

# **RURAL DOCTORS ASSOCIATION OF AUSTRALIA**

**Submission  
to the  
Productivity Commission  
Study of the Health Workforce  
August 2005**

## **Part 1 NEW WAYS TO MEET OLD OBJECTIVES**



This submission is in two sections:

- Part 1 - New ways to meet old objectives
- Part 2 - A sustainable rural specialist workforce

The Rural Doctors Association of Australia believes that Australia's future healthcare workforce must be developed with and supported by:

**1. Equitable funding that supports the health of all Australians**

Funding systems should be backed by incentives rather than penalties and prioritized support for team models of service delivery appropriate to their setting

**2. Change management that builds on past successes and current achievements in rural environments here and overseas**

Successful change management will occur through transparent and consultative approaches built on the best available evidence.

**3. Greater coordination of cross portfolio policy and program development**

This must include reform to reduce wasteful shifting of costs and responsibility between Commonwealth and State/Territory jurisdictions as well as integrated approaches to education and training to support new roles and models of care.

**4. Primary health care as the core of the health care system.**

This demands the development of a national primary care policy.

**5. *Rural proofing* must be rigorously applied to evolving systems.**

Rural communities and their health care professionals must take a leading role in this differential analysis.

**6. Role redesign and realignment must be collaboratively assessed and introduced and implemented with quality and safety as its primary focus.**

New models of care involving role redesign must be developed according to OECD criteria.

## **THE RURAL DOCTORS ASSOCIATION OF AUSTRALIA**

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. Every RDA is represented on the RDAA Committee of Management which meets monthly by teleconference. The autonomous State/Territory associations work and negotiate with relevant bodies in their jurisdictions, while the RDAA Committee 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 RDA members are general practitioners (GPs) and most are men. However, the Association takes steps to ensure that the interests and perspectives of smaller groups within the rural medical workforce are incorporated into its advocacy and negotiations. This has led to the establishment of special interest groups for female doctors and rural specialists, both of which meet regularly to discuss specific and generic rural workforce and health service policy matters. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors (OTDs) who now make up over 30% of the rural medical workforce generally and closer to 50% of it in some States.

The RDAA has a primary focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce to provide quality care to the people of rural and remote Australia. Much of its activity therefore concentrates on recruitment and retention issues and the viability of rural medical practice. However, it also works on particular health and health service issues including Indigenous health, rural birthing services, small rural hospitals and rural and remote nursing practice.

As the only advocacy body with a specific mission to support 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 decision makers and incorporated into the design and implementation of national policies and programs.

## BACKGROUND

Consumers, health professionals, economists, policy analysts and governments recognize the stimulus for the Productivity Commission's study of the health workforce: there is an urgent need to improve the supply, flexibility and responsiveness of the health workforce if we are to maintain and extend the good health outcomes which Australians generally enjoy.

The management of the changes needed to do this must be built on the foundation of quality, safety, expertise and professionalism already in place.

RDAA emphasizes that a focus on the future cannot be used to justify procrastination in addressing current issues of critical workforce shortage and the impact they have on the health and well-being of rural areas. Immediate action is essential to enhance rural recruitment and retention, to reduce barriers which constrain workforce flexibility, to support particularly fragile sectors of the medical workforce like rural specialists and GP proceduralists and to maximize the contribution of female doctors and the incoming cohorts of medical practitioners.

It is generally acknowledged that *the health workforce is the most important of all health system inputs*<sup>1</sup>. However, increasing the size of the workforce - or managing to halt its decline in some areas - is not enough. The question is not how many doctors, nurses or allied health workers could be in place in ten years, but how they are distributed and what models of care and health care systems will be needed, effective and practicable in ten years. Only when these models and systems are identified can the numbers and makeup of the future health workforce be estimated.

However, the evolution and nurturing of a health workforce appropriate to the 21<sup>st</sup> century will be impossible without fundamental reform of the health care system. This reform must include mechanisms which will support the development and sustainability of models of care suited to an ageing population with its concomitant burden of chronic disease and disability, a population with rising expectations of the health care system which at the same time will be producing a decreasing recruitment pool of younger people to succeed the ageing cadre of health care professionals.

RDAA believes that this reform must be based on six fundamental principles:

1. Equitable funding must support the health of all Australians
2. Change management must build on past successes and current achievements
3. Coordination of cross portfolio policy and program development is essential
4. Primary health care must be the core of the health care system
5. *Rural proofing* must be rigorously applied to evolving systems
6. Role redesign and realignment must be collaboratively developed and implemented

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<sup>1</sup> Australian Health Ministers' Conference [AHMC] (2004) – *National health workforce strategic framework*. Sydney, AHMC p 6

**1. Equitable funding mechanisms** must ensure that all Australians, regardless of where they live, receive their fair share of the financial resources designed to support their health. This means a system whereby any deficit in the distribution of the major health funding mechanisms – the Medical Benefits Scheme [MBS], the Pharmaceutical Benefits Scheme [PBS] , the Australian Health Care Agreements [ACHA] and the Private Health Insurance Subsidy [PHIS] – to those who live in rural and remote areas is balanced by other funding.

Rural access to the MBS, and so to the PBS, is constrained by the acknowledged shortfall in the medical workforce outside major centres. The one-size-fits-all Medicare rebate and its inadequate indexing formula contribute to this shortfall and to the problematic viability of a significant proportion of rural medical practices.<sup>2</sup> While some recent initiatives like incentives for bulk billing and support for practice nurses have acknowledged the different environment of rural practice, Australia's health funding system will remain inequitable until the greater complexity and level of responsibility and the higher costs of rural practice are recognized by a loading on the rebate for services provided in rural and remote areas. Rebates must also acknowledge that quality medicine may often involve longer consultations and so reward the doctors who provide them.

Three hundred and twenty two of Australia's 512 public hospitals are small (< 50 beds) institutions in rural areas where they play a vital role in the health and socio-economic vitality of their communities. However, the funds transferred to State and Territory governments through the Australian Health Care Agreements [AHCAs] to run their hospitals are allocated on the basis of admissions. These small hospitals have about 6,962 beds. There are currently 69 principal referral and specialist public hospitals in Australia. They represent 16% of the total number, but contain 62% (n = 33,108) of the nation's 53,000 public hospital beds.<sup>3</sup> This means that, quite apart from other factors, including the higher costs of running tertiary institutions, and urban power blocs, rural hospitals do not necessarily receive a share of the AHCA funding commensurate with their important function in the health and well-being of rural communities. Nor do the AHCAs include any levers to encourage this. It is essential that future Agreements include incentives to direct a more equitable distribution of this funding complemented by proportionate spending on primary health care as a lever for demand management in relation to hospital admissions.

Disproportionate spending on illness and acute care perpetrate perverse incentives, as the newly installed Premier of NSW, Morris Iemma, said recently: "The basis of the funding is how many hospital admissions you have each year, so if you succeed in keeping people well and out of hospital...you get penalized".<sup>4</sup>

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<sup>2</sup> RDAA & Monash University (2003) – *Viable models of rural and remote practice: Stage 1 and Stage 2 Reports*. Canberra, RDAA

<sup>3</sup> Australian Department of Health & Ageing [DoHA] (2005) – *The state of our public hospitals, June 2005 report*. Canberra, DoHA

<sup>4</sup> *The Australian* July 18 2005

The waste, cost shifting, responsibility dodging and duplication inherent in, and fostered by, the Commonwealth/State and Territory fiscal system is the subject of much frustration. Estimates of the cost of these inefficiencies to the economy as a whole range up to \$1.1 billion per annum in the health sector alone.<sup>5</sup>

The implications of the funding/responsibility divide are particularly problematic for rural consumers and their health care providers because of the lower level of health resources available to them. It is possible that a single point of responsibility would improve their situation, but it must be recognized that both levels of government have some political advantage in the *status quo* and the practical and political complexities of change are daunting. However, as one experienced commentator has suggested, moving to a single level of funding and responsibility for rural areas could be an effective compromise.<sup>6</sup> Regardless of which level of government this should or could be, financial arrangements must be adjusted so that funds follow function.

## **2. Building on past success and current achievements**

Rural Australia has led the way in developing innovative and collaborative models of care involving private general practitioners, outreach medical specialists, allied health and hospital services, local governments and businesses and the community. Efforts based around general practice must continue and expand with practical encouragement. Other communities must be supported - through funding and expertise focused on capacity building - to develop initiatives focused on their particular local needs and circumstances. Innovative models such as 'place based health planning' could be considered as part of a framework for more effective resource allocation and workforce development appropriate to particular settings.

**3. Coordinated cross portfolio policy and program development** to avoid the policy dissonance or dis-connect which can undermine otherwise well-intentioned policies is essential to any reform of the health system. Examples of current policy conflict are sadly numerous: closing or downgrading small rural hospitals undermines strategies to attract and retain a motivated rural health workforce and limits the effectiveness of initiatives to support the sustainability of rural and regional areas. At a broad level, the impact of socio-economic conditions, including income and employment and education, on health status is well accepted. Yet the practical application of this knowledge is slow, presumably because it often falls between, rather than across, two or more portfolios. Thus public policy efforts to address licit substance abuse, obesity or poverty, for example, are diluted or delayed.

Nor does awareness of the converse effect – the impact of good health on national wealth accumulation and economic productivity – appear to bear the influence it should in economic, environmental and industrial policy, though the work of the Productivity Commission could be instrumental in changing this.

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<sup>5</sup> Davis M (2005) – Federal system wastes \$2.4 bn. *Australian Financial Review* 14/03/05

<sup>6</sup> Wells R (2005) – The future health workforce: options we do and do not have. Paper presented at the 8<sup>th</sup> National Rural Health Conference, Alice Springs, March

**4. The consultative development and collaborative implementation of a national primary health care policy** must be at the core of reform. Both the process and the policy should direct health system change and workforce redesign.

RDAA strongly maintains that the health system must be reconfigured to put a greater emphasis on disease prevention. The changing burden of disease, with chronic and co-morbid illnesses comprising a greater proportion of health needs and costs, means that the delivery of care must also change. Given that many of these conditions are largely preventable, greater emphasis must be given to addressing their common risk factors and intervening earlier in the disease path.

General practitioners are ‘the hub in the wheel’ of primary health care and so have a significant role in prevention and early intervention and the avoidance of unnecessary hospitalisations.

*Many episodes of expensive hospitalisation could be eliminated through better-resourced preventative and primary care programs.*<sup>7</sup>

Rural doctors are increasingly expected to play a role in public health and population medicine, but as a commentator on health reform wrote recently:

*Primary care physicians [are] naturally expected to play a major role in [these areas] but current remuneration packages make it very difficult for our general practitioners to give an appropriate amount of time to address lifestyle issues with those who most need that advice.*<sup>8</sup>

## **5. Rural proofing<sup>9</sup>**

RDAA contends that the unique circumstances of health care delivery in rural Australia mean that blunt, untargeted mechanisms for system wide reform do not achieve their stated objectives for a substantial proportion of the population.

Rural proofing, or scrutiny based on differential analysis, must be applied to all aspects of the management of health system change to ensure the interests and rights of rural Australians are upheld and progressed. A framework similar to that under development in the United Kingdom should be devised to ensure *that health policies and models of service delivery are rurally sensitive ... [and] rural health services meet the needs of people living in rural and remote communities.*<sup>10</sup>

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<sup>7</sup> McAuley I (2004), Stress on public hospitals – why private insurance has made it worse. A discussion paper for the Australian Consumers’ Association and the Australian Healthcare Association. January, p 19

<sup>8</sup> Dwyer J (2003), Opinion piece. *Australian Financial Review*, June 12 2003.

<sup>9</sup> Rural proofing is a concept developed by the UK Countryside Agency in response to the UK government’s Rural White Paper for England. The Institute of Rural Health there is developing a toolkit for Rural Proofing for Health to facilitate the planning and delivery of health care services that are sensitive to rural needs and settings.

<sup>10</sup> Swindlehurst HF, Deaville JA, Wynn-Jones J & Mitchinson K (2005) – Rural proofing for health: a commentary. *Rural & Remote Health* 5 p1

**6. Role redesign** and the development of models of care appropriate to the population, expectations and resources of Australia in the second decade of the 21<sup>st</sup> century will guide and be guided by the reform process. Although there is widespread recognition that the future health workforce will be constituted differently, in some ways there is relatively little robust evidence to direct this inevitable change. For example, although cost effectiveness is often promoted as an argument for role substitution, there is remarkably little conclusive evidence one way or the other on this point. However a widely respected OECD overview of the implementation of new models and the successful realignment of older roles and responsibilities suggests a set of criteria which should be used in their assessment. These may be summarized as:

- The agreement of the relevant professions on the need for the role redesign and respectful and collaborative approaches to implementing this
- Role definition and education and training to enable the new/expanded roles to achieve their agreed purpose
- A national approach to registration and regulation
- The establishment of clear career and payment structures and adequate and fair funding mechanisms<sup>11</sup>

RDAA would add:

- Adequate funding, including assistance with capital expenditure and infrastructure to support new roles.

## **IMPLEMENTATION**

RDAA believes the implementation of these principles should be characterized by positive approaches which emphasize expenditure on maintaining health and alleviating illness as an investment in productivity rather than a fiscal liability. Demographic ageing should be recognized as a triumph of our health and social system as well as a challenge for the future. Economic modelling commissioned by the National Healthcare Alliance (now the National Healthcare Forum) showed that better investment in health will provide a more productive future with an older and smaller workforce than reduced investment.

*Astute health investment, coupled with system reform and innovation in service delivery will be the most effective way of building the social and economic capital of Australia as we age.*<sup>12</sup>

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<sup>11</sup> Buchan J & Calman L (2004) – *Skill-mix and policy change in the health workforce: nurses in advanced roles*. OECD Health Working Papers 17, Paris, OECD pp 33-4

<sup>12</sup> National Healthcare Forum (2004) – *Towards a healthy and productive older workforce*. Federal budget strategy submission. Unpublished.



A positive approach would see a shift from penalties to incentives, whether at the level of the AHCA's or specific programs, like the bonded medical scholarships. The results of rural retention and Service Incentive Payments show that positive approaches can achieve good results at practice level. At a jurisdictional level, a sensitive system to reward innovation, better health outcomes and more equitable service distribution, though not easily devised, should reap similar benefits.

As indicated above, a constructive approach would recognize the achievements in health service delivery, research and innovation which put Australia's health outcomes in the top international rankings in so many fields. The iconic Royal Flying Doctor Service is only the most high profile example of on-going leadership in developing models of care suited to the Australian culture and environment. Considering the importation of models which work well in other environments should not take precedence over building on successful models of care as they have been evolving here.

RDAAC has prepared a number of submissions which detail its position on health funding, primary health care and the development and implementation of health policies and programs.<sup>13</sup> Therefore this paper will concentrate on rural proofing the role redesign and development of new models of care which are an inevitable part of health system reform.

### **Delegated models**

*Consulting a doctor is the most common action related to health care taken by Australians.*<sup>14</sup> General practice is the hub of primary health care and the gateway to other parts of the health care system. Nationally, GPs provide on average 4.9 consultations per year to 87% of the population.<sup>15</sup> Multidisciplinary teams providing diverse elements of simple and advanced clinical care through a general practice model is the most practical way to extend primary health care to rural people.

RDAAC sees new models already evolving through greater flexibility in the delegation of care by rural doctors to an expanding range of other health care professionals at the local practice level. Practice nurses have been employed in rural practices for several generations and RDAAC strongly supported the introduction of the Commonwealth Practice Nurse subsidy to support and expand their work. This practical incentive to employ registered and enrolled nurses and Aboriginal Health Workers in general practice has been followed by access to new Medicare item numbers for wound dressings, immunisations and pap smears performed by practice nurses on behalf of the medical practitioner.

RDAAC supports extending this access to other services and procedures to enhance the holistic care a general practice can offer a community, a process which should be accompanied by data collection which can guide the development of similar models. However, RDAAC cannot support models of workforce realignment that grow from role

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<sup>13</sup> See [www.rdaac.com.au](http://www.rdaac.com.au) Policies and Submissions. See Attachments 1-3

<sup>14</sup> Australian Institute of Health & Welfare [AIHW] (2004) – Australia's health 2004: the ninth biennial report of the AIHW, Canberra, AIHW [AUS 44] p 394

<sup>15</sup> *ibid* p 297

augmentation within collaborative teams into ideologically based role substitution likely to promote fragmentation rather than integration of health care delivery.

Moreover, RDAA is only too aware of the potentially pernicious effect of metro-centric initiatives on the rural workforce. At best, they may serve to exacerbate existing inequities: for example, 2004 Medicare changes which benefited urban obstetricians, most of whom are in private, Medicare supported, practice, widened the income gap between them and their rural colleagues, most of whom work predominantly in the public sector. This creates a siphon effect which, however unintended, can have a critical impact on rural retention.

The importation of models of care, for example those utilizing mid-level health care providers, from other environments, can be equally hazardous and cannot be supported by RDAA until such time as they are supported by evidence which provides robust indications of their relevance and transferability to rural Australia.

In the delegation model, team members are usually practice employees, though there are good working models where practice personnel and healthcare professionals employed by a local hospital or Division of General Practice form very effective working units. RDAA's policy on Rural and Remote Nursing Practice<sup>16</sup> recommends that the responsibilities of both employer and employee should be embodied in a legal contract based on current industrial standards and awards. The expansion of the delegation model utilizing practice employees will depend on adequate funding. The success of the practice nurse subsidy suggests that subsidization through the Practice Incentive Payments scheme would be an effective way to support the employment of allied health professionals.

The formal redistribution of work between doctors and registered nurses has attracted most attention in Australia. However, the exigencies of rural practice have been blurring demarcation lines across other parts of the workforce, too.<sup>17</sup> In some jurisdictions, paramedics and ambulance officers provide community and hospital based services under delegation. Enrolled nurses and Aboriginal Health Workers are often forced by circumstances into work beyond their formal scope of practice, as are registered nurses.

A properly supported expansion of the delegated practice role could offer them recognition and protection which they do not always have now. Allied health workers could also be integrated into teams in this way. It has been suggested that a supervisory model could enable the skills of International Medical Graduates who do not achieve medical registration here to be used where needed. However, RDAA believes that this could lead to an apparent lowering of standards which would be unacceptable to rural communities and health care professionals.

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<sup>16</sup> see [www.rdaa.com.au](http://www.rdaa.com.au) Policies. See Attachment 4

<sup>17</sup> For example, as Part 2 of this submission points out, GPs with advanced skills or special interests often participate in specialist rosters which would be unviable without them.

The necessarily generalist nature of rural practice and the size of rural communities suggests that some of the very specialized mid-level roles in place or projected in other places – nurse anaesthetists, colorectal surgical assistants or midwives in independent practice, for example – would be unsustainable in sparsely populated areas.

The expansion of the delegated practice model would enable doctors to devote more time to complex areas of care while other health care professionals undertake more routine clinical tasks, the day to day management of chronic conditions and work in areas for which they have advanced training like diabetes education or cardiac rehabilitation. However, the doctor's role would also be extended to include more sophisticated clinical governance and team supervision, which has implications for training and remuneration.

These teams may or may not be co-located within the practice premises. Information and Communication Technology (ICT) and the collaborative development of protocols and guidelines can enable team members to provide services in diverse settings which may be quite distant from the main practice.

### **Collaborative models**

Other models of advanced nursing practice are already in place in some rural and remote parts of Australia, notably Queensland, the Northern Territory and Western Australia. Members of collaborative teams are led by medical practitioners in a consultant role rather than acting under their formal delegation. These nurses, or, in some cases, allied health professionals, are usually public sector employees. It is likely that these models will expand, guided by appropriate education and regulation and supported by mutual respect and transition from managerial to leadership concepts. Their sustainability will depend on adequate and secure funding.

### **Funding**

Role redesign generally excites professional tension and dissension. A specialist union... which is feeling squeezed in terms of multiskilling arrangements allowing other unions to move into its traditional area of coverage, may attach increasing importance to issues of skills and demarcation<sup>18</sup> International studies suggest these are more severe when funding is a potential issue. For example, acceptance of expanded roles has been harder in the United States where it can lead to commercial competition in a fee-for-service environment, than in the United Kingdom where National Health Service funding provides specified salaries for all parties.

It will be up to government to develop funding systems which provide adequate remuneration and resourcing for these team members. The use of Medicare funds through cashing out on a weighted per capita basis is a possibility. However, as RDAA points out in its policy on Funds Pooling<sup>19</sup>, this can be a simplistic and hazardous response to a

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<sup>18</sup> Akhlaghi F & Mahony L (1997) - Service integration and multiskilling in facilities management within the UK National Health Service. *Facilities* 15:3/4 p 70

<sup>19</sup> See Attachment 5

complex situation like generalized funding constraints across a region, although it can be an effective way of meeting a specific purpose. This has been demonstrated in some areas of Indigenous health care and RDAA believes it can be used to extend primary health care services in rural and remote areas through collaborative, GP led multidisciplinary teams. Such schemes, which are likely to be constituted differently in different settings, would have to be designed and implemented in close collaboration with all stakeholders and funded to include piloting, monitoring and regular external evaluation which examines health outcomes, impact on the workforce and stakeholder satisfaction.

As already noted, independent nursing, midwifery or allied health practice is unlikely to be economically viable in rural and remote areas. Even solo medical practice which is supported through Medicare is a precarious commercial proposition. Extending access to direct Medicare support to non-medical providers would put them in the same position. It would also provoke resentment and workforce turbulence in the context of inadequate rebates for some medical services and the lack of proper recognition of those provided in rural and remote areas.

Both the proponents and opponents of extending Medicare provider numbers to non-medical professionals outside the auspices of general practice see it as the key to establishing their role as independent private practitioners. Rural proofing would suggest that commercial considerations would limit the viability of independent private practice, for example in midwifery, in rural areas and question its compatibility with the multidisciplinary team concepts which all parties profess to see as the path to the future.

In rural and remote areas, necessity has long dictated team work. However, changing professional education and aspirations have led to increased tensions about the format of these teams and emerging models. Internal questions of autonomy, maximization of skills and respect are paralleled by external demands for increased services and the cost-effective use of a thinly spread workforce.

Evolving team models can - and must - effectively extend the range of services available to rural and remote communities as the number and scope of practice of one group of health professionals impacts on the supply and scope of practice of another. As a generalist in a team increasingly made up of others with specialized training, the GP must carry the pivotal role of clinical consultant team leader. This implies an expanded role in clinical governance and team supervision for medical practitioners as well as a division of labour which enables them to spend more time on complex care and high level clinical work, thus and making optimum use of the highly skilled medical generalist who spans the primary and secondary care continuum.

This consultative resolution - or revolution - must be underpinned by thorough rural proofing. High level decision making in Australia is, understandably enough, based in larger population centres where the complexities of rural service delivery are often poorly understood. The capacity of rural and remote health authorities or Divisions of General Practice to influence the larger structure of which they are part may be limited. Not all the organizations which purport to cover the interests of the professions concerned have a

strong rural focus. The development of teams and systems which are “pale reflections” of urban models could be impractical or counterproductive.

For example, rural maternity care is highly dependent on the close collaboration of midwives, procedural and non-procedural GPs and obstetricians, paediatricians and other specialists. It is this collaboration which enables them to sustain the services which now provide excellent obstetric outcomes. Models of care which downplay the role of the collective team members in favour of more independent practice may be suitable in urban environments where assistance is available at short notice, but not in other settings.

Independent midwifery practice might be financially feasible in large centres where the potential number of deliveries is sufficient to sustain it. The average annual number of deliveries per procedural GP in small rural centres is 30-50. Almost all (97%) of these occur in the public sector.<sup>21</sup> Combined with other aspects of general practice and, very often, hospital work, this obstetric practice is economically viable. It would not be so otherwise. Independent midwifery practice is hardly likely to be commercially sustainable, even with a Medicare provider number, given the potential caseload. The income would hardly bear the costs of professional indemnity if this were not covered through the public sector.

There are concerns about the feasibility of employing midwives exclusively for maternity care in small rural hospitals in relation to the volume of this work in a full time workload.

Job satisfaction is recognized as a major factor in the retention of health care professionals. Models of collaborative care which enhance this by recognizing and maximizing the skills of all team members can contribute to workforce recruitment and stability. Conversely, models of maternity care which exclude GP proceduralists or confine their involvement to difficult cases can lead them to withdraw from obstetric practice, as experience here and in New Zealand has shown. This leaves the midwifery services with insufficient or no backup and they become unsafe and unsustainable.

Ideology and short sighted budgetary considerations are not necessarily the best drivers of change.

In areas where workforce shortages are the main driver of role reconfiguration, for example Mareeba in Queensland and Corangamite in Victoria, models addressing pragmatic issues of service survival are being developed collaboratively by doctors, midwives and health authorities and the communities. These models are cause for optimism and their progress and evaluation will be an important contribution to rural health care policy and planning.

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<sup>21</sup> RDA NSW Procedural Data Base

### **Rural proofing**

Rural proofing is needed to ensure that models which have proved useful in other settings are not assumed to be so in rural and remote Australia. Rural communities and their health care providers are best placed to do this analysis. If function is to follow demand rather than supply, the criteria may vary from place to place.

RDAA is aware of the rapidly expanding numbers of cascading professional assistants: in the United States, for example, anaesthetics assistants are being trained to assist the clinical registered nurse anaesthetists who have been providing rural and obstetric services there for many years. Some of these models have been subject to more rigorous evaluation than others. Most studies have looked at expansion across professional lines rather than the applicability of new roles in different environments. For example, overseas studies of practice nurses have not placed the same value on their role as rural Australian experience has shown them to deserve here.<sup>22</sup> In some countries, initiatives have been developed in response to specific circumstances. In the UK, for example, the NHS has fostered the role of nurse practitioners as an explicit response to the impact of the European Union Safe Working Hours Directive on the hours worked by junior doctors.

The exigencies of health care delivery in rural Australia demand solutions to problems which are often very specific to the setting. Supporting the proven capacity of Australia's existing rural health care providers for innovation and quality care in a challenging environment, now reinforced by rural clinical schools and university departments of rural health is likely to be a better investment than the importation of models of untested transferability.

In Australia, as elsewhere, the nurse practitioner role has usually been extended through advanced clinical training and the number of nurses working at an advanced level in rural and remote healthcare in Australia is far less than the number working in specialized areas of practice like oncology or renal care. There are approximately 100 designated nurse practitioner positions in various stages of authorization in NSW; 5 of them are in primary health care and 8 are located in rural areas. The first 4 nurse practitioners in Victoria were endorsed in November 2004. They work in wound management, ICU liaison and youth health (2). Although 3 of the 4 original trial sites for nurse practitioners in Queensland were in rural health, only 2 of the 7 sites added in 2005 are in rural health while the trial has been discontinued in 2 of the original rural sites.

Nursing, like medicine, has been tending towards increasing specialization, with undoubted benefits to patient and service provider alike but rural communities need more generalists who will provide a wide range of care. Many rural areas are unlikely to sustain the level of specialized practice for which highly focused but narrowly trained professionals are trained. Multiskilling, with attendant regulatory modification, is more appropriate in the rural context.

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<sup>22</sup> Laurant MGH, Hermens PMG, Braspenning JCC, Sibbald B & Grol PTM (2004) – Impact of nurse practitioners on workload of general practitioners: randomized controlled trial. *British Medical Journal* 328: 927-932

For rural communities and health providers, the concept of substitution<sup>23</sup> is problematic, as it implies that shortfalls in one workforce component can be filled by others in oversupply. This is, of course, far from the case. Optometry appears to be the only health profession which assesses its current rural workforce as adequate. In fact, if greater rural coverage is going to be achieved through multidisciplinary teams, recruitment and retention issues are as important as the development of new roles.

It is often assumed that it will be less expensive to train and pay mid-level professionals. This is by no means clear from the available research. Some studies indicate that the effect of longer consultations, higher resource usage, increased demand and wage creep can counterbalance initial economies. An expanded role in clinical governance and concentration on areas of practice demanding higher skills can erode the projected benefits of workload relief for doctors.

Rural proofing suggests that introducing innovative ways of service delivery to rural and remote areas based on specific rural workforce training programs are better ways to achieve more value for money. This approach would concentrate on strategies to extend the reach and impact, rather than the number, of service providers. It would emphasize the role of ICT in support systems which would enable some services to be provided by less highly skilled practitioners. It would support the capacity of consumers to manage their own health and maximize the investment in health by directing this into primary health care where it can restrain demand through health maintenance and disease prevention.

Rural health care has often led innovation in service delivery and the imperative to develop new models to meet future needs offers rural medical practices, rural doctors and other health care professionals an exciting opportunity to guide the inevitable change in both service delivery and the education and training needed to ensure the changes are positive. However, as the experience-based OECD criteria indicate, all the stakeholders, including health administrators and managers as well as the professions and subspecialties involved, must agree on the objectives of role redesign. This should be easier in rural and remote areas where workforce shortages in all professions and obvious gaps in service delivery are the main drivers for change.

Unilateral change driven by one profession is likely to produce confusion and resentment in other stakeholders, as has already happened in some areas.

The danger is that the opportunity for more effective workforce deployment, role reconfiguration which has the potential to enhance recruitment and retention and positive change management will be delayed or lost if ideology overcomes reality, if funding sources and levels are not fairly determined and demarcation issues are not consultatively

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<sup>23</sup> The term has negative connotations in many rural areas which have been sensitized through policies in other fields which substitute a lower level of service for that previously available. While planners may use it in a technical sense, the word exacerbates fears of “second best will do for the bush” which are not conducive to constructive debate.

resolved. Finally, education and training programs appropriate to changing roles and responsibilities must be developed.

### **Education and training**

If there is an urgent need for a national primary health care policy to provide a framework for new role delineation and models of care, the need for appropriate education and training to support them is equally important.

*Health sector reports have decried the inadequacies of existing educational preparation, with particular emphasis on the need to restructure education to provide a greater emphasis on teamwork and interprofessional issues.<sup>24</sup>*

Yet change has been fragmented and sometimes little more than tokenistic. Shared lectures are a start (and save scarce education resources) but there must be more shared clinical placements and cross-professional activity that will break down long entrenched cultures of difference. This will not occur while education is delivered in traditional silos.

Academic independence is important, but universities and other teaching and training institutions must become more responsive to workforce need. At present, many of the links between the academic and the health care delivery sector are *ad hoc* or based on personal connections. Health care reform may require health departments to have a stronger role in determining course content and structure as a direct way to meeting core health workforce objectives.

The future workforce may require the development of flexible, competency focused modules as a basis for building a network of diverse but complementary career paths which can satisfy the needs of both consumers and providers of health care.

In line with the evidence supporting primary health care as the most effective point of intervention, new courses, modules and training programs should prioritize the development of a workforce adequately trained to provide this.

In line with the needs and circumstances of rural communities, education and training must support the development of a new generation of generalists, doubtless more specialized than those of the past, but equipped to provide holistic care for individuals and communities. Distance learning and on-site team training are particularly apposite for rural health care providers. Education and training delivered in rural settings is an effective way of opening health careers to rural people who are likely to remain to work in their own communities.

More specialized learning modules could be built onto basic generalist tiers to meet the need for different or extended competencies and greater flexibility in the future workforce. For example, these could be developed if a health authority identified a gap in service delivery in a particular field. A graduated competency- based training structure

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<sup>24</sup>Duckett SJ (2005) – Health workforce design for the 21<sup>st</sup> century. *Australian Health Review*, May 29:2 p 205



would allow time for greater choice and staged career development which would contribute to job satisfaction and workforce retention. Education programs founded on common competencies and shared training would enhance understanding and collaboration between professional groups, hopefully replacing rivalry with respect. However, it is naïve to assume that, however cost effective and theoretically attractive, shared education and training will be easy, given the diversity of individual capacity and entry qualifications. Team training would emphasize communication, coordination and integrated models of care.

### **Conclusion**

Changing the roles of rural health care providers is inevitable as the potential workforce shrinks while demand for its services rises. The management of this change presents a challenge that can only be met by applying the principles of collaboration, consultation and flexibility which must also characterize its solutions. It is critical that the shape of the future rural health workforce is designed in close collaboration with the current rural service providers who are so often leading the way in developing practical models to meet the needs of their local communities.

As the only medical professional body with an exclusive focus of rural Australia, RDAA, in partnership with the Australian College of Rural and Remote Medicine is ideally placed to play a role in this process and to ensure that new and evolving models are embedded within the clinical teams which are already providing the quality care that all Australians deserve.

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**RURAL DOCTORS ASSOCIATION OF AUSTRALIA  
RURAL SPECIALISTS GROUP**

**Submission  
to the  
Productivity Commission  
Study of the Health Workforce  
August 2005**

**Part 2  
A SUSTAINABLE SPECIALIST WORKFORCE  
FOR RURAL AUSTRALIA**



# ***A Sustainable Specialist Workforce for Rural Australia***

*A Position Paper prepared by the Rural Specialists Group<sup>25</sup> of the*

*Rural Doctors Association of Australia<sup>26</sup>*

**Rural communities have the right to specialist medical care provided by sustainable specialist medical services and workforce in order to maintain their health at the same level as those living in metropolitan areas.**

## **Executive Summary**

Specialist medical services play an essential role in achieving optimum health outcomes for people in rural and remote Australia. A skilled and responsive specialist workforce must be maintained to provide these services.

Community expectations for locally-based specialist services which provide care equal to that available in metropolitan centres has increased and therefore the issue of sustainability of these services, as distinct from those supplied by outreach, is of increasing importance.

Work has been undertaken into viable models of general practice and procedural general practice but little has been done thus far about specialist services. In the first instance it will be important to concentrate on the “big four” specialist areas - medicine (including paediatrics), surgery, anaesthetics and obstetrics and gynaecology.

Rural specialists provide rural communities with not only clinical services and leadership but also upskilling and support for other practitioners, rural training, research and other activities, the range of which is greater than that undertaken by the majority of metropolitan specialists.

Rural specialists in general work as part of teams, and in rural areas, the concept of specialised (team-based) rather than specialist (individual-based) services is extremely important.

Sub-specialisation has many benefits but the emphasis on it in metropolitan teaching hospitals means that the workforce produced does not cope optimally with working in rural environments where generalism is usually required.

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<sup>25</sup> The Rural Specialists Group is a Special Interest Group of the Rural Doctors Association of Australia established in 2004 to provide advice and expertise on workforce issues relating to the rural specialist workforce as a whole

<sup>26</sup> Principal author: Rick McLean, with input from Nigel Stewart, Hugh Calvey, John Graham, Pieter Mourik, Mark Smith and Susan Stratigos.

Outreach services are an important complement to services provided by rurally-residing specialists but cannot and should not replace local capacity.

Key action areas that have been identified include:

1. Rosters and locum arrangements. After-hours rosters should be no more than 1 in 4 except for brief and infrequent periods. However workforce shortfalls and the exigencies of working in some particularly more remote areas means that it is not always possible to achieve this standard and therefore doctors working in these regions must be supported by triage back-up, special locum relief and specific additional recreational leave.

Guaranteed locum arrangements are essential, particularly for those who are working regular after-hours rosters where they are likely to be required to provide personal attendance after hours on a regular basis.

2. Infrastructure support and information and communication technology. Unless the necessary human and physical infrastructure to support a specialist workforce is available, adequate healthcare cannot be provided. ICT is of increasing importance in rural areas for both clinical practice and continuing professional development and this must be available to rural specialists as a quality and safety issue.
3. Networks and education. Rural specialists rely on network connections with metropolitan hospitals and specialists for clinical CPD and locum support and such arrangements need to be strengthened.

Links between regional specialists, rural clinical schools and University Departments of Rural Health and metropolitan universities and hospitals must also be strengthened.

4. Rural training by specialist colleges. Colleges must be supported to provide rural training.
5. Remuneration. While financial matters are not ranked highly in surveys of the rural medical workforce, there is no doubt that dissatisfaction with inadequate payments, unresolved financial anomalies and funding systems that fail to take account of the circumstances of rural practice can trigger decisions about entering or leaving rural medicine. Remuneration is a particular issue for those who provide after-hours care. Rural specialists support the push by rural general practitioners to gain a rural fee loading in this regard.
6. Promoting successful models. Although successful models are never completely transferable to other settings, analysis of factors which have been critical to their success can be helpful for those seeking solutions to similar problems. There is a need for rural specialists to have a formal role in clinical governance particularly in relation to local service planning and resource allocation.

There is a need for cross-jurisdictional discussion and planning to agree on a range of actions which will effectively progress the agenda of sustainability.

## **Background**

This position paper, which was initially prepared in response to the perception by members of the Rural Specialists Group that sustainability of rural specialist services was an urgent and significant area of unmet policy, focuses on the essential role of these services in achieving optimum health outcomes for people in rural and remote Australia.

It is presented in the context of *Healthier Horizons – a Framework for Improving the Health of Rural, Regional and Remote Australians 2003 - 2007* which was jointly developed by the Australian Health Ministers' Advisory Council's National Rural Health Policy Sub-committee and the National Rural Health Alliance. The over-arching vision of this document is that "people in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities". Its goals are to:

1. improve highest health priorities first
2. improve the health of Aboriginal and Torres Strait Islander people living in rural, regional and remote Australia
3. undertake research and provide better information to rural, regional and remote Australians
4. develop flexible and co-ordinated services
5. maintain a skilled and responsive health workforce
6. develop needs based flexible funding arrangements for rural, regional and remote Australia
7. achieve recognition of rural, regional and remote health as an important component of the Australian health system

Most of these goals are directly relevant to the right of rural communities to the specialist medical care they need to maintain their health and to equitable access to sustainable services which provide this. Rural medical practice, whether it be generalist or specialist, shares much the same challenges - personal and professional isolation, lack of access to educational opportunities and excessive workloads, all of which provide continuing disincentives to rural practice.

Community expectations for locally based specialist services which provide care equal to that available in metropolitan centres have increased. Therefore the issue of sustainability of these services, as distinct from those supplied by outreach, is of increasing importance.

Some might say that finding commonality across specialist groups and diverse geographic environments is impossible or futile: how can the factors needed to support obstetric services in Dubbo be relevant to physician services in the Kimberleys or anaesthetics in Cairns?



Yet while there are certainly issues which are specific to a discipline or environment, unless solutions to current problems are based on general principles and approaches which have general applicability, they will be easily dismissed as confined to a particular craft or jurisdiction and achieve little credibility at a national level. Therefore this paper examines generic issues and develops principles and approaches on which practical strategies can be developed in the context of particular geographic, politico-social and professional environments.

The Rural Doctors Association of Australia (RDAA) and others have undertaken valuable work on viable models of general practice and procedural general practice in rural Australia, but to date there has been little research on workforce viability across the range of the specialist services.

This paper therefore draws primarily on empirical and anecdotal data as well as extrapolations from studies of general practice.

Like the rural GP procedural workforce, the rural specialist workforce is ageing: in general, its demographic profile reveals a much greater number of practitioners in the older age groups and relatively lower numbers of young entrants. Therefore urgent solutions are required. There is little time to address issues of recruitment and retention before a declining specialist workforce has very serious ramifications across rural and remote Australia.

This paper concentrates on “the big four” specialist areas – medicine (including paediatrics), surgery, anaesthetics and obstetrics and gynaecology. Given the extreme shortages of psychiatrists and dermatologists in rural areas, these disciplines have not been discussed. Nor are pathology or radiology included because of the marked trend to centralization and remote servicing, though the need for comprehensive and timely radiology and pathology backup is acknowledged.

The Rural Specialists Group believes that it can play a major role in help shaping policy directions that Productivity Commission might wish to explore in improving the health of that part of the Australian community that is most emblematically ‘Aussie’ – rural Australia.

## **Issues and Requirements**

### **Role and functions of rural specialists**

Rural specialists provide rural communities with:

- clinical services and clinical leadership
- innovative and new techniques
- the potential to provide high level care in emergencies, especially in the absence of rural intensive care and emergency medicine specialists
- upskilling and support of other practitioners including GPs, nurses and allied health professionals

- the opportunity for rural training for undergraduates and specialty trainees, although small numbers of specialists means that the teaching load placed on them is correspondingly higher
- research by, for and within rural communities
- access to more health services and professional support within the region rather than at a more metropolitan centre

This is a greater range of activities than is undertaken by the majority of metropolitan specialists, a fact not generally appreciated in discussions and policy about rural specialist services.

An additional important point is that in most rural areas, specialists treat a greater number of Indigenous patients than most metropolitan specialists do and this often requires additional skills and usually results in lower remuneration.

### **A specialized and interdependent team**

It is important to remember that while GPs can operate without local specialists, rural specialists cannot work without supportive and skilled GPs. Their capacity to provide services can also be constrained by shortages of relevant nursing and allied health services and hospital based junior medical staff. This is often overlooked in metro-centric discussions about specialist services where a never-ending supply of patients is assumed and where the role of the GP in ongoing care is considered less important. There is an increasing realization that in rural areas it is important to consider the concept of *specialized* (team-based) rather than *specialist* (individual-based) services.

As part of a multi-disciplinary team, rural specialists depend on nurses and allied health workers, particularly at hospitals (most rural specialists have attachments at hospitals), the goodwill of the hospital administration and the support of general practitioners. This becomes even more important in smaller centres. The final dimension of the team approach is a good professional relationship with local specialist colleagues, both in the same and other colleges.

The relationship with general practitioners may vary depending on the geographic location and population base. There is the potential for a degree of rivalry and competition, for example around procedural practice. There are places where GPs have become de-skilled as their scope of practice has been restricted or their admitting rights to hospitals diminished. In other places, however, rosters would be untenable if they were not shared by specialist and general practitioners. There is a growing appreciation that collaborative team work, including rosters, can be a major factor in workforce sustainability.

Physicians and paediatricians can work with the support of general practitioners “with an interest” who may not necessarily have formal qualifications in the relevant specialty areas. However if surgeons and, more particularly, anaesthetists and obstetricians, are to optimize the support of general practitioners, the GPs require appropriate levels of procedural training and skills maintenance. The GP procedural training support subsidies

introduced in 2004 are a good example of how supporting one component of the rural workforce can bring advantages to other components.

### **Sub-specialization**

Sub-specialization comes with many benefits, including meeting community requirements for a higher level of skill in a particular area, less demanding Continuing Professional Development (CPD), better working hours and often more remuneration. Particularly in rural environments it is important to recognize the tension between this increasing trend towards sub-specialization within all specialties and the need to maintain some general skills. All medical colleges are now recognizing that they need to support general training and this is a trend that is occurring in many countries across the world. However the revival and nurturing of the generalist specialist in an era of increasing sub-specialization will present significant challenges, but they are challenges which must be met for ongoing viability of rural specialist practice.

### **Sustainability**

The RDAA study *Viable models of rural and remote practice*<sup>27</sup> identified four key areas or dimensions that underpin the viability of rural medical services:

- the professional dimension
- the economic dimension
- the organizational dimension, and
- the family and social dimension.

The 2000 *Rural Stocktake*<sup>28</sup> saw professional isolation, social dislocation and succession planning as crucial factors in workforce sustainability.

The administrative problems faced by GPs may be less significant for local specialists, although for many visiting specialists this is an additional impost that must be undertaken without remuneration.

Remuneration can be a significant issue. For example, recent Medicare changes that allow obstetricians in private practice to charge a significant “booking-in fee” do not benefit their rural colleagues whose practice is usually overwhelmingly in the public sector. This income disadvantage will further exacerbate current difficulties in augmenting or retaining the 134 specialist obstetricians currently practicing more than 100 km from a metropolitan centre.<sup>29</sup>

Whether solo rural specialist practice is sustainable in the long-term is a vexed question. For example, there are at present around 15 solo rural physicians across the country, but it is highly unlikely that they will be replaced, at least by local graduates, when they retire. While there are more rural surgeons, most of them are aged between 55 and 60 years of

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<sup>27</sup> RDAA & Monash University (2003) – Viable models of rural and remote practice: Stage 1 and Stage 2 reports. Canberra, RDAA

<sup>4</sup> Best J (2002) – *Rural health stocktake*. Canberra, Australian Department of Health and Ageing.

<sup>29</sup> Mourik P, *pers.com* May 2005

age.<sup>30</sup> While rural physicians and surgeons tend to run single person practices, anaesthetists and obstetricians and gynaecologists tend to run group practices and therefore may be more likely to achieve a critical mass that enhances the likelihood of sustainability.

### **Outreach services**

The various ways in which the Medical Specialist Outreach Assistance Program has addressed this issue are well presented in other documents. However these hub-and-spoke arrangements tend to be centrifugal rather than centripetal, and do not cover the need to allow rural specialists access to metropolitan sites from time to time.

The implementation of hub and spoke models must include regional centres as the hub - an approach which will assist practice viability and workforce sustainability while also increasing access to services.

In the case of specialist services in remote areas, the development and financing of appropriate sustainable models will require support from a number of jurisdictions.

## **Key action areas**

### **1. Rosters and locum arrangements**

Safety - in terms of both personal safety when working at night and limits on doctors' working hours in the interests of their health and that of their patients - must be recognized as a paramount issue in the design of rosters and after-hours service delivery systems.

Effective after-hours systems must include:

- collaboration between medical practitioners, hospitals and communities
- standards, protocols and relevant training, including structured and subsidized programs for skills development and maintenance
- consistent and adequate remuneration for after-hours services and on-call commitments
- integrated communication and transport systems
- appropriate facilities and equipment in hospital settings, and
- community education to inform expectations and demand

After-hours rosters should be no more than 1 in 4, except for brief and infrequent periods. However workforce shortfalls and the exigencies of working in some, particularly more remote, areas, mean it is not always possible to achieve this standard. In these circumstances, rigid insistence on this standard could lead to the closure of essential services. Therefore doctors working where routine 1 in 2 or 1 in 3 rosters are inevitable must be supported by triage back-up, special locum relief and specific additional recreation leave.

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<sup>30</sup> Thompson D, pers.com. May 2005

After-hours rosters can and do vary according to local conditions, particularly the profile of the available workforce. For instance, a 1 in 4 roster may utilize the full complement of local specialists or a partial complement plus GPs who are prepared to be involved. In smaller sites, it is possible for a specialist to offer a purely consultative service during business hours with all after-hours cover provided by the general practitioners. In internal medicine, a minimal viable arrangement in a more remote site could be constructed with one specialist general physician (VMO or staff specialist with or without a special interest) and two enthusiastic GPs with a special interest in internal medicine. The GPs would continue to look after medical patients admitted under their care on a roster basis, but at some time during business hours have a specialist physician provide consultation and advice on their further management.

However, a minimal provision of this type would also depend on significant outreach back-up from a regional centre. Ideally, this would include regular fortnightly outreach visits by one or more sub-specialty colleagues from the regional centre. These visits would be for 48 hours and integrated into the roster so that the visiting sub-specialist could provide general medical cover at the hospital as well. This would reduce a roster from a 1in3 to something more like a 1in3.5. In Wangaratta, regular visits from a Melbourne urogynaecologist have provided welcome relief to the ageing obstetric workforce there for some years.

Guaranteed locum cover for the specialist's hospital commitment during periods of leave would be essential. This leave would include a minimum of two weeks extra study leave per annum for upskilling visits to the regional centre. Similarly, GPs willing and able to provide cover for their colleagues on the roster would be crucial to the scheme.

An intermediate position for a slightly larger unit would be a four person roster including at least two specialist physicians. This is the minimum number required for sustainability where locum cover cannot be guaranteed for annual leave or where regional centres are unable to provide outreach support.

At a higher level, a minimum roster of four generalists with sub-specialty interests or sub-specialists also providing a general service would be required. If the unit is also providing outreach support to other centres it would require a minimum of five specialists.

However, providing this outreach has advantages beyond the support it offers to smaller centres as it could enable the central regional unit to sustain a wider range of sub-specialties than it could otherwise carry.

As a general principle, locum programs should allow doctors who provide significant after-hours services to have 6 weeks recreational and 2 weeks study leave annually. However, workforce shortages and high costs make this an impractical ideal in many places. Fortunately RDAA has received a grant from the Australian Department of Health and Ageing to conduct a scoping study for the design of a nationally funded Specialist Obstetrician Locum Scheme (SOLS) which could provide this essential support. SOLS is

seen as a prototype which, if successful, will be applicable to other areas of rural specialist practice.

This scheme will address the range of issues related to the creation of a successful locum arrangement, including remuneration and conditions of employment, cross-border registration and indemnity so the results should be applicable to other specialty groups.

However, it must be recognized that the provision of locums cannot be addressed in isolation from the recruitment and retention of practitioners for longer term positions; providing locums is but one part of more complex solutions to recruiting doctors to the country and it can be a powerful tool in persuading practitioners of the merits of country lifestyle and practice.

## **2. Infrastructure support and ICT**

State and regional health services cannot provide adequate healthcare to rural and remote populations unless they ensure the human and physical infrastructure necessary to support the specialist workforce is available. This includes appropriate radiology, pathology and junior medical staff as well as trained nursing and allied health staff. It also includes relevant administrative support: rural specialists are required to undertake a relatively greater amount of administrative work than their metropolitan colleagues and visiting specialists usually have to do this in their own time without remuneration.

Information and communication technology (ICT) is of increasing importance in rural areas for both clinical practice and CPD. It is becoming recognized that ICT will become increasingly important for the transfer of information between the range of healthcare providers to ensure the quality and safety of services and, given the increasing push towards consumer involvement, there will be a greater need for healthcare providers to communicate with patients and patients with healthcare providers as part of their involvement in decision making and information sharing.

It is well known that specialists have in general had a much slower uptake of ICT than GPs for a range of reasons and this has been well documented in the report of the Medical Specialists Taskforce on Informatics in 2004. There has been significant support and encouragement at a Commonwealth level to enable general practitioners to utilise ICT in various aspects of practice and this has assisted with the provision of hardware, software, connectivity and training. Thus far, specialists have not been able to access such support.

Given the need for the connectivity described above into the future, particularly with the initiatives of the National e-Health Transition Authority, and given that it is probably more feasible to link a range of healthcare providers in a geographically discrete rural environment, opportunities exist to assist specialists, by building on existing infrastructure that is available to general practitioners.

### **3. Networks and education**

Although personal and professional networks currently provide much needed support, these must be extended and in some cases formalized. Clinical networks linking rural and metropolitan specialists and hospitals are essential. Rural specialists rely on networked connections particularly with metropolitan hospitals and specialists to provide:

- a ready access for a second opinion on clinical cases
- access for referral of patients requiring higher level services
- a way for the rural specialist to access CPD when required
- a possible source for locums
- continued professional and academic linkages in the event that the specialist may wish to return to the city at some time in the future

The Rural Clinical Schools and University Departments of Rural Health are now providing rural focus points for the development of networks particularly with metropolitan universities, an also with metropolitan Area Health authorities. In the former role they provide academic focuses for teaching medical students and rural research and those who are involved as teachers – many local clinicians – are able to obtain academic titles with the university and access the range of online and other resources that the Universities provide. In the latter role those who are rural teachers provide the perfect role models for potential rural practitioners and there would be great value in strengthening the networks, for example, by giving rural specialists some appointment with metropolitan area health services to strengthen the links and allow for the possibility of smoother transitions either from metropolitan to rural or rural to metropolitan positions.

### **4. Rural groups within colleges and rural training**

Although many rural specialists feel disenfranchised by their colleges, some colleges have developed rural groups that offer varying degrees of assistance to their rural members. The Royal Australasian College of Surgeons (RACS) has provided leadership in this field through its locum service and a rural specialist training program which is supported by both fellows and trainees and has proved successful in producing specialists who are prepared to work in rural areas.

Appropriate training is a prerequisite for the recruitment of a rural specialist workforce. Apart from the RACS, the specialist colleges in general have not been supportive of rural training. As the current Rural Clinical School students enter specialty training, other colleges will need to assist with training that is more attuned to future rural practice.

The vast majority of rural specialists recognize the value of a skilled GP workforce. Many are highly dependent on the diminishing cadre of procedural GPs who provide surgery, anaesthetic and obstetric services. The advanced training pathways which produce procedural GPs should be actively promoted and collaboration between the specialist colleges and the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine strengthened to ensure the sustainability of this essential component of the rural medical workforce.

## **5. Remuneration**

Although remuneration may be perceived as less of an issue for rural specialists than it is in the recruitment and retention of rural GPs, it is none the less an important factor. While financial matters are not ranked highly in surveys of either component of the rural medical workforce, there is no doubt that dissatisfaction with inadequate payments, unresolved financial anomalies and funding systems that fail to take account of the circumstances of rural practice can trigger decisions about entering or leaving rural medicine.

Remuneration issues may vary from specialty to specialty, but where private health insurance rates are low, as in most rural areas where there is little reason for the consumers to pay expensive premiums, the potential income for proceduralists is considerably lower than that of their city based colleagues. This naturally impacts on recruitment: who will join a rural practice when they can earn much more doing the same sort of work in a large city? A few will choose the lower income in exchange for lifestyle advantages, but they would need a very accommodating family. This income disincentive exacerbates other difficulties - urban training perspectives, lifestyle and family considerations and fear of social and professional isolation - in attracting new specialists to a rural environment.

If rural communities are to have enough locally available specialists to meet their needs through services which are safe and sustainable, the competitive edge of city over rural practice has to be eliminated. Current Medicare subsidies which advantage urban obstetricians in private practice have already been mentioned. A similar discrepancy confronts anaesthetists for whom full AMA-recommended fees are the norm in urban practice while it is impossible to achieve this in a rural environment.

Much has been written of the discouraging image of “rural practice as a life sentence”. This is a daunting prospect for younger practitioners who recognize the need to move back to a city environment as their children grow. They will also recognize the significant financial disadvantage they will face when trying to make the move to a more costly environment if their income stream has not been commensurate with their city based colleagues. Those who decide to stay in the country will face high costs if their children have to go into the cities for their education. Nor are they as likely as their urban colleagues to have a second household income to assist with the higher costs of rural practice including those related to the maintenance of professional standards.

Remuneration is a particular issue for all those who provide after-hours care. The Commonwealth Medical Benefits Schedule does not recognise the environment in which rural doctors work nor the type and complexity of services that they provide in an after-hours setting. Remuneration for this work should reflect the training and expertise of those who provide this essential service, taking into account the higher indemnity risks of emergency care and the rates paid for after-hours services in other industries as well as compensation for the personal and family disruption entailed.



Rural specialists join rural general practitioners in advocating for a rural loading to the Medicare benefits for their patients.

## **6. Promoting successful models**

Nothing succeeds like success and it is important that good working models of sustainable rural practice be disseminated for the guidance of professionals and communities facing current workforce shortfalls and future crises. While these successes are never completely transferable to other settings, analysis of the factors which are critical to their success can be very helpful to those seeking solutions to similar problems. However, it is worth noting that the models which have worked well have been based on the active involvement of local specialists at all stages of their development. This reinforces the need for rural specialists to have a formal role in clinical governance, particularly in relation to local service planning and resource allocation.

## **The way forward**

In some of the key action areas outlined above, the primary responsibility for action will lie with the specialist colleges and other professional organizations, and the rural specialists themselves. This is particularly so in relation to rosters, rural groups and networks, training and the promotion of successful models. However, resolving issues of remuneration, infrastructure support and ICT and networks will require co-operation between the colleges and other professional organizations, rural specialists and the Australian Department of Health and Ageing and the health departments of the states and territories.

The Rural Specialists Group intends to work initially with senior representatives of the Department of Health and Ageing to agree on a range of actions to progress an agenda which will sustain the rural specialist workforce and services. However relatively little will be accomplished unless the other jurisdictions join in this collaborative approach - a process that must begin with the acknowledgement that they, too, have a responsibility to work towards agreed solutions.

If the Productivity Commission review is able to achieve such cooperation it will be a great outcome.

**Standing Committee on Health and Ageing**  
**Inquiry into Health Funding**  
**May 2005**



## **Submission by the Rural Doctors Association of Australia**

**This submission is based on the right of all Australians to a fair share of the resources needed to support their health derived from funding systems designed to achieve and equitable distribution of these resources.**

### **Recommendations**

1. The Australian Government must *take a leading role in improving the efficient and effective delivery of highest quality health care to all Australians* through funding systems that facilitate addressing the inequities in health care between rural and urban Australia and Indigenous and non-Indigenous people as a matter of urgency.
2. Additional resources must be directed to rural communities to provide greater access to affordable health care for the third of the Australian population that lives and to redress the current inequitable distribution of federal health funding due to the Medicare underspend due to less access to services and the lower uptake of private health insurance by rural Australians.
3. RDAA contends that higher Medicare reimbursement for rural patients, combined with an appropriate indexation mechanism, is the best way to address the declining rate of bulk billing in country areas and at the same time to remove one of the barriers to viable rural medical practice.
4. Funding and service delivery mechanisms should centre the health care system around the primary health care sector, where more than 80% of health care is delivered, rather than tacking primary care on to the expensive, high-tech, 'heroic' hospital sector.
5. Fee-for-service must be maintained as the basic mechanism for remunerating medical care, but this must be augmented by:
  - incentives for the provision of timely health promotion, prevention and early intervention by primary health care providers
  - funding that facilitates the structured management of chronic diseases
  - models that may be needed to ensure the delivery of quality health care to specific areas or populations
  - support for structures which accommodate the preference for salaried positions in some sections of the medical workforce

6. Coordination of care must be supported by effective information and communications technology and management systems that provide all health practitioners and care givers with access to accurate and timely information about an individual's treatment and support the delivery of structured, proactive care for patients with chronic illnesses.
7. Initiatives that aim to support and improve the health of those who live in the bush must include components to encourage the recruitment and retention of an adequate health workforce.
8. The additional costs, both financial and in human resources, faced by rural practices in meeting the requirements for CPD and accreditation must be recognised and recompensed.
9. Broader health funding systems must be constructed to incorporate collaborative, community partnership based models of local needs assessment and prioritization as a means of more effective resource allocation

## **1. The Rural Doctors Association of Australia**

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. Every RDA is represented on the RDAA Committee of Management which meets monthly by teleconference. The autonomous State/Territory associations work and negotiate with relevant bodies in their jurisdictions, while the RDAA Committee 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 RDA members are general practitioners (GPs) and most are men. However, the Association takes steps to ensure that the interests and perspectives of smaller groups within the rural medical workforce are incorporated into its advocacy and negotiations. This has led to the establishment of special interest groups for female doctors and rural specialists, both of which meet regularly to discuss specific and generic rural workforce and health service policy matters. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors (OTDs) who now make up over 30% of the rural medical workforce generally and closer to 50% of it in some States.

The RDAA has a primary focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce to provide quality care to the people of rural and remote Australia. Much of its activity therefore concentrates on recruitment and retention issues and the viability of rural medical practice. However, it also works on particular health and health service issues including Indigenous health, rural birthing services, small rural hospitals and rural and remote nursing practice.

As the only advocacy body with a specific mission to support 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 decision makers and incorporated into the design and implementation of national policies and programs.

In accordance with RDAA's role as a member-based organisation, this submission focuses predominantly on the role of medical practitioners in rural and remote Australia and the impact of various health policies on rural communities. This means that some of the Terms of Reference for the Inquiry are covered in more depth than others.

## **2. Background**

Research and public opinion surveys spanning many years have shown that Australians have a strong belief in health care as a public good for which responsibility is shared across the community, and in the universality of Medicare as public health insurance coverage for all Australians, paid for proportionately by all taxpayers through the taxation system. However, in the current libertarian policy environment, the idea that *publicly financed health care is essentially a welfare provision*<sup>1</sup> seems to be increasing.

Equity and efficiency are touted as fundamental attributes of our health system. In practice, however, major inequities and inefficiencies in the distribution of resources, services and funding, particularly between urban and rural areas, make a mockery of these principles. And this is despite the demonstrably greater need for health care in rural and remote Australia.

As RDAA has repeatedly pointed out, the diverse and complex physical and professional contexts of health care delivery in rural Australia mean that blunt, untargeted mechanisms for system wide reform will not achieve their stated objectives for a substantial proportion of the population, a contention supported by a growing body of research. Much of this research properly focuses on health outcomes, though increasing attention is being paid to the inequitable distribution of public funding through mechanisms which inadvertently favour those on higher incomes and those who live in urban centres over those who do not. As yet, there is relatively little research that deals specifically with the maldistribution of health resources through publicly subsidized private health insurance and its potential impact on the health status of those in lower socio-economic groups and those who live in rural and remote

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<sup>1</sup>McAuley I (2003)- Funding health care – taxes, insurance or markets? Paper for Health Insurance Summit, Sydney, June 2003 p 4

areas. Those studies that have done so all suggest that this impact will be significant and negative.<sup>2</sup>

Approximately a third of Australians live in rural areas.<sup>3</sup> The Australian Institute of Health and Welfare (AIHW) has summarized the widely acknowledged disparities in health status and health risk between the urban and rural populations of Australia:

*...those who live outside Major Cities [population > 250,000] tend to have higher levels of health risk factors and somewhat higher mortality rates than those in the cities...compared with people in Major Cities, those living elsewhere are more likely to be smokers; to drink alcohol in hazardous quantities; to be overweight or obese; to be physically inactive; to have lower levels of education; and to have poorer access to work, particularly skilled work. They also have less access to specialist medical services and a range of other health services. In addition, numerous rural occupations (for example farming, forestry, fishing and mining) are physically risky, and traveling on country roads can be more dangerous because of factors such as higher speeds, fatigue and animals on the road.<sup>4</sup>*

Standardised mortality data show death rates in Australia increasing with rurality: Australians living in regional, rural and remote areas are 10% more likely to die of all causes than those in major cities, and 50% more likely to do so if they live 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. *The main specific causes of higher death rates outside Major Cities include ischaemic heart disease and 'other circulatory diseases', chronic obstructive pulmonary disease, motor vehicle accidents, diabetes, suicide, 'other injuries' and prostate, colorectal and lung cancer, many of which are largely preventable.<sup>5</sup>*

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<sup>2</sup> Dennis R (2003) – *Health spending in the bush: an analysis of the geographic distribution of private health insurance rebate*. Canberra, The Australia Institute; Dennis R (2005) – *Who benefits from private health insurance in Australia?* Canberra, The Australia Institute; Lokuge B, Dennis R & Faunce TA (2005) – Private health insurance and regional Australia. *Medical Journal of Australia* **182:6**; Walker A, Percival R, Thurecht L & Pearse J (2005) - Distributional impact of recent changes in private health insurance policies. *Australian Health Review* **29:2**

<sup>3</sup> Australian Institute of Health & Welfare (AIHW) (2003) - *Rural, regional and remote health: a study on mortality*. [PHE 45] Canberra, AIHW

<sup>4</sup> AIHW (2004) - *Australia's health 2004: the ninth report of the AIHW*. Canberra, AIHW [AUS44] p 208

While the causes of these disparities between urban and rural health status are complex and diverse, a common factor is that rural Australians are among the poorest groups in the population. Domestic and international evidence linking socioeconomic status – measured by income, employment and educational levels – and health outcomes is unequivocal: people in lower socioeconomic groups experience higher rates of morbidity and premature mortality, on average, than those materially more fortunate. The ABS Index of Relative Socio-Economic Disadvantage shows that non-Metropolitan Australia scores lower on the Socio-Economic Index for Areas (SEIFA) than urban areas. Non-Metropolitan households are more likely to be in receipt of government income support and, in spite of the confounding effect of mining areas, mean annual taxable incomes are lower. The proportion of 16-year olds in full-time education is substantially lower.<sup>7</sup>

Aboriginal and Torres Islander peoples, who constitute approximately 12 percent of the population of remote areas and 45 percent of the population of very remote areas, continue to experience a much heavier burden of preventable disease and mortality at an earlier age than other Australians, including age-standardized mortality rates which are triple those of the non-Indigenous population and so substantially lower life expectancy.<sup>8</sup>

Less access to medical care because of the shortfall of doctors also contributes to lower health status in rural areas.<sup>9</sup> Access to multidisciplinary health care is similarly limited by workforce and funding shortages, particularly in the areas of public health education and gender specific and sexual health services. In other words, the range of health care professionals and ‘substitutable’ services accessible in cities is simply not available in rural Australia. Private medical practice apart, there is very little private sector investment in hospital or other healthcare services outside major centres.

Yet despite their higher health needs and equal right to Medicare as our universal health insurance system, the 30 percent of the population that lives in rural and remote Australia

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<sup>5</sup> *Ibid.*

<sup>7</sup> Bureau of Rural Sciences (BRS) & Rural Industries Research and Development Corporation (RIDC) (2003) – *Country matters: social atlas of rural and regional Australia*. Canberra, BRS [RIDC 03/015]

<sup>8</sup> AIHW (2003) *op cit*

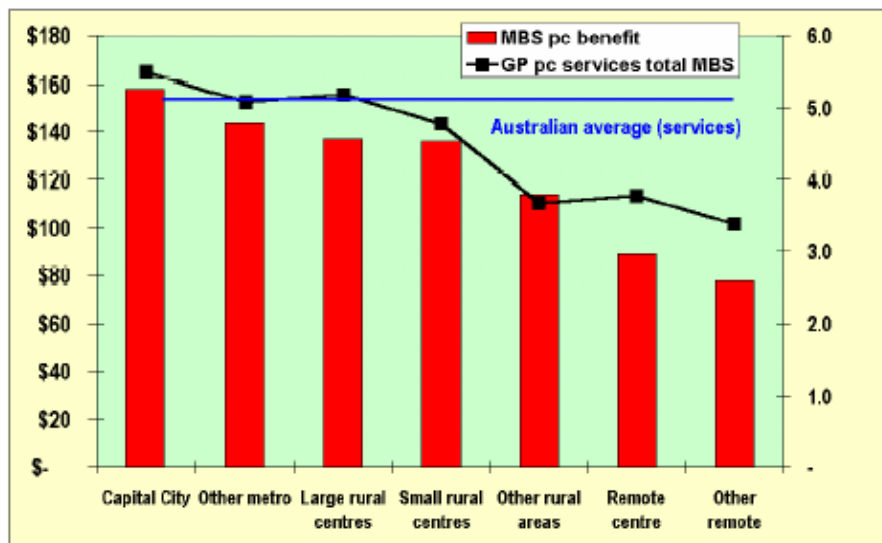
<sup>9</sup> National Rural Health Alliance (2003), A more effective Medicare for country Australians. Canberra: NRHA, February 2003: 41. [www.ruralhealth.org.au/nrhpublic/publicdocs/CD-ROM/data/papers/position\\_papers\\_2003.pdf](http://www.ruralhealth.org.au/nrhpublic/publicdocs/CD-ROM/data/papers/position_papers_2003.pdf), accessed 28/4/05.



accesses only 21 percent of Medicare-funded GP 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 subsidise metropolitan services.<sup>10</sup>

Figure 1 illustrates differences in the number of Medicare subsidized GP services provided in different parts of the country by RRMA (Rural, Remote and Metropolitan Area) classification. In 2001-02, this ranged from 5.5 in capital cities to 3.4 in remote areas. Figure 1 also shows that MBS billing per person falls steadily by RRMA category: in 2001-02 MBS spending was nearly \$160 per person in capital cities, while it was less than half that – under \$80 per person – in Other Remote areas.

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



**Source: DHA (2003) and AMWAC (2000) extrapolated to 2001-02**

RDAА believes that the Australian Government must *take a leading role in improving the efficient and effective delivery of highest quality health care to all Australians* by addressing these inequities in health care between urban and rural Australia as a matter of urgency.

### 3. The need for reform

<sup>10</sup> Wagga Wagga City Council (2003) - Medical services in rural, regional and outer metropolitan areas in Australia. Unpublished.

It is generally acknowledged that the complexity of the Australian health care system, with different services and providers funded by different levels of government, results in waste, duplication, and cost and blame shifting. Estimates of the cost of these inefficiencies to the Australian economy range up to \$1.1 billion per annum in the health sector alone.<sup>11</sup>

Various proposals have been put forward to address these issues. Media reports suggest that the recent Podger review, which has not yet been released to stakeholders, canvasses the establishment of clear funder-purchaser-provider roles that would see regional purchasing bodies 'competing' for health care resources and contracting providers to deliver the necessary services for their prescribed population.<sup>12</sup>

The concept is not new, and while there is strong resistance in Australia to high profile United States models, developments in other countries including New Zealand and the United Kingdom may offer more acceptable interpretations of this approach and its concomitant mix of public and private sector financing and service delivery.

Changes in New Zealand's health funding system in the 1990s widened the potential pool of providers which had previously consisted mainly of public sector or specific professional entities. Relatively large numbers (people speak of a ten-fold increase)<sup>13</sup> of new providers emerged, including a significant proportion that set out specifically to offer services tailored to the health needs of indigenous New Zealanders. In this way, publicly funded services were extended and employment/career opportunities increased for some healthcare professionals.

In the United Kingdom, the massive investment in new and redeveloped hospitals for the NHS will be largely funded through a Private Finance Initiative.

The competition which is both a strategy and an objective of similar paradigms can also be encouraged by changing from annual budgeting systems, which are often based on historical patterns and highly dependent on the negotiating skills of the parties concerned, to service-

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11 Davis M (2005) - Federal system wastes \$2.4 bn. *Australian Financial Review* 14/3/05.

12 Uren D (2005) - States out in health shake up. *The Australian* 6/04/05.

<sup>13</sup> SP, *pers.comm.* May 2005

based funding systems which can underpin purchasing from a plurality of providers and greater flexibility in health care delivery.<sup>14</sup>

Whether any of these models would work in rural and remote Australia is problematic. Private sector investment is not easily attracted to sparsely populated areas of relatively low socio-economic status. A competition based system would inevitably be focused on urban areas where market forces operate, to the potential detriment of the sole public sector provider in areas where they do not. And, as one rural doctor put it:

*A competitive purchaser provider model is not an option where the existence of any services at all is under question.*<sup>15</sup>

RDAA therefore contends that introducing further contestability into health care funding arrangements will not deal with the inequitable distribution of health care resources between urban and rural areas. The lack of services and providers means there is little competition in rural areas, so that traditional market constructs, which are in any case always difficult to apply to health care, are not applicable. Furthermore, a competitive purchaser-provider system would place heavy and perhaps unachievable demands on the skills and capacity of regional purchasing authorities to compete for both human and financial resources. The power of larger, metropolitan authorities with greater access to such resources would place rural areas at increased disadvantage and could lead to further siphoning of resources away from them. It could also exacerbate the imbalance in the system between large city-based institutional health services and low-tech primary health care delivered in the communities where people live.

The difficulties of maintaining an adequate health workforce of both clinicians and administrators in rural areas frequently results in the closure or downgrading of local hospital services in favour of transfers to regional centres. These decisions are usually made without community involvement, and they are not necessarily in the community's best interest. They often seem to be made on the basis of budgetary or workforce considerations rather than health outcomes. For every service provided at a distant site there is a cohort of people who

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<sup>14</sup> UK Dept of Health (2002) – *Reforming NHS financial flow introducing payment by results*. London, Dept of Health; Kirby MJL & Keon W (2004) – Why competition is essential in the delivery of publicly funded healthcare services. *Policy Matters* 5:8

do not access that service because they are unable or unwilling to travel to it. For some people, difficulties or delays in reaching the service will deliver unacceptable outcomes.

One of the fundamental causes of much of the waste in the Australian health care system is the lack of emphasis on primary health care. The more that services are moved from the rural community setting to hospitals and services in regional centres, the more the attention of federal and State governments and the community is directed towards the provision of highly technological and expensive acute care services. While different levels of government may gain short-term advantages through cost-shifting, the overall cost of health services increases and appropriate coordination of locally provided primary health care services declines.

## **5. Appropriate funding arrangements**

The overriding tension in the Australian health care system is that no one level of government takes responsibility for the delivery of essential health care services. Moreover, most commentators would agree that the current health care system

*has little or no rationality. Some services, such as those offered by public hospitals, are free. Some, such as prescription pharmaceuticals, are subject to co-payments, but these are capped. Some, such as ambulatory services, are subject to open-ended co-payments where the consumer bears the risk. And some important services, such as dentistry and physiotherapy, receive no public insurance cover at all.*<sup>16</sup>

Current funding arrangements create artificial barriers between primary, acute and aged care services. This is particularly absurd in rural Australia where the distinction between hospital and community, public and private, acute and aged care services, is largely academic. Doctors practising privately in rural areas are in many places the same doctors who are contracted as Visiting Medical Officers in the local public hospital. Under the joint Federal/State Multi-Purpose Services program, rural hospital beds can also function as long term aged care beds for elderly residents who do not have access to alternative care arrangements.

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<sup>15</sup> RM, *pers. comm.* 9 May 2005

<sup>16</sup> McAuley (2003) *op cit.* p 14

Change in health care delivery is needed to deal with the changing needs of the population as it ages. New, complementary funding mechanisms must reflect the new models of care that are emerging in response to the changing demographics and particular disease profiles. The Primary Health Care Access Program for Indigenous communities in northern Australia which pools contributions from both federal and State-funded services and is managed at the community level to address specific local needs is a good example of this.

RDAA believe that a fee for service system must be the basic mechanism of remuneration for medical services. However, it acknowledges the need to provide other blended payments which reward or recognize particular factors. Some of these payments, for example Rural Retention Payments, are a major factor in supporting the rural workforce and must be maintained. They should also be extended to shore up rural practice through adequate on call and relief arrangements. However, some circumstances, for example in remote areas, where other models like funds pooling may be needed.

RDAA believes that additional dedicated funding is needed to support the coordination of care through multidisciplinary teams of health care providers. Given that *consulting a doctor is the most common action related to health care taken by Australians*<sup>17</sup> clustering these teams around general practice is likely to increase access, enhance service sustainability and generate efficiencies in a thinly stretched health workforce. A reformed health funding system must support this approach and the infrastructure needed to maintain it and it must support cross-disciplinary education and team skills training. It must also provide incentives for the provision of timely health promotion, prevention and early intervention by primary health care providers and facilitate the structured collaborative management of chronic diseases. Aligning funding to parallel a patient's journey through the system would have a significant impact on both health outcomes and overall health system costs.

There is general agreement in the literature about the key areas where health systems can achieve greater efficiency, quality and equity. These include better coordination of care, prevention and early intervention, access to care and affordability.

**i. *Better coordination of care***

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<sup>17</sup> AIHW (2004) *op cit.* p 394

Coordination between general practice, other community-based services and hospitals is haphazard and largely reliant on individual relationships among providers and services. Relatively recent policy initiatives, including the establishment of Divisions of General Practice, the More Allied Health Services program and the Enhanced Primary Care MBS items, have attempted to address this lack of integration. However these initiatives do not deal with the underlying systemic fragmentation and competition among sectors for scarce resources (but the same patients!) that characterise the Australian health care system.

For example, the new MBS dental and allied health items provide Medicare access for multidisciplinary primary care services, but are restricted to those patients with complex care needs being treated under an Enhanced Primary Care Multidisciplinary Care Plan. As Lokuge *et al* note:

*While targeted programs can act as short-term boosters to regional health services, their effect is relatively insignificant compared with the regional importance of mainstream health financing policies and programs: Medicare, the Pharmaceutical Benefits Scheme, and private health insurance (PHI) rebates.*<sup>18</sup>

Coordination of care must be supported by effective information and communications technology and management systems that provide all health practitioners and care givers with access to accurate and timely information about an individual's treatment and support the delivery of structured, proactive care for patients with chronic illnesses. The health system has been relatively slow to adopt the benefits of information technology; current initiatives to achieve greater integration and flow of information among health care providers are welcome, but further research is needed on the drivers of technology uptake in health care, particularly in private medicine, and additional incentives to increase uptake based on relevant strategies.

## ***ii. Prevention and early intervention***

RDAA strongly supports the Minister for Health and Ageing's strong emphasis on health promotion and disease prevention. The changing burden of disease, with chronic and co-morbid illnesses comprising a greater proportion of health needs and costs, means that the

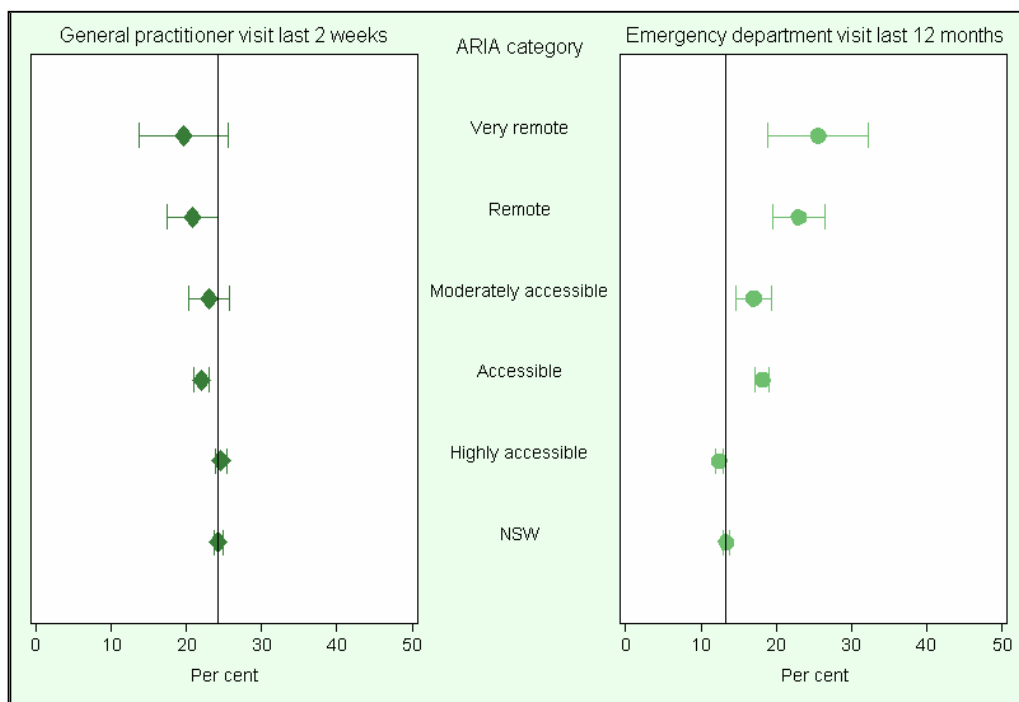
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<sup>18</sup> Lokuge B, Denniss R and Faunce TA (2005), Private health insurance and regional Australia, *Medical Journal of Australia*, **182**: 6

delivery of care must also change. Given that many of these conditions are largely preventable, greater emphasis must be given to addressing their common risk factors and intervening earlier in the disease path.

General practitioners are ‘the hub in the wheel’ of primary health care and play a significant role in prevention and early intervention and the avoidance of unnecessary hospitalisations. Data suggests that where general practice services are limited, hospital admissions are correspondingly higher.<sup>20</sup>

**Figure 2: GP and emergency department visits by accessibility/remoteness, person aged 16 years and over, NSW 1997 and 1998**<sup>21</sup>



Rural doctors are increasingly expected to play a role in public health and population medicine, but as a leading commentator on health reform wrote recently:

*Primary care physicians [are] naturally expected to play a major role in [these areas] but current remuneration packages make it very difficult for our general*

<sup>20</sup> NSWHealth (2004) – *The health of the people of New South Wales: report of the Chief Health Officer 2004*. Sydney, NSWHealth p 151

<sup>21</sup> NSWHealth (2002) – *The health of the people of New South Wales: report of the Chief health Officer, 2002*. Sydney, NSW Health p 132

*practitioners to give an appropriate amount of time to address lifestyle issues with those who most need that advice.*<sup>22</sup>

McAuley suggests that:

*Reforming hospital funding, to bring more competitive neutrality to private and public hospitals, is an important aspect in health finance reform, but it should be only one step in integrating all health care services, including preventative, ambulatory and pharmaceutical care. Many episodes of expensive (and risky) hospitalisation could be eliminated through better-resources preventative and primary care programs.*<sup>23</sup>

### **iii. Access to care**

Lokuge *et al* note that *the lack of convenient, affordable and timely access to general practitioners, specialists and after-hours care is widely accepted as a major problem for Australians living in regional areas.*<sup>24</sup>

A case in point is rural obstetric services. The safety and continuity of care provided by small rural maternity services, staffed by rural GP obstetricians and midwives, has been demonstrated in Australian and international studies. However, recent policy changes apparently based on urban paradigms (or myths?) have seen the closure of over 120 maternity units in numerous rural areas over the last decade. There is no evidence of improved obstetric outcomes, but increasing media reports of unfortunate incidents including roadside births as women are forced to travel greater distances from their homes to seek birthing care.

Denniss argues that:

*Increasing access to health care facilities and allied health professionals in regional areas is critical to improving the health outcomes of people in rural and remote areas compared to those in metropolitan areas... Regional hospitals have*

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<sup>22</sup> Dwyer J (2003) - Opinion piece. *Australian Financial Review* June 12 2003

<sup>23</sup> McAuley I (2004) - Stress on public hospitals – why private insurance has made it worse. A discussion paper for the Australian Consumers' Association and the Australian Healthcare Association. January 2004 p 19

<sup>24</sup> Lokuge *et al* (2005), *op cit.* p 290

<sup>26</sup> Denniss R (2003) - Health spending in the bush: an analysis of the geographic distribution of the private health insurance rebate.

<http://www.google.com.au/search?hl=en&q=rural%2C+private+health+insurance&btnG=Google+Search&meta=cr%3DcountryAU>, accessed 28/4/05 p 2



*traditionally supported GPs and substituted for specialist care in regional areas...  
However, the shortage of GPs persists.*<sup>26</sup>

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 lives in an area of severe shortfall.<sup>27,28</sup>

*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.*<sup>29</sup>

Initiatives that aim to support and improve the health of those who live in the bush must therefore include components that encourage the recruitment and retention of an adequate health workforce, particularly general practitioners. International evidence has shown that the number of primary care physicians is positively correlated with national health outcomes and health care cost containment.

#### *iv. Affordability*

Finding ways to simplify and streamline the health care system must take into account the generally lower socioeconomic status of people in most rural and remote areas. Twelve of the 20 least advantaged federal electoral divisions are classified as rural or remote. Thirty-six of the 40 poorest areas of Australia are rural or remote. Analysis using the Socio-Economic Indexes for Areas (SEIFA) shows that whether measured by indexes of advantage and disadvantage, economic resources or education and occupation, people who live in the cities are generally better off than those who live elsewhere.

The lower rates of bulk billing in rural areas reflect the higher costs of supplying medical services outside major centres. That they are not related to workforce shortfalls can be seen in

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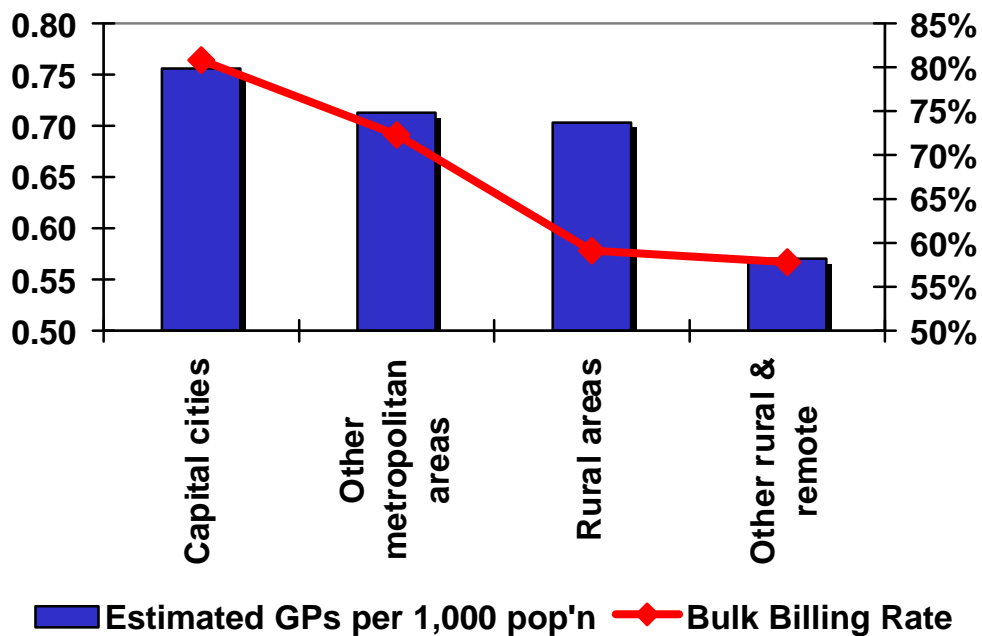
<sup>27</sup> Access Economics (2002) - An analysis of the widening gap between community need and the availability of GP services. A report to the Australian Medical Association. Canberra, AMA

<sup>28</sup> Australian Medical Workforce Advisory Committee (AMWAC) (2000) - The general practice workforce in Australia: supply and requirements - 1999-2010. Sydney, AMWAC

<sup>29</sup> Wagga Wagga City Council (2003), *op cit*.

Figure 3 below by comparing the different rates of bulkbilling in Other Metropolitan and Rural Areas where the patient-doctor ratios are very much the same.

**Figure 3: Bulkbilling rates by area**<sup>30</sup>



Thus halting and reversing the bulk billing decline in rural Australia can only be achieved through strategies that respond to the higher cost structures there. RDAA’s *Viable Models of Rural and Remote Practice* identified economic issues (“adequate rewards for the skills, responsibility and workload of rural and remote doctors”) as a major factor in the sustainability of rural medicine.<sup>31</sup> 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.

International evidence suggests that adequate funding will also help to address workforce shortages, particularly if this is part of wider support for rural areas:

*...increasing physician numbers does not change their geographical distribution, but educational, regulatory and financial policies may be*

<sup>30</sup> Department of Health and Ageing (2003)

<sup>31</sup> RDAA & Monash University (2003)– *Viable models of rural and remote practice: Stage 1 and Stage 2 Reports*. Canberra, RDAA

*effective...To attract more physicians to rural areas, these supply side policies may need to be accompanied by policies that sustain the economic and social viability of rural communities.*<sup>32</sup>

RDAA has been advocating for some years for a differential Medicare rebate for rural Australians to redress the inequity in health funding between metropolitan and rural areas due to both the higher rate of socioeconomic disadvantage and the higher cost of delivering medical services in rural and remote Australia.<sup>33</sup> A differential rebate on socioeconomic grounds (as a proxy for lower health status) alone would be very difficult to apply nationally, however, the application of a rebate based on existing geographic classifications of rurality and remoteness would be manageable and help to address the needs of almost one third of Australians whose lower health status is aggravated by lower access to affordable medical services.

Further, general medical practice varies according to its setting and population intake and country practice is different from urban practice in a number of ways:

*Rural doctors carry a higher level of clinical responsibility and provide a wider range of services in relative isolation... Certainly rural doctors live and work in a different world from their urban counterparts. The psychology and sociology of rural communities are markedly different from the cities. Also the spectrum of illness and injuries with which rural doctors have to cope is specific to rural areas, and the structure and process of health services in the country are quite different.*<sup>34</sup>

The 2003 study of viable models of rural practice also confirmed that rural and remote general practice is more complex and requires a higher level of skills, responsibility and related cost, for example continuing professional development and essential equipment that would otherwise not be available to patients.<sup>35</sup> Furthermore, most rural doctors spend a proportion of their working time (ranging from 10% to 70%) providing acute care in the local

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<sup>32</sup> Simoens S (2004) - Experiences of Organization for Economic Cooperation and Development countries with recruiting and retaining physicians in rural areas. *Australian Journal of Rural Health* **12:3**

<sup>33</sup> RDAA (1999) - *RDAA responses to Regional Australia Summit. Theme 3: Health*. Canberra: RDAA.

<sup>34</sup> Strasser R (1995) - Rural general practice: is it a distinct discipline? *Australian Family Physician*, **24:5**

<sup>35</sup> RDAA (2003) - *Viable models of rural and remote practice: Stage 1 and Stage 2 Reports*. Canberra, RDAA

hospital.<sup>36</sup> This responsibility does not apply in urban areas where hospitals carry their own staff and other health care services are available to complement the range of care – acute, routine and preventive - which the country doctor has to provide without local backup.

The cost and complexity of rural medical practice needs to be recognised and rewarded in the remuneration accessed by rural doctors through the MBS. This could be done through the establishment of a Rural Consultation Item Number (RCIN) or a complexity loading on relevant services. This strategy is advocated by RDAA based on current research and the practical experience of rural doctors across the country.<sup>37</sup> It would address both the complexity of rural medicine and the higher costs of service provision in rural and remote areas. It would also create a financial incentive that will assist in recruiting and retaining rural doctors and improving health outcomes in rural and remote areas.

In addition, use of the WCI5 index for Medicare indexation (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. While the WC15 is a useful Department of Finance tool in other areas of economic policy, it does not cover costs specific to medical practice and therefore results in fee increases that do not keep pace with growth in practice costs. Moreover, while data demonstrates that larger practices can achieve economic efficiencies of scale which enhance their sustainability, areas of low population density cannot support larger practices and many small centres cannot only sustain a solo practice. The viability of smaller rural practices must therefore depend on a more equitable funding system.

One alternative worth noting is the indexed financial support scheme in the RDANSW Rural Doctors Settlement Package. This contract negotiated with the NSW government by the Rural Doctors Association incorporates the AWOTE index and a number of other key determinates of the cost of rural practice. Since its inception in 1987, its scheduled fees have gradually risen from 85 to 130 percent of the MBS fee. The success of the scheme in attracting and retaining doctors to work in rural hospitals (the average length of stay in rural NSW is 16 years, compared to a national average of 9 years) indicates that agreed conditions and appropriately indexed financial support works well when it guarantees adequate

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<sup>36</sup> Mildenhall D, Mara P, Chater B, Rosenthal D, Maxfield N, Boots A, Humphreys J, Jones, J & Jones M (2003) - Sustaining healthy rural communities through viable rural medical practices. Paper presented at the 7th National Rural Health Conference, Hobart.

remuneration and recognises the value of services provided. The adoption of similar models in other states would help to minimise their workforce deficits.

RDAA contends that higher Medicare reimbursement for rural patients, combined with an appropriate indexation mechanism, is the best way to address the declining rate of bulk billing in country areas, to remove one of the barriers to viable rural medical practice and to help address workforce shortfalls.

*At the end of the day we run a small business, we charge for our services and Medicare provides a method of reimbursing patients for those services. If the rebate was set at a level that allowed medical practices to be financially sustainable, then the bulk billing rate would increase. After all this is what happened when Medicare was introduced. It is only in the last few years as the Medicare rebate fell below any reasonable indexation and cost basis that GP's have had to raise their fees to remain viable.<sup>38</sup>*

## **6. Quality and accountability**

Australia has significant safety and accountability mechanisms in place for general medical services. General practitioners who wish to work unsupervised are required to undertake several years of postgraduate education to obtain Fellowship of the Royal Australian College of General Practitioners (FRACGP). The vocational recognition which enables access to higher Medicare rebates is available to FRACGP holders and also to other doctors practising in designated areas of workforce shortage who undertake continuing professional development. Many rural doctors acquire additional skills through training specific to rural medicine, particularly the Fellowship of the Australian College of Rural and Remote Medicine (ACRRM), the RACGP Graduate Diploma in Rural Health or a variety of separate modules, for example relative to advanced emergency skills and procedural medicine delivered by the specialist colleges and some universities. However these additional skills receive no financial assistance once registrar training is completed, nor ongoing financial recognition as would be provided by a merit based system.

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<sup>37</sup> RDAA (2001) - *Rural Consultation Item Numbers Information Pack 2001*. Canberra, RDAA

<sup>38</sup> GS, *pers. comm.* June 2003

In addition, practices that wish to access the federal government's Practice Incentive Payments (PIP) scheme, which now represent around 20% of remuneration, must maintain practice accreditation against the RACGP minimum standards for practices. In addition, some elements of the PIP (such as the Mental Health incentives) require additional training in mental health. The disease specific items all follow evidence-based care protocols.

RDAAs support these initiatives to maintain and enhance the quality of care being provided to the Australian community. However, the additional costs, both financial and in human resources, faced by rural practices in meeting the requirements for accreditation must be recognised and compensated. Solo and small practices in rural towns that cannot sustain larger services, and Aboriginal Medical Services in particular, are severely constrained by a lack of resources and lack of capacity to instigate accreditation processes, which means they are further disadvantaged by not being able to access the payments available through the PIP.

## **7. Private health insurance**

There is good international evidence that heavy reliance on private sector funding of health services results in higher overall public expenditure on health,<sup>39</sup> although one author, from a study commissioned by a private health fund, has argued that *it would cost the government more to allow PHI to dwindle than to continue to support it.*<sup>40</sup>

In Australia, the recent policies supporting uptake of private health insurance have been extremely costly, but alternative methods of subsidising private hospital services, other than indirectly through the private health funds, have not been considered. For example, it has been suggested that government could directly fund the current level of private hospital services for approximately the same amount as the 30% insurance rebate. Furthermore, private *insurance* (as distinct from private health *services*) is relatively inefficient compared with public insurance of health services, with 11.3% of precious health care resources diverted to administration in 2001-02 (compared to approximately 4.8% administrative costs for Medicare, including taxation collection costs).<sup>41</sup>

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<sup>39</sup> McAuley (2004), *op cit.* p 15

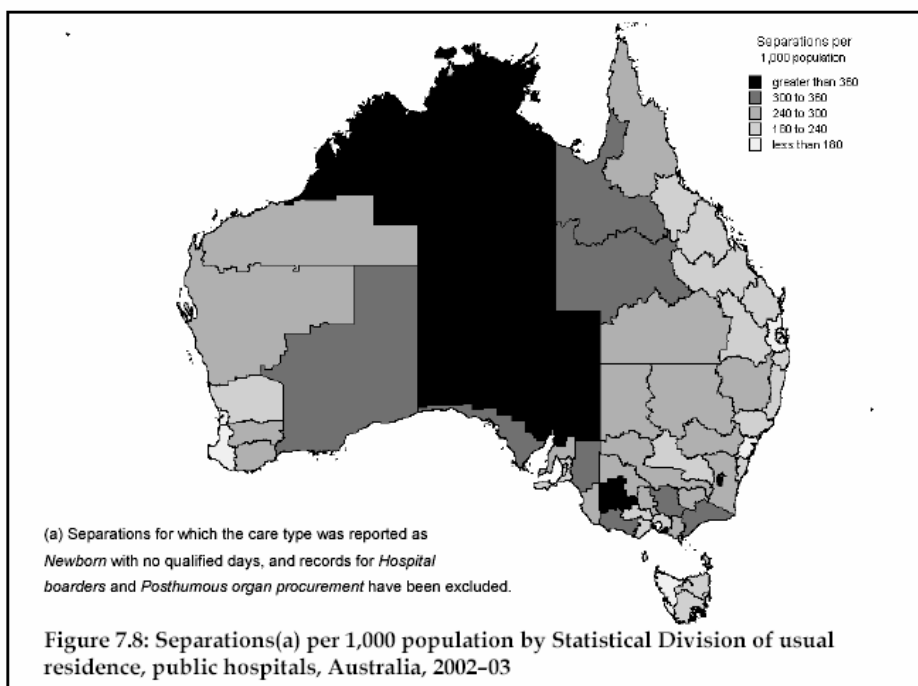
<sup>40</sup> Harper IR (2003) - Health sense: when spending money saves money. *Policy Spring* [www.cis.org.au/policy/spr03/polspr03-3.htm](http://www.cis.org.au/policy/spr03/polspr03-3.htm), accessed 21/04/05

<sup>41</sup> McAuley (2004), *op cit.* p 13

It has also been suggested that the redirection of (financial) resources into the private hospital system has meant that doctors are spending less time providing services in public hospitals where remuneration is generally lower and this is why waiting lists for public hospital services have seen little relief despite the increase in private hospital service provision.<sup>42</sup>

*In health care, particularly hospital care, which is intensive in skilled labour, the most crucial resources are in constrained supply. There are shortages of both medical practitioners and nurses, and any replenishment of supply will take many years. When more money is directed at one sector (i.e. at private hospitals through the private health insurance subsidy), then there is no subsequent increase in resources in the system as a whole. Unless there are productivity improvements available, the inevitable result is some combination of movement of skilled staff from one sector to the other, or a rise in the payment necessary to retain the services of skilled staff.*<sup>43</sup>

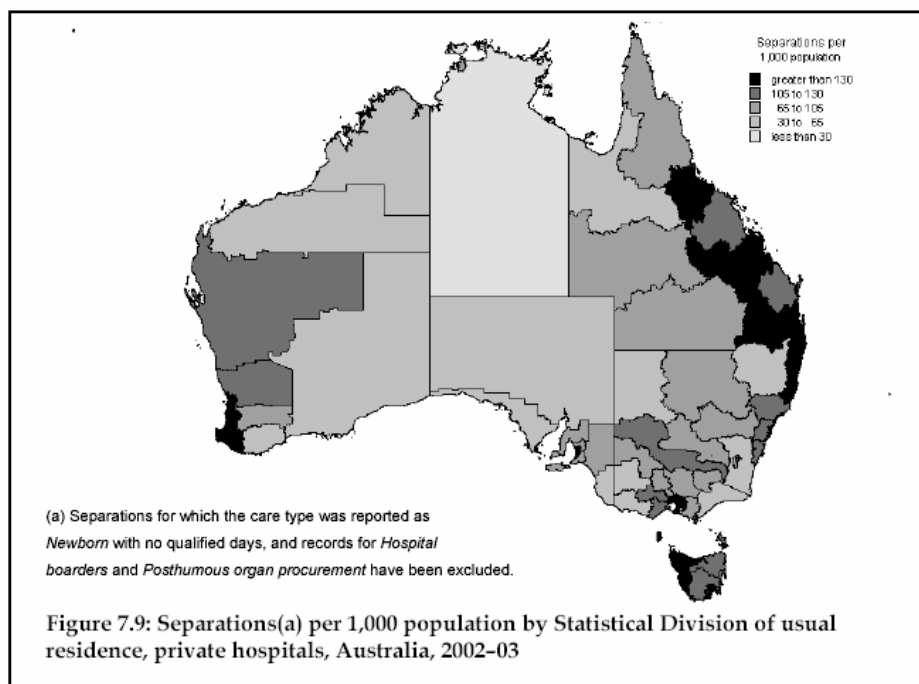
This potentially affects rural areas even more acutely. Private hospitals tend to be concentrated in metropolitan regions.<sup>44</sup>



<sup>42</sup> Duckett SJ (2005) - Private care and public waiting. *Australian Health Review* 29:1

<sup>43</sup> McAuley (2004), *op cit.*

<sup>44</sup> AIHW (2004 - *Australian Hospital Statistics 2002-03*. Canberra, AIHW, [HSE 32] p 173



*Private hospital beds account for 34 percent of total hospital beds in capital cities, but for only 17 percent in small regional centres and 6 percent in other rural and remote areas.*<sup>45</sup>

*One of the main benefits of private health insurance cover is to have access to private hospitals.*<sup>46</sup> Private hospitals make location decisions primarily on financial criteria based on projected numbers of users. Therefore people living in rural and remote areas of Australia are highly unlikely to have the same level of access to private hospitals as those living in metropolitan areas. Furthermore, *the indirect nature of the private health insurance rebate means that the Government is unable to influence the regional distribution of private health services.*<sup>47</sup> People living in rural and regional areas are missing out on both public and private health services.

RDAA believes that the unique conditions of health service delivery in rural areas must be explicitly considered in any initiatives designed to improve *relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government*. In fact, rural Australia has led the way in developing innovative and collaborative models of care involving private general

<sup>45</sup> Strong K, Trickett P, Titulaer I & Bhatia K (1998) - *Health in rural and remote Australia*. AIHW, Canberra, cited in Denniss (2003), *op cit*.

<sup>46</sup> Denniss (2003), *op cit*.

<sup>47</sup> *Ibid*.



practitioners, outreach medical specialists, allied health and hospital services, local governments and the community. These moves must be fostered and resources made available to communities to facilitate similar initiatives focused on their particular local needs and circumstances. Innovative models such as ‘place based health planning’ should be fostered as a means of more effective health resource allocation.<sup>48</sup>

Given income levels are lower in rural and regional areas compared to the national average, private insurance, and the considerable gap fees that accompany use of private services, will also be more unaffordable for a higher proportion of the population in these areas.

Because people who live in rural Australia have less access to private hospitals, those with incomes above \$50,000 (the level at which the tax penalty kicks in) are doubly disadvantaged by being forced to carry private insurance, even though it carries no benefit. If they do not carry it, they may suffer the Lifetime Health Cover penalty for taking out private insurance after age 30 if their circumstances change and they can or need to access private sector services. The private health insurance rebate thus exacerbates the existing health inequalities between metropolitan and regional Australia.

Denniss has suggested that: *Due to their lower rate of private health insurance coverage, rural and regional areas receive an estimated \$100 million less of the Government’s private health insurance rebate than they would if funds were allocated on a per capita basis.*<sup>49</sup>

Further, it has been estimated by the National Rural Health Alliance that rural and remote Australians pay \$43 million more in out of pocket costs on a proportional basis for their health services than those living in urban areas, due to higher average out-of-pocket expenses relating to gap payments for GP and pharmacy services and travelling costs.

The 2004-05 Federal Budget, provided funding of \$830.2 million over 4 years for the Rural Health Strategy, which includes the Regional Health Services, Medical Specialist Outreach Assistance and More Allied Health Services programs, GP and Registrar recruitment and retention programs, rural medical scholarships and the rural private access initiative.<sup>50</sup> In contrast, the private health insurance rebate is estimated to cost anywhere from \$2.5 to \$3.7

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<sup>48</sup> Yeboah DA (2004) A framework for place based health planning. *Australian Health Review*, 29; 1: 30-36.

<sup>49</sup> Denniss (2003), *op cit.*

<sup>50</sup> Australian Government Department of Health and Ageing (2004). Budget 2004-2005 Fact Sheet Health 4.

billion *per annum*, which, it has been shown, is distributed inequitably between urban and rural areas.

Additional resources must be directed to rural communities to provide greater access to affordable health care for the almost one third of Australians who reside there, and to redress the inequitable distribution of federal health funding due to lower uptake of private health insurance by rural Australians.

## **7. Conclusion**

The one third of Australians who live in rural and remote areas carry a higher disease burden than other Australians, yet they do not have equal access to either public or private health services. Workforce shortages of health professionals in the country compound the lower socioeconomic status of rural Australians. The inequitable distribution of government funding through policies such as the private health insurance rebate means that rural Australians, despite their demonstrably greater needs, are subsidising the health care of people who live in urban areas.

RDAA believes that any reforms to the health system must explicitly consider the needs of Australians who live in rural and remote areas and Aboriginal and Torres Strait Islander peoples as they bear the greatest morbidity and mortality burden. This means that policies and programs must be designed to achieve an equitable, rather than equal, distribution of health resources among the population, based on differential needs and ability to access care whether provided by public or private health services.



# **Preventive Healthcare and Strengthening Australia's Social and Economic Framework**

**Rural Doctors Association of Australia**

**January 2005**

# **Preventive Healthcare and Strengthening Australia's Social and Economic Framework**

## **RECOMMENDATIONS**

In response to the call for stakeholder input into the proposed key research themes to be addressed by the National Health and Medical Research Council (NHMRC) in a future targeted research program, the Rural Doctors Association of Australia (RDAA) makes the following recommendations:

1. That given the widespread recognition of the nexus between social and economic factors and health and illness, research must investigate the barriers to the integration of the significant body of evidence already available into national policy and programs and ways to facilitate this in the contemporary cultural, political and fiscal environment.
2. That the proposed NHMRC research program should be formally linked to wider research and reform and review agenda, particularly those related to the National Competition Policy, international trade agreements and income regulation and maintenance policies, to ensure that their impact on the health and well-being of all Australians is understood and taken into account.
3. That the proposed research agenda be closely aligned with the consultative development of a national primary health care policy and coordinated with that of the Australian Primary Health Care Research Institute and other relevant institutions.
4. That all research grants allocated under the future program be required to include specific attention to the health and well-being of the populations of rural and remote Australia.
5. That, given the proportion of the population that lives in rural and remote Australia, their socio-economic and health disadvantage and the previous lack of research into their specific needs, forty percent of all grants under the future program should:
  - have a primary focus on the health of those living in rural and/or remote Australia
  - involve these populations in the design and implementation of research, and
  - be led by appropriately resourced rural based researchers

6. That priority issues for investigation must include:
  - a. the development of a flexible framework to delineate minimum core health service requirements of small rural communities, including those without resident medical care, and associated tools to enable these communities to assess their needs and resources and practical ways of matching them.
  - b. viable models of small rural hospitals including preventive and acute health care services tailored to specific community needs
  - c. the role of small rural hospitals and maternity units in maintaining the health and socio-economic vitality of rural communities
  - d. the health and socio-economic impact of hospital closure or downgrade on small rural communities and a flexible template for assessing this, and
  - e. a specific focus on the socio-economic factors associated with chronic disease and its prevention, diagnosis and management in rural and remote Australia.
7. That research into strategic approaches to the impact of social, economic and cultural factors on the health and sickness of Aboriginal and Torres Strait Islander peoples have an increased focus on community control, local social enterprise and concepts of mutual obligation.

**The Rural Doctors Association of Australia, which represents general practitioners and specialists from all parts of rural and remote Australia, is well placed to participate in the research outlined above and would be happy to do so.**

## **A. The Rural Doctors Association of Australia**

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. Every RDA is represented on the RDAA Committee of Management which meets monthly by teleconference. Each autonomous State/Territory association works and negotiates with relevant bodies in its own jurisdiction, while the RDAA Committee 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 RDA members are general practitioners (GPs) and most are men. However, the Association takes steps to ensure that the interests and perspectives of smaller groups within the rural medical workforce are incorporated into its advocacy and negotiations. This has led to the establishment of special interest groups for female doctors and rural specialists, both of which meet regularly to discuss specific and generic rural workforce matters. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors (OTDs) who now make up over 30% of the rural medical workforce.

The RDAA has a primary focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce that can provide quality 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 medical practice. However, it also works on particular health and health service issues including Indigenous health, rural obstetric care, small rural hospitals and rural and remote nursing practice.

As the only advocacy body with a specific mission to support 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 decision makers and incorporated into the design and implementation of national policies and programs.

## **B. Public policy**

It is now some decades since formal research confirmed what general practitioners and other healthcare professionals have long recognized: that social, economic and environmental factors – income, education, employment, social support, culture, autonomy and infrastructure – have a direct and indirect impact on the health and sickness of individuals and communities. Although the aetiology is not always clear, the evidence is sufficiently robust to demand attention in health policy, programs and service delivery. Yet acute care and clinical investigation continue to dominate health research agenda and funding systems.

*Although the determinants of health are increasingly well characterized and well reported, comparatively few resources are directed towards addressing them. Expenditure on preventive and health promotional services, as a proportion of total health expenditure, has remained static over the last 30 years.<sup>1</sup>*

The benefits of early detection are obvious and compelling evidence supports screening for an increasing group of illnesses. Programs and initiatives like those to address breast and cervical cancer are effective and well received. However, although population screening is inappropriate for a number of conditions, there is very little Medicare support for screening in general practice – the health care service most used by Australians.

Conversely, broad socio-economic research and agendas appear to ignore health implications even more resolutely, or to concentrate on those matters which can be seen to have an obvious and direct impact. For example, public debate on the Free Trade Agreement with the United States included a strong focus on the potential health implications of the impact on the Pharmaceutical Benefits Scheme but little on the potential socio-health implications of broad income and employment issues or importing cheaper American food products that have contributed to the epidemic of obesity in the United States. The Productivity Commission's *Review of National Competition Policy Reforms* suggests the possibility of pricing drinking water at its "true" economic value, but does not refer to the impact this could have on some parts of the population.<sup>2</sup> Suggestions of reduced wage or income maintenance rates have not been accompanied by any analysis of the impact they might have on the health of recipient families.<sup>3</sup>

There are some deeply embedded reasons for this. The positivist, sharply focused scientific paradigms of the nineteenth century led into previously unthinkable progress in the diagnosis and treatment of many illnesses. The extraordinary pharmaceutical and technological developments of the twentieth century reinforced the position of curative medicine and institutions.

Ironically, the earlier triumphs in public health sought the cause of illness in the wider environment and achieved its prevention through better living conditions, public engineering and often simple behavioural change. Many of the advances of the last century have delayed death by enabling more years of managed disease and prolonged disability. The implications of substituting morbidity for mortality are well recognized in the context of demographic ageing. Quality of life is an accepted criterion at many levels. Yet the imperatives inherent in the juxtaposition of these concepts do not always find their way into integrated public policy.

This paradox is not confined to the health system. The effects of economic conditions on health are more commonly acknowledged than the effects of ill-

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<sup>1</sup> Australian Health Ministers' Advisory Council (AHMAC) (2004) - *Report on national health sector performance indicators 2003*. Canberra, AIHW [HWI 78] p.xiv

<sup>2</sup> Productivity Commission (2004) – *Review of national competition policy reforms: discussion draft*. Canberra

<sup>3</sup> for example, in the Centre for Independent Studies differential wages plan, November 2003

health on national wealth accumulation and economic productivity. The latter are more insidious and incremental than the former. They are therefore less likely to engage action in an environment of short term political cycles, particularly when change could disadvantage commercial interests or diminish government revenue or popular appeal. The idea of cross-jurisdiction or cross-portfolio responsibility is acceptable, but the significant shift of power and resources which would follow logically from recognition of the mutual benefits of healthy populations and healthy economies is not.

Thus public policy efforts to combat licit substance abuse, obesity or poverty, for example, are diluted or delayed. Implementation often relies on exhortation which, however evidence based, is seldom a powerful tool for promoting change in individuals or jurisdictions.

Yet evidence demands change, and this change must include:

- integrated macro-level social and economic policies, with a particular emphasis on financial and educational disadvantage, living and working conditions and infrastructure
- realistic and sensitive drivers of behavioural modification
- health policies which reflect the importance of preventive care through appropriate funding systems and focus on equity of access, intersectoral collaboration and flexibility in applying good models of care in diverse environments
- differential analyses to monitor and guide its impact on different parts of the population

This change is needed now as the population ages in a rapidly changing socio-economic environment.

*Although we must do more research to reinforce and expand our knowledge, we have enough information to start now. This will require resources and bipartisan, whole of government support. While the large burden of disease requires continuing investment in healthcare, we must move beyond alleviating damage once it has occurred and invest significantly in preventative health efforts.<sup>4</sup>*

RDAA therefore recommends:

- 1. That given the widespread recognition of the nexus between social and economic factors and health and illness, research must investigate the barriers to the integration of the significant body of evidence already available into national policy and programs and ways to facilitate this in the contemporary cultural, political and fiscal environment.**

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<sup>4</sup> Royal Australasian College of Physicians (RACP) (1999) – *For richer, for poorer, in sickness and in health*. Sydney, RACP p.iv



- 2. That the proposed NHMRC research program should be formally linked to wider research and reform and review agenda, particularly those related to the National Competition Policy, international trade agreements and income regulation and maintenance policies, to ensure that their impact on the health and well-being of all Australians is understood and taken into account.**

### **C. A national primary health care policy**

A national primary health care (PHC) policy would provide a sound basis for change within and beyond the health sector. Definitions of primary health care have multiplied and diversified since Alma Ata. However, as a recent literature review summarized those used in Australian jurisdictions:

*Common priority areas include a focus on population health, balancing prevention/promotion/early intervention, and the management of chronic and complex conditions, addressing the social determinants of health and reducing health inequalities, strengthening community capacity and engagement and building organization and system capacity.<sup>5</sup>*

Primary health care is universally seen as the first point of contact between an individual and the formal healthcare system and the gateway to other parts of the system. *Consulting a doctor is the most common action related to health care taken by Australians.*<sup>6</sup> Nationally, GPs provide on average 4.9 consultations per person per year to 87% of the population.<sup>7</sup> As well as the curative care provided by their urban colleagues, rural medical practitioners are very often also responsible for the acute care of their communities at their local hospital. Preventive health care and surveillance, the management of chronic disease, disability and the conditions of old age are also within their remit. At this level, primary health care, supported by initiatives like the Enhanced Primary Care (EPC) Medicare items, works well.

At a national or population level, however, primary health care is hampered by under-funding and a lack of coherent direction and a clear framework within which knowledge of the social and economic determinants of health can be effectively integrated with clinical expertise and experience into the prevention everyone agrees is better and less expensive than curative and acute care. High profile activities in some areas – to reduce levels of smoking or obesity, for example – are often isolated or fragmented in the sense that they are not well supported in other policy areas. Practical incentives to offer or act on health

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<sup>5</sup> McDonald J & Hare L (2004) – *The contribution of primary and community health services: literature review*. Sydney, Centre for Health Equity, Training, Research & Evaluation (CHETRE), University of NSW p11

<sup>6</sup> Australian Institute of Health & Welfare (AIHW) (2004a) – *Australia's health 2004: the ninth biennial report of the AIHW*. Canberra, AIHW [Aus 44] p394

<sup>7</sup> *ibid* p297. These figures are based on Medicare funded services and do not include those funded in other ways, for example through Aboriginal Medical Services or the Department of Veterans Affairs.

promotion are limited. Workforce shortfalls limit the capacity of doctors, nurses and allied health workers to provide opportunistic preventive care.

RDA members are among the many Australians who see the collaborative development of a national primary health care policy as an essential component of much needed reform of Australia's healthcare systems and structures.<sup>8</sup> Without this, the increasing disparities in health outcomes which mirror the gap between the least and most advantaged groups in the Australian population will continue to widen.

Recognition of the social and economic determinants of health demands that these elements be incorporated into health and wider public policy. However, this does not mean that the role of quality clinical services should be de-emphasized. Universal access to them is in itself a social determinant of health. Eliminating locational, financial and cultural barriers to accessing them must be a fundamental objective of any PHC policy. Applying what is already known about the broader causes of illness is another.

*In the integrated primary healthcare model, the aim is to improve the health of geographically defined populations by providing a comprehensive range of medical, health, social and community services through both horizontal and vertical integration with other parts of the health system.<sup>9</sup>*

RDAA therefore recommends

- 3. That the proposed research agenda be closely aligned with the consultative development of a national primary health care policy and coordinated with that of the Australian Primary Health Care Research Institute and other relevant institutions.**

## **D.1 Health and illness in rural Australia**

The latest health report of the Australian Institute of Health and Welfare (AIHW) summarizes the widely acknowledged disparities in health status and health risk between the urban and rural populations of Australia:

*...those who live outside Major Cities [population > 250,000] tend to have higher levels of health risk factors and somewhat higher mortality rates than those in the cities...compared with people in Major Cities, those living elsewhere are more likely to be smokers; to drink alcohol in hazardous quantities; to be overweight or obese; to be physically inactive; to have lower levels of*

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<sup>8</sup> RDAA will be working with the other members of the General Practice Representative Group (The Australian Medical Association, the Royal Australian College of General Practitioners and the Australian Divisions of General Practice) to develop a national primary health care policy by the end of 2005.

<sup>9</sup> McDonald & Hare *op cit*

*education; and to have poorer access to work, particularly skilled work. They also have less access to specialist medical services and a range of other health services. In addition, numerous rural occupations (for example farming, forestry, fishing and mining) are physically risky, and traveling on country roads can be more dangerous because of factors such as higher speeds, fatigue and animals on the road.*<sup>10</sup>

*The health workforce is the most important of all health system inputs.*<sup>11</sup> Data from the Australian Bureau of Statistics show that while 67% of the population lives in major cities, 80% of all medical practitioners are resident there.<sup>12</sup> The 2001 census recorded approximately 32,000 general practitioners working in Australia. Data from the Australian Rural and Remote Workforce Agencies Group (ARRWAG) recorded 3,855 doctors practising in small rural centres (populations < 25,000) in 2002.<sup>13</sup> A report by Access Economics concluded that *nearly half (44%) of the rural population live in areas of severe GP shortfall.*<sup>14</sup>

The ABS Index of Relative Socio-Economic Disadvantage shows that non-Metropolitan Australia scores lower on the Socio-Economic Index for Areas (SEIFA) than urban areas. Non-Metropolitan households are more likely to be in receipt of government income support and, in spite of the confounding effect of mining areas, mean annual taxable incomes are lower. The proportion of 16-year olds in full-time education is substantially lower.<sup>15</sup>

Suppositions that these figures are distorted by the very poor health and socio-economic status of Indigenous people are ill-founded. Approximately half the Indigenous population of Australia lives outside the major cities. Aboriginal and Torres Strait Islander peoples make up about 24% of the population in remote areas and 45% in very remote areas. However, given the very small proportion of Indigenous Australians in other areas, the contribution of Indigenous data to the demonstrated overall disparities in health and income between urban and rural areas as a whole is not great.<sup>16</sup> Some Indigenous health research issues will be considered later in this submission.

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<sup>10</sup> AIHW (2004a) *op cit* p208

<sup>11</sup> Australian Health Ministers' Conference (AHMC) (2004) – *National health workforce strategic framework*. Sydney, AHMC p6

<sup>12</sup> Australian Bureau of Statistics (ABS) (2003) – *Australian social trends 2003*. Canberra, ABS [4102.0] p71

<sup>13</sup> 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*. Canberra, ARRWAG p9

<sup>14</sup> 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 p10

<sup>15</sup> Bureau of Rural Sciences (BRS) & Rural Industries Research and Development Corporation (RIDC) (2003) – *Country matters: social atlas of rural and regional Australia*. Canberra, BRS [RIDC 03/015]

<sup>16</sup> AIHW (2004a) *op cit*; AIHW (2003) *Rural, regional and remote health: a study on mortality*. Canberra, AIHW [PHE 45]

Thus both clinical and socio-economic data indicate the higher health needs of the non-Metropolitan population. The lower access of this population to health care services, including general and specialist medical care, is now well recognized enough to attract a growing body of policy and research. Reviews and evaluations of Commonwealth programs and measures like those developed under the Regional Health Strategy and the MedicarePlus initiatives will contribute to the further development of both.

However, less attention has been paid to research into specific aspects of sickness and health in rural areas and far less into the impact of social and economic factors on them.

Whether or not these determinants affect different populations in different ways is unclear. European health economists have found that while income related health inequalities can be discerned in all countries studied, regional disparities contributed to the burden of disease in some countries but not in others. It is interesting to note that they also found that health policy was more important than income policy in reducing income related health inequalities.<sup>17</sup>

The diversity of the small communities across Australia suggests that more care should be taken when analysing rural health issues. The health of a community/population cannot be measured properly by using average figures, though this is to some extent inevitable. However, it is at least as informative to look at inequalities between groups within the population. Methods of doing this are increasingly sophisticated, but seldom applied in researching rural health.

Objective investigation of how rural people would prioritize their health needs is another dimension of rural health and social policy which is under-researched. Even where there is overwhelming evidence of high rural risk mirroring higher rural incidence, for example in relation to smoking and obesity and chronic diseases, there is little research to guide ways of addressing this in rural environments. Yet we know that these environments are different in many important ways to the urban environments from which policies and programs emanate.

The urban base of Australia's research infrastructure is an important factor in this lacuna.

*Large project grants from major funding bodies such as the NHMRC or ARC [Australian Research Council], usually designed to address national priorities, are predominantly awarded to urban-based collaborative groups. In addition, by reason of the relative lack of physical infrastructure, equipment and personnel, research in rural*

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<sup>17</sup> Van Doorslaer E & Koolman X (2004) – Explaining the difference in income-related health inequalities across European countries. Presentation at the National Centre for Epidemiology and Population Health, ANU, Canberra 7/12/04. *Health Economics* 13: 609-628

*and remote areas is more frequently qualitative than quantitative in nature, further limiting opportunities to gain funding.*<sup>18</sup>

This is also true of Canada, the country where the distribution of the population and the research establishment most resembles our own.

*Although almost a third of Canadians live in rural, remote and northern parts of the country, the conditions that affect their health in unique ways have not received a level of research attention commensurate with their numbers.*<sup>19</sup>

Fortunately there are signs of growing interest in this field, for example in the development of the national information framework and indicators for rural, regional and remote health by the AIHW<sup>20</sup>, the expanding role of journals like *The Australian Journal of Rural Health* and the electronic *Rural and Remote Health* and the work of university departments of rural health.

There are still significant areas where data definition and collection remain problematic. However, as with integrated public policy to address the wider determinants of health, gaps in what is known should not excuse procrastination when so much is already known.

The National Health and Medical Research Council (NHMRC) is well placed to redress this delay and urban distortion through its research agenda, and RDAA recommends

- 4. That all research grants allocated under the future program be required to include specific attention to the health and well-being of the populations of rural and remote Australia, and**
- 5. Given the proportion of the population that lives in rural and remote Australia, their socio-economic and health disadvantage and the previous lack of research into their specific needs, forty percent of all grants under the future program should:**
  - have a primary focus on the health of those living in rural and/or remote Australia**
  - involve these populations in the design and implementation of research**
  - be led by appropriately resourced rural based researchers**

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<sup>18</sup> Baker PG, Hegney D, Rogers-Clark C, Fahey P, Gorman D & Mitchell G (2004) – Planning research in rural and remote areas. *Rural and Remote Health* 4:226

<sup>19</sup> Kulig JC, Minore B & Stewart NJ (2004) – Capacity building in rural health research: a Canadian perspective. *Rural and Remote Health* 4:274 p6

<sup>20</sup> AIHW (2003) – *Rural, regional and remote health: information framework and indicators Version 1*. Canberra, AIHW [PHE 44]

While much of this research requires a broad focus on sickness and health status, the determinants of health, health services and the impact of national and state policy and funding systems, there is also a pressing need to investigate a number of specific issues. These include: the core health service needs of small rural communities, viable models of hospitals for small rural communities, rural obstetric services, and the prevention, diagnosis and management of chronic disease (particularly cancer and mental illness) in rural Australia.

## **D.2 Health services for small rural communities**

Resource restraints inevitably mean that small rural communities cannot have all their healthcare needs met locally. Sometimes the services that they do have are more determined by history and serendipity than current need. Health authorities trying to balance their budgets and community demands face considerable problems, not least of which is the lack of a clear and consistent framework within which to do this.

The process of developing such a framework through a program of community research projects would be consonant with the principles and objectives of primary health care as it would incorporate the wider determinants of health, develop community capacity and focus on both maintaining health and curing and managing sickness in a specific environment.

Such a framework would provide communities and all levels of government with a valuable template for health service and workforce policy and planning.

Its development would be a two stage process. The first would delineate a set of the core minimum requirements necessary to maintain and improve the health of small rural communities in Australia. This would include evidence based and community supported benchmarks for local and regional workforce (medical, nursing, dental and allied health) numbers, primary, acute and residential care and relevant communication and transport services. It would include benchmarks for the number of rural general practitioners, procedural GPs and specialists, the skills mix of the local healthcare workforce as a whole and the optimum utilization of professional, service and information networks in the environs and wider region. It would also include a set of minimum requirements to meet the preventive, acute and emergency care needs of communities too small to have a hospital or resident medical practitioner.

The second stage would enhance the application of the template through a complementary series of local needs assessments. A standardized methodology with sufficient flexibility to allow for the great diversity of small rural communities would be developed. This would assist small communities, most of them without formal research experience, to prepare an audit of their health needs and actual and potential healthcare resources to meet them. Basic fields of enquiry would include access to relevant health services and possible alternatives (for example, an appropriately trained nurse or ambulance officer providing

extended care in places without a doctor<sup>21</sup>), utilization of existing resources (recreational areas, public computer access) for health maintenance and infrastructure (including transport, communications and professional networks).

With program assistance, communities could then match this against existing models of healthcare which could be applied in their situation. Innovation as well as adaptation would be encouraged.

Some may not see funding or co-ordination of community needs assessment as a function of the NHMRC. However, though communities might use some of the rapid appraisal tools now available, co-coordinating and synthesizing a series of assessments into a flexible national framework would further the NHMRC's primary aim *to raise the standard of individual and public health throughout Australia*. It would also help meet some of the outcome indicators in its Performance Measurement Framework 2003-2006.

RDAAC therefore recommends

- 6.a. The development of a flexible framework to delineate minimum core health service requirements of small rural communities, including those without resident medical care, and associated tools to enable these communities to assess their needs and resources and practical ways of matching them.**

### **D.3 Small rural hospitals and maternity units**

About 529 of Australia's 729 public acute hospitals are small (<50 beds) rural hospitals.<sup>22</sup> Their distribution is erratic and often based on long defunct transport and health systems. Their asymmetrical bargaining position in relation to large prestigious urban institutions means their share of the funding available through the Australian Health Care Agreements is problematic.

These small institutions are currently being closed or downgraded at a very disturbing rate. At least 120 rural maternity units have been closed over the last decade, often without adequate informed consultation, and apparently largely on the basis of budgetary considerations. Decisions on hospital closure appear to focus on the price of providing a hospital, rather than the social and financial cost to the community of having to go elsewhere for treatment and childbirth. Innuendo about quality and safety frequently accompanies their downgrade or closure.

There is no evidence that closing small rural hospitals improves health outcomes and some evidence to the contrary. However, political decision makers are often

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<sup>21</sup> see, for example, O'Meara PF, Kendall D & Kendall L (2004) – Working together for a sustainable urgent care system: a case study from south eastern Australia. *Rural and Remote Health* 4:312

<sup>22</sup> AIHW (2004) – *Australian hospital statistics 2002-03*. Canberra, AIHW [HSE 32] p32. The number of small hospitals is likely to be less at the time of writing.

uninformed about safety issues and therefore reluctant to contest the urban myth that healthcare is better in bigger facilities.

Research in Australia and Canada indicates that small rural maternity units have obstetric outcomes which are at least as good as those in large metropolitan hospitals, even allowing for the transfer of high risk patients to tertiary centres. A soon to be published analysis of 2001 data from the National Perinatal Statistics Unit shows that small maternity units are very safe places in which to give birth.<sup>23</sup> The Society of Obstetricians and Gynaecologists of Canada and the Society of Rural Physicians of Canada have declared that studies *demonstrate good outcomes in low volume settings when access to specialist consultation and timely transfer is available and used appropriately.*<sup>24</sup>

A 2003 study in Western Australia found that experienced surgeons operating on selected patients with careful nursing care in small country hospitals have outcomes similar to urban hospitals.<sup>25</sup>

Small rural hospitals are crucial components of the healthcare, social capital and economic activity of the communities lucky enough to still have them. Hospitals are often the major employer in small towns and a significant contributor to their economic activity through the creation of jobs in businesses that supply services or which are stimulated by the commercial and household spending generated by the hospital and its employees. They are also an essential ingredient in capacity building in rural communities, as an employer, training institution, focal point of civic pride and source of leadership.

Closing or downgrading them undermines other strategies to sustain and stimulate regional and rural development.

Reflecting demographic change, small rural hospitals today often include a residential aged care facility. The social importance of having facilities that enable frail aged family members to stay within their community is obvious. Local aged care facilities also generate significant economic activity.

*However, there is a threat that such aged care facilities may be concentrated – ie contracted – to urban and regional areas for so-called efficiencies. Old people are being forced to move out of their home town! The effect is similar, though not as high profile, as hospital closure or downgrade.*<sup>26</sup>

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<sup>23</sup> Sullivan E & Tracy S - Does size matter? The safety of having a baby in small maternity hospitals. In press

<sup>24</sup> Society of Obstetricians and Gynaecologists of Canada (SOGC), College of Family Physicians of Canada (CFPC) & Society of Rural Physicians of Canada (SRPC) (2002) – *Number of births to maintain competence*. Policy Statement 113; see also their joint position paper: *Rural Maternity Care*, 1998

<sup>25</sup> Hughes-Anderson W, House J, Aitken RJ, Rankin SL & House AK (2003) – Analysis of the outcomes of a visiting surgical service to small rural communities. *ANZ Journal of Surgery* 73,833-835

<sup>26</sup> Dr Ken Mackey, immediate past president, RDAA. *Pers com* 23/01/05



Many of Australia's small rural hospitals, ambulance services and health centres were set up with community effort which has continued to maintain them by fund raising and volunteered services over the years. To lose them is more than a blow to the economy. A recent Canadian study found that hospital closure is

*a "critical incident" in the life of rural communities which leads to long-lasting medical, economic, and psychological consequences ... Without exception, respondents, often with perceptible emotion, discussed the hospital conversion as a significant event that would change the community's social, economic, and political future.*<sup>27</sup>

Closing small rural hospitals is inconsistent with other health policies and programs like the Medical Specialists Outreach Assistance Program (MSOAP), rural training for healthcare professionals and the MedicarePlus initiatives to support proceduralists. It increases the workload of busy regional hospitals, usually without a parallel increase in resources, and de-skills or discards local healthcare professionals. This policy conflict is particularly invidious at a time of severe shortfall in the rural health workforce.

The RDAA study of *Viable Models of Rural & Remote Practice* noted that hospital work increased practice viability. Other RDAA research suggests rural practices depend on hospital work for between 10% and 70% of their income. Access to hospital facilities has been identified as an important positive aspect of rural practice.<sup>28</sup> Procedural medicine (surgery, anaesthetics and obstetrics) is an attraction of rural practice and proceduralists stay longer in rural practice<sup>29</sup> - but there can be no procedural practice without a hospital. Closing procedural units has been found to have an adverse impact on both the recruitment and retention of the GP workforce.<sup>30</sup> Current trends towards centralization of services are a major barrier to maintaining procedural practice.<sup>31</sup>

The survival of procedural general practice depends on adequate rural hospital facilities and staffing. The sustainability of procedural general practice is vital to rural communities.

RDAA therefore recommends research to investigate:

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<sup>27</sup> Petrucka OM & Wagner PS (2003) – Community perception of rural hospital conversion/closure: reconceptualising as a critical incident. *Australian Journal of Rural Health* **11**, 249-253

<sup>28</sup> McDonald J, Bibby L & Carroll S (2002) – *Recruiting and retaining general practitioners in rural areas: improving outcomes through evidence-based research and community capacity-building*. Ballarat, Victorian Universities Rural Health Consortium

<sup>29</sup> Australian Rural and Remote Workforce Agencies Group (ARRWAG) (2003) - Minimum Data Set November 2002

<sup>30</sup> Dunbabin J & Sutherland D (2002) - Procedural medicine in rural and remote NSW: workforce issues

<sup>31</sup> Australian College of Rural and Remote Medicine (ACRRM) (2002) – *Barriers to the maintenance of procedural skills in rural and remote medicine & factors influencing the relocation of rural proceduralists*. Brisbane, ACRRM

- 6.b. viable models of small rural hospitals that can contribute to the provision of primary and acute health care services tailored to specific community needs**
- 6.c. the role of small rural hospitals and maternity units in maintaining the health and the social and economic vitality of rural communities**
- 6.d. the health and socio-economic impact of hospital closure or downgrade on small rural communities and a flexible template for assessing this**

#### **D.4 Chronic disease management**

Chronic disease (conditions likely to persist for at least six months) constitutes about 80% of the burden of disease in Australia today, a figure which will rise with demographic ageing. Apart from mental disorders and asthma, most chronic conditions are more prevalent in those aged over 65. AIHW figures already show a sharp increase in the reporting of long term health conditions: the figure rose from 66% in 1989/90 to 78% in 2001.<sup>32</sup>

Understandably enough, the current management of these conditions occupies much more attention in government policy and funding programs than the prevention which would be a long term investment to reduce their incidence and prevalence. Yet it is imperative to find ways of doing so, particularly in rural and remote areas where they are the major cause of death rates 1.1 times higher than the rate in urban areas.

Cardiovascular diseases are the major cause of this excess mortality, though obstructive pulmonary disease, diabetes and cancer also contributed. Cardiovascular disease is also the largest contributor (21.9%) to Disability Adjusted Life Years (DALYs), followed by cancer, mental disorders and injuries.<sup>33</sup> Co-morbidities are common. All these conditions are debilitating and distressing. They come at high direct and indirect costs to the patient, the community and the health care system.

Yet modifiable risk factors are implicated in all of them.

These conditions are sufficiently prevalent across Australia to warrant their selection as National Health Priority Areas (NHPAs). However, the excess mortality they cause in rural areas demands particular attention to the greater exposure to related risk factors there and equitable access to screening, diagnosis, treatment and management. The NHPAs are already the focus of much research. However, the need for particular scrutiny of how they are experienced by rural populations can be illustrated by looking at cancer.

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<sup>32</sup> AIHW (2004a)

<sup>33</sup> *ibid.*

Rural Australians have poorer rates of survival after cancer diagnosis, at least partially due to more advanced conditions at diagnosis and poorer treatment subsequently.<sup>34</sup> Colorectal and lung cancers contribute about 6% to rural excess mortality. Lung cancer alone accounts for 6% of excess death in rural people under 65.<sup>35</sup> Modifiable risk factors have been identified for both. They include smoking, poor diet and nutrition, physical inactivity and excess weight, all of which are associated with lower socio-economic status – and with living in a rural areas. Yet few public campaigns to promote behavioural change in these matters appear to be adjusted for relevance to the rural environment or to engage people of lower economic or educational status.

There is strong evidence that population screening for bowel cancer can save lives and the Commonwealth is embarking on a national program to do this. This was properly preceded by a pilot that was reviewed positively in 2004. However, “for logistic reasons”, no sites in inland rural areas, and no small towns, were included in this trial on which the future program will be based. Hence it contains no provision to assist rural people who screen positive to access the colonoscopy which is the next stage in the process. This is in spite of the fact that a concurrent study suggests that there is already a lower probability of rural patients completing treatment when referred for rectal cancer.<sup>36</sup>

Another study of lung cancer patients in rural and metropolitan NSW suggests that the former *were less likely to have pathological confirmation of their lung cancer and less likely to undergo any treatment, especially radiotherapy and chemotherapy*. Commenting on survival rates, which were higher in the metropolitan health service district with the highest average incomes and education, it notes other studies that have found excess mortality and poorer survival rates in areas of relative deprivation.<sup>37</sup>

A recent editorial in *The Medical Journal of Australia* commented

*In principle, tackling rural inequality in cancer care and outcomes requires a combination of improved primary healthcare, access to expert multidisciplinary services, and coordination of the two. Evidence that could guide investment decision-making is limited. Present rural health policy is underpinned by the principle that patients should have access to high quality services as close to their homes as is clinically and geographically possible. This policy should improve access to primary healthcare and aid in obtaining earlier diagnosis of cancer and quicker referral to expert care. That these factors will*

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<sup>34</sup> Jong KE, Vale PJ & Armstrong BK (2005) – Rural inequalities in cancer care and outcome. *Medical Journal of Australia (MJA)*182:1 p13

<sup>35</sup> AIHW (2004a) *op cit*.

<sup>36</sup> Armstrong K, O’Connell D, Leong D, Spigelman A & Armstrong B (2004) – *The New South Wales Colorectal Cancer Care Survey Part 1. Surgical management*. Sydney, Cancer Council of NSW

<sup>37</sup> Vinod SK, Hui AC, Esmaili N, Hensley MJ & Barton MB (2004) – Comparison of patterns of care in lung cancer in three area health services in New South Wales, Australia. *Internal Medicine Journal* 34: 677-683

<sup>39</sup> Jong, Vale & Armstrong *op.cit*

*improve cancer outcomes is, however, more an article of faith than supported by evidence.*<sup>39</sup>

The authors suggest that outreach specialist services in a shared care model with local healthcare professionals would appear to be a solution – but this approach, like the suggested system of well-defined pathways tailored to the needs of rural patients also requires further evidence to back its general implementation. The program to delineate core health service needs outlined above would assist in its collection and application.

RDAA therefore recommends

- 6.e. That the proposed research program include a specific focus on the socio-economic factors associated with chronic disease and its prevention, diagnosis and management in rural and remote Australia.**

### **E. Indigenous health**

It is unnecessary to delineate here the disparities between the health and socio-economic status of Aboriginal and Torres Strait Islanders and other Australians. Moreover, as the documentation inviting this submission pointed out, the NHMRC and Indigenous people and health care professionals have already developed a framework to guide research in this field.<sup>40</sup> However, this must be assumed to be a dynamic tool flexible enough to incorporate new approaches and evolving concepts.

Developments since then have included the continuing evolution of autonomy based approaches to health via social enterprise and mutual obligation, the publication of papers commissioned as part of the Review of the Australian Government's Aboriginal and Torres Strait Islander Primary Health Care Program and workforce developments like the establishment of professional associations dedicated to the interests of Aboriginal Health Workers.

RDAA does not presume to speak for Aboriginal and Torres Strait Islander peoples. To do so would be inconsistent with our own policy on Indigenous health.<sup>41</sup> However, RDA members provide healthcare to Aboriginal people across rural and remote Australia and can comment from this position.

While acknowledging that the significant role of psycho-social, economic, cultural and environmental factors on the health of Indigenous Australians and the need for intersectoral action, RDAA knows that an effective, adequately resourced healthcare system tailored to community need is essential if Indigenous health status is to improve. This system must be based on the primary health care which, in conceptual and practical terms, is most appropriate to their needs.

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<sup>40</sup> National Health & Medical Research Council (NHMRC) (2003) – *The NHMRC road map: a strategic framework for improving Aboriginal and Torres Strait Islander health through research*. Canberra, NHMRC

<sup>41</sup> see [www.rdaa.com.au](http://www.rdaa.com.au) - Policies

RDAAC believes that all measures to improve Indigenous health must be underpinned by:

- decent infrastructure – sanitation, housing, transport and communication
- opportunities for education, training and employment
- policies and programs designed and implemented by the community in partnership with government
- relationships between individuals, communities and the health care system characterized by a culturally appropriate and consultative approach
- strategies to increase and support the small Indigenous component of the health care workforce.

Two independent reports have recently shown that the funding provided for Indigenous primary health care is abysmally inadequate.

*We conclude that total health spending on Indigenous populations would need to be increased to a level between 3 and 6 times the national average per capita expenditure to achieve equitable access to effective care.<sup>42</sup>*

*Giving Indigenous Australians the same level of access to primary health care as non-Indigenous Australians with comparable health status would require substantial increases in the medical workforce, of at least 250 FTE medical practitioners spanning GP, pathologists and medical imaging with commensurate increases in access to allied health professionals (nurses and others). It would also require giving Indigenous Australians much more access to the PBS. Overall, we assess the required increase in funding for primary care to be approaching \$400m per annum.<sup>43</sup>*

Underspending on primary health care is truly false economy. Failure to prevent, diagnose and intervene in the course of chronic diseases - including diabetes, end-stage renal disease and cardiovascular diseases - leads to significantly higher costs when people come to need acute care. Research suggests that treating a small number of conditions - including heart disease, pulmonary disorders, cancer and trauma, conditions highly prevalent in Indigenous populations - accounts for about a third of increased health spending. Clearly, higher expenditure on their prevention would make good economic and social sense.

The question then is: what interventions are most likely to be the best investment in particular circumstances? Economic modelling suggests that different approaches will lead to higher or lower levels of returns in relation to different conditions. Clinical primary health care, followed by health promotion and prevention, are shown as the best investment and most cost effective use of

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<sup>42</sup> Dwyer J, Silburn K & Wilson G (2004) - *National strategies for improving Indigenous health and healthcare*. Aboriginal and Torres Strait Islander Primary Health Care Review. Consultant Report 1. Canberra, Office of Aboriginal and Torres Strait Islander Health (OATSIH) p71

<sup>43</sup> Access Economics (2004) – *Indigenous health workforce needs: a report for the Australian Medical Association*. Canberra. p.i

resources in Aboriginal health in the Northern Territory. This is because reducing the burden of disease now requires identifying and treating people with existing conditions. Though health promotion and prevention promise savings in the long term, the economists found they are still less cost effective than clinical primary health care.<sup>44</sup>

Indigenous people are twice as likely to be hospitalized as other Australians. They are seven times more likely to require dialysis for end-stage renal disease and Indigenous mothers are twice as likely to have low birth weight babies who are more prone to chronic health problems in later life. Research suggests that where primary health care is well designed and adequately funded, it can result in overall savings of between 5 and 11 times the expenditure on it over 5 to 20 years and add from 3 to 13 years of healthy life to Indigenous people.<sup>45</sup>

Funding is important, but economic issues are only part - and not the most important part - of the picture. If health services are to succeed, they must be culturally appropriate and acceptable to the people they are designed to serve. This is an axiom of all health care and a basic tenet of primary health care. However, it is particularly crucial in Indigenous health.

*Indigenous communities and individuals must be allowed to identify the best of all perspectives in the development, implementation and evaluation of strategies based on their own explanatory models, causal theories, aetiologies, and public health formulations.*<sup>46</sup>

Healthcare professionals must become aware of these perspectives and understand how to meld them with Western biomedical techniques and approaches. Failure to do so will inhibit the access implicit in primary health care and render much health investment futile. This is well known, but the principle has yet to be applied, even in most obvious ways. For example, in spite of national agreement on the importance of cross-cultural training for hospital staff, recent reporting indicates that this is often tokenistic and frequently overlooked.<sup>47</sup>

Aboriginal Health Workers are crucial to the effective delivery of primary health care: they make up 27% of the primary health care workforce (compared to nursing staff and GPs who comprise 9.4% and 7% respectively of it).<sup>48</sup> The quiet achievements of Aboriginal Health Workers across the country are acknowledged by all who know them, but this appreciation has not been translated into sufficient

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<sup>44</sup> Beaver C & Zhao Y (2004) – *Investment analysis of the Aboriginal and Torres Islander primary health care program in the Northern Territory*. Aboriginal & Torres Strait Islander Primary Health Care Review: Consultant Report 2. Canberra, OATSIH p41

<sup>45</sup> Econtech Pty Ltd (2004) – *Costings models for Aboriginal and Torres Strait Islander health services*. Aboriginal & Torres Strait Islander Primary Health Care Review: Consultant Report 3. Canberra, OATSIH

<sup>46</sup> Phillips G (2003) – *Addictions and healing in Aboriginal country*. Canberra, Aboriginal Studies Press p165

<sup>47</sup> AIHW (2004) – *National summary of the 2001 and 2002 jurisdictional reports against the Aboriginal and Torres Strait Islander health performance indicators*. Canberra. AIHW [IHW 12] p89-91

<sup>48</sup> *ibid.* p83. Figures based on full-time equivalent positions in Commonwealth funded primary healthcare services.

practical support measures, adequate remuneration or the recruitment and training strategies needed if their numbers and effectiveness are to expand.

Aboriginal Health Workers are a valuable part of the general practice team in many areas and RDAA believes steps must be taken to ensure they can be included in all Commonwealth practice nurse initiatives. Their role in community health should be recognized and rewarded in any extension of these measures. This will only be possible when supportive rhetoric turns into national recognition, standardized qualifications, and appropriate legal protection.

Aboriginal Community Controlled Health Services (ACCHSs) are well established and well accepted. They provide comprehensive primary health care to the vast bulk of Aboriginal peoples. However, according to their peak body, the National Aboriginal Community Controlled Health Organisation (NACCHO), their role in research is undervalued and there is enormous scope for enhancing their capacity in clinical research, particularly through multi-centre studies like the NACCHO Ear Trial.<sup>49</sup>

Studies of the social determinants of health all refer to the negative impact of lack of control over important aspects of life. This concept can be extended to communities where the effect may be exacerbated by ongoing personal and group trauma. Earlier approaches to Indigenous health which, however well-meaning, ignored this, failed to achieve their objectives. Yet again, this salutary lesson has yet to be applied in many areas of service design and delivery.

Fortunately the paternalism and *welfareism* of the past are being overtaken by concepts more appropriate to healing and health. Indigenous leaders are putting rights like adequate government services into a framework of shared responsibility. The implied mutual obligation presents an opportunity to move forward through respectful contractual relationships which can guide models of good practice and emerging evidence.

While these concepts are compatible with values explicit in mainstream and Indigenous Australian cultures, their application to health care delivery and intersectoral negotiation is supported by a meagre research base. RDAA believes that Indigenous health research agenda must include examination of these ideas and ideals as drivers of primary health care and other initiatives and recommends

- 7. That research into strategic approaches to the impact of social, economic and cultural factors on the health and sickness of Aboriginal and Torres Strait Islander peoples have an increased focus on community control, local social enterprise and concepts of mutual obligation.**

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<sup>49</sup> Couzos S, Lea T, Mueller R, Murray R & Culbong M. (2003) - Chronic suppurative otitis media in Aboriginal children and the effectiveness of ototopical antibiotics: a community-based, multi-centre, double-blind randomized controlled trial. *MJA* 179: 4

## F. Conclusion

The impact of social and economic determinants on the health of individuals and populations is clear. Though the mechanisms by which this occurs are not yet well understood, their effects are strong enough to demand immediate attention. What is lacking is evidence to inform the translation of what we do know already into effective public policy. The fact that the NHMRC is tackling this complex challenge encourages RDAA to believe there will soon be an exciting opportunity for objective scrutiny of a number of major issues for the health of rural and remote Australia in which it will be happy to participate.

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**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**



**RURAL DOCTORS  
ASSOCIATION  
OF AUSTRALIA**

*Caring for the Country*

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**December 2003**

**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, and 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 the measures to support the procedural rural workforce are**
  - refined and implemented 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.**
- 7. That the re-entry measures proposed for specialists be extended to re-entry into general practice.**
- 8. 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.**
- 9. 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.**

# 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*<sup>1</sup>, 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.<sup>2</sup> Piecemeal measures, however useful in the short term, are not the answer to a sustainable healthcare system for 21<sup>st</sup> 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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<sup>1</sup> Rural Doctors Association of Australia RDAA (2003). *Viable models of rural and remote practice: Stage 1 and Stage 2 reports*. Canberra. RDAA

<sup>2</sup> 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 *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<sup>3</sup> 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 bulk billing 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.<sup>4</sup> 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

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<sup>3</sup> RDAA (2003). *op cit*.

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

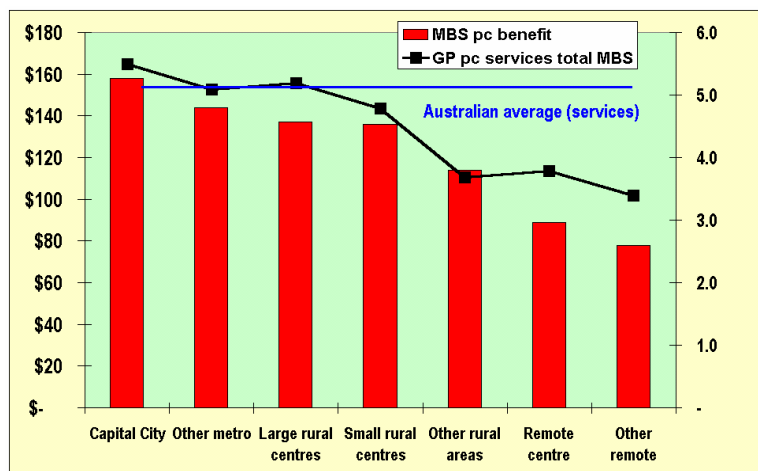
behaviours including smoking, and exposure to occupational hazards such as farm machinery and chemicals. Access to multidisciplinary health care in rural areas is limited by workforce and funding shortages, particularly in the areas of public health education and gender specific and sexual health services.

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.<sup>5</sup>

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.<sup>6</sup>

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



Source: DHA (2003) and AMWAC (2000) extrapolated to 2001-02.<sup>7</sup>

The fundamental strategy of Medicare is a standard rebate to consumers to offset the cost of their primary medical care. Bulk billing allows that the rebate can be assigned to the doctor at point of service, but while access to Medicare is a universal right, bulk billing 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

<sup>5</sup> *ibid.*

<sup>6</sup> Australia. Department of Health and Ageing (2003). Submission to the Senate Select Inquiry Committee on Medicare, July 2003.

<sup>7</sup> *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 bulk billing 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 bulk billing 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 bulk billing will make little difference in rural areas except for those who still bulkbill and I don't believe there are many left...*<sup>8</sup>

RDAA's Viable Models study shows that the average consultation fee in rural practices in 2002-3 was \$32.<sup>9</sup> 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.<sup>10</sup> 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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<sup>8</sup> PMI, procedural rural doctor. *Pers. com.12/12/2003*

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

<sup>10</sup> *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 bulk billing 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.<sup>11 12</sup>

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.

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<sup>11</sup> *op.cit.*

<sup>12</sup> 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.<sup>3</sup>

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.<sup>4</sup>*

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.<sup>13</sup>*

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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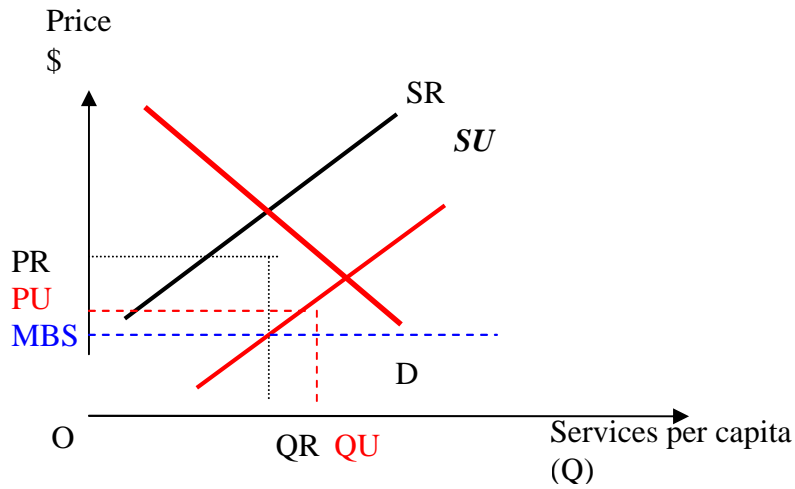
<sup>3</sup> Wagga Wagga City Council (2003). Medical services in rural, regional and outer metropolitan areas in Australia. Unpublished

<sup>4</sup> *ibid.*

<sup>13</sup> RDAA (2003). *Viable models of rural and remote practice: Stage 1 and Stage 2 Reports.* Canberra, RDAA.

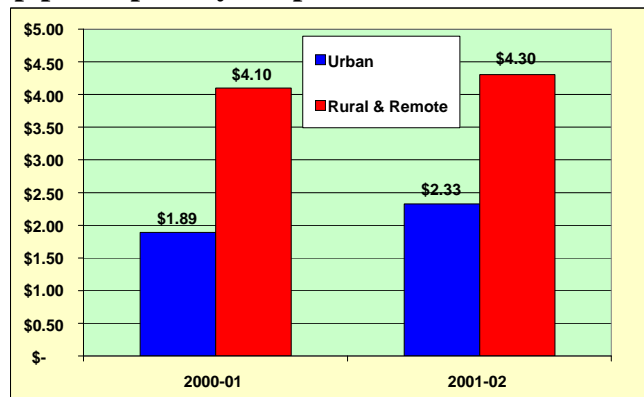
MBS rebate and demand (D), fewer services will be provided per capita at a higher price to the patient.

**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<sup>14</sup>**



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

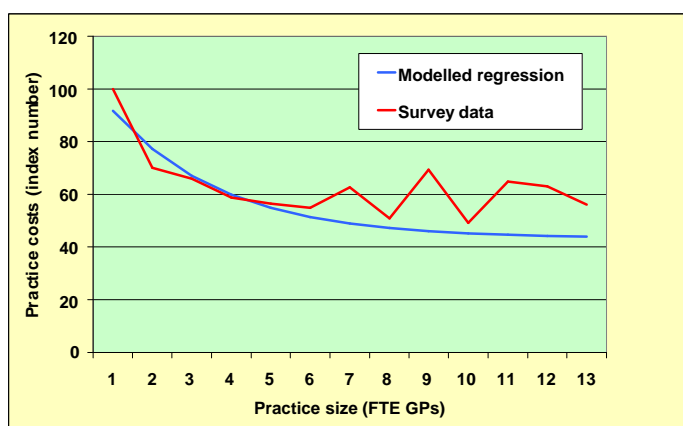
This is related to underlying cost differentials of three main types:

- (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.

<sup>14</sup> 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.*<sup>15</sup>

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.

<sup>15</sup> 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					Total
	3	4	5	6	7	
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

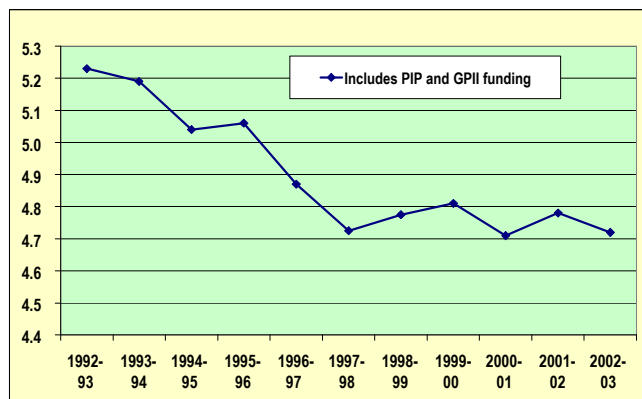
A second option is to establish separate MBS rural consultation item numbers (RCINs). This would achieve the same effect as the rural loading, in terms of providing recognition of increased complexity and costs of rural medicine through the MBS rebate. However, there has been less support for separate 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.

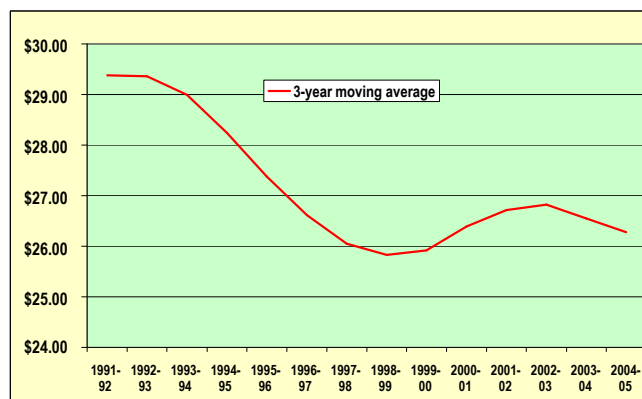
The second key pricing issue is indexation. Indexation to the WCI5 (or half WCI5, as it was for some years) has resulted in an erosion of MBS rebates in real terms as well as an erosion of real incomes of GPs. Figure 5 shows the erosion of Commonwealth spending per full time equivalent (FTE) GP – relative 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**



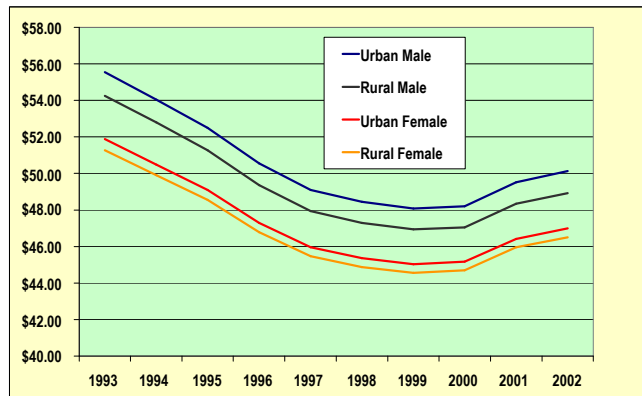
Source: DHA (2003), p20, derived from Figure 8.

**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**

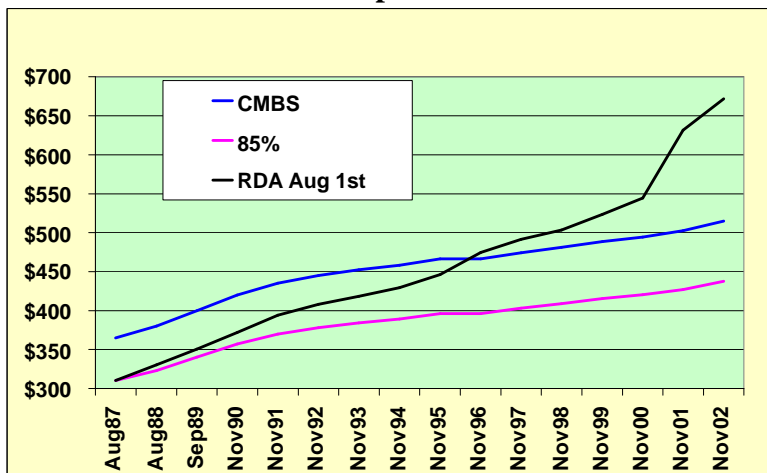


Source: Access Economics (2002).

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 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.*<sup>16</sup>

General practice groups, academics and the Commonwealth have been collaborating on a more appropriate structure that more accurately describes and differentiates between the services provided by GPs. They have proposed a seven tiered structure based on the content and nature of the service, rather than the time it takes to provide it, that 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

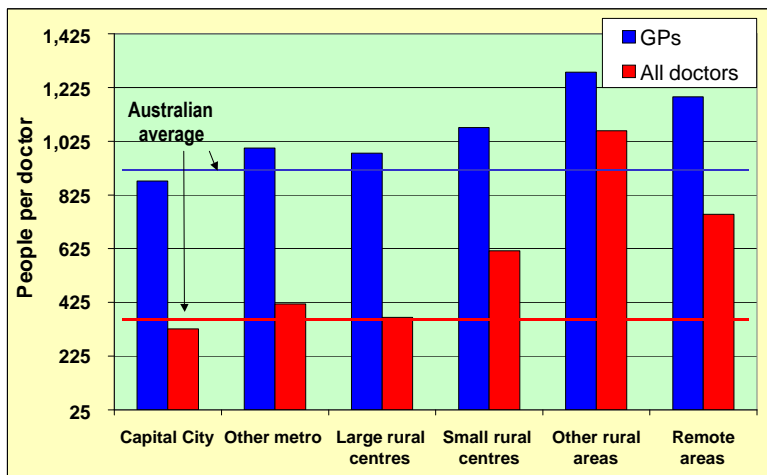
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<sup>16</sup> Attendance Item Restructure Working Group (2003). Report July 2003. Unpublished.

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 bulk billing 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 bulk billing. 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.*<sup>17</sup>

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.<sup>18</sup>

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<sup>19</sup>**

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

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

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

<sup>19</sup> 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 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 measure to support practice nurses.

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.<sup>20</sup> 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 Strait Island Health Workforce National Strategic Framework*.<sup>21</sup> 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**

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<sup>20</sup> 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

<sup>21</sup> 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.<sup>22</sup>*

RDAA has been advocating for a differential rebate for rural Australians for some years.<sup>23</sup> 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

<sup>22</sup> GS, procedural GP, Victoria, *pers.com*. May 2003

<sup>23</sup> RDAA (1999). RDAA responses to Regional Australia Summit Theme 3: Health. Canberra  
RDAA (2001). Rural Consultation Item Numbers Information Pack 2001. Canberra

manageable and help address the needs of 28% of the population there whose lower health status is aggravated by lower access to medical services.

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.<sup>24</sup> 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.<sup>25</sup>

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

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<sup>24</sup> McAuley I (2003). *Bulk billing by income/electorate*. Report to the Australian Consumers' Association. Sydney, ACA

<sup>25</sup> 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

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 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!*<sup>26</sup>

*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!*<sup>27</sup>

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.*<sup>28</sup>

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<sup>26</sup> PMI, procedural rural GP, NSW. *Pers.com.* 13/12/03

<sup>27</sup> GS, procedural rural GP, Victoria. *Pers.com.* 15/12/2003

<sup>28</sup> Walker A (1999). *Distributional impact of higher patient contributions to Australia's Pharmaceutical Benefits Scheme.* NATSEM Discussion Paper 45. Canberra

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.

**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<sup>29</sup>**

	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 RRMA 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.

<sup>29</sup> RDAA (2003). Federal budget submission 2004-05. Canberra

The MedicarePlus provision of 280 full funded short-term supervised placements in outer metropolitan, regional, rural and remote practices is welcomed as well-intentioned. It recognizes the work of the rural GPs who provide invaluable training in fields 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”.<sup>30</sup> 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.

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<sup>30</sup> 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:**

**That Medical Rural Bonded Scholarships be expanded and linked to the new bonded medical school places through the development of a second scholarship option, and a student accommodation and support package with preferential access to the support measures given to those actively involved in promoting 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.<sup>31</sup>

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 few for whom lack of support and opportunity is close to wasteful exploitation.

RDAA recognizes the Government's commitment to ensure that OTDs meet appropriate standards before they are able to practice medicine in Australia and supports 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 practicality of this in the context of today's global communication networks is open to question. RDAA also appreciates the

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<sup>31</sup> Australian Medical Workforce Advisory Committee (AMWAC) (2003). *Annual report 2002-03*. Sydney, AMWAC

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.<sup>32</sup> 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

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<sup>32</sup> 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.<sup>33</sup>

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.<sup>34</sup>

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

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<sup>33</sup> ARRWAG (2003). ARRWAG Minimum Data Set Update Report – 31<sup>st</sup> May 2003. Canberra, ARRWAG

<sup>34</sup> 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 believes 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 implemented 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. GPs 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 time out 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 emphasize 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 practice into account in the development of a set of benchmarks which encompass the minimum requirements for sustainable rural practice at the beginning of the 21<sup>st</sup> 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.

However, 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**

Application to Benchmarks to the Viability Framework	
Practice economics – Remuneration	
<b>Core remuneration</b>	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).
<b>Rural Grants and incentives</b>	Rural retention grant be retained. Incentive component of PIP and local incentives be retained. Additional fee for service incentives reflecting complexity and isolation.
<b>Hospital</b>	Hospital remuneration remain via State based awards and agreements
<b>Infrastructure</b>	10% return on investment
Professional Issues	
<b>Professional education, training and skills</b>	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.
<b>Workforce</b>	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 of a fulltime practitioner per 500 patients may be required to meet community needs in health care.
<b>In hours workload</b>	Number of consultations for a full time equivalent rural doctor should on average be 125 patient consultations a week. Average consultation length 15 minutes.
<b>After hours workload</b>	No more than one in four weeknights and one in four weekends (with compensation in terms of additional time off or remuneration in smaller centres).
<b>Leave</b>	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	
<b>Leadership and strategic planning</b>	Minimum documented practice systems including a strategic business plan. Practice manuals should define administrative and operational aspects of the practice.
<b>Staffing</b>	At least 1.5 support staff per fulltime equivalent rural doctor. Practices should have at least .4 full time nurses and .3 full time practice manager per full time equivalent rural doctor.
<b>Equipment</b>	Equipment should at least meet Royal Australian College of General Practitioner Standards and allow the practitioner to undertake core activities and be appropriately maintained.
<b>Information management and technology</b>	Practices should have a documented information management systems strategy, backup, support, training and maintenance. All rural and remote practices should have broadband internet access.
<b>Practice premises and facilities</b>	Practice premises should reflect local needs and meet building standards for health facilities.





## **RURAL & REMOTE NURSING PRACTICE**

This policy is intended to provide medical practitioners with a broad framework for the collaborative development of primary care nursing in rural and remote Australia.

In this document, the terms nurse and nursing include appropriately trained and qualified registered nurses, enrolled nurses and Indigenous Health Workers.

While education, training, supervision and standards are the mandate of the relevant professional bodies, the Rural Doctors Association of Australia (RDAA) believes that evolving models of partnership demand high levels of cooperation and communication. Major nursing organizations have therefore been consulted in the development of this document.

RDAA supports the development of models of nursing practice which enhance the key role of general practice in primary health care in regional, rural and remote parts of Australia. This support is grounded in the achievements of the many rural practice models in which doctors and registered and enrolled nurses across the country have been working for decades and in current research which has identified factors crucial to the success of these models.

RDAA sees the consultative evolution of flexible models of nursing practice which are compatible with community aspirations as a major strategy to meet the health needs of rural Australia. The development of collaborative and multidisciplinary teams involving medical practitioners, registered and enrolled nurses, Indigenous Health Workers and allied health workers is a cost-effective way to address current workforce shortages and extend the capacity of general practice to provide comprehensive care and continuity of care.

RDAA supports the evolution of rural and remote nursing practice which encompasses diverse roles including those of enrolled nurses, Indigenous Health Workers and practice nurses and models of advanced nursing practice.

### **a. PRACTICE NURSING**

The purpose of practice nursing is to enhance the quality and delivery of health care in the context of general practice. This is a cooperative model of care in which the nurse employed by a practice/general practitioner plays a complementary role by providing a variety of services ranging from clinical care and service coordination to maintaining good health through screening, health promotion and education for individuals and the community.

The role of the practice nurse may vary from one setting to another. In some rural and remote environments, it may involve advanced nursing practice. In some, the practice nurse may be located away from the main surgery or work directly in the community as part of the practice team. In particular environments it may require specific skills and experience, for example in Indigenous health or aged care.

Research and experience indicate that the model is most effective when roles are clearly defined, negotiated between all professional stakeholders and implemented in a way which allows for flexibility.

As employer, the general practitioner/practice carries the responsibilities normally pertaining to that role, for example in the determination of selection criteria, ensuring that working conditions support safe and quality service delivery, professional indemnity coverage, professional development and access to appropriate nursing supervision. These responsibilities should be implemented in the context of current industrial standards and embodied in a formal contract.

Practice nursing can enhance and expand the efficiency and effectiveness of general practice in a number of ways and it can provide a basis for the development of collaborative models of advanced nursing practice.

**Rural medical practitioners will work through the RDAA with nursing and other professional organizations on guidelines and protocols which provide a clear framework for the collaborative development of effective models of practice nursing.**

**RDAA supports the principle that undergraduate and postgraduate nursing education and training should include exposure to, and experience in, general practice models of primary care.**

## **b. RURAL & REMOTE ADVANCED NURSING PRACTICE**

RDAA recognizes that in under-serviced isolated or remote areas, nursing requires an additional and advanced level of responsibility, skill and decision making. This advanced nursing role may include diagnosis, ordering pathology, prescribing and certification. RDAA supports models of rural and remote advanced nursing practice which formalize the role of the specially qualified nurse as part of a collaborative primary care team which includes a general practitioner. This is of particular importance when the responsibilities of the role include diagnosis, ordering pathology, prescribing or sickness certification.

Whether practice, community or hospital based, the advanced practice nurse should:

- possess clinical and academic competencies appropriate to the higher level of autonomy and such special skills and education as needed in particular environments;
- work as part of a team, though this may be frequently in the absence of other team members;
- be guided by clear, consultatively developed protocols for clinical decision making and delegation in compliance with relevant legislation;
- be committed to the mutual professional respect and collaborative models of care which underpin this level of nursing practice.

**RDAA will work with nursing organizations and community and government stakeholders on the development of models of advanced nursing. These should be subject to external evaluation which focuses on quality care and optimum health outcomes for people in rural and remote Australia.**

**RDAA will work with nursing and other professional and government bodies on the development of legislation and policies which provide a clear and consistent framework for collaborative models of advanced nursing practice.**

July 2003



## POOLED REGIONAL BUDGETS

Funds pooling in the Australian health context usually refers to an arrangement whereby a regional authority is set up to control a budget drawn from Commonwealth and State health and related programs. This fund-holding body is then responsible for the allocation of these funds to purchase/provide health services for the population of the area.

Though funds pooling may appear superficially attractive, it has a high potential to separate purchaser from provider in a small market for health services where the funds available may be insufficient to provide quality care across the region.

The Rural Doctors Association of Australia (RDAA) agrees that there is a need to explore innovative options to enhance the health status of Australians who live outside urban and major regional centres. but in spite of the immediate appeal of some aspects of funds pooling, the RDAA believes it represents a simplistic approach to the complex cluster of issues associated with lower health status in rural and remote parts of Australia.

The RDAA believes that there are a number of problems inherent in funds-pooling including:

- less choice for patients
- difficulties in managing or sharing risk
- the odium of decision making in the relatively close confines of a region
- the establishment and maintenance of a new bureaucratic and contracting systems which can absorb funds otherwise available for direct healthcare; and
- the potential for moral hazard where regional authorities or entities could pursue sectional interests at the expense of some areas or parts of the population.

There is little evidence to support the claim that pooled funding based on a capitation average will allow increased expenditure in rural areas. Governments should have increased expenditure in rural areas by now and have failed to do so. Moreover, capitation averaging models may not take important rural issues and cost structures into account. What guarantee would there be under a funds pooling model that sufficient funds would be made available?

Capped budgets impose considerable pressure on providers which could lead to further erosion of the quality of care in rural areas compared to urban Australia. Authorities operating within a fixed budget will be forced to compensate for extra funding in some areas with a commensurate saving in others, perhaps by limiting or withdrawing services or asset stripping. Risk management is difficult in small populations if unexpected costs are incurred. UK experience suggests that a population of 350,000 is required for effective risk management.

The Medicare principle of *access to high quality health care for all according to their needs* is seriously challenged under a funds pooling model. The fund holder determines the provision of services through budget allocations and contracting with providers. Responsibility for equitable and universal access is thus shifted from a central authority to a local fund holder which has the potential to ration services or squeeze costs of the providers. There is also the potential for wide disparity in service provision and access to health services to develop between regions, thereby further eroding the equity inherent in the Medicare principle and the Australian ethos.

Fund holding requires the establishment and maintenance of new bureaucratic systems and processes – management, contracting, etc - which would divert funds from direct patient care. The capacity of smaller and more remote areas to manage this transferred responsibility effectively is likely to be limited. Economies of scale are difficult to achieve in smaller areas and the whole system could be jeopardized by difficulty in attracting appropriately skilled staff to manage these functions.

Proponents of funds pooling argue that it could be used to determine and deliver the most appropriate mix of services to meet the health needs of a particular region and that greater community governance over health planning and delivery would enhance this process. However, it can also lead to asymmetrical bargaining between centres and bodies which are not necessarily well placed to consider the wider implications of their decisions. For example, there has been a deleterious service drift to larger centres at the expense of the small towns in Canadian Provinces that have tried funds pooling. As we have seen in Australia, the resulting loss of social capital has a negative impact on the overall vitality and viability of smaller centres.

There are also concerns that regional pools could act like USA Health Maintenance Organizations (HMO) where the administrators can ration and determine clinical treatment. Some HMOs have found ways of excluding potentially high-cost patients from membership/cover.

Funds pooling is a mechanism which separates purchaser from provider in the market for health services. There is no evidence that it leads to better health outcomes and it is rejected by RDAA.