Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College Submission
January 2023

Pre-Budget Submission 2023

Key Initiatives and Recommendations

Double the Medicare Rural Bulk Billing Incentive for MMM 3-7	**Strengthening Medicare GPG Program -an additional $140 million for General Practices in MMM 3-7**	**Blended funding models and flexible funding pools for rural and remote General Practice to support bespoke, tailored solutions which support the RG model of practice**	**Funding for specific programs to provide wellbeing and support for doctors and doctors in training in MMM 3-7**
$12.5 million per annum to expand and enhance the ACRRM Rural Generalist Training Scheme	**An additional 50 earmarked RGTS places in the John Flynn Prevocational Doctor Program**	**$2.5 million per annum to promote Rural Generalist medicine to rural and remote secondary students**	**$3 million to establish a scholarship scheme to support rural and remote students commencing a medical degree**

Improving access to primary care for people living in rural and remote and Aboriginal and Torres Strait Islander communities can lead to improved health outcomes and avoid the higher treatment costs involved when conditions escalate to requiring secondary or tertiary care. Rural and remote general practice is integral to improving health outcomes for rural and remote Australians but is currently grossly underfunded and needs to be subsidised to remain viable.

Rural Generalists (RGs) are medical practitioners who are trained to meet the specific current and future healthcare needs of Australian rural and remote communities in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.

The 2023-24 budget presents an opportunity for the Federal Government to demonstrate its commitment to building strong and sustainable rural communities and healthcare services. Bespoke funding for rural and remote general practice and increased investment in the National Rural Generalist Pathway will secure equity of access to primary care services and address the continuing poorer health outcomes our most rural and remote Australians. These priority areas for investment have the potential to significantly increase access to high-quality healthcare services in rural and remote areas, and consequently improve health outcomes for people who reside there.

BUDGET PRIORITY ONE: Support rural general practice through bespoke funding models tailored to the needs of rural and remote communities

The College strongly supports increased investment in Rural Generalist practice. RGs are often the only provider of health services in rural and remote areas, and in areas where health services do exist, are often the first point of contact for patients. These doctors work across a range of settings including private clinics, hospital, and healthcare facilities, and in emergency situations.

The broad scope, community responsive work of RGs and their local healthcare team colleagues where applicable, is essential to providing accessible care for people in rural and remote areas. These doctors must be adequately funded and supported to continue to deliver these services across rural and remote Australia.

Issues

Rural and remote general practice across Australia is currently facing a funding crisis, as Medicare rebates fail to reflect the increasing costs of running a medical practice and the reliance on throughput-based funding models which are not fit-for-purpose for the rural and remote context. This is exacerbated by the pressure to bulk bill which can be greater in rural and remote locations due to poorer socio-economic profiles.

In rural and remote practice, there is less opportunity for higher gap payments. There is a general inability to take advantage of quicker consults due to the complexity of many patient presentations, and the lack of other accessible resources/specialist services to refer on to. There is also a capped numbers of potential patients and these patients may often have minimal capacity to pay any additional healthcare costs.

Rural practice owners are disproportionately affected, as urban practices, by comparison, are better placed to generate income from volume, take advantage of quicker consults and niche services, and absorb the cost of complex patients. They are also most likely to have practice nurses who can often undertake a high proportion of the work around for example, care plans, whereas in rural practice, doctor are typically doing this work themselves and being paid the same percentage.

With Medicare funding at levels insufficient to sustain general practice, the rural Practice Incentive Program (PIP) is generally viewed as critical to practice viability.

Solutions

Mechanisms must be considered to appropriately remunerate the broader scope of the rural generalist practitioner through Medicare and other programs.

Blended funding models would provide a supplementary funding source to the Medicare system, particularly for the management of chronic and complex disease, which is more prevalent in rural and remote areas. Funding should incentivise provision of care by a locally based practice and locally based practitioners able to provide in-person care as required, and continuity of doctor-patient relationships.

Flexible funding should be available to specifically support rural and remote, locally based services. This funding must be fit-for-purpose and proportionately recognise and reward the effort and skill of medical/health care providers in meeting their patients' needs. To lend resilience, there needs to be a range of potential funding sources and policy levers. These would enable practices to adopt viable models of care appropriate to community needs and circumstances.

Investment:

- Increase Medicare funding for rural and remote General Practice by doubling the Medicare Rural Bulk Billing incentive for MMM 3-7 as a component of broader practice funding reform.
- Establish designated funding pools to support innovative, flexible, and place-based service models which enable bespoke solutions tailored to the unique needs and circumstances of rural and remote communities
- Increase funding for the *Strengthening Medicare – General Practice Grants Program* to provide an additional $140 million for distribution to general practices in RA 3-7, and increase the available funding for each rural or remote practice to $100,000
- Extend rural specific Medicare Benefits scheme rebates to better reflect practice costs and complexity in rural and remote areas and ensure that patients are not financially disadvantaged in seeking primary care services
- Introduce blended funding models with rural loading which incentivises delivery of in-person services and provision of facilities based in remote and remote contexts
- Introduce funding mechanisms which support the Rural Generalist model of practice as a key policy lever in providing primary care and services which meet community need in a sustainable and cost-effective manner

BUDGET PRIORITY TWO: Bolster funding to create and sustain a National Rural Generalist workforce

There are challenges and disincentives to rural and remote practice which are common to all medical and healthcare professionals, and this is manifest in significant and growing workforce shortages in rural and remote across the spectrum of professions.[1]

Some of these challenges include working with minimal local resources and facilities, the weight of responsibility for patients who have limited access to alternative care, professional and personal isolation, and the professional stress associated with caring for high-needs, low socio-economic patient populations. Financial challenges may include a limited patient population and thus limited capacity to generate income, difficulties in finding work for partners, the cost of accessing professional development and training to work to a broad rural scope, and costs associated with travel to city centres for work and lifestyle reasons.

If government policy is to successfully improve access to healthcare for rural and remote people, it must address all these issues. It must address training, resourcing and personal support for the health and medical professionals who choose to work in rural and remote areas. It must also ensure that they can be sufficiently remunerated.

[1] Australian Institute of Health and Welfare. (2022). *Health workforce.* Retrieved from https://www.aihw.gov.au/reports/workforce/health-workforce

Policies should ensure remuneration structures reflect the higher costs associated with working in rural and remote areas. They should also appropriately incentivise and remunerate the clinical complexity and heightened responsibilities associated with working in these environments. Finally, they should reflect the value of the services that these professionals provide to some of the country's highest needs populations.

Issues

Lack of recognition or support to cover the greater costs and imposts associated with Fellowship training outside major cities has disincentivised rural training options. This is especially true for Rural Generalist aspects of training which until recently were not nationally funded despite these doctors' additional skills such as emergency and obstetric care being essential to the provision of care in many rural and remote communities.

The insufficiency of support has effectively meant that a decision to train rurally or take an ear-marked rural training place has been a decision for greater economic hardship in terms of the costs of relocation and lack of accommodation options, visiting family, and travelling for mandatory education.

Additionally, it has meant signing up for mandatory after-hours, longer hours, working with the professional pressure of not having easy access to specialists, and working with minimal access to peers, and personal and mental health support services available in cities. This inequity of support can lead to negative experiences of rural healthcare and fuels perceptions among both the current and the prospective workforce that rural positions are low-status, poorly valued options.

Solutions

Grow the Rural Generalist Workforce - ACRRM believes growing the national Rural Generalist workforce is a key step toward solving (a) the pervasive doctor and health workforce shortages and (b) inequity of access to an appropriate breadth of healthcare services experienced by rural and remote Australians. ACRRM Fellowship training is the best possible predictor that medical graduates will become long-term rural doctors. General practitioners with ACRRM Fellowship (FACRRM) are four times more likely to be based remotely and 3.4 times more likely to be rurally based, than those without FACRRM, and the percentage of the ACRRM trained doctors that remain in rural practice for five or more years post-training is double that recorded for all GPs who completed AGPT 'rural pathway'.

Support for pre-vocational training in rural practice - There needs to be a strong end-to-end medical training framework that appropriately supports the more costly and arduous path that rural training presents for specialist GPs and RGs. Prevocational training comparable to the previous program (the Prevocational General Practice Placement Program - PGPPP) which involved up to 12-month GP internship posts - should be restored through the new John Flynn Prevocational Doctor Program.

Rebuild the Rural and Remote Training Pipeline - As part of the strategy to support a strong end-to-end medical training framework, additional programs should be funded to generate interest in medical careers and support students along these career pathways. These programs should start in secondary school and continue on to university and target students from a rural and remote background, noting that these students are more likely to return to a rural medical career.

Support for Practitioner Health and Wellbeing - Many of the factors which make rural communities attractive and rewarding places to live and work, are also those that can present the biggest challenges for those training or practising there.

Like their counterparts in the wider community RGs and RGs in training are affected by the social and economic issues which impact on the communities in which they live and work. They feel the economic and social impacts of vagrancies of climate and a reduced range of services.

The importance of practitioner health and wellbeing and caring for and supporting a rural and remote workforce which is geographically dispersed and often working in more challenging circumstances than their urban counterparts must be recognised.

We must ensure the rural and remote medical workforce has access to personal mentoring and support structures to assist them maintain their physical and mental safety and wellbeing.

Investment:

- An additional $12.5 million per annum to expand and enhance the ACRRM Rural Generalist Training Scheme, creating more and better supported funding places and boosting the RG workforce
- An additional 50 earmarked RGTS places in the John Flynn Prevocational Doctor program
- Funding for specific programs to provide wellbeing support for doctors and doctors in training across rural and remote in areas in MMM3-7
- Fund ACRRM to establish and implement and Australia-wide program to promote careers in Rural Generalist medicine to rural and remote secondary students - $2.5 million per annum over 3 years (total cost $7.5 million)
- Partner with universities to establish a scholarship scheme to support rural and remote students commencing a medical degree. An investment of $3 million would provide 100 scholarships of $25,000.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.*** It works to achieve this through a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM has more than 5000 rural doctor members with1000 doctors in training, who live and work in rural, remote, and indigenous communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.