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

FACT SHEET

Restore the Value Proposition of Rural General Practice

Redirect health funding towards comprehensive primary care and address barriers to rural and remote training and practice.

CALLS TO ACTION:

- Establish policies which incentivise provision of care by locally based practices and practitioners to embed continuity of doctor-patient relationships
- Implement blended funding models which consider the distinctions of rural and remote practice and are safeguarded from unintended consequences such as poor continuity of care and low value care business models.
- Improve payments and incentives for rural practice and service and establish better employment arrangements for registrars.

Sustainable high-quality healthcare services are essential to establish and maintain vibrant and sustainable regional, rural, and remote communities. These communities make an invaluable contribution to the ongoing economic and social prosperity of the nation and their importance will increase with the trend in migration to the regions from urban areas.

Targeted investments in a range of areas including primary healthcare reform; health workforce planning; general practice and prevocational training; and the National Rural Generalist Pathway, can provide both an immediate response and long-term solutions to stem the loss of healthcare staff and resources across rural and remote Australia. Investments must comprehensively support these initiatives and ensure high-level commitments convert to ground-level resourcing in rural towns and remote communities.

Rural general practice business model viability

The current rural workforce crisis and increasing lack of interest in general practice reflects systemic failure over many years to build the value proposition for rural practice as a well remunerated, supported, and reliable long-term career path and business proposition. This is highlighted by ongoing failure of Medicare rebates to reflect the increasing costs of running a medical practice.

Operating costs and constraints

In rural and remote areas, costs of practice can be high, in terms of resources, staff, accessing training, and locum support. These all affect business costs while the potential income in rural communities is limited to the size and socio-economic status of the local population. From a business perspective, the size of the client base and their capacity to pay is constrained, and is vulnerable to fluctuations in population and employment levels. Rural areas often have a low socio-economic profile and rely heavily on bulk billing. Medicare funding is commonly not sufficient to sustain general practice and the rural Practice Incentive Program (PIP) is generally viewed as critical to practice viability.

Administrative burdens

Rural practice involves increasing levels of compliance and administration, associated with practice accreditation, clinical credentialling, and continuing professional development. These are taking up an increasing proportion of the work time of rural doctors who are already overworked[1]. Furthermore, meeting these requirements (for example travelling to cities for mandatory upskilling and backfilling with locums) all have higher costs in rural and remote contexts.

Staffing issues

Rural general practices are increasingly struggling to find general practitioners to take over their businesses. All the above issues contribute to a climate in which there is little faith among the next generation of doctors, that governments collectively are committed over time to continuing to support rural communities or their health services.

Funding

There is a need to review Medicare funding level and to consider additional mechanisms to better remunerate rural practice. These should lend resilience to rural practices by providing diversity of potential funding sources and provide a range of policy levers to incentivise models of care appropriate to the diversity of rural and remote communities.

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Rural business models

The College supports the principle of blended funding models, including Voluntary Patient Registration (VPR) as providing an alternative funding mechanism to the Medicare system. It would provide an additional set of policy levers to promote quality care and a diversity of potential funding sources to strengthen the viability and resilience of rural practices' business models. Currently, the Medical Benefits Scheme (MBS) fees structure for management of complex and chronic disease management is underpaid and clearly undervalued compared with fees for rapid throughput.

The Rural and Remote Context

It is important that implementation of a VPR scheme framework explicitly recognise that there may be different policy levers and a need for distinctive approaches in rural and remote contexts. The implemented VPR scheme must ensure it can work effectively in rural and remote contexts and take into consideration the distinctions of healthcare in these areas.

Large corporations are increasingly part of the healthcare service sector and that any funding arrangement must safeguard itself from unintended consequences of low value care business models. Rural communities are especially vulnerable to predatory low value care corporate models which can undermine the viability of locally-based businesses which provide high quality care.

Patient Registration Loading

The College recommends that an implemented VPR scheme should incorporate patient registration loading for being based in a rural and remote location, and for providing face to face medical staff that are permanently available in the locality.

Primary care reform

The health gap for rural and remote Australians is spiralling as rural health workforce shortages are reinforced by diminishing funding for rurally based practice and services. There needs to be an urgent prioritising of more streamlined employment models across all postgraduate General Practice (including Rural Generalist) training—beginning with Internship and progressing through training to fellowship levels and beyond. The Murrumbidgee single-employer model is a positive example. These models should facilitate better remuneration structures and access to leave arrangements equivalent to those who work in comparable medical specialties and/or hospital medicine. The lack of such streamlining currently adds to the dwindling numbers of graduates choosing to commit to general practice work long term.

Further reading

ACRRM Submission Senate Inquiry into the Provision of General Practitioner and related primary health services to outer metropolitan, rural and regional Australians October 2021

ACRRM Feedback on the Draft Primary Health Care 10-year plan November 2021

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

ACRRM's visions is for ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care***. It provides 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.

Endnotes

Russell D (2016) *How does the workload and work activities of procedural GPs compare to non-procedural GPs?* Aust. J. Rural Health (2017) 25, 219–226

FIND OUT MORE

acrrm.org.au/advocacy

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.

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