ROLE and FUNCTION of the RURAL DOCTORS ASSOCIATION of AUSTRALIA (RDAA)

What is RDAA?

The Rural Doctors Association of Australia (RDAA) is a peak national body representing the interests of all doctors working in regional, rural and remote areas of Australia.
This includes general practitioners and specialists; medical students, interns, registrars and vocationally registered doctors; overseas trained doctors; and doctors working in both the public and private sectors.

People living in rural communities in Australia have higher levels of disease and illness, a shorter life expectancy, and poorer health outcomes that those living in major cities.

One of the main reasons for this is a major shortage of doctors in these areas, which impacts on their ability to access health care services.

RDAA's vision is to build a sustainable rural medical workforce that has the qualifications, skills and support necessary to enable them to provide the health care services that are needed, in the locations where these services are needed.

Why was RDAA formed?

RDAA was formed over 20 years ago. At that time, pay and working conditions for doctors in rural areas had not improved for many years, and lagged behind those of their urban colleagues. Many rural doctors felt that the other associations which represented the medical profession at that time were very urban-based, and did not adequately recognise or represent their rural members.

The rural doctors' movement in Australia started with State-based associations. Following the success of some these State-based organisations in obtaining greater recognition for rural doctors and rural medicine and in achieving better pay and working conditions for rural doctors, the Rural Doctors Association of Australia was formed so that united advocacy could take place at the national level, on national issues.

The State Rural Doctor Associations still exist and they are responsible for advocacy on those issues which are state-based. These Associations are members of RDAA.

What does RDAA do?

RDAA operates at the Federal (national) level. Its main activities are:

- **Lobbying and Advocacy** – the Association has frequent contact with politicians, including Ministers, Shadow Ministers, Senators and other Members of Parliament, together with their Advisors. RDAA also works closely with the relevant government departments, and with a wide range of medical, rural and other organisations with related interests.

- **Support for Members** – RDAA provides members with information about government policies and programs; issues and policies. We also provide advice and support to members on specific issues.

  State RDAs often negotiate directly with their State governments about remuneration and working conditions for doctors working in rural hospitals (these are largely funded by State governments). At the national level, RDAA also works to obtain better incentives and pay structures for rural doctors who are working in private practice (which is the responsibility of the Federal government).

  RDAA also sponsors Special Interest Groups which provide support and undertake project work for specific sub-groups. These currently include groups for female doctors, rural specialists and junior doctors.

- **Policy Development and Advice to Government** – RDAA develops policies designed to improve the recruitment and retention of doctors to rural areas and to improve rural training opportunities for medical students and junior doctors. We then promote these policies to Government.
  The Association also provides submissions to Government enquiries and represents the interest of rural doctors on a wide range of Advisory Committees and consultative groups.

- **Research –** RDAA undertakes and supports research projects on rural health workforce and rural health issues, and promotes the findings to government and to the wider community.

RDAA holds an annual conference in conjunction with the Australian College of Rural and Remote Medicine (ACRRM). This conference provides opportunities for professional development through clinical workshops; policy discussion forums; plenary sessions with national and international speakers; and opportunities for rural doctors, medical students and their families to meet and socialise.
The conference is becoming increasingly popular and we are hoping to attract 600 delegates to the 2013 conference, which will be held in Cairns at the end of October.

RDAA does not provide training (this is the responsibility of specialist medical colleges and designated GP training organisations); nor does it set or monitor standards (this is undertaken by specialist medical colleges and the Medical Board of Australia); or undertake accreditation or registration for rural doctors (this is done by the Medical Board and various State jurisdictions).

What are RDAA's Priorities?

- Lobby for targeted and effective incentives and support mechanisms to recruit and retain more doctors in rural areas.
- Develop policies and promote measures that support the long-term viability and sustainability of rural medical practice.
- Provide rural doctors with professional and collegiate support.
- Provide members with access to information and regular updates on key policies and issues.
- Improve access to local health services in rural and remote areas by promoting procedural skills and rebuilding procedural services within rural general practice.
- Support a multi-disciplinary, team-based approach to the provision of health care in rural and remote communities.
- Promote rural medicine as an interesting and rewarding career to junior doctors and medical students.

Who are the RDAA members?

RDAA comprises the Rural Doctors Associations of each State, so technically RDAA is a federation with six members. Each of the State RDAs is responsible for recruiting individual doctor membership fees.
Membership fees and conditions of each of the State RDAs varies, but each State RDA pays a membership levy to RDAA.
RDAA also communicates directly with individual RDA members via newsletters and our website.
Approximately 3,000 rural doctors and medical students are members of a Rural Doctors Association. This is approximately one-third of all doctors working in rural Australia.

How is RDAA administered and governed?

RDAA is registered in Australia as a company limited by guarantee, and as such, it is subject to all the legal requirements which have been set under Australian company law.
The Association is governed by a Board of Directors, which consists of a President, Vice-President, Treasurer, and nominated representatives from each of the State Rural Doctor Associations.
The RDAA Board meets approximately six times per year. Two of these meetings are face-to-face and the others take place by teleconference.

In accordance with Australian legislation, the Association has a constitution which sets out its aims and objectives; how it will be governed; and how its financial affairs are managed.

RDAA has a small staff which works from an office based in Canberra. Staff members consist of:

- CEO, who also acts as the Company Secretary
- Administration Manager
- Media and Current Affairs Manager
- Communications Officer
- Policy Officer

The RDAA Board, under the leadership of the President, determines the Association's policies and priorities, and is ultimately responsible for the administration of the Association under corporate law.
The CEO is responsible for implementing Board policy and for the day-to-day administration and management of the Association.

How is RDAA funded?

RDAA is funded from a number of sources:

- **Government grants** – RDAA currently receives funding from the Australian government to enable the Association to advise government on rural medical issues, and to convey information on Australian government policies and programs to rural doctors. RDAA also receives specific project funding from time to time.
- **Membership levies** – as outlined previously, each State Rural Doctor Association pays a membership levy to RDAA. In return, RDAA provides national representation for rural doctors and circulates information and updates to RDA members by electronic newsletter, printed newsletters and through the Association's website.
- **Sponsorship** – Currently RDAA receives sponsorship from a number of organisations, including Telstra (a major Australian communications company); an investment bank; and a medical indemnity insurance organisation.

- **Other income** – this includes paid advertising in RDAA publications and income from the annual conference.

What has RDAA achieved?

RDAA's key achievements include:

- Raising the profile of rural medicine so it is now recognised as a branch of the profession which has its own unique challenges and which requires a special set of skills. This has led to the formation of the Australian College of Rural and Remote Medicine (ACRRM).
- Recognition of the need for specific training programs for rural practice and allocation of rural training placements.
- Incentives to encourage doctors to move to rural areas and to stay there. These include relocation payments, rural retention payments, rural Practice Incentive Payments, procedural training grants, and scholarships and bonded programs for
- Obtaining funding for national locum relief programs for specialists and general practitioners.
- Rural scholarships and bursaries for medical students.
- A number of key research projects, including a study on Viable Models for Rural General Practice.
- Rural Workforce Agencies which are funded by the Australian Government to recruit doctors to rural and remote areas and to support doctors who are working in those areas.
- Rural Medical Family Networks which focus on providing support for partners and families.

What are RDAA's Biggest Challenges (and opportunities)?

- **Member recruitment and retention** – Membership has remained relatively stable over the past 5-7 years, but we would like to widen our membership base. The challenges associated with member recruitment and retention include:
  - engaging with younger doctors and overseas trained doctors who do not have strong historical linkages with the rural doctors movement
  - competing priorities for doctors in terms of membership of associations
  - maintaining linkages with student members following their graduation
  - fewer rural doctors and an ageing population means a smaller potential membership base
  - how to effectively promote RDAA's activities and achievements to the wider membership and to potential members

  However, there are also opportunities:
  - there are increasing numbers of medical students and junior doctors who will be potential members
  - there is a renewed interest in rural medicine, particularly in procedural medicine, and this also creates more potential members

- **Funding and financial viability:**
  - RDAA is currently over-reliant on government grants which are not a secure form of income, and which also have the potential to compromise the Association's responses to contentious issues
  - Sponsorship, particularly from traditional sources such as pharmaceutical companies, is becoming more difficult to obtain
  - The Association's budget is affected by increasing cost structures which cannot always be met from existing income sources

Opportunities:

- increasing profits from our annual conference
- exploring other sources of income, eg consultancy work –BUT this must not compromise RDAA's key aims and activities
- opportunities for new types of sponsorship support eg via website and e-newsletter, and looking for sponsorship from different areas eg financial management and communications companies

- **Maintaining political influence –** As populations in rural areas decline, their political influence also decreases, and governments tend to prioritise the delivery of services to larger areas where electorates are more marginal.
  There has been a decline in the level of health care services provided in rural and remote areas due to the general belief within the bureaucracy and from health economists that it is less expensive and more effective to transfer rural patients to larger centres for treatment rather than to provide facilities in local communities.
  It costs more to deliver services to rural areas and the cost:benefit ratio is not as attractive to governments.
  Increasing budget constraints make it harder to get funding for rural initiatives and projects.

Opportunities:

- The upcoming federal election will provide an opportunity to highlight rural health issues
- the importance of the resources sector means that there is an ongoing need for health services in rural areas
- there are opportunities to work with other community organisations, eg local government and regional economic development organisations, to lobby for better health services in rural areas
- increasing interest in rural procedural medicine and new workforce models should improve health services to rural areas

What experience has taught us…

- It's important to organise the structure and governance foundations as clearly and simply as possible.
- Be clear about what you want to achieve and set realistic long-term and short-term goals. It's easy to become involved in a lot of issues which can distract the organisation from its key principles and objectives.
- Secure longer-term funding and other support if possible. Keep your funding base as wide as possible for long-term financial sustainability.
- Membership, including member recruitment and retention and providing support and engagement and communication with members, is important.
- Be inclusive and consult with as many people and organisations as possible.
- It's important to maintain working relationships and communication with all levels of government and politicians who can support your organisation.
- Media and promotion will raise the profile of your organisation.
- Be realistic about the workload of key people in the organisation (especially volunteers). Engage administrative assistance wherever possible and where resources are available.
- Be flexible so you can respond to changing circumstances and new opportunities.