



# **Australian Federation of AIDS Organisations (AFAO)**

**Inquiry into the factors affecting the  
supply of health services and medical  
professionals in rural areas**

**Submission to Senate Community  
Affairs Committee**

**16 December 2011**

## ***About AFAO***

The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response. AFAO's members are the AIDS Councils in each state and territory; the National Association of People Living with HIV/AIDS (NAPWA); the Australian Injecting & Illicit Drug Users League (AIVL); the Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA); and Scarlet Alliance, Australian Sex Workers Association. AFAO advocates for its member organisations, promotes medical and social research into HIV and its effects, develops and formulates policy on HIV issues, and provides HIV policy advice to Commonwealth, state and territory governments.

## ***Our perspective on this Inquiry***

AFAO is pleased to provide comments to the Senate Community Affairs Committee Inquiry into the factors affecting the supply of health services and medical professionals in rural areas. Equitable access to health services and medical professionals in rural areas is an ongoing challenge in a country the size of Australia. This is a key issue for the different populations we work with, such as gay men, people who inject drugs and sex workers, whether they have HIV or not. It is crucial that Australians in rural areas are able to access the best of health services and medical professionals. One of the ways to do this is to support expert health services and medical services to share skills with health professionals who have less experience/knowledge of HIV care, treatment and support options.

## ***Access to health services and medical specialists***

Access to specialist health services medical services is essential for all health consumers with complex health conditions, including those living with HIV. For health consumers living in rural areas, these medical specialists/health services are often not readily available. These consumers may end up travelling long-distances, incurring time away from home/work/family, costs of travel and accommodation, as well as the challenge of simply being dislocated. At the same time, some consumers in rural areas opt to travel, bypassing their local GP consultancy or Aboriginal Medical Service, in order to avoid family/social contacts potentially finding about their HIV status and any associated HIV-related stigma.

An alternative way for people living with HIV to access specialist medical/health services in rural areas is by specialists travelling from major capital cities, such as Sydney, to a rural centre for consultations. For those consumers wishing to avoid travelling to access expert care, this is a vitally important mechanism. With the advent of Medicare Locals, AFAO is keen to ensure that there are no disruptions of access to specialist medical/health services. We would be very concerned if, for example, charges were introduced for HIV-specialists from capital city Medicare Locals visiting rural areas.

More generally, we believe that funding, coordination and delivery of HIV prevention services at the level of a Medicare Local would not be efficient and would potentially compromise crucial elements of Australia's partnership response to HIV prevention. State/territory health departments should continue to control state/territory-wide planning and program design for HIV and other BBVs.

### ***Need for expert capacity in rural setting***

A general concern in HIV clinical care in Australia is that the number of general practitioners (GPs) training as HIV antiretroviral (s100) prescribers and able to provide medical care and advice for the growing number of people living with HIV may be insufficient to replace those retiring, reducing their working hours or changing their roles. This is particularly true/acute in rural areas. In this context, it is important to up-skill health professionals with little HIV knowledge and experience to improve diagnostic skills and referral processes to care and other support services.

People living with HIV also require health services and medical specialists who have knowledge and experience of the people with HIV who also have significant co-morbidities. This is particularly an issue for those people who have lived with HIV long-term and/or are older. Expertise/skills in this area has become increasingly important as the cohort of people living with HIV has been ageing.

### ***Mechanisms to provide access to improved HIV-expertise***

General Practitioners who are not s100 prescribers may have limited experience of HIV, including in relation to diagnosis and treatment, and referral to care and other support services. It is crucial that GPs practising in areas with small populations of gay men are better resourced and trained about HIV prevention and treatment strategies – especially given prevalence of depression, self-harm and suicide among young men. One approach that seems to partially address this is the shared-care model. This model, where a s100 prescriber is linked with a GP or nurse, allows for the sharing of expertise and experience. Further rolling-out this model should be explored.

Another mechanism that can enhance the provision of HIV care for rural consumers is the Chronic Disease Management (CDM) Medicare items on the Medicare Benefits Schedule (MBS), formerly known as the Enhanced Primary Care Program. It enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. The items are designed for patients who require a structured approach to their care. However, the bureaucratic set-up is reportedly quite cumbersome, and as AFAO understands it, this has proven to be a barrier to GP participation. Facilitating easier GP participation in the CDM structure should be a priority.

In a rural setting, people living with HIV will often see a nurse at a sexual health clinic for their care. Nurses are not able to prescribe pharmaceuticals and so consumers invariably must wait for a visiting s100 prescriber and/or has to travel themselves to another centre where a specialist/GP is available. This is another factor that may limit access to HIV treatments and needs addressing.

### ***Conclusion***

Australians in rural areas, including those living with HIV, must be able to access the best of health services and medical professionals. This may be through providing more services in areas where rural consumers reside, enabling rural consumers to more easily reach existing services located elsewhere, or a combination of the two. Key also to providing improved access to HIV specialist services is facilitating the up-skilling of those health service providers with little HIV-experience and knowledge, through programs which connect them HIV specialists.