Viable Models of Rural and Remote Practice Project

Stages One and Stage Two Report—**THE RDAA RESPONSE**

RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

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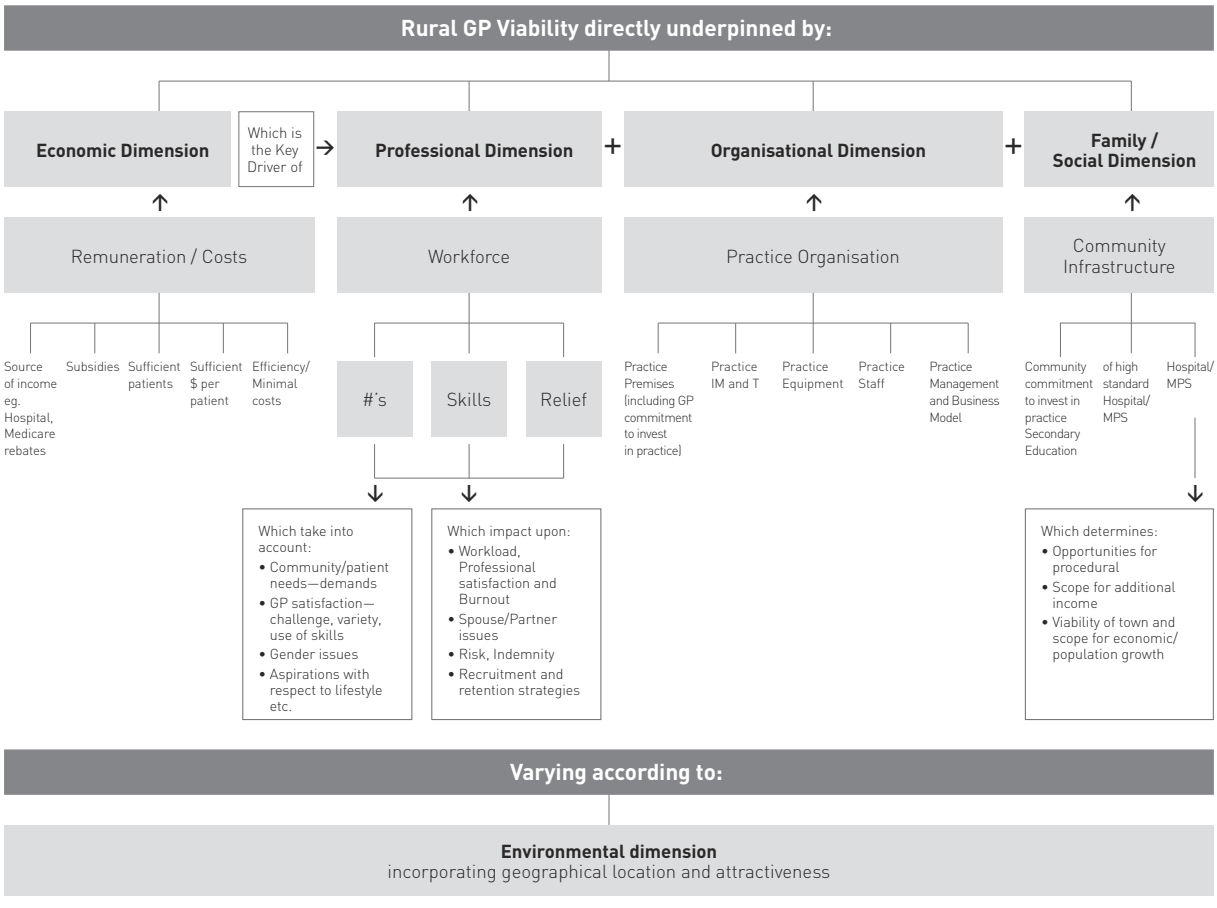
VIABLE MODELS OF RURAL PRACTICE—A PROPOSED FRAMEWORK



SUSTAINING RURAL AND REMOTE PRACTICE THE RDAA RESPONSE

About the RDAA

The Rural Doctors Association of Australia (RDAA) was formed in 1991 to give rural doctors a national voice. The RDAA has a particular focus on improving the health of rural and remote Australians by ensuring they have access to quality health care through training, recruitment and retention of highly skilled doctors. In July 2001 the RDAA was funded by the Australian Department of Health and Ageing (DHA) to investigate the content, context, complexity and costs of medical practice in rural and remote areas and identify the factors affecting practice viability with a view to trialing viable models of future rural practice.

The Problem

Today 30% of Australians live in the bush. They have documented higher rates of chronic illness and injury with consequent higher mortality and morbidity, yet these Australians are served by only 15% of the medical workforce and access only 20% of Medicare rebates.

The Evidence

The RDAA Viable Models Project has shown that doctor shortages persist in many areas in spite of initiatives at both the state and national level. Rural doctors are getting older; burn out is a real threat to them and the communities they serve. Their families are under stress, a major factor in their leaving rural practice. Procedural medicine is still under threat and solutions to local workforce problems have relied almost solely on stop gap measures, such as the employment of overseas trained doctors and locums, without sufficient consideration given to ensuring the sustainability, safety and quality of rural health services.

Data from the Viable Models Project indicates that in rural and remote Australia today one in five practices are not viable and without urgent action this number will rise to over 50% in five years.

The Solution— addressing practice viability

A viable medical practice is one that meets the needs of the community by providing appropriate services in a way that takes account of the financial and personal costs to both the practitioner and their community.

The Viable Models project findings have clearly identified that practice viability is dependent on three key inter-related dimensions:

- **Economic issues** including income, direct costs and return on investment in rural practice
- **Professional issues** including training and skills of practitioners, workforce and workload
- **Practice organisation and infrastructure**

Evidence based benchmarks for practice viability in each of these areas have been established as part of the project to form a viability framework that can be used to identify practices at risk, inform policy development and monitor improvements.

This paper summarises the key initiatives proposed by the RDAA in light of the viability framework and findings from the project.

ECONOMICS OF RURAL AND REMOTE PRACTICE

Problems

- The 30% of Australians living in the bush access only 20% of Medicare rebates.
- The direct costs and opportunity costs of rural and remote practice are high and the remuneration does not reflect the skills, workload, complexity and commitment of rural practitioners
- There is little or no return on infrastructure and practice investment in rural areas
- The increased complexity of the consultation is the result of isolation, the lack of specialist support and limited local diagnostic services.

Evidence

- On average practitioners see 25 patients a day in their consultation rooms for an average 14 minutes a consultation
- Practice costs average 52% of gross income (this does not usually include additional individual non practice costs such as motor vehicle, medical indemnity and professional development)
- Rural and remote practitioners on average worked 56 hours per week with 40% working over 60 hours a week compared with 26% of metropolitan GPs
- Average net income for GPs in group practices is $80 per hour and $55 per hour for solo GPs
- Rural practice consultations have greater levels of complexity and intensity for both common and serious conditions. The rural doctor often also delivers sophisticated hospital services.

Solutions

An economic model has been proposed during the project. The RDAA sees an urgent need to implement all benchmarks in this model with emphasis on:

Grants and Incentives

- Implementation of fee for service incentives with loadings based on rurality and complexity of practice
- Maintenance of established rural grants and incentives

Core remuneration

- Achieving a minimum net income for in hours patient and professional activity of $110 per hour per practice principal
- The source of this core remuneration will be a combination of rebates, patient fees, non incentive component of the Practice Incentive Program (PIP) and other non Medicare rebatable fees
- Adequate indexation to ensure rebates for patients and incentives for doctors keep pace with the real costs of rural medical practice.

PROFESSIONAL DIMENSION

Problems

- Community access to appropriately trained and skilled doctors is under threat with many patients increasingly having to travel for basic medical services and procedural care such as obstetrics
- Doctors working in rural and remote areas are getting older, are burned out and families are under stress
- Solutions to improve recruitment at the local level are focusing almost entirely on short term strategies and overseas trained doctors
- Locums are currently substituting permanent workforce in many rural areas
- Evidence showing safe procedural services such as obstetrics can be provided in the rural community where they are required is often overlooked in the pursuit of economic rationalism.

Evidence

- 37% of the 1,498 doctors who responded to the study survey said they intended to stay in rural practice less than 5 more years
- 61% of doctors reported an inadequate medical workforce in their practice or community
- 40% of doctors are aged 50 years and over
- 24% of doctors practice obstetrics.

Solutions

- Financial incentives for GP registrars and Rural and Remote Area Placement Program (RRAPP) graduates to provide workforce support as locums in smaller practices after appropriate time in rural and remote practice. This solution should be applied particularly where the practice size is not large enough to enable on call, after hours and leave benchmarks to be met.
- Incentives for registrars to undertake procedural training with a view to advanced procedural practice.

A real commitment is required by all stakeholders to achieving the workforce, workload, on call and leave minimal benchmarks described in the Viable Models Report. This will involve improved workforce planning through a risk analysis in every rural and remote practice based on the viability framework.

PRACTICE ORGANISATION AND INFRASTRUCTURE

Problems

- Current premises and facilities in many cases do not reflect community needs, meet professional standards or support quality practice and teaching
- Doctors are reluctant to invest where return is limited or uncertain
- Practices lack appropriate management systems and strategic plans.

Evidence

- Retention of practitioners is improved where high quality facilities are available and practitioners are committed to the practice and community
- While 87% of practices had practice managers, their roles varied and generally did not include strategic planning
- Information management within practices lacked support and was identified as a key risk area.

Solutions

- Grants and other arrangements to ensure appropriate development and maintenance of practice infrastructure and a return on investment for practitioners of at least 10% per annum
- Support for improved practice management and strategic planning for practices
- Consolidation and amalgamation of practices should be encouraged and supported where this is feasible in small towns taking into consideration local factors
- Improved uptake of information and broadband communications technology and integration with other health providers.

Further information and analysis is provided in the RDAA Federal Budget Submission 2004-05, the Viable Models Stage 1 and 2 Report and the policies and position papers available on the RDAA web site: www.rdaa.com.au

SUMMARY

If intending rural and remote doctors can be confident that:

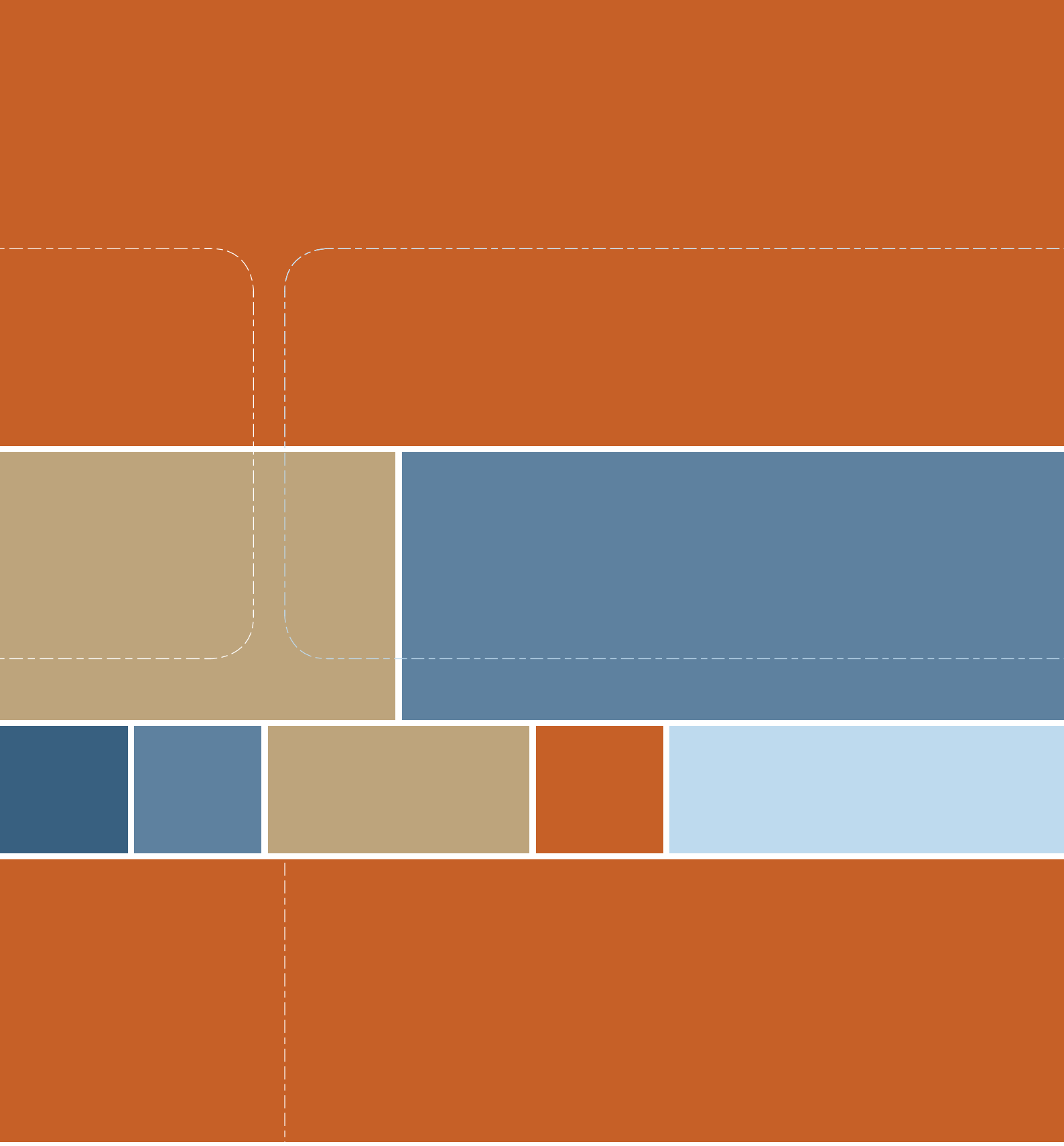
- They will be able to practice high quality medicine in a pleasant and professional setting
- Have enough support from peers
- Can achieve appropriate rewards for their skills, workload and responsibility
- Have adequate recreation leave and family support to avoid burn out and have time off for maintaining skills

And all of the above meet at least the minimum benchmarks described in the Viable Models Report then the fundamental requirements for sustainable practice will have been met.

RDAA supports the adoption of the integrated framework for viability and minimum benchmarks to improve community access to medical services in rural and remote Australia.

BENCHMARKS

Application of Benchmarks to the Viability Framework	
Practice Economics—Remuneration	
Core remuneration	For practice principals for in hours routine activity, $110 net income per hour from Fee For Service (FFS), Medicare, Private fees and Practice Incentive Payment (PIP) non incentive components. (Net income is gross pretax income less practice expenses).
Rural Grants and incentives	Rural retention grant be retained. Incentive component of PIP and local incentives be retained. Additional fee for service incentives reflecting complexity and isolation.
Hospital	Hospital remuneration remain via State based awards and agreements.
Infrastructure	10% return on investment.
Professional Issues	
Professional education, training and skills	Rural Doctors should be qualified to provide comprehensive care consistent with the core skills defined by the Australian College of Rural and Remote Medicine. All doctors should be involved in 10 days recognised continuing professional development per annum and those in procedural practice should take another five days to maintain procedural skills.
Workforce	In larger centres the current ratio of a fulltime GP per 1000 patients is appropriate. In communities where the practitioner is providing in patient, emergency and after hours services a full time practitioner per 750 patients would be appropriate. In areas of high need and isolated communities a fulltime practitioner per 500 patients may be required to meet community needs in health care.
In hours workload	Number of consultations for a full time equivalent rural doctor should on average be 125 patient consultations a week. Average consultation length 15 minutes.
After hours workload	No more than one in four weeknights and one in four weekends (with compensation in terms of additional time off or remuneration in smaller centers).
Leave	Six weeks annual leave plus one day for each week rostered on call. Two weeks leave for basic skills maintenance with an additional one week for procedural skills. Long service leave—a minimum of 13 weeks after every ten years of service and 2 weeks per year there after.
Practice Organisation and Infrastructure	
Leadership and strategic planning	Minimum documented practice systems including a strategic business plan. Practice manuals should define administrative and operational aspects of the practice.
Staffing	At least 1.5 support staff per full time equivalent rural doctor. Practices should have at least .4 full time nurses and .3 full time practice manager per full time equivalent rural doctor.
Equipment	Equipment should at least meet Royal Australian College of General Practitioner Standards and allow the practitioner to undertake core activities and be appropriately maintained.
Information management and technology	Practices should have a documented information management systems strategy, backup, support, training and maintenance. All rural and remote practices should have broadband internet access.
Practice premises and facilities	Practice premises should reflect local needs and meet building standards for health facilities.



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