RURAL DOCTORS ASSOCIATION OF AUSTRALIA

SUBMISSION TO THE PRODUCTIVITY COMMISSION STUDY OF THE HEALTH WORKFORCE

Part II

A Sustainable Specialist Workforce

For Rural Australia

Rural Specialists Group

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A Sustainable Specialist Workforce for Rural Australia

A Position Paper prepared by the Rural Specialists Group[1] of the

Rural Doctors Association of Australia[2]

Rural communities have the right specialist medical care provided by sustainable specialist medical services and workforce in order to maintain their health at the same level as those living in metropolitan areas.

Executive Summary

Specialist medical services play an essential role in achieving optimum health outcomes for people in rural and remote Australia. A skilled and responsive specialist workforce must be maintained to provide these services.

Community expectations for locally-based specialist services which provide care equal to that available in metropolitan centres has increased and therefore the issue of sustainability of these services, as distinct from those supplied by outreach, is of increasing importance.

Work has been undertaken into viable models of general practice and procedural general practice but little has been done thus far about specialist services. In the first instance it will be important to concentrate on the "big four" specialist areas - medicine (including paediatrics), surgery, anaesthetics and obstetrics and gynaecology.

Rural specialists provide rural communities with not only clinical services and leadership but also upskilling and support for other practitioners, rural training, research and other activities, the range of which is greater than that undertaken by the majority of metropolitan specialists.

Rural specialists in general work as part of teams, and in rural areas, the concept of specialised (team-based) rather than specialist (individual-based) services is extremely important.

Sub-specialisation has many benefits but the emphasis on it in metropolitan teaching hospitals means that the workforce produced does not cope optimally with working in rural environments where generalism is usually required.

Outreach services are an important complement to services provided by rurally-residing specialists but cannot and should not replace local capacity.

Key action areas that have been identified include:

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[1] The Rural Specialists Group is a Special Interest Group of the Rural Doctors Association of Australia established in 2004 to provide advice and expertise on workforce issues relating to the rural specialist workforce as a whole

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1. Rosters and locum arrangements. After-hours rosters should be no more than 1 in 4 except for brief and infrequent periods. However workforce shortfalls and the exigencies of working in some particularly more remote areas means that it is not always possible to achieve this standard and therefore doctors working in these regions must be supported by triage back-up, special locum relief and specific additional recreational leave.

   Guaranteed locum arrangements are essential, particularly for those who are working regular after-hours rosters where they are likely to be required to provide personal attendance after hours on a regular basis.

2. Infrastructure support and information and communication technology. Unless the necessary human and physical infrastructure to support a specialist workforce is available, adequate healthcare cannot be provided. ICT is of increasing importance in rural areas for both clinical practice and continuing professional development and this must be available to rural specialists as a quality and safety issue.

3. Networks and education. Rural specialists rely on network connections with metropolitan hospitals and specialists for clinical CPD and locum support and such arrangements need to be strengthened.

   Links between regional specialists, rural clinical schools and University Departments of Rural Health and metropolitan universities and hospitals must also be strengthened.

4. Rural training by specialist colleges. Colleges must be supported to provide rural training.

5. Remuneration. While financial matters are not ranked highly in surveys of the rural medical workforce, there is no doubt that dissatisfaction with inadequate payments, unresolved financial anomalies and funding systems that fail to take account of the circumstances of rural practice can trigger decisions about entering or leaving rural medicine. Remuneration is a particular issue for those who provide after-hours care. Rural specialists support the push by rural general practitioners to gain a rural fee loading in this regard.

6. Promoting successful models. Although successful models are never completely transferable to other settings, analysis of factors which have been critical to their success can be helpful for those seeking solutions to similar problems. There is a need for rural specialists to have a formal role in clinical governance particularly in relation to local service planning and resource allocation.

There is a need for cross-jurisdictional discussion and planning to agree on a range of actions which will effectively progress the agenda of sustainability.

Background

This position paper, which was initially prepared in response to the perception by members of the Rural Specialists Group that sustainability of rural specialist services was an urgent and significant area of unmet policy, focuses on the essential role of these services in achieving optimum health outcomes for people in rural and remote Australia.

It is presented in the context of *Healthier Horizons – a Framework for Improving the Health of Rural, Regional and Remote Australians 2003 - 2007* which was jointly developed by the Australian Health Ministers' Advisory Council's National Rural Health Policy Sub-committee and the National Rural Health Alliance. The over-arching vision of this document is that "people in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities". Its goals are to:

1. improve highest health priorities first
2. improve the health of Aboriginal and Torres Strait Islander people living in rural, regional and remote Australia
3. undertake research and provide better information to rural, regional and remote Australians
4. develop flexible and co-ordinated services
5. maintain a skilled and responsive health workforce
6. develop needs based flexible funding arrangements for rural, regional and remote Australia
7. achieve recognition of rural, regional and remote health as an important component of the Australian health system

Most of these goals are directly relevant to the right of rural communities to the specialist medical care they need to maintain their health and to equitable access to sustainable services which provide this. Rural medical practice, whether it be generalist or specialist, shares much the same challenges - personal and professional isolation, lack of access to educational opportunities and excessive workloads, all of which provide continuing disincentives to rural practice.

Community expectations for locally based specialist services which provide care equal to that available in metropolitan centres have increased. Therefore the issue of sustainability of these services, as distinct from those supplied by outreach, is of increasing importance.

Some might say that finding commonality across specialist groups and diverse geographic environments is impossible or futile: how can the factors needed to support obstetric services in Dubbo be relevant to physician services in the Kimberleys or anaesthetics in Cairns?

Yet while there are certainly issues which are specific to a discipline or environment, unless solutions to current problems are based on general principles and approaches which have general applicability, they will be easily dismissed as confined to a particular craft or jurisdiction and achieve little credibility at a national level. Therefore this paper examines generic issues and develops principles and approaches on which practical strategies can be developed in the context of particular geographic, politico-social and professional environments.

The Rural Doctors Association of Australia (RDAA) and others have undertaken valuable work on viable models of general practice and procedural general practice in rural Australia, but to date there has been little research on workforce viability across the range of the specialist services.

This paper therefore draws primarily on empirical and anecdotal data as well as extrapolations from studies of general practice.

Like the rural GP procedural workforce, the rural specialist workforce is ageing: in general, its demographic profile reveals a much greater number of practitioners in the older age groups and relatively lower numbers of young entrants. Therefore urgent solutions are required. There is little time to address issues of recruitment and retention before a declining specialist workforce has very serious ramifications across rural and remote Australia.

This paper concentrates on "the big four" specialist areas – medicine (including paediatrics), surgery, anaesthetics and obstetrics and gynaecology. Given the extreme shortages of psychiatrists and dermatologists in rural areas, these disciplines have not been discussed. Nor are pathology or radiology included because of the marked trend to centralization and remote servicing, though the need for comprehensive and timely radiology and pathology backup is acknowledged.

The Rural Specialists Group believes that it can play a major role in help shaping policy directions that Productivity Commission might wish to explore in improving the health of that part of the Australian community that is most emblematically 'Aussie' – rural Australia.

Issues and Requirements

Role and functions of rural specialists
Rural specialists provide rural communities with:

- clinical services and clinical leadership
- innovative and new techniques
- the potential to provide high level care in emergencies, especially in the absence of rural intensive care and emergency medicine specialists
- upskilling and support of other practitioners including GPs, nurses and allied health professionals
- the opportunity for rural training for undergraduates and specialty trainees, although small numbers of specialists means that the teaching load placed on them is correspondingly higher
- research by, for and within rural communities
- access to more health services and professional support within the region rather than at a more metropolitan centre

This is a greater range of activities than is undertaken by the majority of metropolitan specialists, a fact not generally appreciated in discussions and policy about rural specialist services.

An additional important point is that in most rural areas, specialists treat a greater number of Indigenous patients than most metropolitan specialists do and this often requires additional skills and usually results in lower remuneration.

A specialized and interdependent team

It is important to remember that while GPs can operate without local specialists, rural specialists cannot work without supportive and skilled GPs. Their capacity to provide services can also be constrained by shortages of relevant nursing and allied health services and hospital based junior medical staff. This is often overlooked in metro-centric discussions about specialist services where a never-ending supply of patients is assumed and where the role of the GP in ongoing care is considered less important. There is an increasing realization that in rural areas it is important to consider the concept of ***specialized*** (team-based) rather than ***specialist*** (individual–based) services.

As part of a multi-disciplinary team, rural specialists depend on nurses and allied health workers, particularly at hospitals (most rural specialists have attachments at hospitals), the goodwill of the hospital administration and the support of general practitioners. This becomes even more important in smaller centres. The final dimension of the team approach is a good professional relationship with local specialist colleagues, both in the same and other colleges.

The relationship with general practitioners may vary depending on the geographic location and population base. There is the potential for a degree of rivalry and competition, for example around procedural practice. There are places where GPs have become de-skilled as their scope of practice has been restricted or their admitting rights to hospitals diminished. In other places, however, rosters would be untenable if they were not shared by specialist and general practitioners. There is a growing appreciation that collaborative team work, including rosters, can be a major factor in workforce sustainability.

Physicians and paediatricians can work with the support of general practitioners “with an interest” who may not necessarily have formal qualifications in the relevant specialty areas. However if surgeons and, more particularly, anaesthetists and obstetricians, are to optimize the support of general practitioners, the GPs require appropriate levels of procedural training and skills maintenance. The GP procedural training support subsidies introduced in 2004 are a good example of how supporting one component of the rural workforce can bring advantages to other components.

Sub-specialization

Sub-specialization comes with many benefits, including meeting community requirements for a higher level of skill in a particular area, less demanding Continuing Professional Development (CPD), better working hours and often more remuneration. Particularly in rural environments it is important to recognize the tension between this increasing trend towards sub-specialization within all specialties and the need to maintain some general skills. All medical colleges are now recognizing that they need to support general training and this is a trend that is occurring in many countries across the world. However the revival and nurturing of the generalist specialist in an era of increasing sub-specialization will present significant challenges, but they are challenges which must be met for ongoing viability of rural specialist practice.

Sustainability
The RDAA study *Viable models of rural and remote practice*[3] identified four key areas or dimensions that underpin the viability of rural medical services:

- the professional dimension
- the economic dimension
- the organizational dimension, and
- the family and social dimension.

The 2000 *Rural Stocktake*[4] saw professional isolation, social dislocation and succession planning as crucial factors in workforce sustainability.

The administrative problems faced by GPs may be less significant for local specialists, although for many visiting specialists this is an additional impost that must be undertaken without remuneration.

Remuneration can be a significant issue. For example, recent Medicare changes that allow obstetricians in private practice to charge a significant "booking-in fee" do not benefit their rural colleagues whose practice is usually overwhelmingly in the public sector. This income disadvantage will further exacerbate current difficulties in augmenting or retaining the 134 specialist obstetricians currently practicing more than 100 km from a metropolitan centre.[5]

Whether solo rural specialist practice is sustainable in the long-term is a vexed question. For example, there are at present around 15 solo rural physicians across the country, but it is highly unlikely that they will be replaced, at least by local graduates, when they retire. While there are more rural surgeons, most of them are aged between 55 and 60 years of age.[6] While rural physicians and surgeons tend to run single person practices, anaesthetists and obstetricians and gynaecologists tend to run group practices and therefore may be more likely to achieve a critical mass that enhances the likelihood of sustainability.

Outreach services
The various ways in which the Medical Specialist Outreach Assistance Program has addressed this issue are well presented in other documents. However these hub-and-spoke arrangements tend to be centrifugal rather than centripetal, and do not cover the need to allow rural specialists access to metropolitan sites from time to time.

The implementation of hub and spoke models must include regional centres as the hub - an approach which will assist practice viability and workforce sustainability while also increasing access to services.

In the case of specialist services in remote areas, the development and financing of appropriate sustainable models will require support from a number of jurisdictions.

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[3] RDAA & Monash University (2003) – Viable models of rural and remote practice: Stage 1 and Stage 2 reports. Canberra, RDAA
[4] Best J (2002) – *Rural health stocktake.* Canberra, Australian Department of Health and Ageing.

[5] Mourik P, *pers.com* May 2005
[6] Thompson D, pers.com. May 2005

Key action areas

1. Rosters and locum arrangements

Safety - in terms of both personal safety when working at night and limits on doctors' working hours in the interests of their health and that of their patients - must be recognized as a paramount issue in the design of rosters and after-hours service delivery systems.

Effective after-hours systems must include:

- collaboration between medical practitioners, hospitals and communities
- standards, protocols and relevant training, including structured and subsided programs for skills development and maintenance
- consistent and adequate remuneration for after-hours services and on-call commitments
- integrated communication and transport systems
- appropriate facilities and equipment in hospital settings, and
- community education to inform expectations and demand

After-hours rosters should be no more than 1 in 4, except for brief and infrequent periods. However workforce shortfalls and the exigencies of working in some, particularly more remote, areas, mean it is not always possible to achieve this standard. In these circumstances, rigid insistence on this standard could lead to the closure of essential services. Therefore doctors working where routine 1 in 2 or 1 in 3 rosters are inevitable must be supported by triage back-up, special locum relief and specific additional recreation leave.

After-hours rosters can and do vary according to local conditions, particularly the profile of the available workforce. For instance, a 1 in 4 roster may utilize the full complement of local specialists or a partial complement plus GPs who are prepared to be involved. In smaller sites, it is possible for a specialist to offer a purely consultative service during business hours with all after-hours cover provided by the general practitioners. In internal medicine, a minimal viable arrangement in a more remote site could be constructed with one specialist general physician (VMO or staff specialist with or without a special interest) and two enthusiastic GPs with a special interest in internal medicine. The GPs would continue to look after medical patients admitted under their care on a roster basis, but at some time during business hours have a specialist physician provide consultation and advice on their further management.

However, a minimal provision of this type would also depend on significant outreach back-up from a regional centre. Ideally, this would include regular fortnightly outreach visits by one or more sub-specialty colleagues from the regional centre. These visits would be for 48 hours and integrated into the roster so that the visiting sub-specialist could provide general medical cover at the hospital as well. This would reduce a roster from a 1in3 to something more like a 1in3.5. In Wangaratta, regular visits from a Melbourne urogynaecologist have provided welcome relief to the ageing obstetric workforce there for some years.

Guaranteed locum cover for the specialist's hospital commitment during periods of leave would be essential. This leave would include a minimum of two weeks extra study leave per annum for upskilling visits to the regional centre. Similarly, GPs willing and able to provide cover for their colleagues on the roster would be crucial to the scheme.

An intermediate position for a slightly larger unit would be a four person roster including at least two specialist physicians. This is the minimum number required for sustainability where locum cover cannot be guaranteed for annual leave or where regional centres are unable to provide outreach support.

At a higher level, a minimum roster of four generalists with sub-specialty interests or sub-specialists also providing a general service would be required. If the unit is also providing outreach support to other centres it would require a minimum of five specialists. However, providing this outreach has advantages beyond the support it offers to smaller centres as it could enable the central regional unit to sustain a wider range of sub-specialties than it could otherwise carry.

As a general principle, locum programs should allow doctors who provide significant after-hours services to have 6 weeks recreational and 2 weeks study leave annually. However, workforce shortages and high costs make this an impractical ideal in many places. Fortunately RDAA has received a grant from the Australian Department of Health and Ageing to conduct a scoping study for the design of a nationally funded Specialist Obstetrician Locum Scheme (SOLS) which could provide this essential support. SOLS is seen as a prototype which, if successful, will be applicable to other areas of rural specialist practice.

This scheme will address the range of issues related to the creation of a successful locum arrangement, including remuneration and conditions of employment, cross-border registration and indemnity so the results should be applicable to other specialty groups.

However, it must be recognized that the provision of locums cannot be addressed in isolation from the recruitment and retention of practitioners for longer term positions; providing locums is but one part of more complex solutions to recruiting doctors to the country and it can be a powerful tool in persuading practitioners of the merits of country lifestyle and practice.

2. Infrastructure support and ICT

State and regional health services cannot provide adequate healthcare to rural and remote populations unless they ensure the human and physical infrastructure necessary to support the specialist workforce is available. This includes appropriate radiology, pathology and junior medical staff as well as trained nursing and allied health staff. It also includes relevant administrative support: rural specialists are required to undertake a relatively greater amount of administrative work than their metropolitan colleagues and visiting specialists usually have to do this in their own time without remuneration.

Information and communication technology (ICT) is of increasing importance in rural areas for both clinical practice and CPD. It is becoming recognized that ICT will become increasingly important for the transfer of information between the range of healthcare providers to ensure the quality and safety of services and, given the increasing push towards consumer involvement, there will be a greater need for healthcare providers to communicate with patients and patients with healthcare providers as part of their involvement in decision making and information sharing.

It is well known that specialists have in general had a much slower uptake of ICT than GPs for a range of reasons and this has been well documented in the report of the Medical Specialists Taskforce on Informatics in 2004. There has been significant support and encouragement at a Commonwealth level to enable general practitioners to utilise ICT in various aspects of practice and this has assisted with the provision of hardware, software, connectivity and training. Thus far, specialists have not been able to access such support.

Given the need for the connectivity described above into the future, particularly with the initiatives of the National e-Health Transition Authority, and given that it is probably more feasible to link a range of healthcare providers in a geographically discrete rural environment, opportunities exist to assist specialists, by building on existing infrastructure that is available to general practitioners.

3. Networks and education

Although personal and professional networks currently provide much needed support, these must be extended and in some cases formalized. Clinical networks linking rural and metropolitan specialists and hospitals are essential. Rural specialists rely on networked connections particularly with metropolitan hospitals and specialists to provide:

- a ready access for a second opinion on clinical cases
- access for referral of patients requiring higher level services
- a way for the rural specialist to access CPD when required
- a possible source for locums
- continued professional and academic linkages in the event that the specialist may wish to return to the city at some time in the future

The Rural Clinical Schools and University Departments of Rural Health are now providing rural focus points for the development of networks particularly with metropolitan universities, an also with metropolitan Area Health authorities. In the former role they provide academic focuses for teaching medical students and rural research and those who are involved as teachers – many local clinicians – are able to obtain academic titles with the university and access the range of online and other resources that the Universities provide. In the latter role those who are rural teachers provide the perfect role models for potential rural practitioners and there would be great value in strengthening the networks, for example, by giving rural specialists some appointment with metropolitan area health services to
strengthen the links and allow for the possibility of smoother transitions either from metropolitan to rural or rural to metropolitan positions.

4. Rural groups within colleges and rural training

Although many rural specialists feel disenfranchised by their colleges, some colleges have developed rural groups that offer varying degrees of assistance to their rural members. The Royal Australasian College of Surgeons (RACS) has provided leadership in this field through its locum service and a rural specialist training program which is supported by both fellows and trainees and has proved successful in producing specialists who are prepared to work in rural areas.

Appropriate training is a prerequisite for the recruitment of a rural specialist workforce. Apart from the RACS, the specialist colleges in general have not been supportive of rural training. As the current Rural Clinical School students enter specialty training, other colleges will need to assist with training that is more attuned to future rural practice.

The vast majority of rural specialists recognize the value of a skilled GP workforce. Many are highly dependent on the diminishing cadre of procedural GPs who provide surgery, anaesthetic and obstetric services. The advanced training pathways which produce procedural GPs should be actively promoted and collaboration between the specialist colleges and the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine strengthened to ensure the sustainability of this essential component of the rural medical workforce.

5. Remuneration

Although remuneration may be perceived as less of an issue for rural specialists than it is in the recruitment and retention of rural GPs, it is none the less an important factor. While financial matters are not ranked highly in surveys of either component of the rural medical workforce, there is no doubt that dissatisfaction with inadequate payments, unresolved financial anomalies and funding systems that fail to take account of the circumstances of rural practice can trigger decisions about entering or leaving rural medicine.

Remuneration issues may vary from specialty to specialty, but where private health insurance rates are low, as in most rural areas where there is little reason for the consumers to pay expensive premiums, the potential income for proceduralists is considerably lower than that of their city based colleagues. This naturally impacts on recruitment: who will join a rural practice when they can earn much more doing the same sort of work in a large city? A few will choose the lower income in exchange for lifestyle advantages, but they would need a very accommodating family. This income disincentive exacerbates other difficulties - urban training perspectives, lifestyle and family considerations and fear of social and professional isolation - in attracting new specialists to a rural environment.

If rural communities are to have enough locally available specialists to meet their needs through services which are safe and sustainable, the competitive edge of city over rural practice has to be eliminated. Current Medicare subsidies which advantage urban obstetricians in private practice have already been mentioned. A similar discrepancy confronts anaesthetists for whom full AMA-recommended fees are the norm in urban practice while it is impossible to achieve this in a rural environment.

Much has been written of the discouraging image of "rural practice as a life sentence". This is a daunting prospect for younger practitioners who recognize the need to move back to a city environment as their children grow. They will also recognize the significant financial disadvantage they will face when trying to make the move to a more costly environment if their income stream has not been commensurate with their city based colleagues. Those who decide to stay in the country will face high costs if their children have to go into the cities for their education. Nor are they as likely as their urban colleagues to have a second household income to assist with the higher costs of rural practice including those related to the maintenance of professional standards.

Remuneration is a particular issue for all those who provide after-hours care. The Commonwealth Medical Benefits Schedule does not recognise the environment in which rural doctors work nor the type and complexity of services that they provide in an after-hours setting. Remuneration for this work should reflect the training and expertise of those who provide this essential service, taking into account the higher indemnity risks of emergency care and the rates paid for after-hours services in other industries as well as compensation for the personal and family disruption entailed.

Rural specialists join rural general practitioners in advocating for a rural loading to the Medicare benefits for their patients.

6. Promoting successful models

Nothing succeeds like success and it is important that good working models of sustainable rural practice be disseminated for the guidance of professionals and communities facing current workforce shortfalls and future crises. While these successes are never completely transferable to other settings, analysis of the factors which are critical to their success can be very helpful to those seeking solutions to similar problems. However, it is worth noting that the models which have worked well have been based on the active involvement of local specialists at all stages of their development. This reinforces the need for rural specialists to have a formal role in clinical governance, particularly in relation to local service planning and resource allocation.

The way forward

In some of the key action areas outlined above, the primary responsibility for action will lie with the specialist colleges and other professional organizations, and the rural specialists themselves. This is particularly so in relation to rosters, rural groups and networks, training and the promotion of successful models. However, resolving issues of remuneration, infrastructure support and ICT and networks will require co-operation between the colleges and other professional organizations, rural specialists and the Australian Department of Health and Ageing and the health departments of the states and territories.

The Rural Specialists Group intends to work initially with senior representatives of the Department of Health and Ageing to agree on a range of actions to progress an agenda which will sustain the rural specialist workforce and services. However relatively little will be accomplished unless the other jurisdictions join in this collaborative approach - a process that must begin with the acknowledgement that they, too, have a responsibility to work towards agreed solutions.

If the Productivity Commission review is able to achieve such cooperation it will be a great outcome.