RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

10 July 2012

Dear Secretary

INQUIRY INTO THE FACTORS AFFECTING THE SUPPLY OF HEALTH SERVICES AND MEDICAL PROFESSIONALS IN RURAL AREAS: RESPONSE TO QUESTIONS ON NOTICE

I write to provide the Committee with a response to two questions on notice posed by Senator Moore to the Rural Doctors Association of Australia on 11 May 2012 when we appeared before the *Inquiry into the Factors Affecting the Supply of Health Services and Medical Professionals in Rural Areas*.

The two questions on notice are as follows:

1. Could you provide more information about Medicare Locals and the removal of the after-hours incentive payment?
2. Could you provide an explanation of why doctors who have worked in rural areas should continue to receive rural incentives for a period time once they move to an urban area?

Medicare Locals and the removal of the after-hours incentive

As our submission indicates, RDAA strongly opposes the removal of the after-hours incentives paid under the Practice Incentive Program (PIP) and the handing over of responsibility for providing financial support for afterhours services to Medicare Locals, as it may impact on the ability of small rural communities to access afterhours services.

GPs who provide after-hours services are about to enter a period of uncertainty. From July 2013, there are no guarantees that the level of after-hours incentive payments they currently receive will continue. While 'guidelines' that indicate that Medicare Locals should continue to support existing after-hours arrangements that are working well, at the end of the day Medicare Locals will be independent entities governed by a Board of Directors who are free to make their own decisions. This includes decisions about what level of financial support is to be provided to existing after-hours services.

RDAA is already hearing reports from some rural doctors that, where after-hours negotiations with Medicare Locals have occurred, there has been a lack of transparency and doctors are being offered unsatisfactory rates for providing after-

hours care, especially when one considers the generous payments being made to telephone triage doctors (up to $260 an hour) or the payments demanded by rural locums (up to $2000 per day). For example, we have been contacted by a small rural practice in South Australia that presently provides an after-hours accident and emergency outpatient service at the local hospital. If the level of after-hours incentive payments to this practice diminishes, this practice will have to cease this service. Patients will then have to travel to the regional hospital, which is already overloaded.

Many rural practices are bulk-billing practices because their patients simply cannot afford additional payments. These practices rely heavily on incentives under the PIP – including the after-hours incentive - to cover practice expenses. The cessation of the after-hours incentive payment could potentially rip ten of thousands of dollars in income out these practices, threatening the continuation of after-hours services and the viability of practices.

RDAA considers that any new after-hours funding and service arrangements must:

1. Guarantee that all the funds allocated for afterhours services under the PIP arrangements will be returned to practices that are directly providing this care for as long as after-hours services are provided.
2. Provide all GPs with the appropriate skills, qualifications and experience with the opportunity to provide after-hours services.
3. Maintain existing activity and service delivery at rural hospitals, so as not to negatively impact on the ongoing sustainability of these facilities in terms of funding, facilities, and staff skill sets
4. Retain existing State industrial arrangements with respect to the provision of after-hours services from public hospitals.
5. Eliminate any potential for cost shifting from State Governments to the Federal Government.
6. Give priority support to practices and communities where after-hours services are most fragile.
7. Provide all doctors and practices in the community with the opportunity to provide input into planning and consultation processes, and ensure that they are made aware of any new arrangements with respect to the funding and management of after-hours services.
8. Require Medicare Locals to consult widely within their boundaries when planning for regional after-hours services and to publicly release a draft plan for a regional approach to the provision of after hours primary care for comment.
9. Include a transparent and robust evaluation framework to ensure that Medicare Locals are accountable both to the local community and to the Commonwealth, for the planning and funding decisions they make.
10. Provide for the establishment of an independent body to review funding decisions made by Medicare Locals in relation to after-hours services, and allow stakeholders affected by any funding decisions to have standing to make submissions to the review process.

RDAA also considers that industrial arrangements under any new after-hours services must:

1. Guarantee a minimum number of hours for which hourly rates are paid.

2. Guarantee hourly pay rates that reflect current industrial arrangements with the States.
3. Not restrict any after-hours arrangements outside hospital Emergency Departments to bulk billing.

Rewards for doctors who spend time in rural areas

RDAA's proposal for a national advanced rural training program includes a proposal for an economic framework for sustainable rural practices.

Under this framework, additional fee-for-service incentives would specifically recognise and reward rural doctors with advanced skills training who utilise these skills in rural and remote settings through incentives that take into account the greater costs and complexity involved with rural and remote medical practice (the complexity payment). The incentives would also compensate rural doctors for the greater isolation, costs involved with rural practice (the isolation payment).

The aim of the national advanced rural training program and the introduction of these incentives is create an attractive rural training pathway that leads to a career in rural medicine and also ensure that communities have access to the services they need.

With the increasing trend towards subspecialisation, many doctors are concerned that a stint in a rural area as a rural generalist will negatively impact on their ability to return to metropolitan practice. To counter these concerns, RDAA believes there should be some acknowledgement of rural service by doctors. This acknowledgement could take a number of forms, including providing doctors who have undertaken rural service, and subsequently return to urban practice, with:

- a proportion of the complexity payment they received during their rural service for a fixed period of time with scaling
- a professional development subsidy, and/or
- access to training if they wish to transition into a subspecialisation, or undertake other continuing professional development.

The availability of these types of supports that acknowledge rural service and support rural doctors who wish to return to urban practice would encourage more doctors to consider spending some time in rural practice, when previously they may not have considered any rural service at all.

If you have any questions about this response, please do not hesitate to contact me.

Yours sincerely

Jenny Johnson
Chief Executive Officer