TMT submission to

Senate Standing Committees on Community Affairs

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

December 2011

Senate Standing Committees on Community Affairs Inquiry

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

Terms of Reference

The factors affecting the supply and distribution of health services and medical professionals in rural areas, with particular reference to:

(a) **the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres;**

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

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

(i) **their role, structure and effectiveness,**

(ii) **the appropriateness of the delivery model, and**

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

(d) **any other related matters.**

Introduction

Tropical Medical Training (TMT) is well qualified to assist the Senate Standing Committee on Community Affairs in their inquiry into "The factors affecting the supply of health services and medical professionals in rural areas" and, provides the following comments for consideration by the Committee.

Based in Townsville, TMT conducts training for the Australian General Practice Training (AGPT) program using a regional structure, supported by local medical educators and professional staff. Training with TMT leads to either Fellowship in the Royal Australian College of General Practice (RACGP) and/or Fellowship in the Australian College of Rural and Remote Medicine (ACRRM).

We provide general practice registrars the opportunity to train for a wide range of medical skills, in urban and rural placements, through our network of hospital, community clinics and general practice training facilities. Registrars can choose comprehensive learning opportunities from urban, regional, rural and remote health facilities. Additionally, we offer an active training program in Aboriginal and Torres Strait Islander health, strongly supported by the Aboriginal Medical Services across the region and the peak body Queensland Aboriginal and Islander Health Council (QAIHC).

The changing demographics of rural and remote communities exert pressure on the limited range of health care services and providers that exist in the regions and their communities. Younger people have been leaving many communities for urban centres, which makes filling professional (and voluntary) health care positions more difficult. Moreover, the number of elderly people remaining in rural communities has increased and this population is living longer. Furthermore, poverty is more widespread in rural and remote areas; so many residents have difficulty in travelling to urban areas to seek healthcare services when required.

This submission looks to put these characteristics into context and provide the Senate Standing Committee on Community Affairs with an overview in line with their Terms of Reference.

TMT’s Region

In commencing our submission it is pertinent to review the characteristics that underpin the provision of general practice services across rural and remote Queensland.

TMT's footprint covers two-thirds of Queensland and services the region through three cities, each with a greater population than Darwin. Our region is equal to the combined size of NSW and Victoria. The training opportunities are very diverse and include the urban cities of Mackay; Townsville; and Cairns; remote centres including Mt Isa in the greater west of Queensland; to the rural regions of the Atherton Tablelands; and the remote communities in the northern most areas of Cape York and Torres Strait Islands. With distances of 400 kilometres separating the major centres and very different cultural and geographical features, general practice across the region offers many opportunities for unique training and health care experiences.

The region can be characterised by the complications of inadequate transportation, large geographic distances (measured by hundreds of kilometres); an aging rural population base; frequent and entrenched poverty; and, complex cultural requirements for health care delivery across the rural and remote communities.

The health care infrastructure across much of the region is characterised by a web of small country hospitals, clinics and nursing homes often experiencing significant financial pressures. Many rural hospitals have financial margins too narrow or too low to support investments in critical plant and technological upgrades. The financial stress on the rural health care system is in large an expression of public policy. It is these features, coupled with fragile healthcare infrastructure at many centres that makes the delivery of rural and remote health care services a formidable challenge across northern Queensland.

Regional Training Provider

As a regional training provider funded by the General Practice Education and Training (GPET) program, TMT has strong support for the regionalisation of general practice training. The program permits the development of valuable localised skill sets that are demanded in rural general practice delivery.

Unlike their urban colleagues, the rural and remote serving general practitioner is frequently called upon to use advanced skills in emergency medicine, anaesthetics and obstetrics in their daily routines in rural and remote regions. These skills have been developed through the AGPT program, particularly in those regional training providers (RTPs), such as TMT, with significant rural and remote locations and with boards committed to rural medical workforce

Promotion of the value and professional rewards of rural practice to registrars – the advent of ACRRM and (in Queensland) the success of the rural generalist program and the support of rurally oriented RTPs.

Also the accompanying significant salary rises for senior medical officers in country Queensland hospitals is a powerful incentive towards training, recruitment and retention for some medical personnel.

Healthcare reform legislation needs to address the infrastructure, plant and technological needs of rural health care facilities, and provide resources to expand health care facilities to undeserved or unserved communities.

(a) the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres;

Factors influencing the decline in the number of general practitioners choosing to work in geographically distant areas include the increasing number of women in medicine; the lifestyle preferences of younger practitioners; and, the increasing amount of student debt; all negatively affect rural health professional recruitment.

Important differences in health outcomes across populations and geographical regions reflect differences in access to healthcare services. Many studies have shown the effect of low access on health outcomes; and the fact that general practitioners most often practice in urban communities rather than rural regions. Rural areas also have lower proportions of all healthcare professionals.

The expected growth of the older population in Australia over the next 25 years will have an unprecedented impact on healthcare system, especially in terms of supply and demand for health care workers. The supply of health care workers may decrease as they age and large numbers retire and/or reduce their working hours. At the same time, older adults consume a disproportionately larger share of the Australian health care services, so actual demand for health care services will grow. The aging of the population will also affect the nature of the skills and services the health care workforce must be equipped to provide, and the nature of the settings in which this care is provided.

<u>Practice Management</u>
Rural economic disadvantage is addressed by strong pressures for rural practices to bulk bill, compared with inner urban sites. At the same time, practice costs are significantly higher. Additionally, investment in practice buildings and services presents a financial trap, as doctor-owners on retirement are unable to cash in their investment. In urban centres there is an increasing flow of practitioners keen to purchase working practices, but in regional areas the opposite is the case and fewer professional colleagues choose to carry the burden of practice management.

Further, rural practices are at a disadvantage when it comes to investing in the costs of infrastructure and technological developments. Current Federal government Practice Infrastructure Grants offset this only to a minor extent for some fortunate practices and do not afford long-term solutions.

Recouping these investments is frequently not possible in remote areas, and therefore the initial investment is not made. This puts the practitioner at a significant disadvantage compared to his/her urban counterpart. It means that not only does the patient not receive the preferred treatment options available in urban centres; the practitioner has increased difficulty in maintaining practical application of the treatment protocols.

Rural health services often experience diseconomies of scale in that their long run average cost increases as output increases. Providing healthcare becomes too expensive; then providers lose money, and close or merge with other services thereby decreasing access. Rural populations then experience an increase in distance and travel time to access necessary healthcare services.

Family Centred-Lifestyle

A significant downside for many practitioners is the compromise that is forced upon their families. A real lack of suitable housing availability and affordability leaves many professionals refusing to accept the regional placements. For many professionals it is only in the major regional centres – Townsville, Mackay, and Cairns – that a reasonable standard of living is offered and the more remote areas lack the attractiveness and requirements for family life. This leads to families often being located many hundreds of kilometres away from the medical practitioner, who many only see his/her family intermittently.

Family connections and a lack of suitable secondary and, of course tertiary, education choices, have led to the alternatives of costly boarding schools for many medical families. Children of urban based doctors are able to live at home and have greater educational choices. TMT has evidence of practitioners who are now seeking to relocate back to a metropolitan area next year. They would choose to stay on in rural and remote medicine for the work, lifestyle, ongoing training and professional development opportunities; and remuneration. However they are relocating solely for the education of their children as the quality of education is not the same as in more major regional areas.

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

Medicare Locals are regarded with a high level of suspicion by the majority of rural doctors. There is little cause to believe that they will have any positive effect on rural recruitment and retention. There is already some evidence that Medicare Local control of afterhours funding will seriously disadvantage rural doctors and patients.

From July 2013, three federal Practice Incentive Payments (PIPs) that have supported rural practices to provide after-hours care will be discontinued, with the funding transferred to Medicare Locals. This will leave Medicare Locals with the responsibility for planning after-hours services, and the power to determine whether existing arrangements will continue to be supported. The practitioners who have historically met this need through their own initiatives will again be disadvantaged.

Further, Medicare Locals will have limited impact on the conduct of professionals working within state government led regions. For example, across all of the Torres Strait medical services are supplied by Queensland Health dominated facilities and will be under that jurisdiction, rather than influenced by the Medicare Local network. Although this may well be a different proposition for Allied Health services, there is no expectation for improvement to the support of rural doctors in a professional capacity.

Healthcare resources and healthcare use varies considerably by level of urbanisation. Because of structural, financial and sociocultural barriers in rural populations, they have fewer healthcare resources than urban populations. These rural resource disparities often lead to adverse health outcomes and rural health status disparities, which are unlikely to be addressed through Medicare Locals.

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

The factors that influence individuals' decisions affecting choice of location in rural and remote areas are well documented. These are more commonly known as "push and pull" factors. Pull factors are identified as those which attract an individual to a new destination, they can include improved employment opportunities over these currently being experienced and career prospects maybe improved if a rural term can be demonstrated; often leading to a higher base income.

Increased rates of pay and allowances have become common to recognise service in rural and remote areas, causing an imbalance across the region for similar occupation roles. But the decreased satisfaction in the choice of living conditions can be detrimental over the more stimulating professional responsibilities and environment.

Push factors act to repel an individual and often mirror the push factors. These include loss of employment opportunities (a practitioner is out of the loop and not visible to attain referrals to higher positions), poorer conditions for both professional and lifestyle; lack of quality schooling opportunities for children; lack of opportunities for spouse employment or lifestyle satisfaction. The complexity of these factors makes their categorisation difficult, but they are generally discussed as individual, organisational, or broader environment factors. They may not individually influence health workers choices and decisions for location or practice in an isolated manner, but rather interact and influence the mindset and decision making processes that an individual may experience.

(i) their role, structure and effectiveness,

Some of the incentive programs recently introduced are well supported and regarded by doctors in rural and remote regions. These examples include the skills training occurring prior to moving to a rural area offered by the ACRRM, the Annual Procedural Up-skilling grants provided through Medicare, and the Queensland Health Rural Generalist programs.

Other financial incentives offered by the Commonwealth funded GPRIPS (formerly RRIPS), means that being a general practice registrar and a junior GP in rural areas can be financially rewarding. However, GRIPS payments are currently 5 months overdue to general practice registrars and the method of how they payments occur seems very complicated and convoluted; with 3 or 4 different organisations all involved (GPET, the RTP and Medicare – 2 different branches of Medicare).

Also the generous professional development leave provided by Queensland Health currently allows Queensland Health rural doctors to maintain their procedural skill-set and learn new skills to remain confident in their geographically and often professionally isolating environment. However, all these advantages have been undone by the illogical reclassification of rural areas through the ASGC-RA, which is addressed later in this submission.

(ii) the appropriateness of the delivery model, and

The introduction of the GPRIPS delivery model has been well-received and largely accepted by rural and remote practitioners. However, the reduced amount for the most remote category - compared with the earlier RRIPS program - is obviously less appealing. Additionally, the problem with the GPRIPS model appears to be the advent of the ASGC-RA classification system. This has been a poorly accepted program and appears to have made multiple rural and remote locations in Queensland equal with regional centres for remuneration.

Procedural Up-Skilling Grants provided through Medicare are again excellent and have been well received. As an example, these grants have made it feasible to work in a remote environment such as Thursday Island. In this isolated location, the number of elective anaesthetics performed by the local general practitioner may not be as high compared to other rural areas. However, the need for provision of anaesthetic skills, particularly in an emergency setting is very real. Being able to access funding to do full-time anaesthetics for 7 days per year has provided the professional development, personal confidence and clinical skill for the doctor to remain in the outlying centre for more than twelve months.

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

Undoing many of the benefits introduced in recent years, has been the illogical reclassification of rural areas through the ASGC-RA system. With minimal local consultation and a lack of understanding of rural and remote centres, the system has significantly altered incentives for training and advancement in regional centres. The introduction of the ASGC-RA erroneously reclassified many locations as less remote and thus attracting less financial incentives to work there in the future. Long hours, heavy after hours on call workload and poor remuneration under Medicare for these services were given some token recognition by the RIP's based on level of rurality/remoteness under the old RRMA classification. This has now been dismembered by ASGC-RA, as city locations are now equally financially attractive.

This change of classification of rurality has had a significant impact and has completely destroyed the small reward of incentive payments for doctors practicing in rural Australia. Inequities in the systemic redistribution have arisen from unethical, inequitable allocations - such as Mackay being classified as less rural than Townsville. This bias has led to doctors choosing to stay in the preferred urban centres of Townsville and Cairns, leading to reduced numbers accepting positions out of those areas.

(d) any other related matters.

Central to the study of rural health is how "rural" is defined. The supply of healthcare is affected by variables such as technological change, the size of the healthcare industry and, most importantly, by demand. As rural residents consume fewer healthcare services, less is supplied. These changes in supply and demand in healthcare perpetuate problems with access to care in rural areas.

Rural populations differ in many ways from their urban counterparts. Many features of the rural environment create barriers to healthcare access. It is important for rural health analysis and discussions to include these differences of financial, sociocultural, and structural factors that are part of the complex web of causation in rural health. These factors affect health seeking behaviours, health service utilisation, and ultimately health outcomes in rural areas.

Sociocultural factors include cultural and spiritual beliefs, language, education, self- reliance and concerns about confidentiality. Financial factors include a lack of private health insurance (due to a lack of services to support health needs) and a lack of income or financial resources to personally pay for needed health services. Structural factors are those that have to do with physical accessibility to healthcare resources. They include the availability of primary care providers, medical specialists, or other healthcare professionals and healthcare facilities.

Structural factors are measured in terms of availability and configuration of healthcare services, transportation to them and distance and time required to travel to them. This does not take into account the dislocation and personal disadvantages suffered by patients seeking health services many hundreds of kilometres from their home and personal support networks of family, friends and carers.

Significant decreases in healthcare services to the already vulnerable, at-risk populations have compounded the existing problem of resource disparities. In recent years changes in the kinds of health problems in rural populations have been noted. Vulnerable populations (persons with HIV-AIDS, the aging, those with chronic illnesses, those who are mentally ill, and/or abused persons) living within rural areas have compounded issues and added challenges associated with resource disparities and access to care.

Loss of community health services, healthcare professional shortages, rapidly rising costs, hospital closures, home care cut backs, fewer specialists services and an aging and retiring medical populations are just a few of the hangers that have led to greater resource disparities for rural populations.

Over the past decade the promotion of rural general practice in medical schools, especially rural and regionally based medical schools such as James Cook University's School of Medicine & Dentistry in Townsville and Cairns; the Australian College of Rural and Remote Medicine; and rurally located RTPs have combined to make it more appealing for those who choose to work in rural and remote areas. And, more recently, the support given by regionally based hospitals within Queensland Health, largely driven by the rural generalist pathway, have added to the level of support for the training of doctors located in rural and remote regions.

CONCLUSION

TMT is pleased that the Senate Standing Committees on Community Affairs has initiated this inquiry into the factors affecting the supply of health services and medical professionals in rural areas. TMT has a recognition and understanding of the hardships and frustrations imposed by the current system on people who are willing to serve in significantly disadvantaged regions of Australia.

The majority of doctors who work in small regional communities do so because they have a passion for rural health and wish to work in these areas. The financial incentives are generous and the work is satisfying. However the extra curricular activities, options available and education for children is commonly a main factor which prompts people to leave these areas. This is a difficult situation as these factors are often outside of the health care providers hands.

Medical professionals are motivated by a complex structure of rewards, in which non-financial benefits play an incredibly important role and are frequently outside the remit of healthcare systems. However, the healthcare services suffer as doctors will relocate to another position or location if their expectations are not met. Doctors working in rural and remote areas are at an advantage if they are able to draw on a personal experience of growing up remotely. Additionally, an association with an RTP, and with an university that has a strong rural focus (such as James Cook University's School of Medicine & Dentistry) has definitely enhanced rural retention rates.

In this context it is increasingly difficult for managers and policy makers to recruit and retain an adequately skilled and motivated health workforce. Motivation and job satisfaction have been proven to be critical to increasing the performance of health workers and thus the performance of the health system.
The problems in recruitment and retention will compound workforce shortages, while inability to motivate health workers will lead to decreased productivity. It is therefore essential for policy makers to have a good understanding of recruitment, retention and motivation factors and issues.

Practitioners who choose to work in remote and rural regions must not be allowed to be continued to be disadvantaged by their location and their patients not receive the identical quality of care and access to services as their urban counterparts receive.

These workforce issues and complexities exist despite the fact that, in general, rural people have greater medical care needs than urban people. The lack of continuity of care, the lack of general practitioners care from birth to death, and a lack of poor preventive care results in more serious and more expensive health a problems. These characteristics have led to a rural dependence on general practitioners, and their decline as a workforce is a major long term concern.

TMT is keen to present further evidence to the Committee if required and would welcome an invitation to participate in briefing sessions.

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