Parliament of Australia Senate Inquiry into the factors affecting the supply of health services and medical professionals in rural areas

Submission by NSW Rural Doctors Network (RDN)
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Background

RDN is the Rural Workforce Agency in NSW. It was established in 1988 (as the Rural Doctors Resource Network) to attract recruit and retain rural GPs in NSW. RDN is a not for profit company limited by guarantee with charitable status. It receives funding from the Australian Government and the NSW Government to administer programs designed to improve the health of rural and remote people in NSW, principally around health professional workforce.

In 1987 there were two seminal inquiries into issues affecting rural GP workforce. The first was by Professor Max Kamien in WA, the second by Nick Shehadie in NSW in response to the rural doctors dispute. Both had similar recommendations around support needed for rural GPs, including an adequate supply of locums, access to continuing professional development, family support and training. Both of these papers can be supplied in electronic form by RDN should the Senate wish.

Since then some things have improved, some become more difficult. Entry to medical training for rural origin students as improved, scholarships both bonded and unbonded are more available. Vocational training with a rural focus has improved greatly, especially with the formation of the Australian College of Rural and Remote Medicine, and the Royal Australian College of General Practitioners addition of its Fellowship in Rural General Practice. Continuing Professional Development is much more accessible to rural GPs especially with the introduction of the internet.

Other areas have not improved or become worse. While the supply of locums is better, it cannot keep up with demand. The numbers of procedural GPs has continued to decline. The GP workforce is older and questions remain about who will replace them. Much of the nature of General Practice has changed, but the systems have not changed to reflect this.

This submission cannot hope to address all the factors affecting the supply of health services and medical professionals in rural areas. Instead it will concentrate on the terms of reference, and within them a few areas that could be changed and would make a difference.

RDN would be most happy to expand on any of these points or appear as a witness before the inquiry.

Terms of Reference

(a) Factors limiting supply of health services and health professionals

- Lack of generalists

  There will always be shortages of health professionals and services in rural and remote areas. What we have seen over the last 20 years has been a continuing creep of these shortages into more populated and coastal areas. One of the problems is the move towards specialism (sometimes called particleism) across all professions. There is a shortage of general physicians and general surgeons, a shortage of generalist GPs, a shortage of general nurses. Instead there has been a drift towards sub-specialisation – hand surgeon or cardiologist, GPs wanting to work in an area of interest, nurses working only in specialist areas such as ICU or renal unit. The size of smaller towns and hospitals makes it unlikely that they will be able to support sub-specialists rather than generalists and workforce and service delivery then becomes a problem

  Recommendation: That Governments support generalist training and service delivery across all health professions.

- Practice structure in General Practice

  General Practice has traditionally been a small business. Increasingly the demands of small business management, including a mass of legislation and regulation mean this model is unattractive to many newer doctors. In the city and large regional centres this is often overcome through the economies of scale made possible by larger group practices and the so called corporate practices. This is not possible in smaller towns, and the corporates do not see the profits they want in rural towns.

  One answer lies in not- for- profit business management for smaller practices, allowing the doctor to concentrate on clinical medicine. Examples include Rural and Remote Medical Services (RaRMS) in NSW which has shown over ten years that it is possible to recruit and retain doctors in such places as Walgett, Gulgong, Gilgandra and Braidwood in the face of adversity. In the "easy entrance gracious exit" model a not for profit organisation administers the surgery for GPs who have their own clinical practice and pay for the administrative services. Many Divisions of General Practice in NSW have similar activity. Yet there is a vacuum of Government policy in the area of business management in rural and remote areas

Recommendation: That the Australian Government develop policy on not-for-profit management of General Practices in rural and remote areas including start up support where necessary

Recommendation: That the Australian Government investigate whether there is a role for Medicare Locals in General Practice business management

- Procedural General Practice

  In NSW the greatest shortages, and the greatest looming shortages are in those midsized towns that support procedural General Practice, and in particular GP Obstetrics and GP Anaesthetics. There is a twin threat of not enough doctors training, and State Health departments either closing or not re-opening such units

  Recommendation: That the Australian and State Governments commit to expanded GP Procedural training

  Recommendation: That research funds be made available for research into the true value of rural and remote procedural GP practice versus centralisation in cities, including economic costs to individuals, families and small towns, and the human cost to individuals, families and small towns

- Other factors are reasonably well known and include availability of locums, family support, continuing professional development and support for rural origin students

(b) Medicare Locals

It is too early to tell what the effect of the introduction of Medicare Locals on the provision of medical services in rural areas will be. What is clear is that:

- They will need to preserve the positive things that have come from Divisions of General Practice, including a local structure for implementation of various funding streams and support for existing GPs, GP practices and associated health professionals
- They may have the possibility for GP practice management (as above)
- There will still be the need for Rural Workforce Agencies to manage what is best done in workforce at a State level

(c) Incentives

(i) Role Structure and Effectiveness

There are a number of types of incentives available. The first are those that immediately and largely affect the doctors income. An example is the Rural Doctors Settlement Package in NSW, negotiated since 1987 between the Rural Doctors Association (NSW) and NSW Health it provides reasonable remuneration for work performed by GPs within the public health system (hospital). It has probably been the single greatest factor contributing to a relatively stable workforce in rural NSW.

The second are those financial incentives that contribute to recruitment and retention of rural GPs. Apart from the Commonwealth retention payments in the most remote areas they are of minor financial impact on the doctors income. They are what Professor John Humphreys calls the "chocolate on the hotel pillow" and I call "a kiss and a cuddle" – they are part of ensuring that the GP and his or her family feel acknowledged and treasured outside their own town. Examples include relocation grants, retention grants and subsidised locum availability (subsidised rather than locum availability – availability has a huge impact). There is little evidence that eg relocation grants actually convince a doctor to move, but anecdotally they do make a difference in the positive attitude of the doctor, especially as they are likely to be moving at a time in their career when they not financially well off.

The third type of incentives are those largely not financial things that can be done to keep the rural doctors and their families feeling supported. Examples include RDN support for its Rural Medical Family Network to implement mentoring for the spouses of IMGs, running family friendly clinical conferences and supporting new rural doctors to attend them so they become part of a wider network and do not feel so isolated.

(ii) Delivery

GPRIP is the main structure for delivery of direct Commonwealth incentives to rural GPs, including relocation and retention grants. GPRIP typically has a central delivery mode where payments are made directly to the GP on the basis of Medicare data, and a much smaller flexible payment mode delivered through the Rural Workforce Agencies that picks up anomalies in service provision where the Medicare data doesn't adequately measure the service. In its payment structure GPRIP works well. Where it is not so good is in eligibility. For instance to be eligible for the relocation component the doctor must have Fellowship of RACGP or ACRRM and have provided at least one Medicare service in the place they are moving from. This successfully excludes almost all doctors relocating to rural or remote areas.

The Rural Workforce Agencies administer a number of incentives in the second and third categories. The importance of the RWA administering these are that they a part of an ongoing and continual support for rural GPs

and their families that tie together undergraduate and early career support with recruitment, education progression and retention. Having this coherence and continuity greatly enhances the effectiveness of what could be seen as a number of small programs. In practice, the RWAs consolidate a number of Commonwealth and State programs and projects into a comprehensive package for rural GPs.

(iii) ASGC-RA

The adoption of ASGC-RA has led to a number of problems, primarily in the lack of discrimination within RA 2. While RDN is committed to supporting GPs across RA 2-5, to do so across the whole of RA 2 would dilute RDN's effectiveness in recruiting and retaining GPs in areas of greater social and professional isolation. RDN therefore introduced a Priority Towns classification within RA 2 for some of RDN's program areas. RDN went back to the raw scores for RA 2 and selected a natural cut off line between those towns with a greater need for GPs, and those with a lesser need for recruitment and support programs.

This has worked reasonably well within NSW. It does not address the issue of some large regional centres having the same (or higher) RA classification than smaller (and often procedural) towns. It is also internal to RDN, and as other organisations such as Universities seek to do the same thing we are likely to have a number of different discriminators applied with RA 2.

(d) Any related matter

(i) Bonded Medical Places (BMP) and District of Workforce Shortage (DWS)

In attempting to alleviate medical practitioner shortages the Australian Government introduced the Bonded Medical Place Program. Around 600 extra medical undergraduate places per year have been created, with the bonded students contracted to spend time after gaining Fellowship in a District of Workforce Shortage

The problem is the many heartland rural towns are not DWS so BMP doctors will not be able to go there. In NSW these include Coonamble, Coonabarrabran, Manilla, Bingera, Gundagai and a host of others. The successful program by the Government to increase the supply of doctors in needy areas is being subverted by the DWS tool that tries to measure need.

It is anomalous that a BMP doctor can practice in Merewether in Newcastle but not in Coonamble. Rural doctors who take registrars and Prevocational General Practice Placement doctors for short terms in trying to grow a rural

GP workforce of Australian graduates then see their towns classified as not in need.

Reccomendation: That the eligible practice criteria for Bonded Medical Place doctors and or the District of Workforce Shortage be amended tp allow BMP doctors to practice in needy small rural towns.