RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Submission to the Senate Select Committee into Issues relating to Access and Affordability of General Practice under Medicare

December 2003

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Caring for the Country

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Senate Select Committee into Issues relating to Access and Affordability of General Practice under Medicare
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Recommendations to achieve the stated outcomes of MedicarePlus

BULK BILLING

1. That MedicarePlus be expanded to include:

- **a loading on GP services delivered in rural and remote areas or a new consultation item number for these services; and**
- **indexation of MBS GP items in line with real growth in medical costs, rather than the generic WCI5 index.**
- **a specific commitment to a quality-focused restructure of MBS attendance items.**

BENEFITS FOR ALL AUSTRALIANS

2. That MedicarePlus include the following measures to address Indigenous health issues:

- **the provision of a separate Medicare item for health checks for Indigenous Australians of all ages, including children; and**

- **the extension of the MBS item covering services provided by practice nurses without a GP present, to include, where appropriate, Aboriginal Health Workers covered by the 2002 Practice Nurse Initiative.**

PATIENT CONVENIENCE

3. That the subsidy for the installation of appropriate IT in rural and remote practices be increased to a level which more closely reflects actual costs.

SAFETY NET

4. That the level of the safety net should be arrived at by a consultative and transparent process which includes both MBS and PBS costs in its calculations.

MEDICAL WORKFORCE

5. That Medical Rural Bonded Scholarships be expanded and linked to the new bonded medical school places through the development of a second scholarship option, with a student accommodation and support package with preferential access to the support measures given to those actively involved in promoting procedural rural medicine.

6. That RDAA's integrated framework for viable rural practice and evidence-based benchmarks based on current Australian research be adopted as the basis for a systematic and systemic approach to rural medical workforce planning and support.

7. That the measures to support the procedural rural workforce are

- **refined and implementing in close consultation with rural doctors;**
- **framed with sufficient flexibility to include all who provide procedural services in both the private and public sectors; and**
- **built around eligibility criteria which reflect the realities of procedural rural medicine.**

8. That the re-entry measures proposed for specialists be extended to re-entry into general practice.

9. That preferential and supported access to re-entry into general practice be made available to those who wish to re-enter or take up procedural rural medicine and urban doctors who wish to return to or take up rural practice.

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MEDICARE

PREAMBLE

The Rural Doctors Association of Australia (RDAA) wishes to reiterate its support for Medicare and more importantly, the principles of universality, access, equity, efficiency and simplicity on which it is based. This submission should be read in conjunction with RDAA's earlier submission to the Select Committee into Issues relating to Access and Affordability of General Practice under Medicare (with specific reference to *A Fairer Medicare)* in which RDAA's interpretation of these principles is set out more fully.

There are many positive changes in MedicarePlus, notably the support for procedural rural medicine and the improvements and additions to workforce measures. RDAA also commends the removal of the compulsory and unbalanced elements in relation to bulk billing as this enables greater utilisation of the incentives. However, in dropping the graded differential for rurality, MedicarePlus has lost the opportunity to recognise significant differences in both the complexity of medical consultations in rural and remote areas, as shown in the recent study, *Viable Models of Rural and Remote Practice*[1], and the cost of delivering health services in a rural setting.

Until these differences are recognized, Medicare will continue to deliver 10 times the per capita amount of taxpayer dollars per annum in Double Bay than in remote areas of Australia.[2] Piecemeal measures, however useful in the short term, are not the answer to a sustainable healthcare system for 21st century Australia. Ultimately, fundamental systemic reform is required, with evidence based changes including:

- a thorough overhaul of Medicare financing to ensure inputs (the levy), quality care (reflected in the MBS item structure) and payments (the rebate) are realistic;

- an equitable distribution of Medicare benefits for all Australians achieved through a differential rebate; and

- a viable medical workforce underpinned by adequate professional, economic and organizational structures.

Since the preparation of our first submission, new material has become available through the Viable Models Study conducted by RDAA in conjunction with Monash University and economic modelling commissioned by RDAA from Access Economics. This and other recent research is used here to show how MedicarePlus can be used to work towards this reform.

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[1] Rural Doctors Association of Australia RDAA (2003). *Viable models of rural and remote practice:* Stage 1 and Stage 2 reports. Canberra. RDAA

[2] Mooney G (2002). Access and service delivery issues ***in*** Productivity Commission & Melbourne Institute of Applied Economic and Social Research - *Health Policy Roundtable*, Conference Proceedings Melbourne. Canberra, AusInfo

1. THE RURAL DOCTORS ASSOCIATION OF AUSTRALIA

RDAA was formed in 1991 to give rural doctors a national voice.

The RDAA is a federal body with seven constituent members - the Rural Doctors Associations (RDAs) of all States and the Northern Territory. Each State has two delegates on the Board of Management of the RDAA, one of whom is president of the autonomous State/Territory association. The Board meets monthly through teleconferences to which non-voting delegates with special expertise are often invited to attend. Each State/Territory association works and negotiates with relevant bodies in its own jurisdiction, while the RDAA Board of Management, supported by a small national secretariat in Canberra, has overall responsibility for negotiations with the Commonwealth and working with national bodies and decision makers.

In keeping with the overall demographic profile of the rural medical workforce, most members of the Rural Doctors Associations across Australia are general practitioners and more than half are men. However, the Association has been responsive to the diversification of the workforce through the creation of the RDAA Female Doctors Group which has been operating since 1999 and a Rural Specialists Group established late last year. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors who comprise 30% of our current workforce.

The RDAA has a particular focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce which is adequately remunerated and supported in order to provide quality medical care to the people of rural and remote Australia. Much of its work therefore concentrates on recruitment and retention issues and the viability of rural general practice. However, the RDAA is also an active participant in policy development on priority health and health service issues including Indigenous health, health financing and advanced nursing practice.

As the only advocacy body with a specific focus on the provision of medical services to rural and remote communities, RDAA has a particular responsibility to ensure that the needs and perspectives of people who live in the bush are heard by all decision makers and incorporated into the design and implementation of national policies and programs.

2. BACKGROUND AND OVERVIEW

This submission acknowledges the adjustments made to the The Fairer Medicare package and the new initiatives proposed in MedicarePlus and assesses them according to the basic principle of Medicare and the actual experience of rural doctors across the country. It also suggests a number of evidence and practice based strategies that are needed to ensure that Medicare is indeed "strengthened to meet the challenges of the future" as well as the needs of the present.

RDAA contends that the integrity of Medicare should be maintained by internal leverage through its fundamental mechanism – the patient rebate – rather than through extraneous incentives. Given that the greater complexity in clinical

presentations in rural areas and the time and skills required to manage them[3] are currently rebated at the same level as faster and less complex urban consultations, this could become a market force syphoning doctors away from the rural workforce. RDAA believes that Medicare would be maintained and strengthened by the introduction of a differential geographically based patient rebate or loading on that rebate.

In practical terms, RDAA believes that the $5 incentive payment to GPs who bulk bill children and cardholders is not likely to be effective in rural areas, where the average gap payment (between the Medicare rebate and the actual charge) is already $7. Instead, based on last year's billing rates, the incentive as proposed would increase the annual income of urban GPs by around $10,000 more than rural GPs. This will attract doctors to work in areas where bulkbilling is affordable, where patients can be seen more rapidly for less complex issues and where costs are lower, such as an urban large group practice.

In keeping with the greater complexity of presentation and the time and skills required, we believe there should be greater acknowledgment within the Medicare item structure of the health needs of Indigenous Australians.

A Fairer Medicare did acknowledge the greater costs and complexity of GP services in rural and remote Australia, but recognition of this fundamental difference has been lost in MedicarePlus. In dropping the principle of a graduated geographically based differential payment, the Government has lost an important opportunity to redress inequity in a system based on equality.

RDAA welcomes the workforce components of the package and the Government's recognition that ongoing shortages are a major factor which must be addressed if equitable access to Medicare is to be available in rural areas. However, as they stand, a number of the initiatives require careful refinement in consultation with major stakeholders in order to achieve their stated objective. These include, for example, measures designed to support procedural rural medicine, re-entry into the medical workforce and Overseas Trained Doctors. RDAA appreciates the opportunity to continue to work with the Commonwealth Department of Health and Ageing on specific adjustments to make these measures practical and effective.

The following sections discuss RDAA's position on a number of the specific issues addressed in the package in relation to bulk billing, benefits for all Australians, patient convenience, the safety net and the medical workforce.

3. BULK BILLING

A lost opportunity for a more equitable Medicare

The latest figures show that approximately a third of Australians live in rural areas.[4] Major determinates of health, including socio-economic and education status are lower in rural areas and compound the higher rates of chronic disease, risky lifestyle

[3] RDAA (2003). *op cit.*

[4] Australian Institute of Health & Welfare (2003). *Rural, regional and remote health: a study on mortality.* Canberra, AIHW

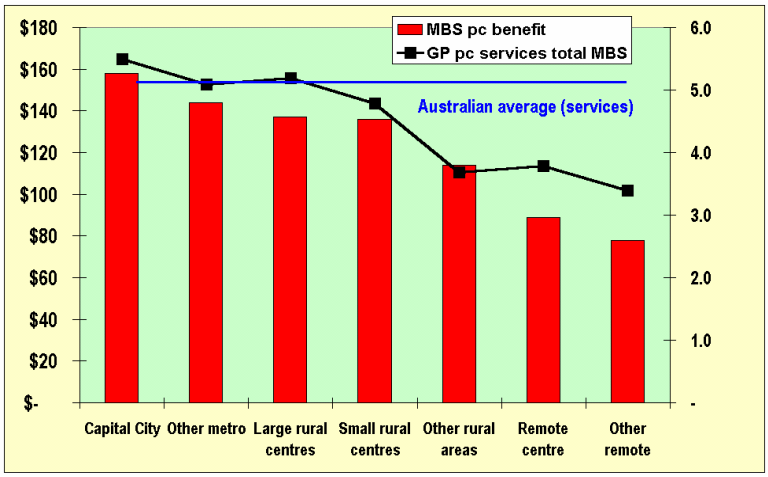
behaviours including smoking, and exposure to occupational hazards such as farm machinery and chemicals. Access to multidisciplinary health care in rural areas is limited by workforce and funding shortages, particularly in the areas of public health education and gender specific and sexual health services.

Standardized mortality rates show death rates in Australia increase with rurality: compared with the rates in major cities, they are 10% higher in regional, rural and remote areas and 50% higher in very remote areas. Life expectancy also declines as rurality increases: from 77.9 to 72.2 for males and 83.9 to 78.5 for females.[5]

Yet despite their higher health needs and equal right to Medicare, our universal health insurance system, the 28% of the population which lives in rural and remote Australia accesses only 21% of Medicare funded GP services.

Figure 1 illustrates differences in services in each RRMA (Rural, Remote and Metropolitan Area) classification, which declined from 5.5 in capital cities to 3.4 in remote areas in 2001-02. Figure 1 also shows that MBS billing per person falls steadily by RRMA category, from nearly $160 per person in capital cities in 2001-02 to less than half of that – under $80 per person – in other remote areas.[6]

Figure 1: Services & MBS benefits per capita, by RRMA, 2001-02



Source: DHA (2003) and AMWAC (2000) extrapolated to 2001-02.[7]

The fundamental strategy of Medicare is a standard rebate to consumers to offset the cost of their primary medical care. Bulkbilling allows that the rebate can be assigned to the doctor at point of service, but while access to Medicare is a universal right, bulkbilling was never intended to be universal. It has always been recognized that in a private enterprise fee for service environment the fee received must recompense the doctor for the cost and skill of service delivery. If, in a given area, the skills required or the costs of service delivery

[5] *ibid.*
[6] Australia. Department of Health and Ageing (2003). Submission to the Senate Select Inquiry Committee on Medicare, July 2003.
[7] *ibid.* & Australian Medical Workforce Advisory Committee (2000). *The general practice workforce in Australia: supply and* requirements *-1999-2010.* Sydney, AMWAC

are higher, it stands to reason that the rate of bulkbilling will be lower as long as it depends on a single fixed rebate.

Strategies to keep Medicare relevant and efficient in the future must be focused on health needs and sound business principles, not opportunity for political advantage.

RDAA believes that the proposal to pay a flat rate financial incentive for bulkbilling is likely to be unhelpful or even detrimental to rural healthcare and potentially undermining to the system it purports to maintain. It rejects the proposal on several grounds:

- the payment as a percentage of total fee is a perverse incentive towards shorter consultations which may impact on quality of care, although it is unlikely to alter the average rural consultation length which is currently 14 minutes;
- the payment is insufficient to make a difference to billing patterns in rural areas where the current average gap is $7;
- the lost recognition of the higher complexity and cost of rural health service delivery will further undermine morale in the rural workforce;
- based on current billing patterns the incentive will increase the annual income of urban GPs by $10,000 more than rural GPs which will impact on workforce patterns;
- the flat rate at which it is set represents a lost opportunity to give under-serviced rural consumers a more equitable share of the insurance scheme to which they as taxpayers contribute equally; and
- the integrity of Medicare is jeopardized by the use of an extraneous mechanism to adjust it.

A paltry payment

The proposed $5 incentive payment to GPs to bulk bill certain patients will not bring bulk billing back to higher levels in rural areas.

> *There is nothing in it for the majority of rural patients and rural docs! An extra $5 for bulkbilling will make little difference in rural areas except for those who still bulkbill and I don't believe there are many left…*[8]

RDAA's Viable Models study shows that the average consultation fee in rural practices in 2002-3 was $32.[9] This means an average gap payment of $7. Even with that gap payment, the study found that one in five (19%) of medical practices in rural and remote Australia are not viable.[10] It is highly unlikely that any rural practice will take up a measure which would entail a loss of $2 a service!

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[8] PMI, procedural rural doctor. *Pers. com.12/12/2003*

[9] Rural Doctors Association of Australia (RDAA) (2003). *Viable models of rural and remote practice: Stage 1 and Stage 2 Report.* Canberra, RDAA

[10] *ibid.*

Wherever the practice, this unrealistic amount will not persuade doctors who are not bulk billing to do so, unless their gap charge is under $5. At best, it may persuade those who are already bulkbilling to continue to do so, thus halting, but not reversing, the overall decline in bulk billing.

Negating other workforce measures

The Viable Models study showed that the sustainability of a rural practice rests on three inter-related dimensions:

- professional issues, including training and workload;
- economic issues, including income and practice costs; and
- practice organization and infrastructure.

The Viable Models study showed Fee for Service (mainly Medicare and gap payments) is the predominant (79%) source of income for rural practitioners. The level of these payments is therefore crucial to the economic viability of the practice. If they do not keep pace with expenditure and generate a sufficient surplus, doctors will succumb to other negative factors and leave the bush.

The study also showed that rural practice costs, which are higher for most generic and medical supplies, absorb about 52% of the gross income of a practice. The Viable Models study found that net income for a practice principle averaged $80 per hour in group practices and $55 per hour in the solo practices which are now much more common in rural and remote areas than in the cities. A number of other significant expenses that are chargeable to the individual doctors, rather than the practice, have to be paid out of this amount. These include medical indemnity, continuing professional education and motor vehicle expenses.[11] [12]

In effect, supporting bulk billing where it currently already occurs through an incentive payment to the doctor is likely to have an unintended perverse effect. As the incentive is too low to have a direct impact in rural areas where low bulk billing rates relate to high costs, it may become a potential economic force which will discourage rural recruitment or retention in favour of those urban areas where doctors have been able to maintain high bulk billing rates. This could further exacerbate the rural workforce shortages. Certainly it will not increase access to doctors or bulk billing rates in rural areas.

[11] *op.cit.*

[12] It should be noted that the figures given for hourly income in the recent ABS report *Private Medical Practice Australia 2001-02* [Cat no 8685.0] are calculated on a standard 35 hour working week rather than the actual average of 52 hours per week for a rural GP. Monetary return per practitioner was calculated by adding wages and salaries paid to them and practice operating profit before tax and dividing by the number of doctors, so it did not take these costs to the individual into account.

Lost opportunity for equity

Figure 1 shows the mal-distribution of Medicare benefits. The 28% of the Australian population which lives in rural and remote areas receives about 21% of the rebates for general practice services. On the basis of population and HIC figures for 1999-2000, it has been estimated that the average per capita Medicare benefit paid in metropolitan areas was $125.59, compared to $84.91 in other parts of Australia. This suggests that approximately $221,009,162 of the Medicare levy collected in non-urban areas flowed back to subsidize metropolitan services.[3]

Access to medical services in rural areas is the limiting factor. It is estimated that while there are approximately 306 medical practitioners per 100,000 patients in metropolitan areas, the ratio is 143 per 100,000 in other parts of the country.

> *The concentration of medical practitioners in metropolitan areas results in inequitable access to services elsewhere and as a consequence, the Medicare rebate which is repatriated to non-metropolitan areas is significantly less…In short, the Medicare levy which is collected from all Australians …regardless of where they live is not repatriated to all Australians equally.*[4]

The Viable Models confirmed that rural and remote general practice is more complex and requires a higher level of skills, responsibility and related cost, for example for continuing professional development and essential equipment which is not otherwise accessible:

> *… this difference does not simply relate to treatment of emergencies or procedural activities. The context of the practice setting including isolation and availability of diagnostic services and professional supports means that rural and remote doctors do not have the same options as metropolitan GPs…Complexity of activity was shown to increase with isolation as measured by RRMA…but this difference did not necessarily relate to RRMA but to the responsibilities of the doctor and availability of facilities and services that vary within RRMA categories.*[13]

A primary issue in the provision of medical services to rural and remote areas is that Medicare rebates do not take account of cost differences relative to urban areas. Figure 2 shows that, if costs are higher in rural and remote areas, the supply curve (SR) is higher than in urban areas (SU); hence, with the same

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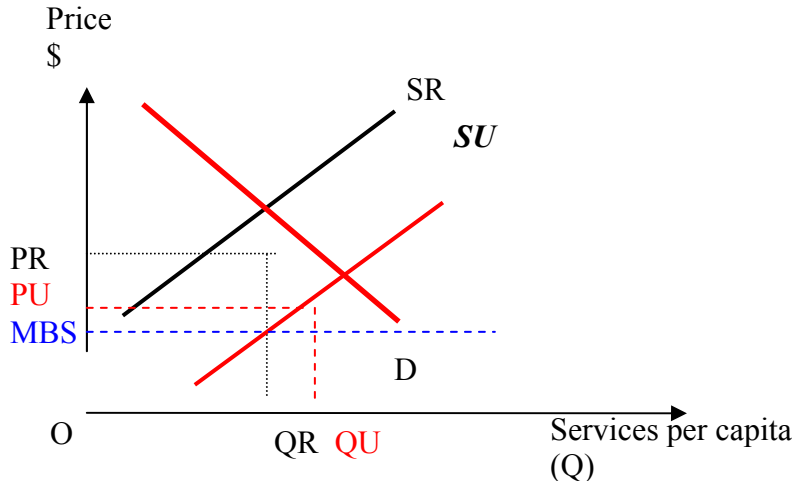
[3] Wagga Wagga City Council (2003). Medical services in rural, regional and outer metropolitan areas in Australia. Unpublished

[4] *ibid.*

[13] RDAA (2003). *Viable models of rural and remote practice: Stage 1 and Stage 2 Reports.* Canberra, RDAA.

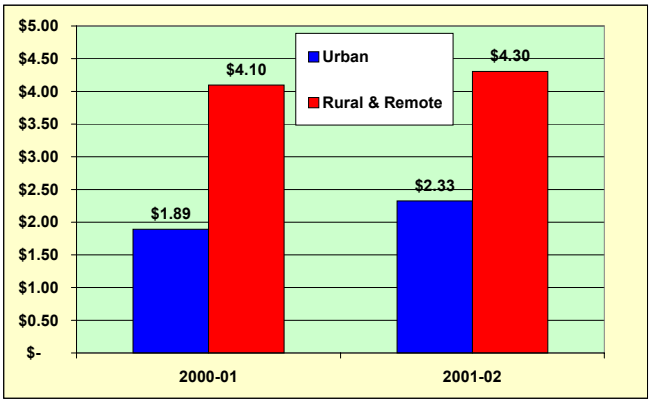
MBS rebate and demand (D), fewer services will be provided per capita at a higher price to the patient.

Figure 2: Supply and demand for medical services, rural and urban



The result is that patients in rural and remote areas are hit twice – once with payment gaps (price barriers since PR>PU) and once with queues (quantity constraints indicating non-price rationing or, ultimately, no access – QR<QU). Figure 3 below shows that prices faced by GP patients in rural and remote areas, who are less able to afford the gaps, are around twice the gaps in urban areas. Quantity constraints, in terms of fewer services per capita, were illustrated above in Figure 1.

Figure 3: Average gap prices paid by GP patients 2000-01 & 2001-02[14]



The gap charge for patients in rural and remote areas is more than double the average charge in urban areas.

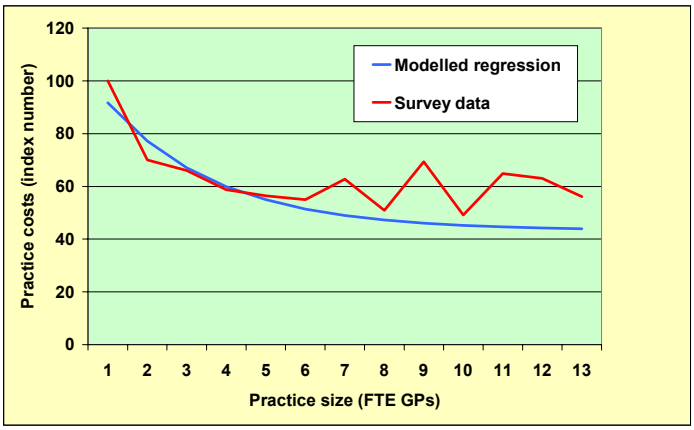
This is related to underlying cost differentials of three main types:

(1) practice costs ,including continuing education and training;
(2) time and travel costs for both patients and providers; and
(3) the complexity and associated responsibility of the services provided.

[14] RDAA (2003). Federal Budget Submission. Canberra, RDAA.

Most rural and remote practices are small (1-3 FTE GPs) with solo practices more common with increasing rurality/remoteness. There are not the economies of scale obtainable in urban areas in areas such as medical and IT equipment. For practice locations without a hospital, there may be a need to purchase expensive items such as ultrasound and X-ray imaging equipment. Figure 4 illustrates that, based on data from the AMA, smaller practices incur higher costs which may be up to twice those of larger practices.

Figure 4: Practice costs higher for smaller GP practices



Source: Access Economics (2002).

Transport, communications and many consumer items generally cost more in the country. Costs of servicing equipment (eg, phone, IT, X-ray, ultrasound) 1,000kms from a service base are substantial. Locum relief, eg for professional development, can cost up to $5,000 per week with $3,000 per week (plus expenses) a minimum. Although purchase or rental costs are lower, there is often a poor or negative return to investment, in contrast to urban areas, which is a significant deterrent to younger doctors buying in and which can prevent older GPs from retiring. There is the substantial opportunity cost of losing a spouse's second income, which is now the norm in Australian households, and of higher education costs for children's education, as well as the family separation that higher education frequently entails.

Because of cost and price differentials, models that try to address a mal-distribution of medical services across urban and rural regions without including pricing solutions will always miss their target. As early as 1998, AMWAC noted that

> *the universality of the rebate across Australia provides no financial weighting for the additional financial and social costs of practice in many geographic or socioeconomically disadvantaged locations, or for higher skill levels and longer consultations which may be necessary.*[15]

In economic terms, the best intervention in this segmented market situation is through the basic price mechanism, the MBS rebate. Support is growing in Australia – in GP groups as well as amongst MPs – for rebates distinguished either by area or socio-economic status. A differential rebate system is already in place in the Quebec province of Canada.

[15] Australian Medical Workforce Agency Committee (1998). *Medical workforce supply and demand in Australia: a discussion paper.* AMWAC Report 1998.8. Sydney. AMWAC

The simplest way to do this would be to introduce a rural loading to MBS GP items for certain rural and remote areas. For example, a loading, graduating with increasing remoteness, could be applied to services delivered in towns and communities in RRMA 3-7. Item numbers would not change. It would also be possible to extend the loading to specialist items. A geographically based loading would be simple to initiate and administer, and would assist in attracting and retaining GPs working in these rural and remote areas, at the same time avoiding any new political divide within general practice.

The total cost is estimated at approximately $187m initially, potentially increasing to around $280m per annum as more services are provided in those areas (Table 1). The lag for the full quantity effect to be realised is estimated to be up to two years.

Table 1: Modelled outcomes: rural loadings on GP MBS items

	RRMA category					
	3	**4**	**5**	**6**	**7**	**Total**
Price loading (% rebate)	1.15	1.20	1.40	1.25	1.5	
Static impact on MBS bill, $m	23.1	33.2	111.7	4.9	13.5	186.5
Quantity response (%)	1.08	1.10	1.20	1.13	1.25	
Dynamic impact on MBS bill $m	34.6	49.8	167.6	7.4	20.3	279.7

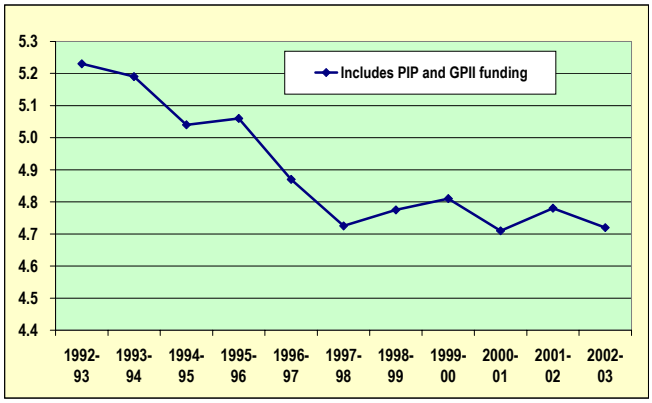
A second option is would be to establish separate MBS rural consultation item numbers (RCINs). This would achieve the same effect as the rural loading, in terms of providing recognition of increased complexity and costs of rural medicine through the MBS rebate. However, there has been less support for separate RCINs from other organisations, and the proposal would involve a greater degree of administrative complexity. Access Economics modelling suggests that funding the RCINs to the same level as the dynamic (long run) impact of the rural loading above, with an allowance ($1m) for the costs of introduction and administration would incur an initial cost of $187.5 million increasing to $280.7 million in 2005-06.

A third option would be to increase the Medicare rebate for medical services delivered in areas of socio-economic disadvantage. A higher rebate, allocated on the basis of an existing income assessment device, perhaps a reviewed Health Care Card, would enable the higher medical costs in rural and remote areas to be borne by Medicare rather than by disadvantaged patients or providers of medical services. However, this option would be more difficult and costly to apply than a loading or differential rebate based on location.

Based on providing a 25% higher rebate for GP services for the poorest 30% of patients, would initially cost $206m, with a maximum dynamic cost estimated as $308m. To extend this to specialist services would cost $425m, while to extend to all services would cost $881m for the whole package.

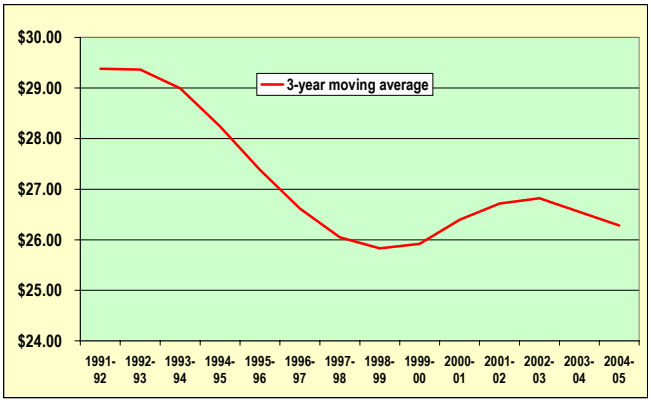
The second key pricing issue is indexation. Indexation to the WCI5 (or half WCI5, as it was for some years) has resulted in an erosion of MBS rebates in real terms as well as an erosion of real incomes of GPs. Figure 5 shows the erosion of Commonwealth spending per full time equivalent (FTE) GP – relative to average weekly ordinary time earnings (AWOTE) – over the period 1992-93 to 2002-03. The erosion includes spending through the Practice Incentives Program (PIP) and other blended payments. Figure 6 shows the decline in real terms in the MBS rebate for Item 23 (the modal level B GP item), as a three year moving average (1989-90 base year, compared to a composite cost index). Figure 7 shows how this erosion of spending has resulted in a fall in real GP hourly earnings.

Figure 5: Average annual Commonwealth spending per FTE GP, relative to AWOTE



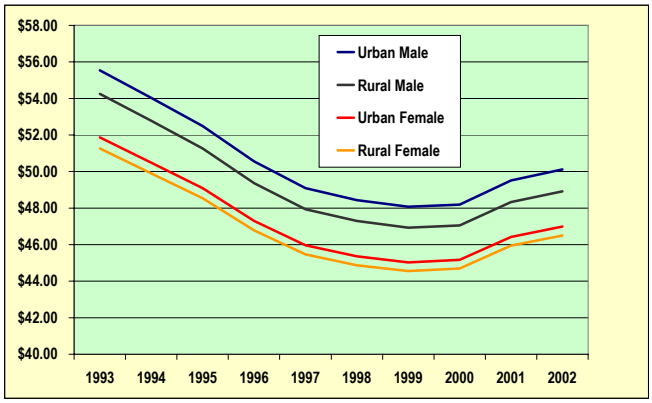
Source: DHA (2003), p20, derived from Figure 8. AWOTE = average weekly ordinary time earnings.

Figure 6: Real MBS Item 23 rebate under WC15 indexation



Source: Access Economics (2002).

Figure 7: Hourly gross GP earnings, annual average, urban and rural by gender

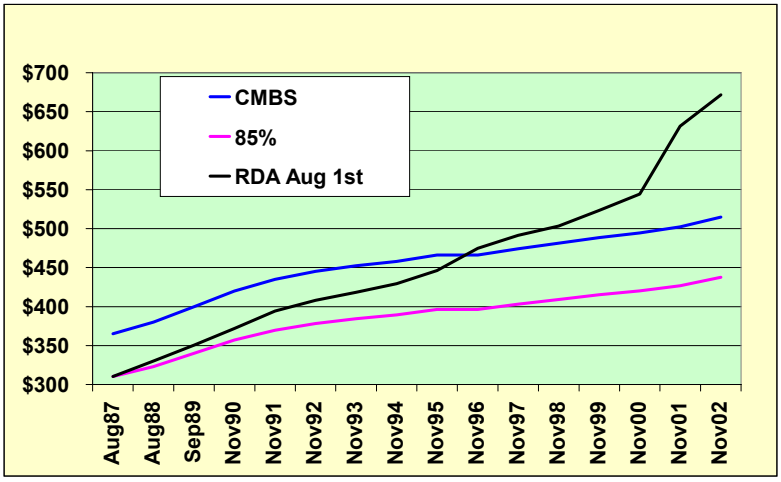


Source: Access Economics (2002).

Clearly the WCI5, while a useful Department of Finance tool in other areas of economic policy, produces fee increases that do not keep pace with growth in health practice costs. There are some clear anomalies in the construction of WCI5, for example the assumption that medical indemnity costs increase in line with CPI. The use of a more appropriate indexation tool is a matter currently under review in the Attendance Item Restructure Working Group (AIRWG), which is considering alternate indices for use in General Practice.

One alternative worth noting is the indexed financial support scheme in the RDANSW Rural Doctors Settlement Package. Since its inception in 1987, its scheduled fees have gradually risen from 85% to 130% of the MBS fee. A key component of the indexation is the Average Weekly Ordinary Time Earnings (AWOTE) index and key costs variables include staff salaries, indemnity and vehicle expenses. The success of this package in attracting and retaining doctors who work in rural hospitals underscores the importance of adequate remuneration and indexation for addressing workforce deficits (see Figure 8).

Figure 8: RDANSW indexation compared to MBS rebate increases



Note: Item 9039/30020 comparison (Item description constant).

RECOMMENDATION:
That MedicarePlus be expanded to include:

- **a loading of GP services delivered in rural and remote areas or separate consultation items numbers for these services; and**
- **indexation of MBS GP items in line with real growth in medical costs, rather than the generic WCI5 index.**

Jeopardizes the integrity of Medicare

The RDAA acknowledges the need for change to Medicare in a changing environment and has been advocating for systemic reform for some time. However, this reform must be grounded in the principles on which Medicare was based and targeted to promote universal and equitable access to general practitioners. Thus it must depend on leverage through the item structure and the rebate which are the fundamental mechanisms of the system rather than through initiatives which distort its paradigms and practical effect by piecemeal tinkering.

An increasing body of international evidence suggests that longer GP consultations are associated with higher quality care. Yet the current MBS attendance item structure favours shorter consultations. The Attendance Item Restructure Working Group formed in 2002 to consider this question *concluded that the existing item structure, with financial incentives favouring shorter consultations, was not optimal for the purposes of supporting quality care.*[16]

General practice groups, academics and the Commonwealth have been collaborating on a more appropriate structure that more accurately describes and differentiates the service provided by GPs. They have proposed a seven tiered based on the content and nature of the service, rather than the time it takes to provide it, and seeks to enhance quality by delineating the minimal parameters of a consultation and encouraging the efficient completion of episodes of care.

This area of reform is extremely complex and requires ongoing constructive dialogue to ensure effective implementation. However, MedicarePlus will remain a makeshift and deficient means of reform until it includes specific commitment to attendance item restructure.

RDAA is concerned that using an external mechanism – an incentive payment to doctors – rather than an adjustment to a fundamental tool of the system – the patient rebate – is not only unlikely to achieve the long term reform and sustainability which most Australians want, but could presage the gradual dismantling of Medicare.

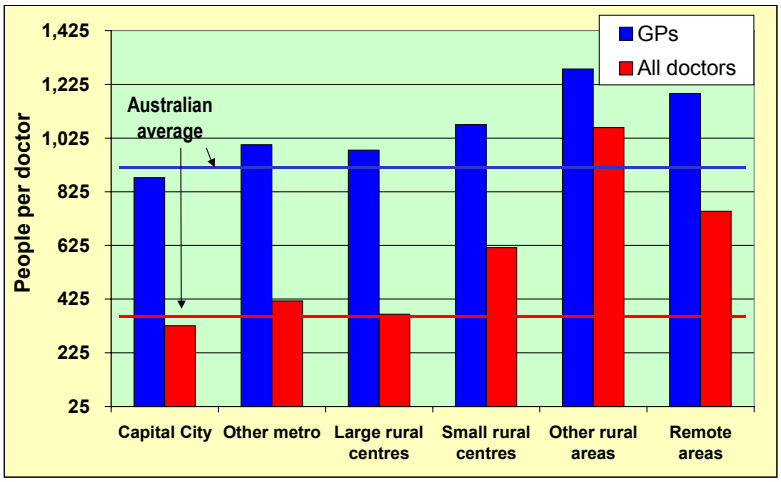
The standard Medicare rebate, and its indexation, reflects urban cost structures and consultation content. It is insufficient to cover the demands of rural practice and thus acts as a disincentive to recruiting and retaining rural

[16] Attendance Item Restructure Working Group (2003). Report July 2003. Unpublished.

doctors. This is why bulk billing rates have fallen in country areas and why they will not rise until a realistic rebate is set reflecting the greater complexity of service, the skills & training required, and the higher cost of service provision.

Low rates of bulkbilling in rural areas are not reflective of patient to doctor ratios which rise from 326 in capital cities (877 people per doctor) to 1,064 in other rural areas (1,282 per doctor) as shown in Figure 9. Logically, if doctors operate in a similar cost environment a higher number of doctors can create competition and drive down the cost of consultations. However, this can only be achieved by seeing patients more rapidly to maintain the level of income per hour. Rural patients present with more complex health needs and rural consultations consequently average 14 minutes. Doctors are then unable to compete on speed of consultation and in a high cost environment are unable to remain financially viable while bulkbilling. It should also be borne in mind that doctors who work in rural areas of Australia have an extraordinary level of long term dedication to their communities and a willingness to work very long hours in a professionally unsupported and often physically challenging environment.

Figure 9: Doctor patient ratios by RRMA grouping, 2000



Source: AIHW (2003).

RECOMMENDATION:

That MedicarePlus include a specific commitment to a quality-focused restructure of MBS attendance items.

4. BENEFITS FOR ALL AUSTRALIANS?

Indigenous Australians

The proposed $2.4 billion investment "in the health of all Australians" does not include specific measures to improve the health of Indigenous people, even though they are recognized to have the highest health needs of all Australians. While Indigenous people may benefit from the generic measures, many Aboriginal and

Torres Strait Islander people will receive little direct benefit. This is extraordinary in a package designed to preserve and build on Medicare, a system grounded in equity, universality and efficiency.

The confusion of equality and equity previously noted in relation to this package and its predecessor is starkly apparent here.

> *There are … different ways of conceiving equity. For example, horizontal equity is about the equal treatment of equal, while vertical equity is about the unequal but equitable treatment of unequals.*[17]

The health of Australia's indigenous population remains a national embarrassment as Aboriginal and Torres Strait Islander people continue to experience a higher burden of preventable disease and mortality at an earlier age than other Australians, including triple the age-standardised mortality rates and substantially lower life expectancy. Indigenous people constitute 1% of the metropolitan zone population, 2% and 5% in Inner and Outer Regional areas respectively, 12% of the population in remote areas and 45% of the population in very remote areas.[18]

Clearly, any package designed to give additional health benefits to all Australians is dishonest and deficient unless it includes specific measures to improve the health outcomes of Indigenous Australians. RDAA proposes two specific initiatives which lie well within the scope of *MedicarePlus*.

RDAA strongly supports the provision of a separate Medicare item number for biennial health checks for Indigenous people of all ages as part of Enhanced Primary Care. The recommendation of the Medical Benefits Consultative Committee for health checks for Indigenous people aged 15 – 55 years is a step in the right direction. However, given the evidence linking good health in infancy and childhood with better health in adult life, RDAA believes there should be no age limits on these checks which should begin in early life.

The 2001 census showed there were 410,000 indigenous Australians (2.2% of the population, up from 1.6% in 1991). In its Federal Budget Submission 2004-05, RDAA estimated that the total cost of the health check without age restrictions for 2004-05 would be $23.9 million. For rural and remote Indigenous people only (approximately 151,000 in RRMA 3-5, 31,000 in RRMA 6 and 94,000 in RRMA 7), the cost would be $15.8 million. Cost estimates for the next three years, based on a 4.5% average AWOTE indexation, would be:

Table 2: Indigenous health check, costed proposal in $ million[19]

	2004-05	**2005-06**	**2006-07**
All Indigenous Australians	23.9	25.0	26.1
RRMA 3-7	15.8	16.5	17.3

[17] Mooney G (2003). Inequity in Australian healthcare: how do we progress from here? *Australian & New Zealand Journal of Public Health* **27**:3

[18] Australian Institute of Health and Welfare (AIHW) (2003). *Rural, regional and remote health: a study on mortality.* Canberra, AIHW (Rural Health Series 2)

[19] RDAA (2003). Federal Budget Submission 2004-05. Canberra

Secondly, the MedicarePlus proposal to support practice nurses through a new Medicare item does not appear to extend to Aboriginal Health Workers (AHWs). Although this important segment of the rural health workforce is in included in the original practice nurse initiative (*Additional Practice Nurses for Rural Australia and other areas of need*, 2001), they are apparently not included in the *MedicarePlus* Support for practice nurses through a new Medicare Item (Fact Sheet 5).

The pivotal role of Aboriginal Health Workers (AHWs) in providing primary care to the population group with the highest health needs in Australia has been well documented.[20] Their importance in facilitating access to much needed primary health care, two-way communication within the healthcare system and helping to identify and bridge gaps between cultural systems is unquestioned. While their role and activities vary widely across Australia, there is no doubt that in many places AHWs are indispensable members of the practice team in providing routine immunizations and wound management.

The new Medicare item for these services when provided by a practice nurse without a GP present should be extended to apply to those Aboriginal Health Workers covered by the Practice Nurse Initiative in those jurisdictions which there is no legal impediment to this.

RDAA appreciates the diversity in the training, formal qualifications and autonomy of AHWs, and the lack of consistency in the medico-legal environments in which they are employed. However, making provision for the extension of the new Medicare item to them should become an integral part of the practical implementation of the *Aboriginal and Torres Strati Island Health Workforce National Strategic Framework.*[21] This would be consonant with the principles and strategies outlined in that document and the commitment of the Australian Health Ministers' Advisory Council to them.

As noted elsewhere, RDAA believes that the range of specified services which can be provided under the new MBS item should be broadened to cover, for example home visits and aspects of maternal and child care. Given their particular role in communication and the delivery of culturally appropriate services and counselling, it is important that appropriate training and support systems facilitate the inclusion of AHWs in any appropriate extensions of the specified services.

RECOMMENDATION:
That MedicarePlus include the following measures to address Indigenous health issues:

- **the provision of a separate Medicare item for health checks for Indigenous Australians of all ages, including children; and**

[20] Curtin Indigenous Research Centre (2001). *Training re-Visions: a national review of Aboriginal and Torres Strait Islander Health Worker training*. A report submitted to the Office for Aboriginal and Torres Strait Islander Health (OATSIH). Canberra, OATSIH
[21] Australian Health Ministers' Advisory Council (AHMAC) (2002). *Aboriginal and Torres Strait Islander health workforce national strategic framework.* Canberra, AHMAC

- **the extension of the MBS item covering services provided by practice nurses without a GP present, to include, where appropriate, Aboriginal Health Workers covered by the 2002 Practice Nurse Initiative.**

Australians who live in rural and remote areas

Those who live in rural and remote areas, Indigenous and non-indigenous Australians alike, and people in disadvantaged urban areas all suffer relatively poorer health. While the causes of this disparity are complex and diverse, less access to medical care because of the shortfall of doctors is certainly a significant factor. Another common factor is that these are the poorest groups in the population. The domestic and international evidence linking health outcomes and socio-economic status – measured by income, employment and educational levels – is unequivocal: people in lower socio-economic groups do not live as long, on average, as those materially more fortunate and they are sick more often. They are less likely to take steps to prevent disease or to have their illnesses detected early.
Thus measures which assume that higher rates of bulk-billing will increase access to medical care overlook the fact that in rural and remote areas, access is limited not by the cost to the consumer, but by the shortage of medical practitioners. The rural market for medical services is relatively inelastic in terms of both supply and demand. Therefore the most effective leverage will be achieved by enhancing the attraction and viability of rural general practice through a higher rebate in these areas.

> *The idea of a universal rebate across Australia is simply not sustainable, and denies rural practices the capacity to bulk bill greater numbers of patients.*
>
> *This is far more of a factor in producing a lower bulk billing rate in rural Australia than our workforce limitations. As we get more remote, the costs of running a practice increase, the number of doctors decreases and the economies of scale in larger practices are lost, further exacerbating the cost of running a practice. It is really not surprising that rural bulk billing rates are low.*[22]

RDAA has been advocating for a differential rebate for rural Australians for some years.[23] Gradually others have come to the view that equal rebates may not be equitable and that those who experience greater socio-economic disadvantage should receive a higher rebate. RDAA agrees with this analysis, but, as noted above, believes a differential rebate on socio-economic grounds (as a proxy for lower health status) alone would be very difficult to apply nationally. However, as both the rate of socio-economic disadvantage and the cost of delivering medical services are generally higher in rural and remote Australia, the application of a rebate based on existing geographic classifications of rurality and remoteness would be manageable and help address the needs of 28% of the population there whose lower health status is aggravated by lower access to medical services.

[22] GS, procedural GP, Victoria, *pers.com*. May 2003
[23] RDAA (1999). RDAA responses to Regional Australia Summit Theme 3: Health. Canberra
RDAA (2001). Rural Consultation Item Numbers Information Pack 2001. Canberra

A rural loading or item number would also address socio-economic issues, as average incomes in rural Australia are some 30% lower than those in inner metropolitan areas. [24] Twelve of the 20 least advantaged federal electoral divisions and 36 of the 40 poorest areas of Australia are classified as rural or remote. Analysis of Socio-Economic Indices For Areas (SEIFA) reveals that, whether measured by indices of advantage or disadvantage, economic resources or education and occupation, people who live in the cities are better off than those who do not, with those in remote areas the least fortunate.

Although targeted initiatives have led to an increase in some sectors of the rural workforce, the shortfall remains acute and likely to worsen as demographic ageing occurs within the current workforce and incoming generations chose to work hours which allow them more flexibility and more balanced family responsibilities. Estimates of the general practice workforce vary widely, but recent research suggests that there is a shortfall of approximately 16% - 18% in rural and remote areas. Nearly half (44%) of the rural population live in an area of severe shortfall.[25]

Therefore initiatives which purport to offer additional benefits to all Australians will remain empty promises unless they include effective and practical measures to encourage the recruitment and retention of an adequate rural medical workforce.

It should be noted that less access to relevant services means uptake of private health insurance is lower in rural than urban Australia. The needs of rural consumers would thus be better addressed by the diversion of this controversial subsidy to prevention and curative health care services. Like the 79% of people whose opinion on tax cuts was sought in mid-2003, many rural Australians would rather see this money allocated to locally accessible healthcare.

5. PATIENT CONVENIENCE

RDAA's response to *A Fairer Medicare* recommended that the benefits of HIC Online should be extended to all practices and it is pleased that this extension is part of MedicarePlus. However, it is not clear that the $9.2 million funding is in addition to that previously available for the expansion of broadband to rural areas.

Moreover, while acknowledging that the proposed grant is meant to contribute to, rather than cover the connection cost, the amount proposed ($1,000 for any rural, regional or remote practice regardless of location or current IT status), is inadequate. The assumption that it will cost these practices only $250 more than it will cost a practice in a capital city is quite out of touch with current realities. For example, in addition to the costs of the equipment, software and installation, practices at a distance from major centres also have to pay the travel and accommodation expenses

[24] McAuley I (2003). *Bulkbilling by income/electorate.* Report to the Australian Consumers' Association. Sydney, ACA

[25] Access Economics (2002). *An analysis of the widening gap between community need and the availability of GP services.* A report to the Australian Medical Association. Canberra, AMA

of the relevant technicians. A more realistic costing to enable rural access to HIC Online would include $3000 for software, plus travel and accommodation for installation and then additional on-going costs for broadband, if available, which are likely to be double the costs in urban areas. This assumes that a fully functioning computer system is already in place at a probable cost of over $30,000.

Again the principle of equity demands that any support for rural patients and their doctors should be not be based on urban cost structures but should graduated to reflect the higher costs that must be incurred in some areas.

6. SAFETY NET

The clear link between socioeconomic status and health suggests that those on lower incomes are likely to require more healthcare and the security of a safety net if they encounter healthcare costs beyond their means. Many people see the level of the two-tiered measure in MedicarePlus as unrealistically high and therefore of little help to those it is designed to support.

> *The safety net is a joke for your average family who has ten trips to the GP a year![26]*

> *What a joke! Even in practices with a large [ie $22] gap charge, the average full fee paying patient or family would need to see one of our doctors 45 times in a year, assuming they were charged for a Level B consultation, and for a pensioner[$10 gap] it would have to be 50 times, ie once a week before they got any benefit out of this![27]*

As it stands, the measure is unlikely to benefit most low income working families or single people unless or until they encounter serious health problems. Most will not incur costs of over $500 for their on-going primary health care.

It is not clear how the threshold of $500 was established; this should be clarified and a transparent process set up to calculate a realistic sum.

The National Centre for Social & Economic Modelling (NATSEM) at the University of Canberra has estimated that people in the lowest socio-economic quintile (Quintile 1) spend between 7.2% and 9% of their after- tax income on subsidized Pharmaceutical Benefits Scheme (PBS) drugs. Quintile 1 includes *the 'working poor', including the 40-64 year olds (35%) who may have worked in casual jobs, moved in and out of the workforce, and earned just above the cut-off levels for government benefits.*[28]

Given the role of both the MBS and the PBS in maintaining and improving health, RDAA believes that expenditure under both systems should be combined in triggering access to a safety net set at a realistic level.

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[26] PMI, procedural rural GP, NSW. *Pers.com*. 13/12/03
[27] GS, procedural rural GP, Victoria. *Pers.com.* 15/12/2003
[28] Walker A (1999). *Distributional impact of higher patient contributions to Australia's Pharmaceutical Benefits Scheme*. NATSEM Discussion Paper 45. Canberra

RECOMMENDATION:
That the level of the safety net should be arrived at by a consultative and transparent process which includes both MBS and PBS costs in its calculations.

7. MEDICAL WORKFORCE

New medical school places

RDAA applauds the establishment of an additional 234 medical school places. However, the bonding of these places to areas of workforce shortage is problematic. While not ideologically opposed to bonding *per se,* RDAA believes that the effectiveness of bonded programs lies in enticement rather than enforcement. In other words, the scheme is more likely to achieve its long term goal of a quality and sustainable rural workforce if it is backed by incentives, financial or non-financial, and it is developed within a framework which presents rural medical practice as a challenge rather than a sentence. RDAA also contends that the investment of $42.1 million could achieve a higher return if it included lessons learnt from successful rural recruitment programs and targeted strategies to raise the number of medical students who take up procedural rural medicine.

The new provision which will allow up to three years postgraduate training in rural areas to count towards meeting the bonding requirement attached to the new places is a welcome step. However, it should be accompanied by other measures, including scholarships and exemption (or forgiveness) from the Higher Education Contribution Scheme (HECS) payments, which are already working in the Australian environment.

At present there are two major publicly funded scholarship schemes designed to get more doctors into the bush. The Rural Australian Medical Undergraduate Service (RAMUS), introduced in 2000, is a non-bonded scholarship worth $10,000 annually for up to 400 students each year who are prepared to participate in a doctor mentor scheme administered by the National Rural Health Alliance. Medical Rural Bonded (MRB) scholarships were introduced in the 2000-01 Budget. They are indexed annually, untaxed and not means tested. In 2003 they were worth $20,950. One hundred scholarships are offered annually to Australian students who contract to practise in rural areas for 6 years on completion of their training. There are severe penalties for breach of contract. For example, a doctor who is unable to fulfil the contracted period of service may be denied access to a Medicare provider number for 10 years.

While these scholarship schemes are useful, they represent the two ends of a spectrum. RAMUS scholarships may or may not lead to rural practice in the end. The conditions of the MRB scholarships are harsh. RDAA believes there is scope for a second MRB scholarship option of lower value with softer terms, as a middle road option that, offered in conjunction with the places offered in MedicarePlus, would continue to encourage rural recruitment. As set out in its Budget Submission, RDAA envisages that the features of such a second option (MRB#2) would include:

- the contracted period of service should be limited to the period of medical school training, allowing for four, rather than six, years post-training service bond for post-graduate medical students;
- as set out in MedicarePlus, up to three years postgraduate training in rural areas could be counted towards meeting the bonding requirement;
- greater options for compassionate exemptions to buy out of the scholarship, for example proportionate repayment or practice in an outer metropolitan area of need, without penalties to the recipient's ability to practice medicine;
- acquisition of at least one procedural skill;
- value of around $15,000 per year, indexed, untaxed, not means tested;
- 50 scholarships offered in the first year (2005), increasing to 100 recipients in 2006 and 150 in 2007.

Table 3 shows that the total cost of MRB#2 would be $1.9m in 2004-05 rising to $5.7m in 2005-06 and $9.7m in 2006-07 (assuming 2% indexation and an average of 5 years for each scholarship offered.)

Table 3: Medical rural bonded scholarships – MRB#2 costing[29]

	2005	**2006**	**2007**
Number of scholarships	50	100	150
Cost per scholarship p.a.	15,000	15,300	15,606
Total additional cost ($m)	3.8	7.7	11.7
	2004-05	**2005-06**	**2006-07**
FY spend	1.9	5.7	9.7

Whether scholarship holders or not, RDAA believes that all health professionals undergoing vocational training in RRMAs 3-7 should be exempted from HECS repayments. Current anomalies which prevent reimbursement until training has been completed must be corrected. As they stand, the conditions of the scheme have the unintended effect of making HECS reimbursement meaningless for some doctors who having reached the minimum annual income threshold (presently $25,348) during their training, have paid off most, if not all, of their HECS by the time they become vocationally registered and then become eligible for reimbursement.

A further problem with bonding schemes based on compulsion rather than support is that they re-enforce negative images of rural medicine as a career so unattractive that students must be coerced into it. RDAA believes that recruitment strategies must include rural exposure, for example through the university clubs and mentoring relationships that allow students the opportunity to experience the challenges and attractions of rural medicine and rural life. Rural clinical schools include placements in country practices as part of their training programs, recognising that workforce networks are best placed to encourage students along a rural career path. However, the capacity of rural GPs to provide further medical student placements is reaching its limit.

The MedicarePlus provision of 280 full funded short-term supervised placements in outer metropolitan, regional, rural and remote practices is welcomed as well-

[29] RDAA (2003). Federal budget submission 2004-05. Canberra

intentioned. It recognizes the work of the rural GPs who provide invaluable training in areas often no longer available in large hospitals and it may increase the service capacity of their practices in the short term. However, considerable research now indicates that influencing people towards rural medicine should begin much earlier than post-graduate training. One Australian study reported that "interest in rural practice wanes as medical education progresses".[30] RDAA believes that equivalent funding should be devoted to supporting positive professional experiences for medical students though adequate financial recognition of the role of the practitioners who train them.

The Commonwealth has recognised the importance of investment in students: now rural vocational training pathways need to be supported and strengthened in practical ways. Funding is needed to provide adequate accommodation for student and junior doctor attachments. Staying with a doctor's family is often unrealistic or inappropriate. Moreover, increasing numbers of students and graduates are older and may require accommodation for their own family members. The local community and health services often assist in *ad hoc* ways but dedicated accommodation is imperative if a viable 'teaching rural practice' model is to be implemented.

RDAA has estimated the costs of some of the practical support needed to ensure as many students and junior doctors as possible have the opportunity to understand the realities and attractions of rural medicine:

- A capital grant of $25,000 as seed funding paid to the placement entity (eg a rural hospital or practice) on application, to upgrade or build suitable accommodation for students and trainees; and
- A Teaching Rural Practice payment at a minimum rate of $500 per student per week, indexed annually, where the GP is involved in direct teaching at least 2-3 sessions per week. At an initial cost of $1.2 million, (estimated on the basis of 8 weeks of placements for 300 students per year annum) this would be a sound investment in the future workforce as well as a much appreciated recognition of the valuable resource embodied in the current workforce.

It is increasingly important to cultivate rural medical practitioners with special clinical interests and to recruit and develop a cadre of doctors with the necessary knowledge and skills to provide the procedural care (notably obstetrics, anaesthetics and surgery) which is now usually provided by specialists in larger centres.

Universities and rural clinical schools that undertake in their funding agreements to provide students with extended exposure to rural procedural medicine taught predominantly by rural GPs should receive preferential access to these support measures.

[30] Laurence C, Newbury J & Wilkinson D (2002). Increasing rural activity and curriculum content in the Adelaide University Medical School. *Australian Journal of Rural Health* **10:**4

RECOMMENDATION:
Expansion of MRB scholarships through development of a second scholarship option, with a student accommodation and support package.

Medical Rural Bonded Scholarships (MRB#2) $1.9m (2004-05) increasing to $9.7m (2006-07) Rural and remote students' accommodation and support package $6.2m (2004-05)

Preferential access to these measures should be given to those actively involved in procedural rural medicine.

Training Places

While the new fully funded GP training places are welcome, there may be difficulties in filling the extra places until the additional medical school graduates begin to come on stream, four to six years away. There will also be on-going competition for trainees, as specialist shortages are also of increasing concern. AMWAC's *Annual Report 2002-03* noted continuing intake shortfalls in such crucial disciplines as obstetrics and gynaecology and orthopaedic surgery.[31]

As noted above, the long term effect of this measure on the rural medical workforce remains to be seen. However, the funding to support practices to offer a placement is a timely recognition of the contribution rural doctors can make to training the next generation of GPs and a practical help to their doing so.

Overseas Trained Doctors

RDAA and rural communities across the country acknowledge the contribution Overseas Trained Doctors (OTDs) are making to better health outcomes in rural and remote areas. However, this must be recognized as a short-term measure – a stop-gap until Australia produces sufficient medical graduates to provide its own medical workforce adequate to meet the needs of all parts of the country. Apart from ethical issues in relation to recruitment from developing countries, the current dependency on OTDs leaves the rural medical workforce vulnerable to the competitive forces of the international market.

In the meantime, questions of clinical standards do arise, and while these relate to a very small proportion of the imported medical workforce, they are a cause of serious concern. Concerns about communication and cultural sensitivity are more widespread. In workforce terms, some OTDs do not appear to receive the support they need to overcome barriers to effective rural practice and there are a small number for whom lack of support and opportunity is close to wasteful exploitation.

RDAA recognizes the commitment to ensure that OTDs meet appropriate standards before they are able to practice medicine in Australia and support the MedicarePlus measures to reduce the red tape and other barriers that are currently preventing or delaying OTDs who meet these standards from practising in Australia. It notes that active recruitment for OTDs will be confined to developed countries though the

[31] Australian Medical Workforce Advisory Committee (AMWAC) (2003). *Annual report 2002-03.* Sydney, AMWAC

practicality of this in the context of today's global communication networks. RDAA also appreciate the opportunity to work with government and other organizations as part of an on-going reference group to refine the proposed measures.

This refinement must include efforts to ensure that changes to visa conditions and requirements are modified to ensure that some of the current disincentives, including lack of access to Medicare funded services, and in some, case, to State education, do not undermine the attractions of easier entry.

RDAA believes that a core cultural competency standard should be established. This should go beyond language proficiency to include relevant communication skills and cultural understanding and sensitivity. It is essential that increasing professional support is paralleled by national, State and local strategies to meet such a standard.

General Practice Nurses

Nurses have been an integral and valued part of the rural general practice team for generations and RDAA was instrumental in having their contribution to the general practice team recognized through the subsidies made available through recent initiatives. It was also instrumental in the inclusion of Aboriginal Health Workers in these initiatives. RDAA welcomes the new MBS item for specified services that can be provided by the General Practice Nurse without a doctor present.

However, RDAA believes that these activities could be extended to include, for example Pap smears (which will often offer a woman a welcomed choice of service provider), home visits and aspects of maternal and infant health for which they have the appropriate training. The Commonwealth should encourage standardization of legislation to make this possible in all jurisdictions. This applies particularly to the very desirable extension of this measure to include Aboriginal Health Workers where this is possible.

RDAA believes that this measure will not only achieve shorter waiting times for patients, but is a step towards the formal development of the team models of service delivery which are needed if adequate healthcare is to be available in rural and remote Australia.

Procedural Rural Medicine

RDAA and the Australian College of Rural and Remote Medicine (ACRRM) have been leading the urgent drive for recognition and support for procedural rural medicine.[32] Unless this fragile and declining component of the rural workforce receives targeted support, the health and socio-economic well-being of rural Australia will be jeopardized. The National Minimum Data Set auspiced by the Australian Rural and Remote Workforce Agencies Group (ARRWAG) shows only approximately 935 of the estimated 3,855 rural general practitioners are still

[32] Stratigos S & Nichols A (2002). Procedural rural medicine: strategies towards solutions – a paper prepared for the AHMAC National Rural Health Policy Subcommittee, October 2002; ACRRM (2002). *Barriers to the maintenance of procedural skills in rural and remote medicine & factors influencing the relocation of rural proceduralists.* Brisbane, ACRRM

providing the obstetric, anaesthetic and surgical procedures which rural communities want and need. [33]

Recent increases in the rural medical workforce have not included a proportionate number of proceduralists: Only 16% (n=456) of rural GPs practice anaesthetics. Most of them have been in their current practice for over 5 years. The new rural recruits -those who have been in their current practice less than 5 years, will not, as things stand, maintain even this level of anaesthetics: over 90% of them report that they do not work in this field.

Currently about 24% (n=706) of rural doctors practice obstetrics, but the proportion of rural GPs who report regular obstetric work falls as time in current practice falls, from about 30% of those in their current practice for 5 years or more to less than 20% of those in their current practice for less time. Or, put another way, over 80% of those in their current practice less than 5 years report no obstetric skills. Feminization may help to halt this decline a little, as both the number of the females in the rural medical workforce and the number of them taking up obstetrics is increasing. However, these young women are more likely to become part-timers than their predecessors and the increasing shortfall in obstetric practice has to be considered in terms of the higher fertility rates in rural and remote areas.

The situation in surgery is particularly grave. About 10% (n=287) of rural GPs now practice surgery regularly. However, 95% of those in their current practice less than one year do not practice surgery and 93% of those in their current practice less than 5 years report no skills in surgery.[34]

While the decline in each area is problematic in itself, a loss or deficiency in one area of procedural practice inevitably leads to losses in the others, as for example, surgeons are unable to practice when there is no anaesthetist.

MedicarePlus contains the first specific national initiative to support procedural rural medicine and is therefore to be welcomed. However, there are two caveats: the future of procedural rural medicine does not lie solely within the mandate of the Commonwealth. State and Territory policies, particularly in relation to the role of small rural hospitals, have a major role to play and collaborative support systems must be established through the Australian HealthCare Agreements and other mechanisms if procedural rural medicine is to survive.

Secondly, both the measures to support rural proceduralists need consultative refining and careful implementation to ensure they achieve their objective. The first of these provides up to $10,000 a year for locum services to free a doctor for a fortnight's procedural upskilling. However, it is very difficult in most places to obtain rural locums, especially those who can supply procedural services. This means that the measure must be implemented with sufficient flexibility to benefit

[33] ARRWAG (2003). ARRWAG Minimum Data Set Update Report – 31st May 2003. Canberra, ARRWAG

[34] Pope J & Deeble J (2003). *Reality bites: rural and remote workforce information – a preliminary analysis of the Australian Rural and Remote Workforce Agencies Group Minimum Data Set October 2003.*Canberra, ARRWAG

both solo practitioners and small practices which must rely on locums and the larger rural practices that cover the absences themselves.

The loading on rural procedural work must be applied in such a way that it supports all those who provide major procedural services. The arbitrary eligibility criterion of 10% of HIC funded services is meaningless because most rural proceduralists provide the greater part of their services in the public sector or through other funding mechanisms like DVA and WorkCover or similar systems. This is particularly so since the current indemnity crisis. The use of HIC procedural items numbers to identify proceduralists is also problematic. Tying the subsidy to mandatory Continuing Professional Development would exclude those for whom this is not required. RDAA believe that the best way to provide this support would be by a quarterly retrospective tax invoice from the practitioner, certified by the hospital/s where, by definition, all procedural work is performed.

Further investigation is also needed to ensure that proceduralists practising in practices which are not accredited are not disadvantaged.

RECOMMENDATION:
That the measures to support the procedural rural workforce are

- **refined and implementing in close consultation with rural doctors;**
- **framed with sufficient flexibility to include all who provide procedural services in both the private and public sectors; and**
- **are built around eligibility criteria which reflect the realities of procedural rural medicine.**

Workforce Re-Entry

There can be little doubt that these measures are likely to help utilize Australia's considerable investment in medical education and training. They are also compatible with the aspirations of the increasing proportion of the workforce which wants to take time out of medical practice for family or other reasons.

Nor is there any doubt that such a measure is needed for both GPs and specialists. It is difficult, then, to understand why they are so much more comprehensive for the latter group. GP's provide the acknowledged hub of the primary healthcare which underpins the health of all Australians. General practice here, as in other countries, is no longer as attractive as it once was. Most of the rising proportion of female doctors do choose general practice, but these younger women are twice as likely as their male counterparts to take timeout of the medical workforce to have or raise a family. There have been a number of excellent studies of female rural GPs over the last few years, and bodies like RDAA and ACRRM include active and articulate female doctors groups.

Both the literature and feedback from these groups emphasizes the value female doctors, particularly proceduralists, place on mentorship and flexible training.

RDAA maintains that the measures designed to support re-entry into the specialist workforce must also be extended to the frontline – to general practitioners.

Furthermore, the funding to GPET regional training providers should be conditional on their undertaking to provide refresher courses that are flexible in both time and location, so opportunities to take them up will be maximised. This funding should include a mentoring program which gives preferential and supported access to doctors who want to return to, or take up, procedural rural medicine and to urban doctors who would like to take up the challenges of rural locum work or fulltime practice.

RECOMMENDATION:
That the re-entry measures proposed for specialists be extended to re-entry into general practice; and

Preferential and supported access to re-entry into general practice be made available to those who wish to re-enter or take up procedural rural medicine and urban doctors who wish to return to or take up rural practice.

Structural Issues

Training medical students and junior doctors, supporting a temporary overseas trained workforce, facilitating re-entry, practical recognition for procedural rural medicine and expanding the role of general practice nurses are all essential to addressing workforce issues. However, a sustainable rural medical workforce demands systematic support in other key areas. RDAA, in association with Monash University has recently completed the second stage of a unique study of the viability of rural medical practice in Australia. On the basis of this national research, the project developed an integrated framework for viable models of rural general practice. The model takes the economic, professional, organizational and social dimensions of rural practiced into account in the development of a set of benchmarks which encompass the minimum requirements for sustainable rural practice at the beginning of the 21st century.
(See Table 4)

RDAA contends that higher Medicare reimbursement for rural patients is the best way to address the declining rate of bulk billing in country areas and at the same time remove one of the barriers to viable rural medical practice.

RDAA research shows that unless MedicarePlus initiates major systemic reform which enables rural medical practices to meet these evidence-based benchmarks, it will remain a lost opportunity to ensure equitable healthcare for the people of rural and remote Australia.

RECOMMENDATION

That RDAA's integrated framework for viable rural practice and evidence-based benchmarks based on current Australian research be adopted as the basis for a systematic and systemic approach to rural medical workforce planning and support.

Table 4: RDAA Benchmarks for sustainable rural practice

cation to Benchmarks to the Viability Framework	
ice economics – Remuneration	
remuneration	ractice principals for in hours routine activity, $110 net income per from Fee For Service (FFS), Medicare, Private fees and Practice tive Payment (PIP) non incentive components. ncome is gross pretax income less practice expenses).
Grants and incentives	retention grant be retained. tive component of PIP and local incentives be retained. onal fee for service incentives reflecting complexity and isolation.
ital	ital remuneration remain via State based awards and agreements
tructure	eturn on investment
ssional Issues	
ssional education, training and	Doctors should be qualified to provide comprehensive care stent with the core skills defined by the Australian College of rural Remote Medicine. ctors should be involved in 10 days recognised continuing ssional development per annum and those in procedural practice d take another five days to maintain procedural skills.
force	ger centres the current ratio of a fulltime GP per 1000 patients is priate. mmunities where the practitioner is providing in patient, emergency fter hours services a full time practitioner per 750 patients would be priate. as of high need and isolated communities of a fulltime practitioner 00 patients may be required to meet community needs in health
urs workload	er of consultations for a full time equivalent rural doctor should on ge be 125 patient consultations a week. ge consultation length 15 minutes.
hours workload	ore than one in four weeknights and one in four weekends (with ensation in terms of additional time off or remuneration in smaller es).
e	eeks annual leave plus one day for each week rostered on call. weeks leave for basic skills maintenance with an additional one for procedural skills. service leave – a minimum of 13 weeks after every ten years of e and 2 weeks per year there after.
ice Organisation and Infrastructure	
ership and strategic planning	um documented practice systems including a strategic business ice manuals should define administrative and operational aspects of actice.
ng	st 1.5 support staff per fulltime equivalent rural doctor. ices should have at least .4 full time nurses and .3 full time practice ger per full time equivalent rural doctor.
oment	ment should at least meet Royal Australian College of General itioner Standards and allow the practitioner to undertake core ies and be appropriately maintained.
nation management and ology	ices should have a documented information management systems gy, backup, support, training and maintenance. al and remote practices should have broadband internet access.
ice premises and facilities	ice premises should reflect local needs and meet building standards alth facilities.