RURAL DOCTORS ASSOCIATION OF AUSTRALIA

WORKING BETTER FOR MEDICARE REVIEW

Submission from the Rural Doctors Association of Australia

KEY RECOMMENDATIONS

- A classification model that differentiates between metro, regional, rural and remote communities is essential
- Financial incentives and supports should be scaled for rurality and remoteness
- A change to the current utilisation Modified Monash Model (MMM), should only be progressed if it can be demonstrated a new tool will offer improvements to MMM
- Investment and support to enhance the profile of rural and remote medicine is required in lieu of the effectiveness of the DPA as a distribution mechanism
- Redesign of the bonded medical program to support rural students access to CSP medical school places is needed
- A forced distribution mechanism is long-term counter-productive
- Information regarding any limitations on practice for overseas trained doctors recruited to Australia needs to be easily accessible and fully disclosed in recruitment activities
- Overhaul of the design of the criteria for District of Workforce Shortage is needed, with consideration to impacts of fly-in visiting services on potential local permanent workforce

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 believes there must be a mechanism to differentiate between the profiles of our communities from major cities to the very remote communities of Australia. Across this spectrum access to health services is very different, lifestyle and education opportunities are very different and these differences impact on the ability to recruit and retain health care professionals.

It is critically important that the use of any mechanism or lever to influence the distribution of the medical workforce is fully disclosed, with information readily available, regarding the impacts of these policies to the future workforce including medical students, early career doctors and to doctors being recruited from overseas.

RDAA is a strong advocate for targeted support for health services based in Modified Monash Model (MMM) 3-7 communities, which RDAA classes as 'Real Rural'. RDAA has long held the position that large regional centres, classed MMM2, being defined as rural within Government programs or initiatives targeted at rural and remote health services significantly disadvantages those services based in 'Real Rural' communities.

What are we trying to achieve with the various policies, programs and distribution mechanisms?

While there are areas of outer metropolitan cities that are struggling to attract the medical workforce they need, these challenges are very different to those faced by rural and remote health services when recruiting and retaining staff. It is appropriate and necessary to design mechanisms to increase rural workforce. For those programs and levers intended to increase distribution to rural areas there needs to be recognition of the differences between rural and outer regional areas, with preferential support for rural.

Roles in rural and remote areas are impacted by more then the business model, workplace culture and pay rates. Factors affecting recruitment and retainment include issues like access to professional development, the expectation and necessity of providing services which are less financially viable, and impacts on a clinician's time such as residential aged care services and after hours care. In addition to this there are lifestyle implications for a medical practitioner moving to these communities; where their partner will work, children's schooling, religious considerations and the list goes on. These are simply not considerations when recruiting to services in outer metropolitan areas, even for those services who are finding it difficult to attract staff. The challenge is vastly different and needs different solutions.

Rural classifications need to be applicable for the level and scope of health services available locally, but also need to consider a range of lifestyle factors when applying it to a health workforce distribution arrangement.

While there are practices in capital cities and outer metropolitan areas that have workforce challenges, when considering the recruitment potential of these jobs it must be understood by policy makers that, for the most part, these medical practitioners will not choose to live in the lowest socio-economic suburbs of our capital cities, even if they work there. Their life is not where they work. They do not send their children to schools in these suburbs, they don't shop in the local supermarkets and they aren't restricted to that suburb for their social life. In contrast, for medical

practitioners and most other health care professionals working in rural and remote areas, for the most part their life must be based in the community in which they work.

It is therefore necessary to recognise these differences practically when implementing policy. Rural and remote solutions should be just that. Not solutions that are expanded to address targeted workforce issues in outer metropolitan areas, because when you expand them beyond rural it further disadvantages rural and remote communities who are competing for workforce against roles in large regional and outer metro areas.

Australia must have a geographical scaling mechanism

There is a well-documented health disadvantage for people living in rural and remote Australia, and the maldistribution of our medical practitioners and other health care professionals is a contributing factor.

The national average of practicing Medical Practitioners per 1,000 head of population in Australia is 4, placing it equal 15th in OECD countries, with the average being 3.7. Australia's growth of medical practitioners per capita in the period of 2011-2021 is the highest in the OECD.[i]

Interestingly Australia's share of doctors aged 55yrs or older is 24% where OECD average is 33%

However, despite the growth in medical practitioner numbers, the maldistribution of the workforce across Australia continues. There are 403 clinical medical practitioners per 100,000 head of population in major cities compared to 273 in outer regional and 223 in very remote, where geographical spread is also a key barrier to access.[ii] The poorer health outcomes for people living in rural and remote Australia can be directly linked to the lack of access to medical practitioners and other health care professionals.

Health data consistently demonstrates that the biggest barrier to care is access and, particularly, access to quality care within a multidisciplinary team. Putting a telehealth service or a single clinician into rural or remote towns does not address the access need.

The changing face of the medical workforce

For the past 20 years Australia has relied on overseas trained doctors to provide services in rural and remote communities. Over this time the number of domestic graduates choosing to work in rural and remote areas declined, and the hospital systems in our capital cities and largest regional centres

retained ever-increasing numbers of early career doctors through the need/guise for increased quality and safety.

The workforce profile continues to change:

- Today, more than 50% of RACGP members obtained their primary medical degree overseas
- ACRRM's RGTS program bucks the rural trend and is oversubscribed, with 190 suitable candidates for 100 positions for the 2024 intake process undertaken in 2023.

Rural medical workforce planning must accommodate the impacts of resignations and retirements, which is often not a one-for-one replacement. It is now more likely to be one-to-two or one-to-three, based on both the changing skill set of doctors, a preference for not working full time in clinical practice, and a need to reduce after hours on-call time to achieve the desired work-life balance. A vacant position does not necessarily indicate an issue of service need. There are many influences on positions that are not filled, including business model (private billing only, mixed billing or bulk billing), whether it is an accredited training practice, and a key factor is the workplace culture and reputation of a general practice.

Geographical Classification:

Modified Monash Model (MMM)

RDAA has been a strong supporter of the application of MMM to define rurality and remoteness as previous classification models were significantly flawed.

General practice distribution mechanisms, 3GA programs and a suite of incentives utilise the MMM to articulate key elements of policy in relation to workforce distribution and scaling of incentives.

MMM2 represents the largest regional centres and outer metro areas and should never be included in 'rural' intended programs or initiatives.

Current issues associated with MMM are created not by the model itself, but how the model is used to define rural areas for programs to direct and support workforce distribution initiatives. Rural (MMM3-7) is often lumped together with outer regional (MMM2) under a banner of 'rural' resulting in initiatives intended for rural communities being diverted to large regional and outer metro (MMM2) areas.

All too often big-ticket announcements of program investment into rural health are available in MMM2, large regional, as well as MMM3-7, real rural. The result of this is that the bulk of resources are absorbed into the largest regional centres where it is easiest to attract staff, deliver care and administer and apply for programs and grants, resulting in very little of this advantage being realised by communities in MMM3-7.

The strength of the application of MMM is that it can be, and is, used in a range of incentives to support and recognise the difference in practice for medical practitioners working in rural and remote settings in comparison to those working in metropolitan areas.

For example the bulk billing incentive, where the incentive is scaled to become higher the more remote the MMM classification becomes. This mechanism recognises that there is lower patient throughput and higher costs for delivering patient care in these communities. These communities usually not only have the highest rates of bulk billing, but also the highest out of pocket expenses for non-bulk billed patients[iii]. The Workforce Incentive Program (WIP) Doctor Stream is similar in recognising additional costs for medical practitioners providing care in rural and remote communities.

MMM has also been successfully applied to programs to recognise the context of practice. These programs recognise the complexity involved in providing care in very small or isolated communities, often as a member of a very small local health care team. An example of this includes procedural grants administered by RACGP and ACRRM, the Rural Advance Skills Workforce Incentive Program. In rural and remote medicine GPs often have additional responsibilities on top of the patients seen in their practice. This includes inpatient care at the hospital, on-site care to residents of aged care facilities, emergency care, after hours care, and areas of advanced clinical skills such as obstetrics and anaesthetics, and increasingly, non-procedural areas such as paediatrics and mental health.

The idea of opening these incentives up to services with workforce shortages in large regional or outer metropolitan centres is a regular occurrence. RDAA strongly recommends against this, and believes that initiatives specifically designed to address the metro and large regional issues are required, and that extending rural-intended initiatives into these areas not only does not provide any long-term solution to workforce issues in large regional and outer metro areas, but further disadvantages services in rural and remote communities.

Scenario

Government may be keen to increase support to Aboriginal Medical Services (AMS), particularly with consideration to those services located in outer metropolitan areas. If a rural and remote incentive is expanded to include these services, the AMS in a rural area will lose any advantage they had in attracting the workforce interested in Indigenous Health in comparison to an AMS in a city, where there are many personal lifestyle and career benefits. The AMS in the rural/remote location in this scenario should be the recipient of both the WIP (Doctor Stream) and the Rural Advance Skills Workforce Incentive Program, with the city-based AMS able to apply a separate workforce initiative to attract staff.

RDAA strongly recommends against any change in the application of MMM to programs, unless a new model can be developed that demonstrates it does not put rural and remote

communities at a disadvantage. Any suggestion to reverting back to former rural classifications would not be supported.

No classification system can perfectly represent every unique community, but MMM has been a significant improvement on any of the previous rating classifications.

Prior to MMM implementation and adoption, most Commonwealth Programs utilised the Remoteness Area (RA), the Australian Statistical Geographical Standard (ASGS)[1]. There are a number of agencies, including the Australian Institute of Health and Welfare that continue to use this classification. This is concerning as it is does not provide a clear picture of the real need in many rural communities.

Its application significantly disadvantaged rural communities in relation to its use regarding health services.

Example

Utilising the online map Kingaroy and Dalby are classified as Inner Regional. Both have rural hospitals (level 3 service profile based on Queensland Health Clinical Service Capability Framework) with a rural generalist medical model, 24/7 emergency care, birthing, and local GP services. Kingaroy and Dalby are classified MMM 4 locations.

The referral centre for Kingaroy and Dalby is Toowoomba, also classified Inner Regional, which has a full time consultant specialist medical workforce at the hospital (Level 5 service profile) and access to two private hospitals. Toowoomba is classified MMM2.

The large regional centre of Cairns, which has a tertiary level hospital and private referral services, is classified as outer regional in this system, so GPs in Cairns were eligible for higher incentives than doctors working in actual rural communities. Cairns is classified as MMM2.

These gross inaccuracies in the classification of regional, rural and remote communities means that if initiatives or incentives are applied using this system, many smaller rural communities are disadvantaged when their level of incentive is the same as those in a much larger centre. For example, the cost of providing primary care to Kingaroy or Dalby, along with the associated expanded skill set, increased level of services and additional on-call burden, is significantly higher and more expensive to provide than a primary care service in Toowoomba, and yet the supports available would be the same.

[1] https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas#interactive-map

If a new geographical classification was to be developed, it would need to be developed through a focused project of informed experts.

Any new system must be developed by health care professionals with actual knowledge and experience in rural communities. The steering committee should have strong representation from 'real rural' with a minimum of 50% of the membership, as well as the Chair, comprised of GPs, practice managers and other health care professionals from MMM3-7 locations. All members should demonstrate an understanding of the impacts of changes to rural classifications on the broad range of programs and initiatives that would be impacted by any rurality scale change, prior to commencement. This should not be an educational exercise for interested parties but a focused project led by informed experts.

RDAA does, however, believe that an additional level of MMM7+ would be beneficial, to enable recognition of the very small and very remote communities that have limited health infrastructure and intermittent services.

RDAA strongly opposes a return to any former scale, and stresses that the utilisation of a new classification system should only be approved if it can demonstrate that it will improve on the current system. We need to stop delivering more to our largest centres while leaving people living in rural and remote communities behind.

Distribution levers:

Section 19AA

This section of the Health Insurance Act is a quality and distribution lever to limit access to Medicare billing to permanent resident/Australian citizens doctors with a Fellowship or who are on an approved medical college training program, or to a limited range of workforce programs. Non-Fellowed doctors must have been on an approved 3GA program to bill items eligible for a Medicare rebate, however the various 3GA programs have broad application which has supported the continued maldistribution of the medical workforce.

Training Programs

The **3GA programs** that cover the training period only really apply to general practice training where there is a direct link to workforce distribution. For those on non-GP training pathways, the majority of their time is spent in the public hospital system with registrars only doing a minimal amount of Medicare billing, if any, during this period. Non-GP trainees utilise provider numbers for referring and requesting, and to provide assistance at operations, with only limited billing for private work.

The growth in non-GP specialist training, which is predominately based in capital cities or the largest regional centres, has only made the maldistribution of the medical workforce worse.

The **Australian General Practice Training** (AGPT) program, which allocates 750 places to the general pathway and 750 to the rural pathway (training to occur in MMM 2-7 locations), has had limited success in addressing the maldistribution of the medical workforce. For the last seven years the rural pathway has been significantly under-subscribed. Of the 750 positions for the rural pathway, 150 are allocated to Australian College of Rural and Remote Medicine (ACRRM) and 600 to RACGP. All 750 of the general pathway positions are allocated to RACGP.

The way the positions are allocated, along with the approach of some of the former Regional Training Organisations, contributed to the perception that the rural pathway was a second-rate pathway. The attitude of: *"If you didn't get onto the general pathway, not to worry, you can do GP training on the rural pathway."* has been very damaging to the perception of rural GP and RG careers within the junior doctor cohort.

The positive signs for the ACRRM's Rural Generalist pathways, both on AGPT and the **Rural Generalist Training Scheme** (RGTS) which are limited to MMM2-7 locations, should be attributed to the type of work an RG does and its appeal to medical students and early career doctors once they understand what this career encompasses. This success is as a result of the positive aspects of the career and its marketing, as opposed to a policy lever that forces people into rural.

Retention rates for ACRRM registrars remaining in rural locations in post-Fellowship years is impressive with over 70% still practising in rural after five years.iv

Funding mechanisms for training programs

The funding of GP Training programs is conditional on meeting specific targets; however, these targets are generally process measures with no post-fellowship outcome measures.

Through the transition to college-led training, RDAA strongly recommended Government and the Department introduce outcome measures such as rural retention for rural pathway at one, three and five-years post Fellowship. This would enable the Colleges to be innovative in developing strategies, but also accountable for the outcomes of initiatives, such as the hybrid model RACGP has used for recruitment to its rural pathway positions.

The strict application of position quotas is anticompetitive and has stifled interest in rural generalist medicine as well as impacting the growth of trainee numbers with ACRRM, which the current over-subscription of positions clearly demonstrates. With the new RGTS program showing strong signs of interest, changes to the AGPT position allocation must be explored, along with overall GP training program design. There also needs to be some flexibility in funding allocations to support successful recruitment of registrars to areas where they are most needed available for Colleges to access based on their numbers, as opposed to a completely pre-determined number of positions for each college.

Rural Locum program

The approved 3GA locum program, approves placements for up to six months in one practice to cover a vacant position or period of leave. Unfortunately, due to the vacancy rate in rural and remote practices, the availability of a locum to cover leave periods through this program has significantly dropped. The rate paid by private agencies has driven the fees charged to health services and practices up to level that are not sustainable in the medium term. For rural general practice, which is a small business, locum fees are simply not affordable.

This program does not serve as a lever to producing or supporting rural workforce.

After Hours Medical Deputising

Medical Deputising services are rarely present in any community of MMM 4-7, if at all. When they are in use, these services often utilise doctors subject to the 10-year moratorium but with limited opportunity for them to undertake their GP training as part of their job.

These services enable city-based general practice to access a PIP after hours payment for putting a sign on the door and a voice mail on their phone, while rural and remote doctors continue to provide in person, genuine after-hours services.

With Government now funding Urgent Care Centres it appears that these services have not been able to meet the full need of the community, and it may be timely to review their future role in the primary care service models.

Section 19AB

RDAA's position is that promoting and supporting rural medical practice so that is viewed as a career of choice is essential to addressing the maldistribution of doctors into rural and remote Australia. Mechanisms that force a cohort of doctors to work rural results in long-term reputational damage to rural medicine and further detracts from this exciting field of medicine as a career.

While the 10-year moratorium applied under section 19AB of the Health Insurance Act 1973 is not RDAA's favoured policy position, for many years it has been relied upon by rural and remote communities to recruit and retain a doctor. It is therefore critical that changes that affect this lever must be initiated concurrently with other changes that offsets the loss of these doctors.

James Cook University has produced data to demonstrate that, for the vast majority of overseas trained doctors, once their moratorium period is served they will relocate to a larger regional town or (for most) a capital city. RDAA does not believe that 19AB doctors should be expected to remain in rural and remote medical practice for life (five to seven years is more than a reasonable contribution to these communities), however the data demonstrates that 19AB is not a long-term strategy to address the maldistribution of doctors.

District Priority Area

This is a mechanism aimed to distribute the GP workforce that are subject to 19AB and bonded scholarship holders.

For **medical bonded scholarship holders** it continues to be a challenge to manage their return of service, which takes up significant resources. RDAA believes there needs to be a mechanism to support rural-based students to access CSP medical school places, but the program in its current format provides minimal contribution to addressing the maldistribution of the medical workforce.

For **19AB doctors,** including international medical graduates and overseas students who are domestic graduates, DPA was the key mechanism that resulted in these doctors taking up positions in rural and remote communities.

Recent adjustments have broadened the automatic DPA classification from MMM 5-7 to include MMM3 and MMM4, and then further broadening to include all MMM2 and a number of MMM1 locations. The result of these changes is that this lever is no longer part of a rural and remote medical workforce solution.

RDAA has repeatedly and strongly recommended to Government and the Department of Health 'rural solutions' should not be extended out to large regional centres or metropolitan areas, as it only negates any impact of the initiative in a rural or remote setting.

The new **Pre Fellowship Program (PFP)**, which replaces the **More Doctors for Rural Australia Program**, now allows doctors on this program to work in DPA areas in MMM1-7. As a result, the PFP will favour general practices in MMM1 -2 and provide very minimal workforce into real rural areas. Remote communities will be most disadvantaged by this program change which is now a support for all overseas trained doctors coming to work in Australia. It is part of a national medical workforce solution, but it is no longer a rural and remote medical workforce solution.

Exceptional circumstance applications

RDAA is a member of the working group that reviews requests for DPA classification under exceptional circumstances. To date RDAA has not supported one application.

RDAA recommends that if an exceptional circumstance process is included in future design, there needs to be a much more comprehensive assessment criteria than GP numbers, and service need. There should also be scope to grant it to a specific practice rather than an entire GP catchment area.

Consideration for exceptional circumstance should look at issues such as:

- Is the practice an accredited training practice for Students, John Flynn Prevocational Program and Registrars, or if not accredited, do they have the appropriate staffing profile to be accredited? Being an accredited training practice, demonstrates the ability to break the

cycle of reliance on recruitment of overseas doctors, and also shows that if the practice does recruit a doctor from overseas, they have the ability to support them to progress into an accredited general practice training program and gain Fellowship, giving the doctor longer term career options in Australia.
An in-principle approval from RACGP or ACRRM would be appropriate evidence.

- Is the practice bulk billing only and can it demonstrate the need of the patient cohort?
- Geographical location, what other practices are in the area, and are they party to the application? This is certainly a current consideration and a discussion point in the current process.
- Doctors recruit doctors, so if senior medical staff from a practice are overseas trained it makes sense that their network for potential future workforce will extend to their country of origin.

District of Workforce Shortage

This mechanism is relevant to the non-GP specialist workforce. It needs a significant overhaul and redesign with consideration to the barriers the specialty colleges put in place in relation to training accreditation and supervision, and the impacts of fly-in and fly-out specialists to recruit permanent staff to the local area.

RDAA has received reports by consultant specialist members who work in regional hospitals that they have been unable to attract domestic consultants and their ability to recruit from overseas is hindered by not being classified as a District of Workforce Shortage due to fly in fly out consultants doing a significant number of elective lists, and the corresponding Medicare activity. These doctors do not contribute to the after-hours roster and may provide limited public hospital work.

The issue of recruitment of specialists from overseas, is in order to make public hospital consultant specialist jobs attractive, they are often established as a combination of public and private work. This enables an increased headcount of consultant specialists who are available to do the after-hours public roster, but without a DWS classification this staffing model is not possible.

Conclusion

There is significant scope for improvement in the design and application of many programs aimed at addressing the maldistribution of Australia's medical workforce. Some parts are working well, such as the MMM classification model, and do not need to be replaced unless a new model with significant benefits is designed. Other initiatives have been proved over many years to be unsuccessful in addressing this distribution, despite having many millions of dollars invested in them. These programs need to be discontinued or redesigned.

Further investment and support to enhance the profile of rural and remote medicine is required in place of forced distribution mechanisms, assisted by financial incentives and supports that are scaled for rurality and remoteness which help address the financial impost of lower patient numbers and the increased level of services that need to be provided.

i https://www.croakey.org/wp-content/uploads/2023/11/Health-at-a-Glance-2023-report.pdf
ii https://www.aihw.gov.au/reports/workforce/health-workforce#rural
iii https://www.aihw.gov.au/getmedia/05dbd806-0708-40c1-9a9c-8099c3f36faa/aihw-hwe-94.pdf?v=20231019170236&inline=true
iv https://www.acrrm.org.au/docs/default-source/all-files/acrrm-policy-priorities-grow-workforce.pdf?220608