RURAL DOCTORS ASSOCIATION OF AUSTRALIA

The Hon Josh Frydenberg MP
Treasurer
Parliament House
CANBERRA ACT 2600

17 December 2019

Dear Treasurer

The Rural Doctors Association of Australia (RDAA) welcomes this opportunity to provide a submission for the forthcoming 2020-21 Federal Budget.

The attached submission commends the Australian Government's efforts to address rural health issues through its Stronger Rural Health Strategy. However, it is vitally important that these efforts are consolidated through ongoing investment if they are to make a difference to the health of rural people. Additional investment to ensure that medical training pathways deliver the advanced skilled practitioners needed in rural communities – and that these practitioners are retained in rural areas – will also be required.

RDAA looks forward to working with the Australian Government to achieve better health outcomes for rural and remote Australians.

Yours sincerely

Dr John Hall
President

RDAA Pre-Budget 2020-21 Submission

RDAA is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.

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

It is well recognised that there is a significant maldistribution of medical and other health professionals and services in Australia along a metropolitan and rural and remote divide. Lesser access to health professionals and services in rural and remote communities is a persistent problem contributing to significantly poorer health outcomes for people living in these areas.

RDAA acknowledges that the Australian Government has announced a number of initiatives to redress some of the many issues in relation to this rural health workforce maldistribution and lack of access to health services as part of its Stronger Rural Health Strategy. It is imperative that these current efforts are consolidated through ongoing investment – with appropriate monitoring and evaluation to ensure effectiveness – if they are to make a positive difference to the health of rural and remote people. Additional funding must also be committed to address identified blockages in rural medical training pathways and barriers to rural medical workforce recruitment and retention to ensure that initiatives are efficient and sustainable.

Summary of recommendations

RDAA calls on the Australian Government to act on the following recommendations:

- Commit funding to ensure that the implementation of the National Rural Generalist Pathway (the Pathway) is sustainable. This will entail continuing funding beyond the 100 places commencing in 2021 (committed in the 2018-19 Federal Budget under the Stronger Rural Health Strategy).
- Quarantine a minimum of 350 Australian General Practice Training (AGPT) posts per year as rural generalist posts (no budgetary implications).
- Expand the Junior Doctor Innovation Fund (JDIF) to support an additional 120 intern and 120 Post-graduate Year (PGY) 2 positions in Modified Monash Model (MMM) 1 primary allocation facilities but require rotations in MMM 3-7 areas.
- Enable Medicare billing by JDIF PGY2 doctors.
- Establish 60 new advanced skill positions to address bottlenecks identified by jurisdictions.
- Utilise the current underspend of monies on the AGPT 2020 rural pathway funding to create additional subsidised places for the Australian College of Rural and Remote Medicine (ACRRM) Independent Pathway and the Royal Australian College of General Practitioners (RACGP) Practice Experience Program (PEP) in MMM 3-7 areas.
- Use any underspend of AGPT monies after 2021 to create a flexible pool that both ACRRM and the RACGP can recruit against to maximise intake of eligible applicants.
- Commit funding for 10 Regional Training Hub (RTH) non-GP specialist posts in each of the RTHs.
- Expand funding for the Specialist Training Program (STP) to create positions that require the supervisor and registrar to provide services in smaller regional, rural or remote locations either part-time or via visiting service arrangements.
- Provide specific funding to support the training of generalist specialists (such as general surgeons) needed by rural and remote communities.
- Expand funding for the Support for Rural Specialists in Australia (SRSA) to support professional development and skills maintenance.
- Expand investment in general practitioner (GP) telehealth services to Modified Monash Model 4-5 areas to improve access to healthcare for rural and remote people.
- Streamline telehealth funding to ensure that it is targeted to specialists who provide face-to-face services in rural and remote areas.
- Continue to fund the National Rural Health Commissioner position as an ongoing role.

Key issues:

National Rural Generalist Pathway

The National Rural Generalist Pathway is about training future generations of doctors to work in rural and remote Australia. While the $62.2m allocated to the Pathway in the 2019-20 Federal Budget is sufficient as initial establishment funding and there have been some recent moves to operationalise it, further funding to ensure that the Pathway is embedded as a rural health workforce strategy is necessary.

Secure ongoing funding is needed to ensure that the Pathway can deliver the highly skilled rural generalists needed in rural and remote communities into the future. Training these doctors takes time (typically at least 10 years from starting university to completing Fellowship training with a medical specialty college, and often longer with advanced skills training), and recruitment to training positions has a significant lead-in time. Resources need to be allocated well in advance so that so that systems and processes are in place for commencement of the annual intake that generally begins in March/April of the previous year.

It must also be recognised that there are significant costs to general practices associated with training junior doctors. For example, a loss of revenue occurs when a consultation room is allocated to a non-billing service. Enabling JDIF PGY2 doctors to bill under Medicare would offset these costs.

- Commit funding to ensure that the implementation of the National Rural Generalist Pathway is sustainable. This will entail continuing funding beyond the 100 places commencing in 2021 (committed in the 2018-19 Federal Budget under the Stronger Rural Health Strategy).
- Quarantine a minimum of 350 AGPT posts per year as rural generalist posts (no budgetary implications).
- Expand the JDIF to support an additional 120 intern and 120 PGY2 positions in MMM 1 primary allocation facilities but require rotations into Modified Monash Model 3-7 areas.
- Enable Medicare billing by JDIF PGY2 doctors.

There are also a number of points along the Pathway in relation to advanced skills training that have been identified by jurisdictions as bottlenecks. There is considerable competition for a number of procedural and non-procedural advanced skill places. The bottlenecks created by small numbers of available registrar positions can be addressed by creating advanced skills positions in non-tertiary hospitals where there is additional capacity for training and supervision.

- Establish 60 new advanced skill positions to address bottlenecks identified by jurisdictions.

Australian General Practice Training

Australia now trains a sufficient number of doctors for the needs of its population. However, there is an ongoing trend toward choosing specialisation and sub-specialisation training rather than general practice during prevocational years. There are many reasons for this including misconceptions about the work of GPs, perceptions about the relative status of GPs compared with non-GP specialist colleagues, and remuneration concerns. It has been recently reported that there will be a significant shortage of General Practitioners in Australia by 2030[1].

This is particularly concerning for communities in rural and remote Australia that already experience medical recruitment and retention challenges. The general practice rural pathway training program was undersubscribed in 2019, and early indicators are that there will again be a significant undersubscription in 2020. This will have long lasting implications for rural communities. The ability of rural and remote Australians to access local medical services – already much poorer than their more urban counterparts – will be further compromised. This situation must be urgently addressed.

Choosing the ACRRM Independent Pathway is one way for doctors to pursue rural general practice training, offering a structured but flexible approach. The RACGP PEP also offers a self-directed approach. Currently these programs are only partially Commonwealth funded and therefore require some self-funding. Utilising AGPT monies that have not been expended to create additional subsidies for these programs undertaken in MMM 3 -7 locations would make them a more attractive option, appealing to doctors who need or wish to take a non-traditional route to rural practice.

- Utilise the current underspend of monies on the AGPT rural pathway funding to create additional subsidies for those on the ACRRM Independent Pathway or the RACGP PEP in a MMM 3-7 location.
- Use any AGPT underspent monies after 2021 to create a flexible pool that both ACRRM and RACGP can recruit against to maximise intake of eligible applicants.

Rural non-GP specialists training

Thus far, little progress has been made in ensuring regionally- and rurally-based training for non-GP specialists. While some non-GP specialist colleges have functioning rural initiatives, others do not.

[1] https://www2.deloitte.com/au/en/pages/economics/articles/general-practitioner-workforce-report-2019.html. Viewed 11 December 2019.

RDAA has identified a number of areas for investment to improve access to non-GP specialist services so that people from rural communities have the care that they need at the time and place they need it.

In part, the lack of Commonwealth commitment and investment in relation to funding specific training posts for non-GP specialists in RTHs has contributed to the lack of progress as RTHs have focused on undergraduate and, in some States rural generalist, training. There is an opportunity to reduce the shortage of non-GP specialists providing services to rural and remote areas by committing to fund specific non-GP training posts in RTHs which are set up to ensure rotations in MMM 3-7.

The Specialist Training Program (STP) supports 900 training posts through the specialist medical colleges and the Integrated Rural Training Pipeline (IRTP)-STP announced as part of the Mid-Year Economic and Fiscal Outlook (MYEFO) December 2015, created an additional 100 STP posts in rural areas that were allocated over two years (2017–2018) with the requirement that all trainees in those posts must complete at least two thirds of their total Fellowship training in a rural area. This program is still funded using the Australian Statistical Geography Standard - Remoteness Area (ASGS-RA) classification system which divides Australia into 5 classes (Major Cities, Inner Regional, Outer Regional, Remote and Very Remote)[2]. RDAA strongly believes that this program should be transitioned to the Modified Monash Model classification system to more accurately reflect rural and remote Australia and align with other Department of Health initiatives for these areas.

Expanding STP funding to create positions that require both supervisor and registrar to provide face-to-face services in smaller regional, rural and remote locations will also help to redress the lack of access to non-GP specialists. Additional specific funding should be directed to support the training of generalist specialists (such as General Surgeons) needed by rural and remote communities, and to the Support for Rural Specialists in Australia (SRSA) program to support professional development and skills maintenance.

- Commit funding for 10 Regional Training Hub (RTH) non-GP specialist posts in each of the RTHs.
- Expand funding for the Specialist Training Program (STP) to create positions that require the supervisor and registrar to provide services in smaller regional, rural or remote locations either part-time or via visiting service arrangements.
- Provide specific funding to support the training of generalist specialists (such as General Surgeons) needed by rural and remote communities.
- Expand funding for the Support for Rural Specialists in Australia (SRSA) to support professional development and skills maintenance.

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[2] https://www1.health.gov.au/internet/main/publishing.nsf/Content/4AAA78E3A7D8FA47CA257BF0001B73E0/$File/STP%20Operational%20Framework%20-%20Final%20September%202019.pdf p 14 Viewed 04 December 2019

Telehealth

RDAA (together with ACRRM) has previously proposed a model for the provision of GP telehealth services in Modified Monash Model areas 4-7. RDAA welcomes the investment that will allow GPs to provide telehealth consultations in areas MMM 6-7 announced on 29 October 2019. To further improve access to primary health care services this initiative should be expanded to include MMM 4-5.

Transitioning the classification used for specialist telehealth services from the ASGS-RA to the MMM and streamlining funding arrangements to ensure that it is targeted to specialists who provide on the ground services in rural and remote areas rather than supporting metropolitan specialists who have no face-to-face to contact with their rural and remote patients should also be implemented.

- Expand investment in GP telehealth services in Modified Monash Model areas to encompass 4-5 to improve access to healthcare for rural and remote people.
- Streamline telehealth funding to ensure that it is targeted to specialists who provide face-to-face services in rural and remote areas.

National Rural Health Commissioner

The National Rural Health Commissioner role is a critical one, providing visible leadership within the rural health sector in addressing medical (and other health professional) workforce planning, service models and future innovation. It provides tangible evidence of the importance of Rural Health, particularly while it remains part of the Regional Services portfolio. As such, funding should be committed to maintain the National Rural Health Commissioner role as an ongoing one.

- Continue to fund the National Rural Health Commissioner position as an ongoing role.

Conclusion

The maldistribution of the medical workforce continues to be problematic with rural and remote Australia continuing to experience significant inequities in access to medical services and health outcomes. Consolidation of current efforts to redress issues as well as sustained political commitment and investment will be critical to achieving meaningful improvements in rural and remote health.