimum period of time.

RDAA also believes the impact of these grants is undermined to a certain extent by the requirement that such grants be considered taxable income. This means, for example, if a rural medical practice receives a $500,000 grant under this program, the net value of this grant will actually be around $350,000 after tax.

GP superclinics

RDAA supports the establishment of GP Super Clinics in rural communities with government funding where the community is asking for a GP Super Clinic, where the community needs the services offered by a GP Super Clinic and where the establishment of a GP Super Clinic does not comprise the continued viability of existing general practices.

The Federal Government's GP Super Clinic Program has been plagued by problems. Targets for the completion of these clinics have not been reached, and decisions about the locations for the clinics appear to be based on politics rather than the actual primary care needs of communities. In some locations where GP Super Clinics have been established, operators have struggled to staff the new clinics and have had to rely on locums or fly-in and fly-out doctors.

The Federal Government is making a significant investment in GP Super Clinics, allocating $280.2 million to the program in 2007-2008 and additional funding provided in 2010-11. RDAA believes that a better use of some of this funding would be to provide GP infrastructure grants for existing rural practices that have a history of providing quality care to their communities. Such grants could assist them to expand the range of services they can provide and/or train additional medical students and young doctors.

PART 3: IMPACT OF MEDICARE LOCALS IN RURAL AREAS

RDAA believes the work of Medicare Locals should always build on the strengths of existing primary health care services, particularly those provided through general practice.

RDAA has long advocated for coordinated primary health care in the rural setting with the rural generalist practice at the centre of all primary care arrangements. Strong primary health care delivers improved population health and improved health outcomes.[31] Many chronic diseases such as diabetes, heart disease, and cancer - which lead to serious illness and premature deaths - can also be prevented or better managed through primary health care.

However, efforts to build strong, coordinated primary health care in rural and remote Australia are often impeded by a significant shortage of GPs and other health professionals.[32]

A large number of Medicare Locals have already been appointed, yet it remains unclear how Medicare Locals will operate and how they will benefit patients or communities. A key concern for RDAA is how Medicare Locals will handle the transition to performing a myriad of complex roles in the primary health care space and the impact this transition will have on rural doctors as the principal providers of primary health care, as well as afterhours and hospital-based services in rural communities.

The potential scope of the work of Medicare Locals is both diverse and far-reaching. Medicare Locals will coordinate primary health care planning and delivery, tackle local health care needs and service gaps, drive improvements in primary health care, work with LHNs and the aged care sector to improve patient journeys, and plan and support local after hours face-to-face GP services.
If all of these roles are done efficiently, effectively and transparently for the benefit of all communities within the reach of a Medicare Locals, there will be worthwhile outcomes for GPs and their patients. If they are not, valuable health dollars could be wasted, the gap between the health of people living in rural and remote areas compared to people living in metropolitan areas could widen and the GP workforce – particularly rural areas – could be disheartened and discouraged.

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[31] Australian Institute of Health and Welfare (2008), *Review and Evaluation of Australian Information about primary health care: A focus on general practice*, Canberra
[32] [2]Australian Government Department of Health and Ageing (DoHA), 2008. *Report on the Audit of Health Workforce in Rural and Regional Australia,* April 2008, Canberra.

3.1 GP REPRESENTATION ON THE BOARDS OF MEDICARE LOCALS

Consulting a GP is the most common action related to health care undertaken by Australians. This frontline contact with a doctor provides a unique opportunity to provide care for acute and chronic health conditions, as well as to engage patients in health promotion and illness prevention activities. In view of the pivotal role of GPs in primary care, RDAA believes that governing Boards of Medicare Locals require strong leadership from GPs.

Where the boundaries of Medicare Locals extend beyond metropolitan areas, Board membership should include rural representation.

3.2 MEDICARE LOCALS AS FUND HOLDERS

RDAA does not support the establishment of Medicare Locals as fund holders. In particular, RDAA strongly opposes the proposal to abolish the afterhours PIP payments and devolve responsibility for funding afterhours services to Medicare Locals.

From July 2013, existing afterhours incentive payments for general practice provided under the Federal Government's Practice Incentive Program (PIP) will cease and alternative funding arrangements implemented by Medicare Locals.

RDAA believes there is a real danger that transferring this responsibility to Medicare Locals may impact on the ability of people living in small rural and remote communities to access primary care. If the level of funding currently provided to rural GPs who provide afterhours services comes under threat under these new arrangements, the financial viability of rural practices may be undermined as many are small practices vulnerable to a loss in income.

Many doctors working in rural practices struggle to achieve a work/life balance, particularly where they provide afterhours and emergency care at the local hospital work. On call rates can be very high, particularly where there are workforce shortages, resulting in "burn out" if these doctors do not receive additional time off and adequate financial compensation.

In view of these challenges, RDAA is very concerned that the withdrawal of the PIP afterhours incentive and the handing over of the responsibility for planning, coordinating and funding afterhours services to a third party may demotivate some GPs and lead them to walk away from providing afterhours services. Indeed, this is exactly what occurred in England in 2004 when responsibility for planning, securing and coordinating afterhours services was transferred to Primary Care Trusts. Almost all GPs (90%) walked away from providing afterhours services, leaving the Primary Care Trusts to come up with options for

afterhours care.[33] This left patients requiring afterhours medical care to present to Emergency Departments and Primary Care Trusts scrambling to employ expensive locums and health professionals from private firms.

The PIP is a transparent, national process of providing support for all eligible general practices that provide afterhours services. It allows GPs to participate in afterhours services where they have the necessary skills and qualifications.

Under the new process, PIP will be replaced by locally-based arrangements for allocating funding that will be determined by the Boards of Medicare Locals. The potential for conflicts of interest is substantial. Many health professionals sitting on such Boards will have a private practice, or be affiliated with a private practice, that may wish to seek funding from Medicare Locals. Requiring the CEO or Board of a Medicare Local to make decisions about allocating funding to a Board member is less than ideal.

Where funding is allocated to one practice over another practice in circumstances where someone who works at, or is affiliated with, the successful practice is a member of the Medicare Local Board, there will inevitably be a perception of bias. This will undermine the credibility of the Medicare Local and damage its relationship with local health professionals.

There is a real potential for a conflict of interest where the Medicare Local is a fund holder and also becomes a service provider. What happens where a Medicare Local establishes a new after hours service in a community because the local medical practice did not provide this service, and some time later the practice is purchased by a doctor who wants to compete with the Medicare Local in terms of providing afterhours services?

If Medicare Locals decide not to continue to fund practices that have been providing afterhours care in rural communities for some time, this decision will cost rural practices tens of thousands of dollars each year. This represents a serious financial threat to the viability of rural practices.

There are no guarantees that Medicare Locals will continue to provide the level of funding currently provided under the PIP to practices who are already providing afterhours services to rural communities. Guidelines issued by the Department of Health and Ageing that recommend that existing afterhours arrangements that are working well should continue to be supported provide little reassurance, as they are merely ‘guidelines’.

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[33] Grol, Richard, Giesen, Paul and van Uden, Caro, *After-Hours Care In The United Kingdom, Denmark, And The Netherlands: New Models,* Health Affairs, 25, no. 6 (2006): 1733-1737

Ultimately, it is up Medicare Locals to decide how to allocate such funding.

RDAA is receiving reports from members complaining that, where afterhours negotiations have occurred, there appears to be a lack of transparency and understanding surrounding after hours care proposals by some Medicare Locals in rural communities. We believe there is the strong potential that more pressure, not less will be placed on the shoulders of rural doctors. Funding will be lost from the very practices that are currently providing a comprehensive service.

There are also some unanswered questions about how the work of Medicare Locals in relation to afterhours services will impact on State-based industrial agreements under which doctors provide afterhours services through local hospitals. RDAA has concerns that the new arrangements will create an environment that allows for cost-shifting to occur from State Governments to the Federal Government. With Medicare Locals now funded for the planning and funding of local face-to-face after hours services, State Health Departments may step away from afterhours industrial agreements. If this occurs, afterhours services in some rural and remote communities may collapse.

RDAA believes that the existing afterhours incentive payment under the PIP should be retained as a more transparent process for allocating these types of payments.

3.3 THE ACCOUNTABILITY OF MEDICARE LOCALS

To ensure Medicare Locals represent value for health dollars, the impact of Medicare Locals on all the communities they serve should be measured and reported. Medicare Locals are not “local”. Some will service a whole State or Territory. Others will cover vast geographic areas with dispersed communities. A real concern for the RDAA is that the work of Medicare Locals covering large geographic areas will focus on encouraging and supporting the delivery of primary health care in larger, regional centres where it is relatively easier to attract and retain rural health workers and achieve better economies of scale.

RDAA advocates for the Federal Government to establish a framework to measure the performance of Medicare Locals that clearly articulates how Medicare Locals will be held accountable for their work. This should include performance indicators that are capable of measuring the differential impact of the work of Medicare Locals across urban, regional, rural and remote communities.

PART 4: OTHER RELATED MATTERS

4.1 DISTRICTS OF WORKFORCE SHORTAGE/TARGETED WORKFORCE AREAS

RDAA holds strong concerns about the interface between districts of workforce shortage (DWS) and section 19AB of the *Health Insurance Act 1973* (the Act) and the Bonded Medical Places scheme.

RDAA believes the DWS is failing smaller rural communities where doctors work longer hours to compensate for workforce shortages. This is illustrated in some of the current anomalies.

An area is a DWS for general practitioners if it falls below the national average for the provision of medical services for the specialty, based on the latest Medicare billing statistics. Overseas trained doctors (OTDs) are able to access the Medicare benefits arrangements under Section 19AB of the Act if they choose to practise in a DWS as a general practitioner.

The major concern is that these criteria do not fully appreciate the clear difference in the nature of the medical workforce problem in rural and remote areas and the significant demands rural practice places on practitioners and their families.

The fact that many rural doctors are willing to work longer hours, and endure a heavy on-call workload, works against them under the DWS program. For example, only two doctors work permanently in the town in the small NSW rural community of Gundagai (population of around 3,000 people). For the next 28 days, because of medical workforce shortages, these two doctors will be providing round the clock care from their general practice and at the local hospital during office hours and afterhours. As providing this level of coverage is a regular occurrence, the Medicare billing statistics for Gundagai hide the level of workforce shortage and obscure the hours worked by the two doctors to maintain medical services. As a result, Gundagai is not classified as a DWS. This story is replicated in numerous small rural towns across the country.

If the two doctors in Gundagai decided to only provide general practice services during office hours Monday to Friday, and no afterhours or hospital-based services, the Medicare billing statistics would tell a different story.

The personal costs associated with working longer hours and having an on-call workload, particularly in the absence of adequate rewards and supports, impact on the professional satisfaction of rural doctors and the sustainability of rural practices. Such personal costs impact on the ability of small rural communities to

attract and retain the next generation of GPs who are seeking a better work/life balance than previous generations of GPs.

The inappropriate classification of small rural towns as not being DWS impacts on the ability of rural practices to alleviate medical workforce shortages by employing doctors who are required to provide a return of service in an area classified as DWS as part of scholarships provided under the Bonded Medical Places (BMP) schemes. The doctors under the BMP scheme will be completing their Fellowships in the coming months and looking to be GPs in an eligible location. The anomalies in the DWS mean that time spent working in heartland rural communities such as Gundagai, Wonthaggi, Cootamunda and Temora will not count towards their return of service.

RDAA has been advised by the Australian Department of Health and Ageing (DoHA) that the DWS system is under review and that a new system – Targeted Workforce Areas (TWA) – will be implemented early next year. RDAA understands that the TWA will use a fixed national doctor to population average ratio rather then a moving national average, involve a move to annual reporting of TWA against the fixed national average ratio (as opposed to quarterly reports) and use of current full time equivalent (FTE) workforce figures for calculating doctor numbers.

RDAA has raised a number of concerns about the proposal for TWAs. One concern is that the move to annual reporting of TWA against the fixed national average ratio may cause problems for smaller rural communities. If a small rural community is not classified as TWA, but they lose a doctor at the beginning of the year, these communities may have to wait until the end of the year to get an updated TWA status. In smaller rural communities, the loss of one doctor from a small practice of two or three doctors can have a substantial impact on the workload of the remaining doctors, particularly where the practice provides afterhours and hospital-based services.

In addition, under the proposed TWA, the calculation of a FTE doctor will be based on Medicare billing. So in small rural towns like Gundagai, the volume of work performed by the two permanent doctors will also paint a picture of Gundagai being a town with adequate medical workforce.

The design of the DWS and the proposed TWA fails to understand, and take account of, the nature of rural practice. This failure is having a significant impact on the ability of small rural communities to access medical services and to attract and retain doctors.

RDAA believes that more work needs to be done on the design of the TWA system before implementation to ensure the system did not disadvantage small rural communities.

4.2 RURAL PROOFING

The RDAA believes the Australian Government should undertake formal rural proofing of all proposed health policies and programs to ensure they are sensitive to the probable significant differential impact in rural and remote Australia.

Rural proofing is shorthand for "a process that involves assessing how policies will work for rural people and places, and, so, ensure that the policies are implemented fairly and effectively."[34] It is a process that requires health policy-makers to genuinely understand and assess the impact of any proposed health programs and policies on a rural community's healthcare needs and on existing rural health services.

It provides an opportunity for health policy-makers to make upfront adjustments to policies and programs to ensure the health services will be appropriate for individual rural and remote settings.[35]

The process of rural proofing can hold governments accountable for rural health delivery and outcomes, particularly if assessments of the impact on rural health outcomes are reportable to the public.

Experiences of rural proofing

Over the past decade, a number of countries have introduced rural proofing to address the inequities that exist in health service provision across urban and rural areas.

Rural proofing for health is mandatory in England, where tools have been developed to help policy-makers to identify and assess the impact of policies and programs across different localities.

Government Departments and regional Government Offices in England are required to report annually on how their policies have been rural proofed, and an assessment of rural proofing is published annually.

Recent reviews in England report mixed progress with implementing rural proofing across Government.[36]

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[34] Commission for Rural Communities (2009), *Rural proofing guidance*, England.
[35] Swindlehurst, HF, Deaville, JA, Wynn-Jones, J and Mitchinson, K (2005) *Rural Proofing for Health: a Commentary*, International Electronic Journal of Rural and Remote Health Research, Practice and Policy.
[36] See, for example, Commission for Rural Communities (2007) *Monitoring rural proofing*, England, and Atterton, J, (2008) *Rural Proofing in England: A Formal Commitment in Need of Review*, Centre for Rural Economy Discussion Paper Series No.20.

Where rural proofing has been implemented more successfully, the policy areas had commonly embedded the rural proofing process within key policy making processes, applied rural proofing to the design and delivery stages of policy development, and received strong support for rural proofing from senior officials.[37]

Engagement and consultation with stakeholders also appears to be an indicator for successful implementation of rural proofing.[38]

In view of these lessons learned overseas, the process for rural proofing health policies and program in Australia should be:

- embedded within key policy making processes
- engaged early in the policy/program development stage
- supported and oversighted by senior management
- undertaken by policy-makers who are well informed and advised on rural distinctiveness,have received appropriate training and are appropriately resourced to conduct rural proofing, and
- underpinned by an evidence-based approach to policy-making.

The implementation of rural proofing should be accompanied by an accountability framework to ensure that engagement in this process has a meaningful outcome for people living in rural and remote areas.

Key challenges for Australian health policy-makers engaging in rural proofing will include understanding when rural proofing should be applied, engaging stakeholders effectively, delivering rural proofing consistently and taking full account of the diversity of rural and remote communities.

4.3 THE NEW RURAL HEALTH AGENCY

The Federal Government announced in May 2011 that it would provide funding for a new Rural Health Agency.

The former Minister for Health, the Hon Nicola Roxon MP, indicated that she envisaged that the agency will play a public advice role and have the "seniority of leadership and status to co-ordinate funding and policy, as well as argue the benefits of regional health funding across Government."

[37] Atterton, J, (2008) *Rural Proofing in England: A Formal Commitment in Need of Review*, Centre for Rural Economy Discussion Paper Series No.20

[38] Commission for Rural Communities (2007), at 10.

The RDAA welcomes the establishment of this new agency, and urges the Federal Government to ensure the agency has the resources, skills and expertise required to undertake rural proofing of proposed health programs and policies.

The RDAA also urges the Federal Government to ensure the new agency is a strong, independent advocate for rural health and is positioned to have a real influence on the design of health policies and programs and seek adjustments where necessary.