Submission to the
Senate Community Affairs References Committee

Inquiry into the Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

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About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.

RDAA's vision for rural[1] and remote communities is simple – excellent medical care. This means high quality health services that are: patient-centred; continuous; comprehensive; collaborative; coordinated; cohesive; and accessible, and are provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their communities.

Introduction

RDAA thanks the Senate Community Affairs References Committee for the opportunity to provide a submission to its inquiry into the Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians (the Inquiry), and makes the following remarks to provide some context for its response to the Terms of Reference that are discussed in the Key Issues section of this document:

- Rural people continue to have poorer access to all health professionals and services and poorer health outcomes than people in cities.
- Rural and urban General Practice are vastly different in complexity, scope and circumstances.
- Maldistribution of the medical workforce (people and skills) is real and must be urgently addressed.
- The scope of this Inquiry is very broad. There is a risk that proposed solutions and recommendations will attempt to be one-size-fits-all. RDAA warns strongly against this approach.
- The Modified Monash Model (MMM)[2] should be the whole of government geographical classification system for Australia. Rural and remote communities should be defined as those in MMM 3-7, and provision of general practitioner and related primary health services in these communities be considered separately from services in outer metropolitan and large regional centres that are in MMM 1-2, particularly in relation to workforce distribution.
- Current and former policy settings have had varied success, and the ways in which that success is measured are concerning.
- Solutions must involve the collaborative effort of the Australian Government, state/territory and local governments, medical and broader rural health sector stakeholders, including rural consumers/communities.

[1] Within this document the term 'rural' is used to encompass locations described by Modified Monash Model (MMM) levels 3-7. Rural doctors are rural GPs, Rural Generalists and consultant specialists (resident and visiting) who provide ongoing medical services in these areas.
[2] The Modified Monash Model is a scaled classification system measuring geographical remoteness and population size with MMM 1 being a major city and MMM 7 being very remote.

- A range of initiatives will be required to recognise, value and support the training and work of rural General Practitioners (GPs) and Rural Generalists[3,4] to maintain the viability and sustainability of rural General Practice.
- The COVID-19 pandemic, and disasters such as the 2019-20 bushfires, have highlighted some of the weaknesses in GP and primary care service provision in rural areas that also compromise hospital services.
- Rural health in Australia is currently in crisis. While there are many positive aspects of rural General Practice and there have been some apparently successful workforce initiatives over the years, they have not remedied the continuing maldistribution of the medical and other health workforces. The shortages of medical professionals and skills in many rural communities, increases pressure on those that are practicing in those areas, and on emergency departments (EDs), as those unable to access a GP in a timely way seek treatment. Continuity and quality of care for rural residents is impeded. This must be urgently addressed.

Summary of Recommendations

- Re-establish General Practice as a career of choice for new generations of doctors through training pathway enhancements and improved remuneration arrangements, including entitlements.
- Recognise the need to develop a range of targeted solutions specifically for disadvantaged populations in urban and regional areas that are separate from rural and remote initiatives.

RDAA has developed a Rural Medical Workforce Plan that incorporates many of the reforms for General Practice included in the recommendations below. Urgent action is required to prevent a worsening rural health care crisis, including:

- Embedding the MMM 3-7 classification as the definition of rural.
- Improving the provision of medical training and Continuing Professional Development (CPD) in rural areas by:
    - Fully implementing the National Rural Generalist Pathway.
    - Discontinuing the separation of Pathways within the Australian General Practice Training (AGPT) program, and providing Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) with clearly defined targets and incentives for improved workforce distribution and provision of quality training.
    - Increasing Rural Generalist Training Program positions by a further 100.

[3] The 2013 Cairns Consensus Statement on Rural Generalist Medicine defined 'Rural Generalist Medicine' as "the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following: • Comprehensive primary care for individuals, families and communities; • Hospital in-patient and/or related secondary medical care in the institutional, home or ambulatory setting; • Emergency care; • Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues; • A population health approach that is relevant to the community; • Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs." https://ruralgeneralist.qld.gov.au/wp-content/uploads/2017/07/Cairns-Consensus-Statement-fd.pdf (p2)

[4] The Collingrove Agreement defines a Rural Generalist as "a medical practitioner who is 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/or community settings as part of a rural healthcare team". https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/National%20Rural%20Health%20Commissioner%20-%20Communique%201-July%202018.pdf (p4)

- Fully implementing the recommendations from Rural Health Multidisciplinary Training (RHMT) program review.
- Expanding and strengthening medical student and junior doctor rural exposure initiatives, including:
  - Increasing the number of Rural Junior Doctor Training Innovation Fund (RJDTIF) places to 400 FTE positions as it transitions to the John Flynn Prevocational Doctor Program (JFPDP).
  - Aligning RJDTIF rotation numbers with desired outcomes.
- Expanding the Rural Procedural Grants Program (RPGP) to support non-procedural advanced skills maintenance and professional development.
- Developing return to rural practice skills programs for doctors returning to rural practice.

- Valuing the work of rural GPs and Rural Generalists by:
  - Expediting recognition of Rural Generalism as a sub-specialty within General Practice.
  - Supporting initiatives that promote General Practice as a career of choice, and the positive aspects and benefits of **all** rural medical careers, including rural General Practice.
  - Connecting Medicare rebates to the procedures not to consultant clinician specialities.
- Supporting the rural GP and Rural Generalist workforce by:
  - Developing and implementing workforce initiatives that incentivise and support **all** Australian doctors (International Medical Graduates (IMGs) or Australian-trained) to complete their training, and remain, in rural areas.
  - Identifying and investing in the trialling and rollout of targeted, solutions-focused rural workforce initiatives.
  - Reallocating responsibility for the More Doctors for Rural Australia Program (MDRAP).
  - Investing in specific initiatives to promote doctors' self-care.
- Maintaining the viability and sustainability of rural General Practices through:
  - Simplifying Commonwealth-funded programs , incentives and processes to enable remuneration packages for General Practice to be more easily defined and articulated.
  - Meaningful reformation of the Workforce Incentive Program (WIP).
  - Establishing post-Fellowship rural retention rate targets and incentives for ACRRM and the RACGP.
- Supporting the provision of General Practice and related primary care services that are needed in rural communities by:
  - Developing innovative models to enable and support multi-disciplinary team-based care.
  - Redistributing funding to support practices that provide genuine after-hours services.
  - Developing nationally consistent credentialing policies and procedures, including by establishing a national digital information repository to support eCredentialing.
  - Developing a nationally agreed approach to the movement of medical personnel during health crises.

- Ensuring planning for infectious disease outbreaks factors in workforce requirements
- Investing in rural hospital infrastructure and equipment to improve preparedness for infectious disease outbreaks.

- Evaluating all rural policy initiatives against achievement of stated objectives. Amend any initiative not delivering positive outcomes or redirect funding to rural initiatives that are succeeding or to evidence-based new initiatives.

Key issues

- The scope of this Inquiry is too broad. In RDAA's view, these matters should be investigated by two separate inquiries: one for areas classified as Modified Monash Model (MMM) 3-7 and one for regional and outer metropolitan areas in MMM 1-2, or, at a minimum consider the two different contexts within which GPs function at each step of this Inquiry.
  - RDAA holds the firm view (as outlined in our 2021-2022 Federal pre-Budget submission[5]) that the MMM 3-7 classification should be used to define rural areas. Rural policy and program development, funding and implementation must be based on this definition. Any opening of rural programs to metropolitan areas, as has happened in the past, would not be fit-for-purpose, diluting already insufficient funding allocations for these programs, and making any meaningful change impossible.
  - RDAA acknowledges that there are issues in relation to the provision and current state of General Practice and related primary health services in pockets of outer urban and large regional centres that are problematic and will require targeted interventions. However, the issues confronting them are different to those in rural communities and must not be conflated. City-centric reforms and initiatives to address primary health care issues will not resolve these issues in rural communities. Unless parameters are clearly defined and dissimilarities recognised, there is a risk that any proposed solutions will make little, if any, difference.
- Rural communities are very diverse: in size; in degree of remoteness; in demographics; and in a range of other socio-economic, cultural, environmental and climatic ways. People who live and work in these communities also have health care needs that differ markedly from those in outer urban and large regional centres where there is significantly easier access to a range of health professionals and services.
  - There is clear evidence that serious disparities in health outcomes and life expectancy for rural Australians continue to exist. Rural health outcomes are significantly worse than the health outcomes for Australians living in metropolitan areas. People living in rural areas have higher rates of hospitalisations, deaths, injury and higher rates of risky health behaviours that increase risk of life-time harm[6].
  - A $4 billion Medicare expenditure differential[7] reflects the lack of access to Medicare billable services in (MMM) 3-7.
- Rural General Practice is vastly different to General Practice in more urban areas.
  - With reduced access to specialist care and other health professionals, the scope of rural General Practice is broader and patient care often more complex than in urban settings, requiring different sets of skills. Rural GPs and Rural Generalists provide primary in a range of settings other than private General Practice, and secondary

[5] https://www.rdaa.com.au/documents/item/1363
[6] https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health
[7] National Rural Health Alliance Strategic Plan 2019-22. https://www.ruralhealth.org.au/sites/default/files/Strategic-plan_2019-22_Indicators_of_Success.pdf

care as Visiting Medical Officers (VMOs) or salaried doctors in hospitals. Unlike their metropolitan colleagues many rural GPs and Rural Generalists provide services in rural hospitals under emergency or VMO arrangements.

- Patients may have to travel long distances to see their Rural Generalist or GP, and, notably, often even further for consultant specialists or other health professionals. This involves significant time and other costs for these patients that impact on their health behaviours. Doctors may also have to travel to see their patients.
- The differences between metropolitan and rural General Practice are demonstrated by the need for a separate rurally-focused medical college: ACRRM. Formal recognition of Rural Generalism as a sub-specialty of General Practice is currently in process via the Australian Medical Council (AMC).
- It is reported that due to the nature of rural GP and Rural Generalist training and work, competition for workforce is not with city-based GP locations, but rather with other specialty training programs. Training positions for nearly all other specialties are predominately based in state hospitals. This has a huge impact on remuneration. Leave accruals, professional development entitlements, penalty rates, salary sacrificing options and other benefits create remuneration packages that rural General Practices struggle to compete with.
- The workforce solutions for rural GPs, GP VMOs and Rural Generalists should be very different from those in urban, office-based General Practice, because the issues are very different. Some have already been evolved, and can provide key examples of solutions that could work in other rural and remote locations. Workforce solutions and programs to target the disadvantaged and minority groups in outer metropolitan and regional areas require separate thinking and separate solutions. Rather than conflating them with rural programs and funding, these areas of need must be investigated in their own right with targeted solutions developed to address them.

- There is a significant maldistribution of the medical workforce across Australia:

Table 1: 2018 Medical Workforce Distribution[8]

	MM1	MM2	MM3	MM4	MM5	MM6	MM7	Total
Total FTE	81827.6	9462.0	6419.1	2279.7	2087.5	996.2	545.0	103725.0
FTE per 100,000 population	454.5	427.1	407.3	236.9	119.9	352.5	256.4	415.0

- While these distributions of the medical workforce figures are important, they do not give an indication of the geographic area covered by rural General Practices: in some places patients and doctors travel significant distances for health care. Nor do they reflect skills shortages, or the circumstances, broader scope, and complexity of practice that rural GPs and Rural Generalists undertake. Rural GPs and Rural Generalists also have less junior doctor support.
- Generational change has also had an impact on the distribution of GPs and Rural Generalists across the country. Expectations around fatigue management and work-

[8] https://hwd.health.gov.au/webapi/customer/documents/factsheets/2018/Medical%20Workforce%20Summary%20Factsheet%202018.pdf

life balance are notably different. Rural doctors are also no longer place-bound. They may move to multiple rural locations, or between rural and urban locations, depending on professional and personal opportunities, preferences and life circumstances. They often have multi-role careers.

- Rural General Practice sits within a rural health ecosystem. There are multiple issues impacting on the training and employment of rural GPs and Rural Generalists, and on the provision of equitable access to primary care and related services in rural communities, that are multi-faceted, interlinked and interdependent. Issues cannot be addressed in isolation. Hospitals and other health services are compromised when rural General Practice becomes unviable or unsustainable.
    - There are fewer consultant specialists in rural areas than in urban areas by a large margin, and consequently fewer local referral pathways. The lack of a consultant specialist workforce means that having the right rural GP or Rural Generalist with the right skills in the right place is critical.
    - Although this Inquiry is focused on the provisions of General Practice and related primary care services, it should also consider what is needed in the secondary and tertiary sectors to facilitate the improvement of primary care services. This should not be dismissed as being outside the remit. It is particularly important for rural health as the primary and secondary care sectors often share their workforce, and referral pathways are much more integrated. Greater integration of models of care would enhance the sustainability of many rural services.
- RDAA has developed a number of key principles to underpin a set of training, teaching, attraction and retention initiatives that provide a pragmatic way forward to support the Rural Generalist, rural GP and rural consultant specialist workforce to meet community needs, and achieve improved primary care and related services and patient health outcomes in rural areas. Recommendations include mechanisms to streamline or amend existing processes and programs and ensure rural funding allocations are actually spent in rural areas to achieve stated objectives[9].
- Former and ongoing initiatives have had varying degrees of success in improving primary, and other, health services in rural areas. The current reform agenda, including the 10-Year Primary Care Plan and the National Medical Workforce Strategy, appears to be addressing a number of identified issues but much more work is required to tackle these issues. Whether the implementation of these plans and strategies is successful and real health outcomes for individuals and populations achieved remains to be seen.
- Problems with the provision of General Practice and related primary care services in rural areas will not be resolved by the Australian Government alone. Solutions must be developed alongside state/territory and local governments and other rural health stakeholders including: medical Colleges; medical peak bodies; regional training organisations (RTOs); rural health workforce agencies (RWAs); the broader health and community sectors; rural consumers; and rural communities.
    - The Australian Government does have the central leadership role in improving primary care, and in developing and implementing policies and programs (including to support the training, recruitment, employment, and retention of the General Practice workforce) and funding primary health through the Medicare Benefits Schedule (MBS) and various other mechanisms.

      Historically, the Council of Australian Governments (COAG) was the vehicle for the federal government to set key deliverables for state health systems linked to their funding. This would translate to Key Performance Indicators (KPIs) for the Chief Executive Officers (CEOs) of Local Health Districts (LHDs) and Hospital and Health

[9] https://www.rdaa.com.au/documents/item/1364

Services (HHSs) in states/territories (who receive approximately half of their funding from the Commonwealth). The National Federation Reform Council (NFRC) and the National Cabinet Reform Committee (NCRC) on Health, have taken on this role but it appears without the same level of direction or enforcement.

  - Transparency and accountability must underpin all policy and program development and implementation. Ensuring accountability continues to be problematic, including in relation to programs funded partly by the Commonwealth and partly by the state or territory. KPIs for these programs should be linked to continued federal funding. For example, the establishment of state-based Rural Generalist programs as part of the National Rural Generalist Pathway has been highly variable, with some states being able to demonstrate key achievements to facilitate training while others are unable to do so. In Queensland there are quarantined intern positions to support Rural Generalist training, and New South Wales (NSW) has invested in the creation of additional advanced skill posts. In South Australia no such quarantining exists, nor is there any investment in additional positions to facilitate Rural Generalist training. A KPI to establish a state-based Rural Generalist training program, and demonstrate quarantined funding or additional investment to support the program could be required for continued Commonwealth investment.

- The reputation of General Practice as a career of choice has been badly damaged. Evidence from the University of Western Australia, using data from the Australian Health Practitioner Regulation Agency (AHPRA) on medical practitioners graduating in 1985-2007 and registered with AHPRA in 2019, indicates that there has been a significant drop in the number of practising GPs from about 40 percent to about 15 percent[10]. Findings are consistent with the reported drop in number of medical graduates who intend to undertake General Practice training[11]. This can be attributed to the damage caused by the 2013-2020 Medicare Freeze and impacts on GP remuneration, increasing subspecialisation of the medical workforce, and policy changes which many perceived as much more restrictive than was actual.
- Crises such as the COVID-19 pandemic and the 2019-20 bushfires have served to highlight critical weaknesses in General Practice and related primary care service provision in rural areas, including lack of preparedness for future emergencies and disasters, including pandemics.
- Providing general practitioner and related primary care services in rural areas is challenging. A range of initiatives will be required to recognise, value and support the training and work of rural GPs and Rural Generalists to maintain the viability and sustainability of rural General Practice and ensure continued access to high quality health care for all rural Australians.

[10] https://insightplus.mja.com.au/2020/14/radical-drop-in-graduates-interested-in-general-practice/
[11] https://www.mja.com.au/journal/2020/212/9/decline-new-medical-graduates-registered-general-practitioners

Current state of GP services

- GPs are often the first and most frequently utilised point of contact within the Australian health care system. Close to 90 per cent of Australians consult a GP at least once each year[12] with more than 85 percent of those reporting multiple visits[13].
- Only between 4.2 per cent and 6.8 per cent of total health expenditure in Australia (between $7.8 billion and $12.4 billion depending on the classification used) is allocated to delivering General Practice services[14]. The National Rural Health Alliance (NRHA) estimates that the disparity in Medicare expenditure between rural and urban areas is $4 billion[15].
- In 2019, the Deloitte Access Economics General Practitioner Workforce Report found *"that Australia is heading for a significant undersupply of General Practitioners by 2030…The number of new general practitioners entering the market will not keep pace with increasing demand for healthcare"*[16]. If this trend continues there will be a significant impact in rural areas where access to primary health services is already much poorer, in part due to declining ratio of GPs per 100 000 people as remoteness increases[17].
- These distribution of GP figures are important, but in isolation, also do not paint a complete picture of the workforce pressures impacting on rural General Practice:
    - Poorer access to rural GPs and Rural Generalists is compounded by poorer access to consultant specialists (both visiting and resident). There is a continuing geographic and skills maldistribution of the whole medical workforce in Australia and to other health professionals in rural areas. Local referral pathways may not exist leading to a number of negative impacts on patients' physical and mental health, and significant time, financial and social imposts associated with travel and accommodation when they need more specialised care. This adds to the Medicare disparity noted earlier. However, workforce measures that look at Medicare spending alone completely ignore the workforce required to safely staff rural hospitals.
    - Rural General Practice is part of a broader rural health ecosystem involving complex inter-relationships between the General Practice, local, regional, and tertiary hospitals, and other health and community services. If General Practice services become unviable and unsustainable in rural areas there will be a domino effect on consultant specialist, nursing, dental and allied health care in these areas, severely compromising the health system and patient health outcomes. As one rural specialist noted: *If [rural] General Practice falls over, we'll all fall over.*
    - Long-term General Practice vacancies exist in some rural areas despite the active involvement of communities and other stakeholders in recruitment. Propping up these services with locums can be expensive, and can undermine continuity and quality of care if locums do not have the appropriate skills and/or they do not work regularly in the same community. Rural workforce agencies have had limited success in recruiting doctors into rural areas, although they have been working on this for many years. There is a need for more specialised recruitment sections, that are authorised to implement innovative models of employment across primary and

[12] https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2019/contents/gp-attendances/gp-attendances
[13] https://www.aihw.gov.au/reports-data/health-welfare-services/primary-health-care/overview
[14] https://www1.racgp.org.au/ajgp/2021/september/general-practice-and-primary-healthcare-health-exp
[15] National Rural Health Alliance Strategic Plan 2019-22. https://www.ruralhealth.org.au/sites/default/files/Strategic-plan_2019-22_Indicators_of_Success.pdf
[16] https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-general-practitioners-workforce-2019-021219.pdf
[17] General Practice workforce providing Primary Care services, Australia, Remoteness Area - Statistics by calendar year 2. Aust and remote summary GP FTE per 100,000 population, https://hwd.health.gov.au/resources/data/gp-primarycare.html

secondary services, in both state health departments and federally-funded workforce organisations that work closely with relevant stakeholders.

- VMO rural hospital services are at crisis point in most rural areas. For example:
  - In South Australia, contract negotiations between rural doctors and the South Australian government have failed to reach a resolution. If these doctors choose to move, either to urban locations or to other states, the negative impact on the provision of General Practice and hospital services will be significant. The quality of care for rural South Australians will also be compromised.
  - There have been some well publicised incidents in NSW[18,19] that resulted in serious illness or death attributed to lack of access to face-to-face medical care. The use of 'virtual' doctors (telehealth) to provide emergency care can be an important, value-adding part of rural health care if the model of care is based on highly skilled clinicians providing telehealth backup alongside a permanent, on-the-ground, physical workforce. This type of model can help rural doctors to avoid fatigue and burnout, helping to preserve and sustain the permanent rural workforce. However, 'virtual doctor only' models without any on call back up from an on-the-ground clinician must not be utilised. Telehealth should complement, not replace, face-to-face care.
  - There has been an increasing use of virtual doctors in emergency departments, primarily in NSW but also in other parts of Australia. With this model becoming more widely available as technology improves, there seems to be a reduced sense of need to recruit GP VMOs to replace those currently being driven out of rural hospitals by the administrative burden attached to the VMO role. If this becomes the default position for rural hospitals it will undermine rural General Practices that depend on diversified income streams to remain viable, and will be detrimental to patient care.
  - The viability and sustainability of private rural General Practice in Queensland and NSW are being challenged by an increasing number of doctors wanting hospital-based, "Rural Generalist-type" positions due to the high guaranteed income rates required to attract and retain doctors in these challenging roles, and enhanced on call and recall remuneration for after-hours work in comparison to the historic GP VMO fee-for-service arrangements. This is also linked to continued accrual of leave entitlements for sickness, long service, family and professional development and other benefits. The increased medico-legal risks that generalist doctors who work across a range of specialties have, is also a consideration.
- Permanent fly-in, fly-out (FIFO) and drive-in, drive-out (DIDO) relief workers and locums are an important part of the rural health workforce delivering services when resident doctors are unavailable, allowing Rural Generalists and rural GPs to be away from their practices for CPD and medical conferences to maintain and improve their skills (a requirement of registration), and to take vacations. Time away for physical and mental health and the prevention of burn out is critically important.
  - Many rural communities rely solely on permanent FIFO/DIDO workforces. Doctors with the right skills to meet community needs are difficult to attract and retain in many rural areas. Permanent FIFO/DIDO doctors with the right skills can provide a sustainable alternative.
  - While there are some FIFO/DIDO doctors and locums who understand rural health care and are committed to working in rural areas, many do not have the

[18] https://www.news.com.au/lifestyle/health/health-problems/nsw-inquiry-into-rural-health-hears-womans-dying-father-was-treated-by-a-virtual-doctor/news-story/4a464a012b444e8788ceb4389fe887e5
[19] https://www.smh.com.au/national/we-couldn-t-believe-it-woman-bleeds-to-death-in-nsw-hospital-with-no-doctors-on-site-20201011-p563z1.html

right skills or mix of skills for rural practice. High throughput, locum-reliant or temporary FIFO-reliant models delivered by an under-skilled workforce, with no continuity of care, can put quality of care at risk. These models are not good for the community, nor are they sustainable. Under-skilled IMGs or city GPs looking for a tree change are **not** fit-for-purpose in the rural VMO workforce.

- The federal and state division of responsibilities for health that characterise the Australian health system have implications for rural doctors, particularly those who work across both in General Practice and hospitals.
  - With the Australian Government primarily responsible for primary care and jurisdictional governments for hospitals, funding is an ongoing issue. There are some areas within the health system where roles and responsibilities overlap and one level of government can implement policies which impact on the costs incurred by the other level. The lack of access to primary care in some rural areas leading to increased presentations at the local hospital Emergency Department (ED) is an example of the funding tensions that exist.
  - The Productivity Commission notes that *"While the payment models used in Australia have advantages (fee-for-service in primary care, activity-based funding in public hospitals), there is evidence that these models can encourage over-servicing, reduce quality and safety, and lead to fragmented care and cost shifting"* [20]. There are reports of moves to categorise some procedures (such as endoscopies) as outpatient services that could therefore be billed through Medicare. However, it became apparent that under Activity Based Funding the payments to the hospital would be greater if they were inpatient procedures.
  - Political blame shifting for systemic faults is also an issue and is not constructive. The Mitchell Institute notes the complexity of Australian Commonwealth/state relations and its impacts: *"The current roles and responsibilities for the Commonwealth and states are unclear, have contributed to cost and blame shifting and are duplicative whilst, at the same time, leading to gaps in services. There has been no one government responsible for leadership, or stewardship, of the national health care system."*[21]

- Ongoing erosion of local rural health infrastructure and services is negatively impacting on workforce capacity. While this is being reversed in some isolated cases, it continues in many rural areas. For example, there has been some progress toward reopening birthing centres in rural Queensland, but there have also been a significant number of rural birthing service closures (over 150 across Australia) and others are still under threat. This means that the Rural Generalist workforce (GP Obstetricians and GP Anaesthetists who provide both maternity services in these units and primary care in the community) becomes insecure. Flow-on effects culminating in poorer health and community outcomes include: de-skilling of medical professionals; leaving for new jobs in other communities where they can use all their skills; deskilling and movement of other health professionals (such as midwives); operating theatre service reduction; and reduction of antenatal, postnatal and paediatric services.[22]

[20] https://www.pc.gov.au/news-media/news/pc-news/pc-news-may-2015/improving-australia-health-system/improving-australia-health-system-pc-news-201505.pdf p5
[21] https://www.vu.edu.au/sites/default/files/australian-health-services-too-complex-to-navigate.pdf p22.
[22] https://www.rdaa.com.au/documents/item/1406

Current and former policy initiatives

The impact of current and former policy initiatives on the provision of GP and related primary care services in rural areas has been, and continues to be, variable. These initiatives include, but are not limited to, those listed in Table 2.

Table 2: Select current and former policy initiatives

Distribution Priority Area (DPA) and 10-year Moratorium	
Overview	**RDAA Feedback**
The DPA identifies places in Australia where there is insufficient access to doctors to determine where IMGs and Foreign Graduates of Accredited Medical Schools (FGAMS) subject to the 10-year moratorium (that binds doctors whose medical degree/s were not obtained in Australia to working in a priority areas for a period of 10 years unless scaling credits apply) can practice in order to access Medicare under section 19AB of the Health Insurance Act 1973 • Enables recruitment of doctors who trained overseas to work in rural areas. A DPA Review is currently tabled with the Distribution Advisory Group.	While many Australian doctors that are IMGs or FGAMS continue to provide much needed services in rural areas, reliance on the DPA mechanism as a workforce solution is problematic: • Vacant positions in an area does not necessarily mean there is a shortage of GPs that area. Many GPs who request exemptions from the Distribution Advisory Group (DAG) are in areas where the GP workforce per capita is high but they simply cannot recruit to their own practice for a range of reasons. • Many of the IMGs sent to rural areas are insufficiently skilled for rural practice and they are forced to work outside of their trained discipline. They require high level supervision to ensure safety and quality. Many sites that experience recruitment difficulties do not have the senior doctors required for Level 1 supervision[23]. • The supply of doctors can be interrupted (as has been demonstrated by the COVID-19 international travel restrictions). • Australian trained doctors must also be recruited to, and retained in, rural areas to address maldistribution. • While the Australian-trained supply of doctors has increased there continues to be an overall maldistribution of doctors and skills between city and country as Australian-trained doctors elect to stay in urban areas. Until the distribution balance shifts to domestically trained doctors in these areas, specific action directed to supporting these medical professionals is needed.
• **Institute workforce initiatives that provide incentives and support for all Australian doctors, IMGs or Australian-trained graduates, to complete their training and remain in rural areas.**	

[23] The Medical Board of Australia details supervision requirements to ensure safe practice by IMGs. Level 1 is the highest degree of supervision https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Supervised-practice-guidelines.aspx

Modified Monash Model (MMM)

Overview	RDAA Feedback
Australian geographical classification system that allows more granularity than previous systems.	The MMM is thus far, the best rural classification system that Australia has seen. Training, recruitment, retention, and support measures (including rural incentives) can be better targeted. However, a number of programs, data collectors and reporting measures continue to use the Australian Statistical Geography Standard - Remoteness Areas (ASGS-*RA*) framework making comparisons, analysis of issues and targeting of programs far more difficult.

- **Embed the MMM 3-7 classification as the whole of sector definition of rural for research, data collection and reporting as well as for federal and state/territory government departmental policies, programs, funding and incentives.**

Medicare/Medicare Benefits Schedule (MBS)

Overview	RDAA Feedback
Australian universal health insurance scheme.	Funding of General Practice through the current fee-for-service/MBS model is problematic in many rural areas and is proving to be unsustainable in those areas. • Rural Australians do not access Medicare Benefits Schedule (MBS) or the Pharmaceutical Benefits Scheme (PBS) at the same rates as metropolitan people. • There is a $4 billion per annum health expenditure inequity between metropolitan and rural areas : per capita less is being spent on their health care, demonstrating that people living in rural communities have poorer access to health care providers to claim on their Medicare insurance.
A Medicare rebate freeze was first introduced in 2013 but not fully lifted until 2020.	Immediate and continuing impacts on the viability of rural General Practices (and therefore on the viability of rural hospitals), including the reputational damage to General Practice as a career due to the high-profile media attention to the issue that was played out between the Australian Government and peak bodies and was witnessed by all junior doctors and medical students.

- **Simplify Commonwealth-funded programs, incentives and processes to enable remuneration packages for General Practice to be more easily defined and articulated to support recruitment. Claiming through the MBS is only one part of a total remuneration package.**

The MBS Review (the Review) ran from 2015 to 2020. It was established to *"consider how MBS items could be better aligned with contemporary clinical evidence and practice…The Australian Government is progressively considering and implementing the recommendations"*.	Throughout the Review there are examples of changes made to limit access to particular MBS items rather than manage the compliance issues. This impacts negatively on rural General Practice. For example, due to the over-billing of an electrocardiogram (ECG) item changes made to limit access to tracing and reporting to consultant specialists only fail to recognise the context of rural General Practice, and significantly reduce local access to a comprehensive service by local GPs and Rural Generalists. RDAA also consistently warned of an accumulated impact if changes reinforced professional siloing. Unfortunately, the patients who are most negatively impacted as a result of the MBS review are rural patients. If a Rural Generalist provides a procedure that is within their scope of practice, the rebate should be the same as if that same procedure was provided by a consultant specialist.

- **Connect Medicare rebates to the procedures not to consultant clinician specialities.**

Australian General Practice Training (AGPT)

Overview	RDAA Feedback
AGPT is the Commonwealth funded mechanism for medical registrars to train in General Practice. There are two main application streams: General Pathway (750 places) and Rural Pathway (750 places). • It is delivered by RTOs with ACRRM and the RACGP responsible for selection, curriculum, standards and accreditation. • AGPT has been under-subscribed for a number of years, necessitating reforms including transitioning responsibility for the delivery of GP training to the Colleges. Other application streams are the Commonwealth	RDAA believes the transition to College-led training is a key opportunity to progress a range of reforms for the program, includes cessation of the General and Rural Pathway concept, and the development of a new approach to incentivise rurally based training, and reward quality training in all locations. The Rural Pathway has been undersubscribed for the past five years. The allocation of places into Regional Training Organisation boundary areas, and between Colleges (the RACGP 1,350 places, ACRRM 150 places) has contributed to the undersubscription. RDAA recommends that a competitive element for places be introduced to maximise the recruitment to rural training. Currently funding aligns with intake to training programs. RDAA strongly recommends that through the transition process an incentive based on post-Fellowship retention in rural General Practice is developed to motivate Colleges. Return on investment for GP training comes when doctors are able to work unsupervised and, in the medium term, can contribute the supervision of future GP registrars. RDAA proposes that, as an interim solution, a competitive element is introduced to the AGPT selection process: through the setting of time frames for the

funded Remote Vocational Training Stream (RVTS) (providing vocational training towards Fellowship of both Colleges), and the ACRRM Independent Pathway and RACGP Practice Experience Program (both self-funded).

completion of selection by the Department of Health and, in the second round of applications:

- Vacant positions be distributed equally between Colleges
- Places be reallocated should one college be oversubscribed and the other undersubscribed.
- Targets and incentives be established for General Practice Colleges linked to post-Fellowship rural retention of GPs (measured at 1 year, 3 years and 5 years post-Fellowship).

- **Discontinue Pathways within AGPT and provide Colleges with clearly defined targets and incentives for improved workforce distribution and provision of quality training.**

- **Pending a full overhaul of the Pathways, implement a competitive element to the AGPT selection process.**

National Rural Generalist Pathway

Overview	RDAA Feedback
The National Rural Generalist Pathway (the Pathway) is a dedicated medical training pathway to attract, retain and support rural generalist doctors. $62.2 million across the forward estimates was committed in the 2019–20 Federal Budget to create the Pathway.	RDAA is a strong advocate for the Pathway, but rollout has been much slower than anticipated. This has negative implications for the flow of trainees and doctors into rural GP and Rural Generalist careers, and therefore on access to General Practice services and health outcomes for rural people. More funding and a significant administrative effort are required to ensure that the Pathway is fully implemented. Transparency and accountability must underpin all implementation processes. Risk mitigation strategies may be necessary to ensure that: • Pathway goals are not diluted by state needs and allocated funding is not dissipated through state bureaucracy coffers. • Primary care elements of Rural Generalist practice are not abandoned by practitioners who wish to focus on their advanced skill and emergency work.

- **Fully implement the National Rural Generalist Pathway as a matter of urgency.**

Targeted, solutions-focused workforce initiatives	Innovative workforce solutions have significant potential to remove rural training, recruitment and retention barriers and streamline the Pathway. For example, the Murrumbidgee Local Health District (LHD) single employer model – where the LHD remains as the employer of Rural Generalist trainees in that district – enables trainees in the district to retain accrued benefits and entitlements if they choose to undertake Rural Generalist training. If successful, the model will eliminate a major impediment to the uptake of General Practice-based training and could provide a template for other areas.

- **Identify and invest in the trialling of targeted, solutions-focused rural workforce initiatives and in the broader rollout of successful pilots.**

- **Expand single employer options for senior and trainee Rural Generalists.**

	Siloed funding streams for rural health services (including Medicare, state health funding, My Aged Care, and the National Disability Insurance Scheme) are an issue for rural primary care, particularly in areas of market failure. Consolidating multiple funding sources into a single fund to facilitate the creation of GP-led, patient-centred, multidisciplinary teams would reduce inefficiencies, duplication and red tape.

- **Combine multiple funding streams for rural health services to establish GP-led, patient-centred, multidisciplinary teams, particularly in areas of market failure.**

Workforce Incentive Program (WIP)

Overview	RDAA Feedback
WIP Doctor Stream provides financial incentives to practise in regional, rural and remote areas	RDAA was instrumental in establishing this incentive. It is a key initiative to retain the rural GP and Rural Generalist workforce. However, it is time for this incentive to be updated to reflect not only rurality, but also to recognise and incentivise the provision of services to a rural community. As a lead advocate for the reform of WIP in this way, RDAA fully supports a design (based on the Collingrove definition of a Rural Generalist), that recognise the different elements that make up the scope of practice and service of a Rural Generalist and also ensures that doctors who do part of the role are also appropriately recognised.

	The design proposes four tiers based on: a) Rurality – scaled as current system for MMM 3-7 b) Fellowship of ACRRM and/or the RACGP or on an approved training program –recognising provision of a standard of care from a quality perspective c) Provision of after hours emergency care – incentivising service provision that an increasing number of doctors do not want to participate in and that city GPs not required to provide d) Completion of an accredited advanced skill and provision of service in that clinical area (for example in obstetrics, anaesthetics, mental health). The concept is supported by RDAA, ACRRM, RACGP and AMA.
• **Fully implement the tiered program for WIP.**	
WIP Practice Stream provides financial incentives to General Practices to engage a range of health professionals to support multidisciplinary team-based care.	RDAA fully supports this program, and believes that it is essential to support GP-led multidisciplinary team care that is patient centred. RDAA is wary of proposals for an uncapped arrangement as there is a risk that the rural workforce will be further drained into large regional and metropolitan centres.

Stronger Rural Health Strategy

Overview	RDAA Feedback
An initial $550m across the forward estimates was committed in the 2018-19 Federal Budget to the Stronger Rural Health Strategy: a range of targeted funding, programs, incentives, and bonding arrangements.	While RDAA welcomes this investment there are concerns with the implementation and evaluation number of the programs and incentives that sit under the Stronger Rural Health Strategy umbrella. Existing programs and incentives should be evaluated to ensure that they funding allocated to rural programs and supports is actually being spent in those areas and are making a difference on the ground.
• **Evaluate all initiatives against achievement of stated objectives. Amend any initiative not delivering positive outcomes or redirect funding to rural initiatives that are succeeding or to evidence-based new initiatives.**	
100 Rural Generalist training places were allocated to the ACRRM from 2021 (additional to the 1,500 AGPT places currently funded by Commonwealth).	RDAA supports the allocation of the additional 100 funded GP training positions to ACRRM. Due to Department of Health processes, the contract enabling this was signed in 2021 and recruitment to positions will see some trainees commence in 2022. While the curriculum and culture of ACRRM is focused on rural and remote communities, the effectiveness and attractiveness of the program is reduced due to policy restrictions of the AGPT Program. Some of the issues

	may be addressed as a result of transition to College led-training, but not all. Retention of post-Fellowship doctors in rural areas gives an indication of the efficacy of programs. A further 100 Rural Generalist positions should be allocated based on ACRRM retention data.
• **Increase the Rural Generalist Program positions by a further 100.**	
The Rural Health Multidisciplinary Training (RHMT) Program supports health students to undertake rural training. An independent evaluation of the RHMT program was concluded in mid-2020.	RDAA supports the Review recommendations.
• **Fully implement the recommendations from RHMT review.**	
The Murray Darling Medical Network established five rurally based university medical school programs in the Murray-Darling region of New South Wales and Victoria.	Investment into medical student training in rural settings critical to addressing workforce distribution issues. RDAA supports all such Australian Government, but investment must coincide with investment to create additional rotations/positions in real rural settings in the junior doctor years. Medical internships are predominately based in cities or large regional hospitals, with minimal options for GP or rural placements. For example, there are only 12 intern positions located outside of Adelaide in South Australia. Rurally placed medical students have to relocate to a more urban centre for their internships, where they are exposed on a daily basis to consultant specialists who will be actively recruiting them into their training programs and future registrar jobs. If medical school investment is not followed by real access to rural or GP rotations/placements during their junior doctor years, the pathways to rural medical careers will continue to be fragmented.
• **Align RJDTIF rotation numbers with the training numbers of rurally placed medical students.**	
The More Doctors for Rural Australia Program (MDRAP) aims to increase the number of vocationally-recognised doctors in rural areas.	MDRAP seeks to support doctors to progress towards successful application to a General Practice training program. However, the placing of this program with the Rural Workforce Agencies has fragmented a strong initiative.
• **Reallocate responsibility for the MDRAP program to the two General Practice Colleges.**	
Office of the National Rural Health Commissioner.	RDAA strongly supports the 2017 creation of the National Rural Health Commissioner (the Commissioner) role, and the later establishment of the Office of the National Rural Health Commissioner, to ensure that rural

	health remains a key priority for the Australian Government and Australian Department of Health, regardless of the Ministerial make-up of the incumbent Government (whether or not a Rural Health Minister with a separate portfolio is appointed). RDAA believes the work of the Commissioner and their office should be outcomes focused, with key areas being outlined for development and implementation, including the timely implementation of the National Rural Generalist Pathway.
Rural Bulk Billing	Rurally targeted bulk-billing incentives and later changes that recognise additional challenges facing General Practices as remoteness increases are very welcome, and will help to maintain General Practice viability particularly in areas where patient through put is low. However, a single strategy cannot provide a solution to rural workforce issues. Additional strategies directed at specific needs in relation to training, recruitment and retention will be required.

Practice Incentives Program (PIP)

Overview	RDAA Feedback
PIP aims to support General Practices to maintain services in key areas, and participate in new programs to embed them into the Australian health system through nine individual incentives, including Quality Improvement, eHealth Incentive, Teaching Payment and the COVID-19 Vaccine General, PIP includes:	PIP is critical to the integrity, viability and sustainability of rural General Practice services.
Procedural GP Payment	This is a critical payment to encourage rural General Practices to recruit and retain procedural GPs with an approach that focuses on broader community (including hospital) needs. It offsets the costs for these doctors to be out of the practice and therefore not contributing to the daily running costs of the practice, for example, when one or two doctors are called to the hospital to deliver a baby and their GP patient appointments are cancelled or rescheduled for a later time. Administration and nursing wages still need to be paid even though the GP is not billing, or overtime paid for practice staff to stay back if appointments are rescheduled.

Aged Care Access Incentive	Many city-based General Practices, while having the option to provide certain services, often do not due to the relative economic return in comparison to regular consultations in the practice. For example, fewer metropolitan GPs undertake Residential Aged Care Facility visits. Rural GPs do not have these options if their practices are to remain feasible.
After Hours Incentive	RDAA objects to after-hours payments being paid to General Practices where the only requirement is to provide direction to an alternate provider for after hours services (for example, a sign on the door and a voice mail message providing contact details to that alternate provider). Practices are paid $1/patient Standardised Whole Patient Equivalent for this level of service where the GPs in the practice are not required to provide any after hours care to their patients, but can still receive a payment.

- **Incentivise genuine after-hours services by redistributing funding to increase payments to practices that provide a service staffed by their regular GPs or Rural Generalists or through a practice collaboration.**

Indigenous Health Incentive	Rural GPs understand the obligation they have to provide a full range of GP services due to the nature of small communities. Many rural GP practices, outside of the AMS and ACCHO sectors, provide comprehensive quality health care to Aboriginal and Torres Strait Islander patients but do not have access to many of the additional funding mechanisms available to those organisations.
Rural Loading Incentive	By providing assistance tiered for MMM 3-7 as a percentage loading on other PIP eligible payments this payment supports practices to meet the increased challenges of recruitment and retention of GPs the more remote the practice location is. It is used to assist in meeting relocation, accommodation and other costs in an effort to create an attractive remuneration package for rural GPs. This must stay as it is a critical to the viability of General Practice.

- **Continue the Rural Loading Incentive as a critical support measure to maintain rural General Practice viability.**

Rural Procedural Grants Program (RPGP)

Overview	RDAA Feedback
RPGP supports procedural GPs (Rural Generalists who are GP Obstetricians, GP Anaesthetists and GP Surgeons) in rural and remote areas to attend relevant CPD activities, focused on both skills' maintenance and upskilling. Note: A review of the RPGP is in process. Submissions close 8 October 2021.	RDAA supports this program as it provides financial assistance for rural doctors to maintain and improve their procedural skills. It is a critical mechanism to help maintain a high level of quality in rural obstetric, anaesthetic, emergency and surgical services. Rural obstetricians, anaesthetists and surgeons are allocated 10 days/year under this program. It is essential that this level of support is continued as sites may have low through puts but higher staffing headcount due to fatigue management and on call demands. The program should be expanded to include support for non-procedural advanced skill maintenance. As a guide three days financial assistance is provided for emergency skill maintenance and upskilling. If non-procedural advanced skills were provided with the same level of professional development support, it would be a strong developmental step for rural health service provision.

- **Expand RPGP to support non-procedural advanced skills.**

Rural Junior Doctor Training Innovation Fund (RJDTIF)

Overview	RDAA Feedback
RJDTIF supports rural junior doctor training places. • Commonwealth funding for 110 Full Time Equivalents (FTE) rurally based Postgraduate Year 1 (intern or PGY1) and Postgraduate Year 2 (PGY2) positions • Increases to 200 FTE by 2025 as the John Flynn Prevocational Doctor Program (JFPDP) transitions to junior doctor placements.	A key recruitment concern is the lack of exposure to rural General Practice that junior doctors need to make informed choices about their future career. RDAA members consistently provided feedback that the former junior doctor program, Prevocational General Practice Placement Program (PGPPP), was a key point of recruitment for rural sites, particularly in relation to future AGPT registrar recruitment. RDAA supports the recent policy changes to expand the RJDTIF to include prevocational doctors from Internship through to PGY5. It also expanded to allow primary allocation facilities (intern hospitals) located in MMM 1 to participate. The program needs to be expanded to 400 FTE which will expose a minimum of 1600 junior doctors to a rural rotation. This is less than half of all domestic Australian medical graduates each year. The rotations should also include placements in rural hospitals that include a GP VMO or Rural Generalist workforce.

- **Expand RJDTIF/JFPDP to 400 FTE positions, and ensure rotations include placements in rural hospitals with GP VMO or Rural Generalist workforce.**

- **Align program growth with targeted outcomes (for example, with the percentage of domestic graduates taking up General Practice as a career, or the percentage of domestic graduates taking up a career in a stream of rural medicine).**

Innovative models of care

Overview	RDAA Feedback
'Trial ready', localised innovative models of care through the Primary care Rural Innovative Multidisciplinary Models (PRIMM) grants. The National Rural Health Commissioner has been tasked with supporting the development of these trials.	There is a need for innovative models, that embrace flexible arrangements to support doctors and other health professionals to train and work across General Practice, community and hospital settings.

- **Further develop innovative models of care that enable and support multidisciplinary team-based care.**

Current reform agenda

Over recent years the Australian Government has developed, or is in the process of developing, a number of national health strategies. It has also instituted a range of reviews to consider broad policy reforms and initiatives, such as the 10-Year Primary Care Plan and the National Medical Workforce Strategy.

RDAA remains concerned that rural health considerations, including in relation to General Practice and related primary care services, have not been adequately included in many of these strategies, and that implementation will fail to deliver any improvement for rural communities. Others appear to be addressing identified issues but, again, whether the implementation of these plans and strategies is successful in achieving any real improvement in services and health outcomes for individuals and populations is yet to be seen.

- There is significant concern among rural clinicians that funding meant to support rural health is depleted by bureaucratic processes and paperwork to the point that it does not significantly help in the provision of on the ground services. Any funding reform must be viewed through an "outcomes" lens with appropriate checks and balances to ensure investment achieves results.
- Most concerning is that many reviews and strategies seem to be based on metrocentric assumptions. There appears to be little understanding of the differences in scope, complexity and circumstances of practice. In rural areas General Practices are impacted by a range of unique socio-economic, technological, demographic, geographic, climatic,

environmental and cultural factors, and by their degree of remoteness, as well as by local, state and national business and professional requirements.

- Rural GPs and Rural Generalists have a broader scope and role in comparison to city GPs. They also report working longer hours. They provide services in the General Practice, the hospital, the residential aged care facility, the school and other community settings. With less access to a junior doctor workforce supporting hospital services, their roles vary from the smallest task in relation to patient care to triaging of new patients to the most complex treatment of inpatients. Some rural GPs and Rural Generalists provide outreach services or have teaching and research interests that may also require significant travel.
- Rural General Practices as small businesses also have different business models to their urban colleagues. General Practice is not sustainable in many rural towns unless doctors are also able to undertake VMO work to diversify their income streams.
- There is a rural health crisis in Australia. Rural GPs and Rural Generalists must be better supported to ensure that the health of rural Australians is not placed at further risk.
- Supporting the training, recruitment and retention of **all** rural health workforces is a critical issue that must be addressed as an urgent priority to facilitate a seamless, integrated health system.

Training policy, structures and processes

Australian General Practice Training Vacancies and Pathways

The under-subscription of medical graduates to the AGPT program is cause for significant concern. Deloitte Access Economics modelling has projected a significant undersupply of GPs by 2030[24]. While the number of medical graduates has grown, there has been significantly greater demand for consultant specialist places.

Table 3: AGPT vacancy rates[25]

AGPT Vacancy Rates		
Year	**Available training places**	**Vacancies**
2017 AGPT	1500	Over-subscribed by 8 places
2018 AGPT	1500	40
2019 AGPT	1500	93
2020 AGPT	1500	171
2021 AGPT	1500	66

- Although there was a decrease in the number of vacancies from 2020 to 2021, this does not indicate a reversal of the trend. RDAA understands that the AGPT vacancies outlined in Table 3, are Rural Pathway vacancies. Any vacancies are more likely to be in smaller and more rural communities that are already underserviced.

[24] https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-general-practitioners-workforce-2019-021219.pdf
[25] Source: Department of Health as at 12 February 2021

- 1350 AGPT places are allocated to the RACGP. Places are divided between the General Pathway (750 places) and the Rural Pathway (600). All 150 AGPT places allocated to ACRRM are rural places.
    - The division on the AGPT into the General Pathway and the Rural Pathway has failed to deliver GP registrars to rural areas. This has necessitated a rethink of the way GP training is being promoted and conducted.
    - Amending procedures to capture those graduates who are interested in General Practice rather than those who apply as a fallback position is important. For example, although the institution of an application fee reduced applicants to AGPT it also stopped people who had no intention of undertaking General Practice training unless all other applications for training and hospital positions fell through.
    - Targeting promotion of rural training options to graduates who are intending to become GPs as their first choice will be critical to increasing recruitment and retention as those trainees become Fellowed.

- **Discontinue Pathways within AGPT and provide Colleges with clearly defined targets and incentives for improved workforce distribution and provision of quality training.**

College-led training

There are a number of concerns with current AGPT arrangements, particularly in relation to the management and flexibility of training, response to individual needs and quality of training delivered through the RTOs, college-imposed time constraints for the completion of program elements while training and working, lack of part time opportunities and/or limitations on part time hours that are most disadvantageous for trainees who take maternity leave or have young families.

- Policy changes introduced to align General Practice training with training by other specialist Colleges were not well communicated to supervisors or trainees, leading to some misconceptions about flexibility and limitations throughout the training period. This is harmful to the reputation of General Practice programs.

The transition of the AGPT to College-led training offers an opportunity to address concerns, reset and re-educate stakeholders and develop measures to support a work-life balance while maintaining requirements necessary for the consolidation of clinical learning.

- The structure of training programs and support mechanisms are critically important in attracting medical graduates to the AGPT and retaining them through training and post-Fellowship.
- Consideration must be given to the ranking of applicants within the AGPT. Rural General Practice and Rural Generalism has suffered from the perception that only those who “can’t make it” in the city undertake rural General Practice training. Transparent selection processes to ensure that rural positions are not allocated only to those applicants who require significantly more supervision and assistance.
- An indication of the success of training programs in delivering doctors to rural areas can be measured by post-Fellowship retention rates. Table 4 provides information on ACRRM post-Fellowship data.

Table 4: ACRRM post-Fellowship retention rates[26]

Rural Retention Rate		
	All AGPT (rural trainees)*	**ACRRM AGPT trainees***
1 year after Fellowship	57%	80%
3 years after Fellowship	45%	79%
5 years after Fellowship	42%	74%

*AGPT trainees with rural places (ACRRM trainees inclusive)

RDAA submitted a request to the RACGP for information on post-Fellowship retention rates of trainees from the Rural Pathway and/or FARGP, RACGP advised that they were unable to provide this data.

- **Establish targets and incentives for the Colleges linked to rural retention of GPs post-Fellowship measured at 1 year, 3 years and 5 years post-Fellowship.**

- **Increase the Rural Generalist Program positions by 100 (additional to the 100 already committed), based on the ACRRM retention data of trainees post-Fellowship.**

Expectations of trainees

- Evidence shows that those with rural backgrounds are more likely to return to practice in a rural area[27,28]. However, care must be taken that this is not an expectation and programs developed accordingly. Many rurally born trainees do not return to rural areas for a variety of professional and life circumstance reasons.
- Trainees who have positive training experiences in rural areas are also more willing to consider rural practice[29 ,30]. Ensuring early exposure to rural practice during university and prevocational training is an import aspect of this.

Recruitment and retention of Australian trained doctors

Interest in General Practice as a career choice has declined in recent times. This is reflected in a report by the Medical Deans Australia and New Zealand[31] and in the decline of medical graduates registered as GPs[32].

[26] *Fact Sheet: Workforce outcomes of ACRRM's Rural Generalist Model* provided by ACRRM.
[27] O'Sullivan, B, Russell, DJ, McGrail, MR and Scott, A, 'Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence' (2019) 17(1) *Human resources for health* 8.
[28] https://www.mja.com.au/journal/2020/213/5/recruiting-and-retaining-general-practitioners-rural-practice-systematic-review
[29] Russell, DJ, McGrail, MR, Humphreys, JS and Wakerman, J, 'What factors contribute most to the retention of general practitioners in rural and remote areas?' (2012) 18(4) *Australian Journal of Primary Health* 289.
[30] https://www.mja.com.au/journal/2020/213/5/recruiting-and-retaining-general-practitioners-rural-practice-systematic-review
[31] https://insightplus.mja.com.au/2020/14/radical-drop-in-graduates-interested-in-general-practice/
[32] https://www.mja.com.au/journal/2020/212/9/decline-new-medical-graduates-registered-general-practitioners

Medical culture

Many doctors believe that unfavourable attitudes toward General Practice, and within General Practice, have permeated through the medical system engendering a negative culture that impacts on recruitment efforts and on the health and wellbeing of all doctors.

- The focus of the Australian health system has been on the acute care rather than prevention and primary care. While efforts are underway to redress this imbalance there is still a systemic bias, which values specialist and sub-specialist care over generalist care, that can be reflected in negative attitudes (particularly from those in some metro-centric consultant specialists and Colleges) towards those who choose generalist careers, whether that be as GPs, Rural Generalists or generalist consultant specialists.
- Medical undergraduates (and post-graduates undertaking a medical degree) are often exposed to this culture early on and develop attitudes that influence future career choices.
- Some GPs perceive themselves and their profession in a negative way. Despite being in a recognised specialty, GPs may compare themselves unfavourably with their consultant specialist colleagues. This is reflected in a 'just a GP' sentiment that can undermine advocacy and reform discussions.
- These attitudes are not universally held. Members of RDAA's Rural Specialists Group (comprising rural consultant specialists from many different specialties) have noted that deep respect for their GP and Rural Generalist colleagues exists. While acknowledging that there are perceived biases on the part of some GPs and Rural Generalists, they feel that this often reflects the preconceptions of those doctors. Feedback includes:
    - *General Practice is at the forefront of community medicine. GPs are the people we send our families to.*
    - *Without GPs I wouldn't have a practice. They entrust the care of their patients to me. I know the GPs and they know me.*
    - *In rural areas, it really is about an having an ecosystem and mutual respect.*
- Some public rural hospitals have a management culture that disrespects doctors. The rise of the director of Nursing/Facility Manager position has given all of the power, Human Resources delegation authority, and budgetary control to administrators with no on the ground medical input. Rural doctors working as VMOs, contractors or even as salaried doctors (as in some parts of Queensland), have little input or control over hiring other doctors, changes to establishment, purchase of equipment and consumables. Despite being expected to take the responsibility are for clinical care, medical leaders in these hospitals yet have no delegation authority. Medical clinicians are only given this in large regional hospitals. There have been many reports of doctors who have been subjected to poor treatment moving to other places or leaving rural practice all together.
- Rural doctors are as vulnerable to bullying and harassment (including racism, sexual assault and other harassment) as people in any other profession or location. They are also potentially less well supported, particularly when they are part of small teams under workforce pressure, and poorer access to advice and appropriate channels for support and action.

- Individual practice workplace cultures can also be negative, with a lack of commitment to education and training in some. An unwillingness on the part of some practice owners to move past traditional employment arrangements ("this is what we have always done, this is what's on offer so take it or leave it" attitude) is also a factor in creating unsupportive workplaces. This can lead to the disillusionment of trainees and movement out of rural General Practice training.

- **Continue existing and develop new initiatives that promote General Practice as a career of choice, and the positive aspects and benefits of all rural medical careers, including rural general practice.**

Changing expectations

The professional and personal expectations of the more recent generations of rural doctors have changed. These doctors are more committed to maintaining a work-life balance and want the flexible employment arrangements and conditions, and the community amenities in rural locations (including digital connectivity, easy access to transport, and opportunities for physical, cultural and religious activities), that enable them to do so.

- On call arrangements can be extremely burdensome if there are insufficient doctors with the right skills to share the roster. Workforce planners often seek to replace a rural GP or Rural Generalist who has retired or left the area with a single person, but many doctors are unwilling to move to areas with the onerous on call requirements that might entail.
- For many rural GPs and Rural Generalists, after-hours service provision is a reality of the job, particularly when role includes hospital services as well. An increasing number of rural doctors who want to have a more metropolitan General Practice model refuse to provide after-hours services. RDAA believes that to be sustainable, a baseline ratio for after-hours on call arrangements of 1:4 doctors is necessary.
- A critical mass of doctors is also important to ensure positions can be backfilled so that doctors are able to take leave, attend conferences, undertake continuing professional development (CPD) and provide professional support. Reliable access to appropriately skilled locums is also necessary for this.
- Current time constraints for General Practice training and employment can be can create work-life balance difficulties. For example, having and parenting children often requires significant blocks of time away from training and work. This can be problematic if a trainee is required to complete training within a specified time period.
- Rural internships and General Practice registrar placements are a key mechanism to increase recruitment of doctors to rural areas. Placements and appropriate strategies to meet personal and professional needs must be put in place and underpinned by adequate funding.
- Employment arrangements and support for early career Senior Medical Officers (SMOs) and recently Fellowed GPs or Rural Generalists are also an issue. RDAA has been made aware that new Fellows and provisional SMOs can find themselves feeling overwhelmed and unsupported post-training. They either elect to remove themselves from those positions to bigger centres after a few months or burn out within a couple of years.

If medical Colleges, rural hospitals and General Practice owners fail to recognise these changing lifestyle and professional expectations and needs, and are unwilling to negotiate flexible arrangements with respect to training, terms of remuneration and employment conditions, recruitment of Australian doctors will continue to be problematic.

Return to rural practice

Consideration must also be given to how best to support skills maintenance and upskilling for doctors, particular Rural Generalists, who leave rural practice for life circumstance reasons (such as no access to quality local high schools for children) who fully intend to return to rural practice. These doctors are often unable to utilise their advanced skill for the period of time that they are practicing in larger centres. Ensuring that they are able to maintain their skills and upskill when needed is a value for money proposition.

RACGP is leading some work in relation skills maintenance and upskilling, as is the Queensland Rural Generalist Pathway team.

Industrial negotiations

Some industrial frameworks and agreements do not adequately recognise the scope and complexity of the work a rural doctor performs across different settings. Arrangements are complex, inflexible and often opaque. Accountability is also an issue.

- Industrial issues in South Australia in relation to contracts for VMO services in rural hospitals[33] demonstrate the inherent insecurity of General Practice services in many rural communities and the pressures to leave. If GPs are forced to move elsewhere, there will be significant impacts on patient health and outcomes, and on costs to the health care system.

- Similarly in NSW, while some VMO fee-for-service arrangements work well, others are not fit-for-purpose. Paying a flat rate tied to a specific procedure or service causes issues when the payment does not take into account: the extended time needed to see hospital patients due to the complexity of a case; the amount of additional work such as admission paperwork and charting medication; ensuring compliance with an increasing number of policies and procedures; and implementation of electronic record keeping and other computerised medical systems.

- Financial losses are incurred primarily through time away from the practice, mostly due to the more lengthy and complex admissions, and the increasing numbers of people attending the ED. The system is unattractive to established doctors and trainees alike. They are responding by being unwilling to work on VMO on call rosters. In the Hunter New England area, for example, rural doctors have been seeking different arrangements (such as sessional rates or salaried roles) rather than lose people. Negotiations with the Primary Health Network (PHN) and Local Health District (LHD) have failed multiple times, leaving hiring locums as the only alternative. This can be costly and may not be conducive to high-quality continuity of care and good patient outcomes.

- Ensuring that the state/territory industrial agreements under which health professionals work are nationally consistent will be important to achieving sustainable, high quality primary health care.

Professional satisfaction

The role of professional satisfaction is often underestimated in the development of recruitment and retention strategies for rural areas. Rural Generalists want to work in places where they can practise their advanced skill. If Rural Generalists (having procedural or non-procedural advanced training and skills) cannot utilise their skills in practice, they will choose

[33] https://www.rdaa.com.au/documents/item/1586

to locate to places that offer them this opportunity, creating gaps in the provision of high-quality local health care for rural and remote patients. This will further compromise their health outcomes – already poorer than those of people living in urban centres – and will negatively impact on training options for future Rural Generalists.

General Practice business models and governance

Rural General Practices are small businesses. In Australia, General Practice is primarily funded through a combination of fee-for-service (private billing where the patient is billed an out-of-pocket fee, a portion of which may be claimed as a rebate from Medicare rebate if eligible) and bulk billing.

- This system of funding can be problematic in rural areas as:
    - Rural areas are more likely to be low socio-economic areas[34]. Rural GPs and Rural Generalists do not enjoy the same freedoms that doctors in more urban areas do with respect to choosing to privately bill to supplement income.
    - It is activity-based and highly structured to specific activities that require enough GPs to bill the items, and does not reflect the broader scope and complexity of rural practice
        - Medicare fails when there are relatively few GPs in an area as it does not fund nursing and allied health components. For example, a GP must see everyone presenting for wound dressing to enable billing as nurse items are not available. While a WIP payment is available to support practices to engage nurses, it does not cover the costs of time and consumables.
        - Bulkbilling encourages high volume through-put of patients (as a way to manage income and viability issues) rather than high quality care, particularly in relation complex needs and chronic disease management.
            - Low value care generates greater emergency department (ED) attendance and late presentations of conditions resulting in worse patient outcomes.
            - GPs must be enabled to deliver the highest possible quality of care to a manageable cohort of patients
        - Consideration must be given to the use of supported blended payment models in some communities to ensure primary care facility that utilises the medical workforce as and when available but maintains an acceptable level of care at all times using nurses, nurse practitioners and telehealth.
- Many rural doctors are reliant on hospital work to maintain their practice feasibility.
    - The ongoing threat of service reduction or closure of these facilities impacts negatively on the attractiveness of General Practice ownership.
    - VMO fee-for-service arrangements are often not fit-for-purpose and are resulting in a workforce unwilling to work on VMO on call rosters. This threatens General Practice viability and risks rural GPs and Rural Generalists leaving rural practice, further compromising access to high quality health care for rural people.
- General Practices must also be accredited in relation to standards for safety and quality of care.

[34] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Socio-Economic%20Advantage%20and%20Disadvantage~123

- Quality and Safety standards must be better enshrined in an appropriate accreditation framework that is robust and contextually relevant. Current RACGP guidelines do not achieve this.
    - Standards should apply to state/territory government primary care facilities as well as GP-led practices.
    - A set of access and equity standards for rural communities should be developed as key performance indicators for medical Colleges, training providers, and state/territory and Commonwealth programs.

- General Practice is having difficulty in attracting trainees with medical graduates giving preference to consultant specialist training. Until the funding of junior workforce in both rural primary care and the hospital system are addressed for, barriers to training and working removed, and flexible arrangements introduced, more GP hours will be required.
- Practice ownership is unregulated, unlike pharmacies that have licensing requirements.
    - This means that overservicing is more likely to occur, particularly in more affluent areas where people can afford to pay (the 'worried well') but it can also occur in low socioeconomic areas where one issue-one consultation bulkbilling operates ('patient churn' servicing).

The impact of the COVID-19 pandemic on doctor shortages in rural Australia

While the impact of the COVID-19 pandemic on doctor shortages in rural Australia is included in the scope of this Inquiry, it is important to note that rural workforce shortage and maldistribution issues were well entrenched before the COVID-19 pandemic began, and will continue beyond it unless action is taken urgently.

The pandemic has, however, clearly exposed existing weaknesses in Australia's health system, particularly in rural Australia. These must be remedied to ensure both preparedness for any future crises (including pandemics) and the sustainability of rural practice.

- As many rural doctors also work in the hospital and emergency space, the impact of infectious diseases (such as COVID-19) on them, their risk and exposure, is vastly different to office-based General Practice in cities.
    - Many rural hospitals are unprepared for widespread infectious disease outbreaks and do not have a surge workforce readily available, or the capacity to accommodate and support a surge workforce brought in from elsewhere.
    - Many rural hospitals are dealing with critical doctor shortages due to COVID-19 exposure in the workplace and the need to separate COVID-19 positive patients from general medical inpatients.
        - Doctors exposed to unknown COVID-19 cases have had to be put on furlough, leaving rosters seriously understaffed.
        - Rural doctors have been working extended shifts and back-to-back on call coverage for months at a time, causing fatigue, physical and mental stress and harm. There are significant implications for quality of care and safety of patients.
    - Most rural hospitals do not do they have the appropriate infrastructure or equipment to manage pandemics.

- Most rural hospitals do not have the negative pressure rooms necessary to isolate patients, nor do they have equipment to assist in the protection of staff (for example, McMonty Medihoods[35] .
- For rural hospitals to manage widespread infectious diseases in house, separate areas will need to be set up and maintained. This will require an additional workforce including Rural Generalists or rural GPs with Joint Consultative Committee on Anaesthesia level, or critical care skills. To date, this has not been factored into planning in the majority of states.

- **Invest in rural hospital infrastructure and equipment to improve preparedness for infectious disease outbreaks and protect medical personnel many of whom also provide primary care services in their communities.**

- **Ensure planning for infectious disease outbreaks factors in workforce requirements for staff with appropriate skills in the event of an outbreak.**

- Some rural communities rely on interstate permanent and relief FIFO or DIDO clinicians, with some dependent solely on these doctors. Communities experience doctor shortages for this reason. The situation is exacerbated by inconsistent and inefficient credentialing and defining the scope of practice processes across Australia[36]. During the COVID-19 pandemic, it has been further compounded by strict border closures and travel restrictions.
  - Rural communities are being under-serviced with rural people missing out on primary and secondary healthcare.
  - With increased pressure and lack of relief workers, some rural hospitals may be forced onto "bypass" with inadequate staff levels to function. Bypass will occur when medical or nursing staff are furloughed, and hospitals are required to deep clean. This entails lengthier patient transport potentially leading to worse patient outcomes, bureaucratic issues related to applications for exemptions.
  - A national approach to credentialing to facilitate the movement of doctors (including locums) to provide ongoing services and crisis support should be developed. This should include the establishment of a national repository for doctors' information to support eCredentialing.
- The advent of the COVID-19 Delta variant and spread beyond densely populated centres, has been even more challenging for rural doctors and communities than earlier waves.
  - Health care workers have not been considered essential in most jurisdictions, in part due to Chief Health Officers and state bureaucrats seeing them as avoidably coming from, and going into, high-risk situations. This has increased pressure on doctors and communities already stressed by doctor shortages.
  - A nationally consistent approach to bespoke, targeted, health care worker exemptions should be developed to facilitate cross border medical workforce travel during crises.

[35] https://www.rdaa.com.au/documents/item/1339
[36] https://www.rdaa.com.au/documents/item/795

Risks could be mitigated by the establishment of national protocols covering such things as: the use of serial rapid antigen testing (RAT); home quarantine; and mandatory full vaccination for work in health care settings.

- **Develop a national approach to credentialing to facilitate doctors (including locums) to more easily work in rural locations across the country, including by establishing a national doctor information repository.**

Develop a national approach to allow medical personnel to travel during health crises, including by:

- **Creating a register of appropriately qualified Rural Generalists (who understand both rural General Practice and rural hospital systems)**
- **Establishing deployment processes and appropriate supports. Specific processes and protocols can be identified to be activated when needed.**

Doctor health and wellbeing

Negative impacts on the health (including mental health) and wellbeing of rural doctors that can be caused by working in pressurised, short-staffed situations or in crisis situations (including pandemics and those caused by adverse events such as bushfires).

- **Invest in specific initiatives to promote doctors' self-care and provide them with appropriate external supports.**

Conclusion

The funding, organising and delivery of General Practice and related primary care services in rural Australia is a complex. Rural General Practices and practitioners are subject to a range of federal, state and medical body policies, programs, processes, protocols and procedures covering training, recruitment, employment and retention that are often fragmented, and sometimes competitive.

General Practice is also part of an inter-dependent rural health ecosystem that must be responsive to the specific health needs that exist in diverse communities. Any policy and program initiatives must be mindful of the ways that other parts of the ecosystem facilitate high quality primary health care, and ensure the mitigation of any unintended negative impacts.

There have been many initiatives to address specific rural health issues – including workforce issues – some appear to have been successful (or partially successful) in meeting their goals. However, these often seem to be measured by process evaluations rather than outcome evaluations, including to measure whether there is increased interest in rural General Practice training, and whether academic, clinical, employment and other supports for junior doctors and registrars work in retaining these trainees during the program and in rural areas following Fellowship. If doctors are not being recruited to rural General Practice training in sufficient numbers, and not remaining in rural areas during and after training, the sustainability of the workforce is at risk.

Australia is currently not producing a rural medical workforce comprising a sufficient number of doctors with skills aligned to community needs, who can work independently and without supervision. This compromises all rural health services and rural patient health outcomes.

Redressing this situation will require non-partisan political leadership, and the informed involvement of all levels of government collaborating with rural health stakeholders, to streamline approaches and actions to maximise the likelihood of success and minimise any unintended adverse consequences.

Recognising, valuing and supporting the training and work of rural GPs and Rural Generalists is central to the sustainable provision of General Practice and related primary care services needed in rural communities.