RDAA response to the Senate Community Affairs References Committee on the Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians - Interim Report

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About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and their patients and communities.

RDAA's vision for rural and remote communities is simple – excellent medical care. This means high quality health services that are: patient-centred; continuous; comprehensive; collaborative; coordinated; cohesive; and accessible, and are provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their communities.

Introduction

RDAA welcomes the opportunity to provide this response to the Senate Community Affairs References Committee Interim Report on the Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians.

RDAA reiterates its concern that the need to ensure policy responses differentiate between outer metropolitan and rural[1] areas, has not been clearly articulated. It is absolutely critical that the primary care service issues in outer metropolitan areas are not conflated with those in rural areas.

- The reasons for and drivers of inequities of access to primary care health professionals and services in rural areas are different to those which impact on metropolitan fringe and large regional communities. This means that targeted initiatives must be developed and implemented to maximise their effectiveness and chance for success.
- Rural health has also suffered from the redeployment of investment intended for rural programs into larger regional or metropolitan areas. There is significant potential for this to happen again if outer metropolitan, and larger regional areas are equated with rural areas when considering primary care services.
- There is a real risk that opening rural programs designed to address rural workforce issues will have unintended but serious consequences for the rural medical workforce. In particular, the Distribution Priority Area (DPA) has functioned to funnel a much needed international medical workforce into rural areas but it is likely that the proposed relaxing of restrictions will reduce the number of International Medical Graduates and Foreign Graduates of Accredited Medical Schools going to rural communities. The introduction of other strategies to negate this will be critical just to maintain the existing, let alone improve, distribution of general practitioners (GPs) in rural areas.
- Any review of the DPA must also examine the exceptional circumstances review process which offers an avenue of appeal through the Distribution Working Group (DWG). There are concerns with this process that must be addressed.
- The Modified Monash Model (MMM) classification system has also been flagged for review. There has been some criticism of the MMM, particularly from those who feel that they have been disadvantaged by the use of this system. RDAA regards the MMM as the best classification currently being used as it offers greater granularity than the Australian Statistical Geography Standard - Remoteness Areas (ASGS-*RA*) or other frameworks. This allows better targeting of programs and incentives to the

[1] RDAA uses the term 'rural' to encompass locations described by Modified Monash Model (MMM) levels 3-7. Rural doctors are rural GPs, Rural Generalists and consultant specialists (resident and visiting) who provide ongoing medical services in these areas.

rural areas where they are needed. There is an apparent move to undermine the MMM as a mechanism for allocation of incentives and loadings that, if successful, will further destabilise an already strained rural medical workforce.

- RDAA believes that making training and positions in rural areas more available to doctors during their undergraduate, junior doctor and registrar years is a critical strategy to improve the recruitment and retention of doctors in these areas. RDAA supports the transition of the Australian General Practice Training (AGPT) to being College-led, and notes that a number of key reforms to improve rural general practice training can be achieved through the transition process.

The previous Australian Government's failure to deliver investment to achieve the health reform envisaged in Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022–2032 is also of critical concern.

Response to Recommendations

Recommendation 1
2.98 The committee recommends that the Federal Government further investigates the provision and distribution of general practitioners in rural and regional Australia.

RDAA is concerned that any 'further investigation' of provision and distribution of general practitioners in rural and regional Australia will not reveal any new information but will delay action to address an urgent need. Immediate action to relieve pressure (such as streamlined credentialing and a disaster response register), and a more considered wholistic approach to the training and distribution of doctors and other primary care providers is necessary. RDAA has advocated for a number of solution-focused strategies with respect to this.

It is important that any consideration of strategies does not focus on the idea of 'national self-sufficiency' (p40). This is notional concept and cannot simply be taken to mean increasing the number of Australian domestic graduates to some algorithmic, pre-determined level. There is a real risk that 'national self-sufficiency' will be interpreted to mean a need for more medical school places. This would produce more graduates but do nothing to ensure that they are distributed as junior doctors and registrars to where they are needed in rural communities, or that following training they will choose to work in a rural area. Metropolitan Australia generally does not need more graduates.

What is needed is a clear pathway into rural general practice careers from selection into, and completion of, university medical degrees, through to completion of fellowship with the general practice specialty colleges. Recruitment and retention strategies to alleviate the maldistribution of fellowed doctors across the country are also essential.

Consideration must be given to not only to the number of domestic graduates but also to the number of domestic graduates in rural training positions at all levels. Any increase in Commonwealth Supported Places must be accompanied by faculty and curriculum benchmarks to deliver general practice teaching and student supervision, and aligned with increases to rural intern and PGY2 positions or, at a minimum, with 10-12 week rural rotations to expose students to rural general practice careers. Positions in areas classified as Modified Monash Model (MMM) 3-7 should be full time in preference to the rotation experience.

Recommendation 2
2.102 The committee recommends that the Government's review of the Modified Monash Model is open to public consultation, including from communities themselves, and is progressed as a matter of priority.

A review of the MMM should consider that other currently available classification options do not offer the same level of granularity to target programs and incentives that the MMM does. RDAA acknowledges that using other datasets – such as Socio-Economic Indexes for Areas (SEIFA) data, and tools, such as Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) – in conjunction with the MMM system to better understand areas of general practice service need and inform allocation decisions would be beneficial in ensuring that initiatives are being targeted appropriately.

However, there is a significant risk that if the specific supports for rural primary care practitioners that are allocated using the MMM are more broadly applied because of a conflation of outer urban issues with rural issues, this would undercut rural medical practice and impact on viability and sustainability of services in rural areas.

While broader application of supports (and changes to DPA restrictions) may appear to be a promising way to attract doctors to outer metropolitan locations it is likely to reduce the number of doctors going to more rural locations. Differential location-based supports are necessary not just to attract doctors to rural areas, but also to retain them (including by supporting access to Continuing Professional Development, other interests such as medical research, and lifestyle needs for doctors, their partners and families including partner employment, childcare, educational opportunities and safe housing).

Recommendation 3
2.105 The committee recommends that the Department of Health and the Distribution Working Group assess the outstanding exceptional circumstances review applications as a matter of priority

There has been a significant number of applications from individual practices to change their classification. These must be examined using a locational lens: whether other practices within a given area are experiencing workforce shortages must also be examined to evaluate possible causes. If the issues are external to the applying practice and can be demonstrated to be impacting on other practices in the area, this is likely to be a legitimate reason for exception. If, however, the applying practice is the only one in the area experiencing difficulty in recruiting doctors (for example, because they have a poor workplace culture) they should not be supported to employ a doctor from an already vulnerable group.

RDAA understands that the Distribution Workforce Group (DWG) has been working through these applications as rapidly as possible.

However, members have expressed concern that sometimes recommendations may not align with final decisions. RDAA has attempted to follow up on the decision-making process and outcomes, and was advised that other information pertaining to applications has been used to make decisions. Clearly, this is unacceptable because, by implication, this means that recommended rejections can also **not** be accepted. The potential for politics to become an influencing factor is significant, and sets a dangerous precedent that will impact on rural general practices. If the DWG is to be efficient and effective, it must be given **all** relevant information. As a matter of principle, transparency of process should be an operational tenet for all health committees.

Recommendation 4
2.112 The committee recommends that the Department of Health develops benchmarks for the optimal distribution of primary health professionals.

RDAA is wary of using a nationally standardised 'optimal' level of distribution of primary care professionals as a construct for developing benchmarks. Determining such a level is particularly problematic for rural areas where the scope, complexity and circumstances of medical practice are very different to more urban areas. Australian rural communities are extremely diverse, with a range of socio-economic, technological, demographic, environmental, cultural and other factors impacting on the delivery of primary and other health services. This means that the 'optimal' number of primary care professionals in one community may be very different to another.

Recommendation 5
2.114 The committee recommends that the Department of Health conducts a comprehensive and wholistic review of the Stronger Rural Health Strategy and that performance benchmarks be established to assess the effectiveness of the overall strategy and of its programs.

RDAA is actively participating in this review which is underway. RDAA is of the view that all governmental policies and programs should be regularly evaluated using an outcomes framework and, therefore, generally supports this recommendation. The evaluation should lead to continued support for initiatives that are demonstrably achieving intended outcomes. Where the evaluation reveals initiatives are not fulfilling expectations, the rural health investment should be redirected to the development of new evidence-based rural initiatives.

Recommendation 6
2.123 The committee recommends that the Federal Government investigates substantially increasing the Medicare rebates for all levels of general practice consultations, as well as other general practice funding options.

RDAA supports this recommendation. The Medicare Benefits Schedule (MBS) underpins the delivery of primary are services in Australia but rebate levels have not kept pace with the demand for or costs of providing general practice services, impacting greatly on the viability and sustainability of rural practices. Rural Generalists should also be able to access the relevant specialist items when they provide these services in their area of advanced skill.

Other funding options and models of care must also be seriously considered and urgently implemented as affordable health care and expanding out-of-pocket costs (OOPs) continue to be issues. Current cost of living pressures mean that Australians may choose to put off consulting with, or not see, a doctor for regular health care and chronic condition management. This is an especial concern in rural areas where the indirect costs of accessing that care may be greater (for example, the cost of fuel for a 3-hour round trip to the rural general practice).

Some general practices are already running at a loss in order to provide bulk billed services to vulnerable populations (such as pensioners and other health care card holders) as they are the only providers in their small rural communities. These patients cannot afford to drive any further for appointments or pay any gap fees. As these clinics have a duty of care to provide health services for these patients, they bear the loss of revenue while their operating costs are continuing to increase. This is not sustainable, and could ultimately lead to the closure of those practices and loss of primary care services for the whole community.

Recommendation 7

3.96 The committee recommends that the Department of Education, Skills and Employment, in collaboration with universities, reviews the primary care components of the medical education curriculum, with a view to ensuring that general practice is a core component of the curriculum.

Ensuring exposure to general practice throughout the medical education curriculum is an essential step to improve the uptake of general practice as a career. Setting minimum faculty and curriculum benchmarks to deliver general practice teaching and student supervision should be adopted, and underpinned by supports for rural GPs and Rural Generalists who teach and supervise trainees as well as providing clinical services for patients.

The use of more rural GPs and Rural Generalists as lecturers and trainers in universities, particularly in metropolitan universities, would increase exposure to rural medicine and rural general practice, and help to promote a culture shift and the value rural training and careers.

Recommendation 8

3.100 The committee recommends that the Department of Health expands the John Flynn Prevocational Doctor Program and re-instates the John Flynn Placement Program aimed at attracting medical students to rural and regional general practice.

RDAA has strongly advocated for medical student and junior doctor pre-vocational exposure to rural medicine and welcomes this recommendation.

Recommendation 9

3.105 The committee recommends that the Government investigates the adequacy and suitability of the Australian General Practice Training placements allocated to the relevant general practice training colleges.

The transition of Australian General Practice Training (AGPT) to become college-led offers an enormous opportunity to ‘get it right for rural’. Using a one-year, three-year and five-year post-graduation rural metric to assess impact of college training pathways on rural medical workforce retention would provide a useful point of comparison, and provide valuable outcome data for making decisions on the number of places awarded to the two general practice colleges. Training place allocation between the two colleges should be linked to outcomes. This is particularly important to increase the number of rural and remote placements and retain the trained GPs and Rural Generalists in these communities into the longer term.

There has also been a lack of independent evaluation and accountability in relation to the performance of a number of training organisations, with respect to their post-graduate training programs and processes, support for the rural medical workforce and their outcomes in relation to workforce distribution. Developing and implementing outcome key performance indicators and reducing the number of Commonwealth-funded organisations should be considered.

Another important training issue is the attraction of pre-vocational doctors to general practice training. Thus far, these doctors have been unable to transfer their entitlements accrued while working as a junior doctor within the hospital system to employment as a registrar in a general practice. This can be a significant disincentive for doctors to select general practice as their career specialty. Female GPs are further disadvantaged by the possible loss of continuous service accrual (required under maternity leave provisions) if they move to general practice training.

The situation is more complicated for Rural Generalist registrars who have two employers: the private general practice and the local rural hospital. This arrangement has significant implications for administration and management, as well as for contract negotiations, where there is no overarching statewide hospital GP Visiting Medical Officer (VMO) arrangement as is the case in Victoria. RDAA strongly supports the concept of the single employer model for rural generalist registrars.

Discussions with various jurisdictions indicate that there is interest in a model where the state becomes the single employer through Health Service Districts (or state health areas by any other name) employing Rural Generalist registrars/trainees under the provisions of the relevant state medical industrial award. This has been piloted in Murrumbidgee Local Health District in New South Wales, and has been supported by the Commonwealth Government granting a 19(2) exemption which enables the registrar/trainee to bill Medicare items when working in general practice. The general practice in turn reimburses the state for the hours the registrar/trainee is working in the general practice clinic.

Under this single employer arrangement there are existing award provisions that registrars/trainees can be employed under, and a jurisdictional willingness to absorb some of the financial risk of employing a registrar/trainee who works across two sites (the hospital and the private general practice).

It must be noted, however, that the term ‘single employer model’ is often used to refer to proposed reform to enable portable entitlements for all GP registrars. RDAA would argue the GP registrar discussions should be referred to as ‘employment reform’ rather than a ‘single employer model’, as most registrars have only one employer at any given time. In principle, RDAA supports the work Australian Medical Association (AMA) has been progressing in this area, but believes that the single employer model for Rural Generalists should not be dependent on the success of the AMA employment reform advocacy for GP registrars. Stakeholder discussions have indicated that there appears to be little to no appetite for jurisdictions to extend this arrangement to the broader group of GP registrars who do not provide a service in their local hospital.

The single employer model provides an opportunity to make Rural Generalist employment more attractive than regular GP employment for a period of time by significantly improving current arrangements for Rural Generalist registrars. This small advantage should be seen one measure to address the maldistribution of the medical workforce across Australia and the inequities in health care and outcomes.