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Royal Flying Doctor Service

16 December 2011

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

e-mail: community.affairs.sen@aph.gov.au

Dear Sir/Madam

Re: Factors affecting the supply of health services and medical professionals in rural areas

Thank you for the opportunity to submit this letter for consideration by the Senate Standing Committees on Community Affairs inquiry into the factors affecting the supply of health services and medical professionals in rural areas.

The factors impacting on the delivery of health services to remote and small rural communities have already been thoroughly researched and much of the RFDS's experience aligns with the published evidence. We are aware that the National Rural Health Alliance, of which the RFDS is a member, is preparing a submission that will comment in some detail on the Inquiry terms of reference a) and c) and as such we will provide no additional commentary on these issues.

RFDS would suggest that it is too early to tell what impact Medicare Locals (MLs) will have on the provision of medical and other health services. We note a key focus for MLs will be building partnerships and establishing relationships with existing service providers. Given the RFDS services nearly 70% of the nation's landmass and overlaps with 10 (of 63) MLs across Australia, it will be important that the RFDS is viewed as a significant player in the MLs developments. To this end it will be crucial that the RFDS is included on the ML governance structures both at a local and national level if the organisation's expertise in remote health care is to be fully utilised.

In regards to current recruitment and retention incentive programs RFDS supports the graded payments based on length of service and degree of remoteness. However, we do not support the non-targeted inclusion of outer metropolitan areas into the program. RFDS believes that either outer metropolitan areas should be completely removed from the program or that a more targeted approach is taken focusing on low socio-economic areas or specific services such as Aboriginal health services. The savings from this restriction could be used to increase the incentives to the remaining locations, thereby increasing the overall effectiveness of the program.

RFDS experience shows that all previous classification schemes have had deficiencies and the ASGC-RA scheme, whilst better, is no different. The scheme does not adequately differentiate large regional, small regional, remote and very remote areas well enough. For instance, smaller towns one hour from larger regional centres have the same classification, despite significantly more disadvantage.

Once again we would alert the Inquiry to the NRHA's forthcoming submission on this issue which will detail the appropriateness of the ASGC-RA system for rurality classification, however it results in a number of anomalies and is therefore not sufficient.

RFDS believes that while adequate remuneration is an important issue in improving recruitment and retention of staff, it is not the only one. Other key issues are the level of on call and limited professional development opportunities. On call demands on staff could be reduced by rotating staff through FIFO arrangements, permitting rosters that minimise fatigue accumulation and devolving on-call to remote telehealth services that diagnose and treat (not just triage). Professional development opportunities could be maximised through incentives to support ongoing professional education and providing locum relief. Other factors, such as spousal employment opportunities and education options for children need to be strongly advocated to the relevant government departments.

Finally, we would suggest that governments could learn a lot from the RFDS when it comes to exploring ways for improving the recruitment and retention of staff in remote health care settings. The RFDS has been an exemplar of health service provision in remote and small rural areas for many years. The key components for our success include:

- Valuing our staff by our actions and employment conditions.
- Utilising a fly-in, fly-out model of service provision. This allows a tailored and dedicated service to the remote location requirements and benefits to professional, personal and family life from living in a larger centre.
- Providing a diagnostic and management telehealth service that supports rural practitioners generally and is aware of the capability and morbidity patterns of the regions that call us. It provides the first medical contact for callers and significantly reduces the disruption to the health staff based in the community.

In many cases this has been achieved over the course of RFDS history, despite not being able to compete with the financial incentives provided by state governments and the private sector. Having said this, in more recent times, we have had to move to offer salary packages more in line with other health care providers, one of the factors which has resulted in the costs of our services being much greater than the government funding we receive. While this has been manageable in the short term, it is not sustainable and unless government funding is now increased, we will be unlikely to maintain current levels of service or maintain our strong recruitment and retention levels.

If you require any further information do not hesitate to contact me.

Yours faithfully

Greg Rochford
National CEO
Royal Flying Doctor Service