RDAA Pre-Budget 2022-23 Submission

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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 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

Rural[1] Australians continue to have poorer health outcomes than people in cities. Current and former policy settings have had variable success in addressing the health inequities that exist for rural people.

Inadequate access to health professionals and services is a key aspect of this. The maldistribution of the medical workforce across the country and challenges, such as the impact of the COVID-19 pandemic, have made it more difficult to recruit and retain medical professionals in rural areas.

It is vitally important that efforts to reform rural health programs to improve patient health outcomes are consolidated and refined if the health of rural people is to be measurably improved. Achievement of desired outcomes, not program process, should determine whether programs continue to be funded or whether funding to should be redirected to other new, or existing, rural programs. This would require appropriate evaluation strategies.

Summary of Recommendations

While the progression of a number of initiatives advocated by RDAA is welcome, RDAA has also identified additional ways in which access to medical professionals and services can be improved to better support the health rural Australians.

RDAA calls on the Australian Government to:

Fully implement the National Rural Generalist Pathway, including by:

- Rolling out a single employer model for Rural Generalist trainee doctors nationally.
- Increasing the number of junior doctor rotations through the John Flynn Prevocational Doctor Program (JFPDP) from the committed 200 FTE positions by 2025 to 400 Full-time Equivalent (FTE).
- Developing a nationally consistent bundled payments system for Australian General Practice Training (AGPT) registrars, supervisors and practices.

Reform the Workforce Incentive Program (WIP) – Doctor Stream.

[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.

- In addition to the current Modified Monash Model (MMM)[2] 3-7 rurality scale being applied, introduce tiers to:
    - Recognise and incentivise the provision of after-hours emergency care in rural areas.
    - Recognise and incentivise the provision of areas of advanced clinical skill (examples include, but are not limited to, obstetrics, anaesthetics, mental health, paediatrics, and surgery).

Expand consultant specialist outreach services and provide support for local consultant specialist practices in rural areas.

- Increased use of telehealth to provide consultant specialist services must be balanced with in person care. Telehealth should be complementary to in person consultations.
- Support for local consultant specialist practices in rural areas is needed to sustain these services in rural areas.

Establish a national e-Credentialing system.

- There is a clear need to establish a national e-Credentialing system to: reduce the administrative burden associated with credentialing; streamline recruitment and employment processes; and facilitate the movement of doctors across local health districts and state borders.

Establish a disaster register of Rural Generalists and rural General Practitioners (GPs).

- Rural doctors who have the requisite knowledge, skills, experience and training, can be deployed when and where required during emergencies and disasters, including pandemics.

Develop strategies to support the recruitment and retention of critical professionals in rural areas.

- Strategies to address factors that are unrelated to an individual's profession, but that impact on decisions to move to or remain in rural communities, must be developed and implemented.

Recommendations are outlined in more detail on pages 6 to 11 of this submission.

[2] The Modified Monash Model (MMM) is a scaled classification system measuring geographical remoteness and population size with MMM 1 being a major city and MMM 7 being very remote.

Background:

- In October 2020, RDAA presented its Rural Medical Workforce Plan[3] to the Minister for Health, the Hon. Greg Hunt, and former Minister for Regional Health, the Hon. Mark Coulton. This Plan was developed with the understanding that the Australian Government and Department of Health (the Department) were open to reform within existing budgetary allocations. The Plan:
    - Aims to deliver better outcomes and improved programs for the level of investment the Commonwealth Government allocates each year to address the impacts of the maldistribution of the medical workforce in rural Australia in an effort to improve health outcomes in these communities.
    - Identifies significant duplication within Commonwealth programs that presents opportunities for: the streamlining of programs; increased accountability in relation to outcomes for the investment; and savings that can be re-invested in rural medical workforce programs. The total funding pool for medical workforce initiatives is just over $1billion.
- A number of initiatives that align with RDAA's Rural Medical Workforce Plan are being progressed, including:
    - Recognition of 'real' rural communities as those classified as MMM 3-7 through initiatives such as:
        - changes to the bulk billing incentive to provide a higher rebate for MMM 3-7 (scaled for remoteness)
        - changes within the junior doctor rotation program for rotations to be in MMM 3-7 locations
        - infrastructure for diagnostic equipment replacement initiative in MMM 3-7 locations.
    - Increased number of junior doctor rotations through re-investment of the medical student John Flynn Placement Program (JFPP) funding into the JFPDP.
    - A Department of Health-led consultation on nationally consistent bundled payments for AGPT registrars, supervisors and practices.
    - Department of Health engagement of external consultants to review accreditation systems and processes for general practices and GP training.
- Recommendations in this submission are focused on achieving better health comes for rural people through consolidating existing initiatives, targeting programs to MMM 3-7, reforming systems and processes, realigning Commonwealth programs and investment, and reducing duplication and administrative burden.

[3] RDAA. 2020. RDAA Rural Medical Workforce Plan. https://www.rdaa.com.au/documents/item/1364

Detailed Recommendations

Fully implement the National Rural Generalist Pathway, including by:

- Rolling out the single employer model for Rural Generalist trainees [4,5] nationally, including expanding the Murrumbidgee Medicare Benefits Schedule (MBS) 19(2) arrangement [6].
    - The recruitment and retention of prevocational trainees and Rural Generalist registrars under this arrangement has demonstrated early success. Junior doctors are overwhelmingly in favour of the model.
    - Employment arrangements for Rural Generalists (who work in general practice and in hospitals) provide an excellent opportunity to address many of the negative aspects of general practice training as compared with other non-GP medical specialty fields for this critical and much needed medical workforce.
    - Other States have indicated an interest in taking on this model where they become the employer of the trainee doctor, and are reimbursed by general practices through utilisation of MBS billing under a 19(2) arrangement for the time trainees work in general practice.
        - RDAA supports broad reform of the employment arrangements for all GP registrars. However, State jurisdictions have expressed specific interest in underwriting the employment arrangements for Rural Generalist registrars due to the nature of their work across both primary and secondary services.
    - Overall, the model is cost neutral for the Commonwealth. The State system incurs the financial risk.
- Increasing the number of junior doctor rural rotations from 200 FTE to 400 FTE to have the necessary impact on rural service provision and to maximise recruitment and retention potential.
    - Currently, a 110 FTE allocation facilitates a minimum of 440 junior doctor rural rotations from larger hospitals, located mainly in MMM 2 locations, into general practice in MMM 2-7 locations.
    - With the transition of the JFPP from medical student placements to prevocational placements by 2025 (JFPDP), rural junior doctor positions will increase to 200 FTE (a minimum of 800 rotations).
    - Rural general practice training has an annual intake of 750 AGPT places: 150 Australian College of Rural and Remote Medicine (ACRRM) Rural Generalist positions, 150 Royal Australian College of General Practitioners (RACGP) tentatively allocated Rural Generalist positions, and 450 RACGP general practice positions. An additional 100 Rural Generalist positions is also allocated to ACRRM.
        - The current numbers do not allow for any attrition.
        - The vast majority of sites are not exposing the junior doctors to a rural generalist experience.
    - RDAA supports recent policy changes which have expanded the program to include junior doctors from internship through to Post Graduate Year 5, as well as including MMM 1 hospitals as a primary employment centre of junior doctors. This aligns with

[4] RDAA. 2020. New employment model for Rural Generalist trainee doctors a win for the bush (media release). https://www.rdaa.com.au/documents/item/938
[5] https://www.mlhd.health.nsw.gov.au/careers/medical-services-careers/murrumbidgee-rural-generalist-training-pathway-(mr
[6] Described in Australian Government Department of Health.2021. Evaluation of the COAG Section 19(2) Exemptions Initiative - Improving Access to Primary Care in Rural and Remote Areas: Final Report. pp14 & 36-37 https://www.health.gov.au/sites/default/files/documents/2021/12/evaluation-of-the-coag-section-19-2-exemptions-initiative-improving-access-to-primary-care-in-rural-and-remote-areas-final-report.pdf Downloaded 25 January 2022.

RDAA survey results which indicate there are many junior doctors based in tertiary/capital city hospitals that have an interest in rural medicine.

- RDAA proposes the program be expanded to 400 FTE to support a minimum 1600 rotations. This would:
  - provide a much needed boost to medical workforce numbers in rural and remote Australia, in real terms.
  - allow for attrition of those junior doctor who discover rural general practice or rural generalism is not for them. These doctors will benefit from their rural experience in their future careers, where they may, at some stage, provide care to rural patients. Doctors who have an understanding the challenges of access to health services for rural patients, often adjust their care plan to align with the patient's needs and not just apply a city-centric model of care.
  - expose junior doctors to other career and training opportunities beyond rural generalism and rural general practice (such as the consultant specialties of surgery, general medicine, cardiology, and psychiatry) and potentially help source quality candidates for the Commonwealth-funded Specialist Training Program (STP) which is often under-subscribed[7].
  - RDAA also proposes that the program should include rural hospitals in MMM 4-7, with a requirement that a minimum of 25% of the trainee's time is spent in community-based primary care/general practice (based on ACRRM training which requires that during their rural years, registrars must complete 25% of their training in a general practice environment). It is important to note that small rural hospitals are not funded for training in the same way the large regional and tertiary hospitals are funded. They are either block funded or have a hybrid activity and block funding mechanism.
  - Total funding required to expand to 300 FTE for 1200 rotations is estimated to be $48 million, or $64 million to expand to 400 FTE for 1600 rotations.
  - In 2019/20 workforce funding allocate to the junior doctor training program was $44,909,000[8]. This figure also includes the intern positions funded in private hospitals by the Commonwealth. Assuming that half the amount is allocated to rural GP placements, approximately $40m in new funding would be required to expand the program to 300-400 FTE.

- Developing a nationally consistent direct and bundled payments system for AGPT registrars, supervisors and practices.
  - RDAA acknowledges and welcomes the work of the Department of Health has undertaken in relation to AGPT Registrars and the Direct Payments concept.
  - RDAA proposes that as a first phase, a single Commonwealth support package payable to rural GP and Rural Generalist registrars every six months of their training period be provided.
    - this should include all Commonwealth-funded payments such as Workforce Incentive Program (WIP) payments, rural bursaries, and potentially procedural payments to support the recruitment. Some payments are currently not scaled. All included payments should be scaled using the MMM classification system.
    - RDAA provided a proposal with a suggested payment inclusion schedule to the Department of Health and to the offices of the Minister for Health and Minister for Regional Health. The Department has progressed work in consultation with the peak bodies on nationally consistent payments for registrars, supervisors and practices within AGPT. However, it has not yet expanded this out to consolidate

[7] Advised by the Australian Government Department of Health.
[8] Australian Government Department of Health Rural Health Workforce Programs 2019-20 Health Workforce funding document.

a range of other Commonwealth incentives to create a bundled payment. RDDA will continue to provide feedback on this work.

Reform the Workforce Incentive Program (WIP) – Doctor Stream.

- WIP reform has been part of RDAA's advocacy for over three years. The reform package outlined in Table 1 below, proposes creating a tiered system which recognises service provision and is aligned with the Collingrove Agreement definition of a Rural Generalist[9]:

Table 1: RDAA Proposed WIP Reform Tiers

Tier	Eligibility	Percentage of current payment/loading
1	Rural classification (scaled on MMM 3-7)	60 % of current payment
2	Fellowship of a general practice college or undertaking approved training program*	40 % loading
3	Provision of after-hours emergency services (available to at least 11.00 pm)**	30 % loading
4	Completion of an accredited advanced skill (with at least 12 months training) and demonstrable provision of service in the area of advanced skill.	30% loading

* For Australian General Practice Training (AGPT) Registrars, Independent Pathway and Rural Generalist 100 registrars, RDAA's preference is to have one bundled payment under their Commonwealth Training Support Package to ensure that Fellowed rural doctors would not be disadvantaged under the new tiered system.

** Hospital engagement would not be required as some GPs provide 24/7 emergency medical support to their local community.

  - The concept is supported by RDAA, ACRRM, RACGP and the Australian Medical Association (AMA).
  - The AMA position (re-confirmed as late as 25 August 2021) is that new funding should be allocated for this.
  - As a compromise, RDAA proposes allowing doctors currently receiving WIP – Doctor Stream payments the option of continuing existing arrangements or transitioning to the new program. All new rural doctors would be subject to the provisions of the new program. Under these arrangements there would be no financial disadvantage to any doctor currently receiving payments.
  - In 2019, through United General Practice Australia (UGPA), it was proposed that this reform be funded through Primary Care Reform. UGPA became the National Council of Primary Care Doctors (NCPCD) and the RACGP re-joined the group. In June 2021, a tabled discussion indicated that this reform may be better aligned with workforce reform. Based on further conversations during January 2022, neither RDAA nor the AMA would object to either funding allocation being used for this reform.
  - If every doctor on the program transitioned and was eligible for the additional tiers the increased cost to the program is estimated to be $69 million. However, this scenario is unlikely, and there will be savings in future years due to the change in the rural location foundation payment for all new doctors.
  - RDAA is willing to collaborate with the Department of Health to establish criteria in relation to the transition arrangements and any limitations.

[9] Australian Government, National Rural Health Commissioner. 2018. National Rural Generalist Taskforce Advice to the Rural Health Commissioner on the Development of the National Rural Generalist Pathway. https://www.health.gov.au/sites/default/files/documents/2021/05/advice-to-the-national-rural-health-commissioner-on-the-development-of-the-national-rural-generalist-pathway_0.pdf p5. Downloaded 24 January 2022.

Expand consultant specialist outreach services and provide support for local rural consultant specialist practices.

- RDAA holds a strong view that telehealth is not replacement for in person care, but should be complementary.
- It is essential that the increased uptake of telehealth (particularly telephone consultations) by consultant specialists throughout the COVID-19 pandemic, is balanced with in person consultant specialist consultations.
- A $20 million investment would allow an expansion of consultant specialist outreach services in rural areas and improve access to a range of specialties for rural people.
- Extending existing support provided to rural general practices (through Primary Health Networks) to local rural consultant specialist practices would be a cost effective way to sustain these services in rural areas. This would include:
    - practice management support
    - professional development activities for medical practitioners and their staff.

Establish a national e-Credentialing System

- RDAA has a strong position on the need for a national e-Credentialing system[10]. This would significantly reduce duplication in the credentialing process across the states and individual health service districts.
- RDAA's position on credentialing is supported by the AMA.
- The first step would be to establish a secure national repository for medical practitioner documentation with defined permitted access arrangements for medical colleges and credentialing bodies.
- RDAA believes a national e-Credentialing system would significantly reduce the onerous administrative burden that credentialing entails (many of the processes are still paper-based and duplicative), and assist to mobilise the workforce by streamlining recruitment and onboarding processes for new doctors and Visiting Medical Officers, and facilitating the movement of locums and consultant specialist outreach service providers.
- This process would also be beneficial for any National Rural Generalist and rural GP Disaster Register.
- RDAA also proposes that States are engaged to consider nationally consistent approaches to credentialing requirements, processes and systems, as there is significant variance which has an impact on the level of service provision in many rural communities.
- The estimated cost for an existing product (similar to the Western Australia system, for example) is $20 million.

Establish a National Rural Generalist and rural GP Disaster Register.

- RDAA, together with ACRRM, has advocated for the establishment of a Disaster Register for Rural Generalists and rural GPs since 2016[11].
    - Suitable qualified rural doctors can be deployed to provide medical support in any part of Australia during emergencies and disasters and during recovery periods.

[10] RDAA. 2019. Credentialing and defining the scope of practice of Rural Generalists. https://www.rdaa.com.au/documents/item/795

[11] RDAA & ACRRM. 2016. The Role of the Rural GP in Disaster Response and Pre-hospital Care. https://www.rdaa.com.au/documents/item/61 (this document is currently under review).

- Clearly articulated eligibility criteria are needed to ensure these professionals have suitable qualifications, skills and recency of practice.
- Additional training must be provided to ensure that eligible doctors understand both the systems and processes within State Disaster Management systems and the Commonwealth role in emergency and disaster management, prior to any deployment.

- The NSW Rural Doctor Network (RDN) has led the establishment of a state-based register/Expression of Interest process which was activated during the 2019-20 bushfire season and now during the COVID-19 pandemic.
  - RDAA would support an expansion of the RDN register to be active at all times as a proactive, rather than reactive, response to emergency and disaster management.
  - RDAA has also been approached by the Royal Flying Doctors Service (RFDS) seeking our support for a similar concept.
  - RDAA has no provider preference, but believes that a proposal that aligns the RDN process with that of the RFDS would have some real strength.
- The estimated cost to establish national register is $3 million. An additional $1 million in recurrent funding would be required for management of the register. The RFDS option may also have additional funding requirements due to the skills maintenance element they would be able to provide the doctors on the register.

Develop strategies to support the recruitment and retention of critical professionals in rural areas.

- Professionals who provide key services critical to the liveability and viability of rural communities include: health care workers (such as rural including GPs/Rural Generalists, nurses, and pharmacists); teachers; police officers; and executive managers (such as the local council CEO and town planners)
  - There are often financial incentives and other support measures to attract these people to rural communities. However, there are often issues outside an individual's profession that influence the decision to move to or stay in a rural community, such as the needs of a partner and children.
  - In May 2021, RDAA surveyed over 350 medical students and junior doctor. 59 per cent indicated that partner employment was a perceived barrier to training in a rural area or having a career in rural medicine.
  - GP Registrars also identify access to child care as a key consideration when deciding where they will work, as many have partners who may also be a healthcare or other professional.
- Invest $50 million to support the employment of the partners of critical professionals in rural areas to facilitate the recruitment and retention of these professionals.
  - Allow exemptions to open merit-based recruitment processes through the Fair Work Commission to permit the direct appointment of partners of rural critical workers to a position, provided they meet any mandatory minimum requirements of that position.
  - Incentivise local businesses or organisations by offering a one-off $30,000 grant (managed through Local Government) if they employ partners of a rural critical professionals above their staffing establishment. If, there is an existing vacancy, the grant would be reduced to $15,000 to facilitate direct appointment.
- Facilitate access to childcare by providing exemptions to maximum caps for the number of children permitted in a childcare facility (up to 5 over limit) to accommodate the children of rural critical professionals.

- The exemption would continue until such time as attrition returns the number of children in care to approved numbers. No additional children can be enrolled until other vacancies arise unless a new rural critical worker requires childcare.