Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
CANBERRA ACT 2600

Dear Secretary

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

Summary
I have lived and worked in the same town with a small Public rural Hospital for thirty years including Obstetrics. I gave up last month. At my age I cannot continue to crawl out of bed in the middle of the night to do what is an Intern's job elsewhere seeing all and sundry more often than not patients not from my Practice or even my town. There is a grave discrepancy and apparent lack of understanding by DoHA of the different workloads especially Hospital Public On Call between the nine to fivers operating from offices in Regional Towns, covered 24/7 by Base Hospitals and Interns and Emergency Physicians and those doctors working in small rural towns covering small rural Public Hospitals 24/7. The lack of many services in these small towns especially at night and weekends make it much harder on families especially those with small children. Our students and Registrars see this and rarely now will settle anywhere more rural than a RRMA 3 or 4.

Are the current incentives and grants are working
They are not. Due to recent changes, and no After Hours Call, my nearest Regional Centre is thriving, one Practice having expanded to 16 doctors from 10 last year whilst we have gone from four FTE to two. The difference in financial Incentives are minimal especially when one realises they are taxed at nearly 50% anyway so any apparent difference is nearly halved in most cases. An important exception which must be maintained are the Commonwealth Procedural Grants to fund skill maintenance in Obstetrics, Anaesthetics and Emergency work. Without these payments, made per day spent upskilling, I would have had to cease years earlier.

Is ASGC-RA is working to deliver incentives where they are most needed
ASGC-RA is perverse and completely distorts the rural picture. ABS has published that it regards a city of over 100,000 population as metropolitan/urban yet GISCA completely ignore this. Distance is only a small part of the picture. Town size is much more important than distance as is the On Call requirement and lifestyle eg coastal vs inland. Housing, family support, schooling, spouse employment and accessibility are much more important. ASGC-RAs reliance on something as meaningless in the country as road distance ignores such inventions as aeroplanes. Sure I am 13 hours return by road from Sydney, but I regularly do the return trip daily in 2 hours by plane plus 2 hours return drive to the nearest airport. Consequently my patients more commonly go to Sydney for Tertiary treatment because they fly, rather than drive to the nearest Tertiary Hospital 4 hours away. GISCA ignores this. There is absolutely no justification for any town with a population of over 100,000 eg Hobart, Darwin and Townsville

being regarded as rural. A major misunderstanding with RRMA was that RRMA 5 was the least attractive of the Rurals due to small size and lack of services whereas RRMA 6 were the best of the Remotes mostly with airports, 24/7 services and often a huge tourist industry eg Broome. Hence many previously negotiated Incentives were quite rightly weighted in favour of RRMA 5 over the much more attractive RRMA6. ASGC-RA ignores this well documented situation.

Accessibility of CPD
is a much over-rated problem with the Procedural Grants offered by the Commonwealth assisting when the Internet and reading Journals cannot provide the Hands On.

Medicare Locals, particularly in relation to after hours services.
Our local Division of General Practice has always been completely immaterial to my Practice, being based over two hours away, even when I was a Board Director. Its replacement, the Medicare Local, will be just as ineffective, however their stated claim to cover After Hours was just the incentive I needed to pull out of After Hours On Call especially with the withdrawal of the PIP incentive. These community services in rural areas are far better managed, as we always have done, by being based at our rural Hospitals. We don't need Medicare Locals when services would be much more efficiently run and provided and co-ordinated by the local Hospital with funding via the Hospital District Board. The co-ordination of private practices, local Hospital, allied health, home nursing and pharmacy has always been a highlight of rural Practice much envied by my urban colleagues.

Thank you for your time. Please address any queries to my email address supplied.

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