Independent Expert Panel

Report on the public consultation and advice to Government on the redesign of the General Practice Rural Incentives Programme

Contents

Introduction

On 31 October 2014, the Government announced major changes to its workforce classification systems. This includes replacing the current classification system, the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA), with a newly developed system, the Modified Monash Model (MMM). The announcement also included an overhaul of the District of Workforce Shortage (DWS) system, which will become operational from 2 February 2015. Combined, these changes provide for greater transparency and certainty for undergraduates and doctors seeking to train and work in rural and remote Australia.

The delivery of rural health workforce programmes through updated and redesigned classification systems will provide a significantly improved and more accurate assessment tool for determining eligibility for rural health workforce incentives. These incentive programmes are funded to encourage doctors to live and work in regional, rural and remote areas of Australia, where they are needed most.

On 1 December 2014, as part of these reforms, the Government announced its appointment of an independent expert Panel to lead public consultation and to provide advice on how the General Practice Rural Incentives Programme (GPRIP) could be redesigned to better achieve the original intent of the programme.

The aim of GPRIP is to provide some compensation for factors that have been identified by research as having a negative influence on attracting doctors to rural and remote Australia. These factors include higher overall workloads, increased responsibility for public hospital work including providing on-call and after-hours services, difficulty taking time off, difficulty sourcing employment for spouses or partners and lack of choice in schooling opportunities.

GPRIP provides incentives to encourage more doctors to tale up and to continue to practise in rural and remote communities. The desire of Government and profession to ensure the provision of the “right doctor with the right skills is in the right place to meet community needs” will require a multifaceted approach, such as through the coordinated use of other rural workforce programmes. GPRIP forms part of a package of educational and structural programmes and incentives that are designed to build capacity within practices to support the provision of cost effective, high quality, continuing and comprehensive care in general / rural practice and into extended care settings.

For example, while the Panel recognised that GPRIP provides part of the solution to deliver a sustainable outcome in supporting viable models of practice, it also accepts that it cannot provide the whole solution. In relation to unsupervised emergency care which is a desirable characteristic of rural practice but a negative predictor for rural retention, the Panel concluded that the mechanisms to support better recognition of unsupervised emergency care should be explored via other existing programmes. In this case, in order to

avoid setting up another bureaucracy the PIP Procedural grant could be expanded.

The Panel noted that the GPRIP will likely be the first of the rural health workforce programmes to transition to the new classification system, the MMM. Under its mandate, the independent expert Panel also considered the unique and important benefits around the rural immersion of junior doctors, the importance of a coordinated, rural training pipeline for workforce delivery, but also the range of other professional, practice, education and social benefits in having junior doctors trained in rural and remote Australia, whether they will become rural doctors or not.

Members of the Independent Expert Panel

Chair Dr Steve Hambleton

Member Dr Paul Mara

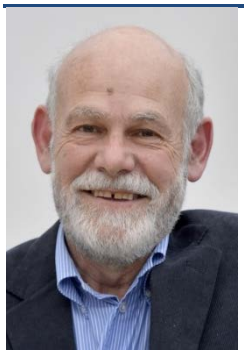
Member Professor John Humphreys

Biographies

Chair: Dr Steve Hambleton MBBS FAMA FRACGP (hon) GAICD

Dr Steve Hambleton is the former Federal President of the Australian Medical Association (AMA), a position he assumed in May 2011 after serving a two-year term as Federal Vice President. Dr Hambleton is a University of Queensland graduate (1984) and an experienced General Practitioner serving at the same general practice at Kedron in Brisbane since 1988. He was President of AMA Queensland in 2005-6 and served on the AMA Council of General Practice at a State and Federal level for more than 15 years.

Dr Hambleton was the AMA representative on the National Immunisation Committee from 2006-2010, and was a member of the Pharmaceutical Benefits Advisory Committee. He joined the AMA Taskforce on Indigenous Health in 2005 and was Chair from 2009 to 2014. Dr Hambleton is on the Board of the Australasian Medical Publishing Company and he served on the Australian National Preventive Health Agency's Expert Committee on Alcohol from 2011 - 2014. He served as a Member of the Clinical Care Standards Advisory Committee of the Australian Commission on Safety and Quality in Health Care and is a current member of the Australian Atlas of Healthcare Variation Advisory Group. Dr Hambleton was appointed Chair of the National eHealth Transition Authority in June 2014 and for his services to general practice was awarded an honorary Fellowship of the RACGP in September 2014. Dr Hambleton was elected to the board of the Avant Mutual Group Limited in November 2014.



Dr John Humphreys

Dr John Humphreys is the Emeritus Professor at Monash University School of Rural Health in Bendigo, and a Chief Investigator for the Centre of Research Excellence in Rural and Remote Primary Health Care. Educated at the University of Melbourne (BA Hons, DipEd) and Monash University (PhD), he has worked at several universities in Australia and overseas. Dr Humphreys has published widely on rural health service provision, workforce recruitment and retention, and rural health policy and presented more than 100 national and international keynote and invited presentations.

Dr Humphreys was awarded the University of New England Vice-Chancellor's Award for Teaching Excellence, the Dr Louis Ariotti Research Award for innovation and excellence in rural and remote health research, and Honorary Life Membership of the Australian College of Rural and Remote Health. In addition to his academic career, John has been engaged by State and Commonwealth Governments to undertake several major rural health program evaluation projects (including the National Rural Health Strategy, the Rural Incentives Program, the Regional Australia Summit, and the Rural Undergraduate Support & Co-ordination Program), and has been a member of many reference and advisory groups for national rural health programmes.

Dr Paul Mara

Dr Paul Mara is a practising rural doctor and practice principal in Gundagai NSW where he works in Gundagai Medical Centre with his wife, Dr Virginia Wrice.

He was a founding executive member of the Rural Doctors Association and formerly President of the Rural Doctors Association of Australia and NSW. He was an officer of both organisations for over 20 years. He was also the first Director of General Practice in the Australian Medical Association and in this and subsequent roles assisted with negotiations regarding Commonwealth Government 1992 reforms in General Practice that led to changes to training for general and rural practice, establishment of Divisions of general practice, development of the current system of accreditation for general practice and the

first GP Rural Incentives Program. As secretary of the RDANSW he negotiated the Rural Doctors Settlement Package for hospital VMOs working in NSW small rural hospitals and was a member of the NSW Ministry of Health RDA Liaison Committee.

He undertook consultancies into Rural Medical Workforce and Training in the 1990s and was a principal researcher and organiser along with Professor John Humphreys in the RDAA's Viable Models of Rural and Remote Practice Project.

He is currently Managing Director of Quality Practice Accreditation Pty Ltd, an independent company that accredits General Practices for the purposes of the Practice Incentives Program.

As a rural doctor he provided obstetrics and anaesthetics services for around 25 years in Tumut Hospital and continues to provide in-patient, on-call, after-hours, emergency and outpatients services in Gundagai Hospital as a Visiting Medical Officer.

He has been a Fellow of the Royal Australian College of General Practitioners since the early 1980s and is also a Fellow of the Australian College of Rural and Remote Medicine and holds a Diploma of Obstetrics. With Dr Wrice he has supervised medical students, GP Registrars and Prevocational GP trainees for many years. He is Adjunct Professor of Rural Medicine at the UNSW Wagga Wagga Clinical School.

In his various professional and organisational capacity he has personally visited hundreds of practices in metropolitan, rural and remote areas of Australia and remains committed to efficient and effective delivery of primary care services.

Outside medicine he has an interest in bushwalking, mountaineering, flying and sailing and has participated in two recent Sydney to Hobart Yacht Races.

This report was funded by the Australian Government Department of Health (the department) and commenced in December 2014. Secretariat support was provided by the department.

Terms of Reference

Review of the application of the Modified Monash Model to the General Practice Rural Incentives Programme

Background

1. The General Practice Rural Incentives Programme (GPRIP) was introduced in 2010 to attract and retain doctors in regional and remote communities, as defined under the Australian Bureau of Statistics' Australian Standard Geography Classification system as being in Remoteness Areas 2 to 5.
2. Since its introduction, rural stakeholders have raised legitimate concerns about the delivery of incentives in accordance with the ASGC-RA system, identifying that this creates disincentives for doctors to practise in small rural communities, where doctors can receive the same incentive payments to work in larger and well-serviced regional centres in the same remoteness categories. The system is discouraging doctors from working in the places they are needed most – small rural communities.
3. The Senate Inquiry report on *Factors affecting the supply of health services and medical professionals in rural areas* tabled in August 2012, recognised stakeholder concerns and recommended that the ASGC-RA system be replaced with a system that takes account of regularly-updated geographical, population, workforce, professional and social data to classify areas where recruitment and retention incentives are required.
4. This recommendation was further considered in the 2013 independent Review of Health Workforce Programmes. Both review reports supported an alternative classification model proposed by Professor John Humphreys and his colleagues from the Monash University School of Rural Health.
5. The Government has decided to introduce a new classification system, the Modified Monash Model, and this decision was announced on 31 October 2014. The Modified Monash Model takes account of differences between rural locations, rather than remoteness alone. It is based on an updated ABS remoteness model, the Australian Statistical Geography Standard (ASGS), overlayed with categories that separate inner and outer regional locations (RA2 and 3) in accordance with population size.
6. The Government is seeking advice on how the new Modified Monash Model should be applied to the GPRIP, and has established an Independent Expert Panel to consult with interested stakeholders and provide impartial advice to Government.

Scope of the Review

7. The review will provide opportunities for key rural stakeholders to provide views about the operation of GPRIP, and how it should be modified.
8. The review will consider the existing policy parameters of the GPRIP, and provide advice on how the programme should be modified to deliver effective recruitment and retention incentives, taking into account the new categories established under the Modified Monash Model.
9. The review will provide advice on streamlining and simplifying the GPRIP.
10. The review will consider the value of providing rural exposure for junior doctors.
11. The review will not make recommendations in relation to Government expenditure levels, but should provide advice about the principles upon which Government funding would be best applied to increase the size of the rural and remote medical workforce, and the retention of the rural and remote medical workforce.
12. The review will consider changes to GPRIP in the context of other incentive programmes.
13. The review will be conducted by an Independent Expert Panel of members appointed by the Government, with secretariat support provided by the Department of Health.
14. The review report will be provided to the Assistant Minister for Health, copied to the Prime Minister and the Minister for Health, by 16 January 2015

Executive Summary

On 31 October 2014, the Government announced major changes to its workforce classification systems, including a shift from the ASGC-RA to the Modified Monash Model (MMM). The Independent Expert Panel was appointed on 1 December 2014 to provide advice to Government on the application of the GPRIP to the new MMM. GPRIP was introduced in 2010 to attract and retain doctors in regional and remote communities under the previous ASGC-RA classification system, and is regarded as a primary incentive in the retention of doctors to rural locations. The MMM will provide an improved tool for the determination of eligibility and payments under GPRIP, and to ensure the right doctor with the right skills is in the right place. In addition, the Panel was asked to consider issues in relation to the rural immersion of junior doctors and rural training pathways.

The objectives of the review were:

- To provide opportunities for key rural stakeholders to comment on the operation of GPRIP and how it should be modified.
- To consider the existing policy parameters of the GPRIP and provide advice on how the programme should be modified to deliver effective recruitment and retention incentives, taking into account the new categories established under the Modified Monash Model.
- To provide advice to the Government on streamlining and simplifying the GPRIP.
- To consider and report on opportunities to provide rural exposure for junior doctors.

On 1 December 2014, the Panel called for submissions from all key organisations and the general public to assist them in making recommendations to the Government. In addition, the Panel sought assistance from key organisations through a consultative roundtable and individual discussion process.

As part of its consultation process, the Panel received and reviewed 41 submissions and spoke with 14 key stakeholders. These included the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP), the Rural Doctors Association of Australia (RDAA), and the Australian College of Rural and Remote Medicine (ACRRM).

Through its deliberations, the Panel has developed 12 recommendations for consideration by the Government.

Conclusion

The change in the supply and distribution of rural doctors has resulted in fewer requirements for incentives in larger regional centres. In the main, the key characteristics identified as adversely affecting recruitment and retention in rural areas no longer exist in these larger regional centres. Incentives need to be applied where they are more likely to compensate for the negative factors affecting recruitment and retention and support for comprehensive practice.

Evidence shows that rural doctors in smaller rural locations and remote areas are required to possess an advanced skillset including procedural and emergency medicine, and are required to have greater workload flexibility to incorporate on-call and hospital duties to meet the needs of the community. The majority of this additional workload is identified and is supported through a range of measures in addition to the GPRIP. The Panel noted that a large proportion of doctors currently practising in regional and remote locations are either in-training or completing return-of-service obligations and as such, many do not yet have the necessary skills to meet the needs of their communities. Increased numbers alone are not the solution.

Following the Government announcements the understanding of the nature of the medical workforce problem in rural and remote Australia has now effectively moved from a limited concept of geographical maldistribution of workforce with fewer doctors in the country and more in the cities to one that is defined by an improved understanding of community health needs and appropriate service delivery models.

A concentration on *numbers* of doctors, rather than community access to defined services and the training, skill sets and practice structures required to deliver these services has limited or even detracted from attempts to resolve the medical workforce issues. Thus many small rural communities require access to comprehensive primary care, emergency services, hospital care and maternity and procedural services. This in turn implies broadly skilled practitioners and teams operating within a training, referral and visiting service network as a 'system of care'.

A head-count of 'GPs' just does not suffice as a measure of this, nor whether Medicare-subsidised medical services in the district are less than the national average. The political and public rhetoric has changed to encompass imperatives such as community needs, continuity of care, need for social and health capacity building within communities, appropriate practitioner training and skill sets, vertical and horizontal integrated care and viable models of practice.

Implicit in a viable practice model is sustainable delivery of services in rural and remote communities that are comprehensive and continuing across primary care / general practice into extended settings. Inherent in the model must be scope for adequate succession planning and system solutions that go beyond individual commitment, skills and personalities.

GPRIP incentives should recognise the work performed by these doctors subject to their ongoing commitment to rural practice, and form part of the range of incentives that reflect the commitment of doctors to using their advanced skillset to deliver high quality, comprehensive primary care to local communities over and above any mandated return of service requirements.

As a retention incentive, it is important that the GPRIP is made available during critical points in the rural doctor's career path, and the available evidence indicates that a major critical point is around two to three years of service. The Panel also concluded that rural doctors require greater access to leave provisions to allow for upskilling, recreational leave, etc. both during and after their training.

The Panel concluded that it is essential that junior doctors continue to have access to early and ongoing pathways to rural practice that will provide high quality general practice training through extended placements in rural locations.

Given the benefits for doctors, practices and the community of education and training in rural and remote areas, that go way beyond immediate and sustainable workforce relief, it is important that junior doctor education and training is not limited to only those doctors who seek to practice in rural or remote areas, but also available for doctors who may seek other career paths.

The development of new training pathways will require key input and support from state jurisdictions and educators to ensure a fully integrated and coordinated medical education and training pipeline.

Abbreviations and Acronyms

Term	Definition
ABS	Australian Bureau of Statistics
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
ARIA	Accessibility/Remoteness Index of Australia
ASGC-RA	Australian Standard Geographical Classification - Remoteness Area
ASGS	Australian Statistical Geography Standard
BMP	Bonded Medical Places scheme
CPD	Continuing professional development
CRANAplus	Council of Remote Area Nurses Australia
DWS	District of workforce shortage
FTE	Full-time equivalent
FWE	Full-time workload equivalent
GP	General practitioner
GPRA	General Practice Registrars Australia
GPRIP	General Practice Rural Incentives Program
HWPC	Health Workforce Principal Committee
IMG	International medical graduate
MBS	Medicare Benefits Scheme
MMM	Modified Monash Model
MRBS	Medical Rural Bonded Scholarship Scheme
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHA	National Rural Health Alliance
OECD	Organisation for Economic Cooperation and Development
OTD	Overseas trained doctor
PGPPP	Prevocational General Practice Placements Program
PGY	Postgraduate year
PIP	PIP – Practice Incentives Program
RA	Remoteness area
RACGP	Royal Australian College of General Practitioners
RCS	Rural Clinical School

Term	Definition
RDAA	Rural Doctors Association of Australia
RLRP	Rural Locum Relief Program
RRMA	Rural, Remote and Metropolitan Areas
RoS	Return of service obligation
RRIG	Rural Relocation Incentive Grant
RRP	Rural Retention Program
RTPs	Regional training providers
RVTS	Remote Vocational Training Scheme
RWAs	Rural Workforce Agencies
SA	Statistical area
SLA	Statistical local area
SSD	Statistical sub-division
UDRH	University Departments of Rural Health
VR	Vocationally recognised (registered)

Recommendations

Recommendation 1

1 (a). The panel recommends that GPRIP be delivered through retention payments to doctors providing primary care services in small regional, rural and remote communities (MM 4-7). Automatic payments should continue to be administered through the Medicare system in accordance with qualifications, service obligations, geographic classification, Medicare billing and length of service

1 (b). The Panel also recognises that rural GPs often deliver additional complex care within their communities, particularly in MM 3-7, but reflecting this within GPRIP payments is not the most efficient mechanism to reward this higher level of community service. As such, the Panel strongly recommends that some funds from the existing GPRIP be redirected to existing programmes which already recognise this more complex work, such as the Practice Incentives Program (PIP) Procedural General Practitioner Payments, for the purposes of increasing payments in MM 3-7 as well as including a payment recognising unsupervised emergency department work.

Recommendation 2

The Panel notes from the available workforce retention data including median lengths of stay that a critical point in time when incoming Specialist General Practitioners leave rural medical practice is after two years of service in MM 4-5 and after twelve months in more remote locations. Therefore, the Panel recommends that GPRIP payments should commence at this time point for new entrants. For GP Registrars, and other non-Fellowed doctors participating on training or workforce programmes, payments should commence two years after the achievement of Fellowship for doctors continuing to practice in MM 4-5 and after one year for doctors continuing to practice in MM 6-7.

The Panel recommends that doctors who are completing return-of-service obligations under the Medical Rural Bonded Scholarships Scheme and International Medical Graduates who are restricted under section 19AB of the Health Insurance Act 1973 also gain access to GPRIP incentives at those critical discretionary time points (two years after they have completed their obligations in MM 4-5 and after one year in MM 6-7).

The Panel noted from the data that currently a significant number of doctors who complete their service obligations do not remain in rural areas. Accordingly, to increase retention, doctors who have contributed to rural practice during their training and/or return-of-service should receive a joint cumulative payment (taking into account their service and location over the previous five years) at the first payment point.

Recommendation 3

The Panel recommends that after the commencement of payments, eligibility will be assessed quarterly and GPRIP incentives be paid annually.

Recommendation 4

The Panel recommends that scaling of payments continue under GPRIP in recognition of geographic location, billing amounts and period of rural service. For new entrants in MM 4-5, the first payment would occur at the end of year two, a small increment at year three, and another increase to the maximum at year five. New entrants in MM 6-7 would receive a first payment at year one, an increment at year three and at year five at which point the maximum would have been reached.

Recommendation 5

The majority of stakeholders recognised that the minimum and maximum thresholds had not been altered since the programme's inception and the overwhelming majority agreed that they should be adjusted upwards.

The Panel recommends that thresholds be adjusted upwards and levels be informed by current median workloads. The maximum thresholds should be easily achieved by a practitioner working full-time and the minimum thresholds should be easily achieved by practitioners working part-time. Finally the relativities for various levels of payments should be informed by the relative risk of retention identified in the most up-to-date available Australian research.[1]

Recommendation 6

In recognition that many doctors are providing outreach services, the Panel recommends that GPRIP payments continue to be based on the practice location, regardless of practitioner or patient address.

[1] Russell et al. Human Resources for Health 2013, 11:65 http://www.human-resources-health.com/content/11/1/65

Recommendation 7

The Panel acknowledges that many rural skills are maintained for a period of time and where necessary, rural refresher courses are available for doctors who wish to return to rural practice. The Panel therefore recommends that doctors who leave rural practice for up to five years not be penalised through the loss of service status on their return to rural practice. Doctors returning to rural areas after a period of absence that is longer than five years, however, should commence GPRIP under the terms for new entrants.

Recommendation 8

The Panel recommends that the existing MBS categories for GPRIP continue unchanged. If telehealth items are considered in the future the Panel recommends that assessment for payments should be made in accordance with the doctor's physical location – not the patient location.

Recommendation 9

The Panel recommends that equal incentives for equal work be a guide when rewarding doctors providing services in more than one location per quarter. Higher MMM categories should dominate. That is, where the maximum threshold is achieved in a single higher MMM category, the higher incentive should be paid. Where the thresholds are reached through various locations, pro-rata payments should reflect the proportion of work in each location.

Recommendation 10

The Panel noted concerns about the low uptake and high drop-out rates of the relocation component of GPRIP and also that various other mechanisms of support are provided to assist recruitment, such as, but not limited to those offered through Regional Training Providers, Rural Workforce Agencies, and state, territory, and local governments. In view of these, the complexity of the current arrangements and the lack of impact on any lasting rural retention, the Panel recommends that funds allocated for relocation grants be redirected into retaining long-serving rural doctors.

Recommendation 11

The Panel acknowledges the advantages gained through early and ongoing rural immersion at various training stages, and strongly recommends that the Government consider a range of options to introduce a programme that provides high quality community medicine and general practice training in rural and remote areas through extended placements for junior doctors. Prevocational training exposure should be considered as part of a coordinated rural training pipeline to fill the current gaps identified around high quality training opportunities in rural and remote Australia at prevocational career stages.

The Panel recommends that the Commonwealth take a leadership role in the prevocational junior doctor education and training by working closely with states and territories, the medical colleges, universities and local health services to ensure a sustainable system of rural prevocational training is established as part of a fully integrated and coordinated rural medical education and training pipeline.

Recommendation 12

The Panel considers that ongoing analysis and evaluation of GPRIP is vital. It recommends that an evaluation strategy be formulated at the onset of the programme, and that regular evaluation using sentinel indicators of GPRIP effectiveness be undertaken to ensure that GPRIP is achieving its objective of retaining the right doctor with the right skills to meet the needs in rural and remote communities.

Background

The General Practice Rural Incentives Programme (GPRIP) was introduced in 2010 to attract and retain doctors in regional and remote communities, as defined under the Australian Bureau of Statistics' Australian Standard Geographical Classification - Remoteness Areas 2 - 5.

Since its introduction, rural stakeholders have raised concerns about the delivery of GPRIP incentives in accordance with the ASGC-RA due to perceived inequity for small towns that are classified in the same remoteness category as larger towns, where doctors can receive the same incentive payments to work in larger, well-serviced regional centres. The current system may be discouraging doctors from working in the places they are needed most: small rural communities.

The Panel noted that long working hours, excessive on-call duties, difficulties in accessing leave provisions – along with a lack of employment opportunities for spouses and adequate education facilities – are some of the main considerations discouraging medical practice in small communities[2].

GPRIP is a demand-driven programme which provides payments automatically to doctors practising in eligible locations, based on the remoteness of their location, their Medicare billing levels, and the length of time they have been providing services in non-urban Australia. Since its introduction, demand has exceeded original expectations and budget allocation.

GPRIP payments are currently made in accordance with the ASGC-RA in areas classified as RA2 (Inner Regional), RA3 (Outer Regional), RA4 (Remote) and RA5 (Very Remote). Payments are scaled to provide the greatest benefit to doctors practising in the most remote areas and increase each year to a maximum amount after five years of service.

Under the existing GPRIP based on the ASGC-RA, 13,000 doctors are supported. Payments are made annually (except during the first half year service in RAs 3-5), and retrospectively.

The Government is committed to a redesign of GPRIP to recognise the needs of small rural communities where residents often experience significantly poorer health outcomes, which can be allayed in part by ready access to appropriately and reliably staffed primary care services.

The Senate Inquiry report on *Factors affecting the supply of health services and medical professionals in rural areas* tabled in August 2012, recognised stakeholders concerns and proposed that consideration be given to the replacement of the ASGC-RA with a system that takes account of regularly updated geographical, population, workforce, professional and social data to better classify areas where recruitment and retention incentives are required. This issue was further considered in the 2013 *Independent Review of Health Workforce Programmes*. Both reviews supported the alternative classification model proposed by Professor John Humphreys and colleagues at the Monash University School of Rural Health.

[2] The Australian Journal of Rural Health (2012) 20, 3-10

Updating from the ASGC-RA to the new classification system, the Modified Monash Model (MMM) will change the classification system used to determine eligibility for GPRIP. Accordingly, the GPRIP then requires redesign in relation to the new system, the MMM, to ensure that incentives payments are targeted to where they are most needed. Based on what doctors do and the context in which they practice, the MMM better categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and town size. The system developed to recognise the challenges in attracting health workers to more remote and smaller communities.

On 31 October 2014, the Federal Assistant Minister for Health, Fiona Nash, announced major changes to the workforce classification systems that have held back progress in encouraging doctors to work outside big cities: "It is creating perverse incentives for doctors to move to large, coastal towns and does not recognise that the challenges of recruiting doctors to small rural towns," she said. It was further announced that GPRIP would be the first health workforce rural distribution program that would transition to the MMM.

While having the required number of health professionals is essential in being able to provide health services, so too is equitable needs-based distribution of those professionals. The geographic spread of the health workforce does not reflect the distribution of the population[3] and there are significant variations in the availability of doctors, nurses and midwives in the different regions of Australia. In particular the ratio of doctors per 100,000 population is markedly lower in outer regional, rural and remote areas of Australia than in major cities.

Distribution problems can stem from difficulties in attracting the medical workforce to rural and remote areas and then in retaining those who have relocated, at least for a reasonable period. Research indicates that it is the total personal and professional experience including non-remunerative benefits, and not salary alone, that impacts on recruitment and retention.[4]

Financial incentives for rural doctors need to be supported by Government however, there are concerns around whether current programmes are effective and financially viable. The causal impact of financial incentives alone upon recruitment and retention is often asserted, but seldom demonstrated.[5] Evidence suggests that these payments are only one of many factors influencing doctors' decisions whether to stay in, or move to, rural areas.

GPRIP is but one of a number of programmes designed to support practitioners and practices in providing improved access to healthcare for rural and remote communities. These programmes include both financial incentives and educational and other structural programmes that aim to build the *professional, educational, infrastructural, economic and ultimately, workforce capacity* within systems, to provide viable and sustainable services needed by communities.

[3] The Independent Review of Australian Government Health Workforce Programs, 2013

[4] J Humphreys *et al*. "Improving Workforce Retention: Developing an integrated logic model to maximise sustainability of small rural and remote health care services", *Australian Primary Health Care Research Institute ANU College of Medicine, Biology & Environment, 2009.*

[5] The Independent Review of Australian Government health Workforce Programs, 2013

In this context GPRIP should be seen as providing funding that supports practitioners and practices to build the capacity to provide care in both primary care (general practice) and extended settings, such as in hospitals and indigenous communities that are high quality, cost effective, comprehensive, continuing and sustainable. GPRIP should not be seen solely, or even primarily as an income support scheme for doctors.

The other government programmes and payments that support regional, rural and remote practice, include both explicit and implied incentives through Medicare. Examples include; the bulk-billing incentive item for areas of need and procedural MBS items for non-specialists that provide procedural services (mainly in rural hospitals), the rural loadings applying to the Practice Incentives Program (PIP) for practices in regional and rural Australia, the specific procedural practice grants that are available through the PIP, the Council of Australian Governments (COAG) approved Section 19(2) exemptions under the Health Insurance Act 1973 to allow remuneration to state governments providing non-admitted and non-referred primary health care services in approved locations such as small rural hospitals, and infrastructure grants to support practices in building sustainability by improving teaching capacity.

Vision and Guiding Principles

The Panel used the following vision and guiding principles to review stakeholder submissions, and to make recommendations in relation to how GPRIP could be redesigned using the recently-developed MMM.

Vision

To support rural communities to sustainably recruit and retain the right doctors, with the right skills working in the right places, to deliver appropriate and effective high quality services that meet the health care needs of rural and remote communities.

Guiding principles

The principles of equity, service sustainability, parity, effectiveness, flexibility, fit for purpose, accessibility and quality have guided all stakeholder consultations and committee deliberations. Specifically, recommendations have been developed drawing on the following overarching principles:

- GPRIP should exist within a frame work of other incentives and is only one element in the goal to deliver on the above vision.
- Monetary incentives that are available should be properly targeted and should be structured to minimise perverse outcomes.
- Incentives to retain doctors should reflect the increasing requirement for skills and responsibilities associated with increasing isolation.
- Incentives to retain doctors should take account of both professional and non-professional considerations associated with practice location.
- Incentives to retain doctors should contribute to improving the equity of access to health services for rural and remote Australian communities.

The Panel noted that monetary incentives alone are insufficient to achieve the vision and that positive experiences from properly-structured, rural placements – at all stages of the training pipeline – are of great benefit in contributing to the likelihood of taking up rural practice and thereby reducing the maldistribution of the medical workforce across Australia.

Methodology

The Panel reviewed and considered information received from a number of different sources, including the views and concerns of key stakeholder groups and individuals. Information and evidence was also gained from a number of source documents and relevant published research articles.

On 1 December 2014, following Minister's Nash's announcement and media release, the website accepting public submission located at: www.health.gov.au/consultation hub was established to provide information. Additionally, key stakeholder organisations and the states and territories were contacted and invited to participate and provide written submissions.

Public Submissions

41 submissions were received and reviewed by the panel, comprising 19 (46.3%) from individuals and 22 (53.6%) from key stakeholder groups and the health workforce sector/rural medical organisations. The states and territories were advised of the process and invited to submit their input through the Health Workforce Principal Committee. Responses were received from a number of jurisdictions. A summary of the major stakeholder groups' written submissions is at Appendix 1.

A breakdown of organisations that submitted responses, by state and territory, was:

- 9 from NSW
- 5 from QLD
- 2 from Vic
- 1 from TAS
- 1 from NT
- 1 from WA

Key aspects of Individual Public Submissions

Individual submissions covered a variety of topics and areas of concern, some of which were outside the scope of the terms of reference. However, the panel read and considered all submissions provided. Overwhelmingly, these submissions endorsed the change to, and implementation of, the MMM as a replacement for the current geographical classification system.

The majority of these submissions also supported financial incentives being targeted at 'rural' and 'remote' general practitioners, but were evenly split as to whether they should commence at MMM category 3 or MMM category 4, noting that although these payments could be modest, they sent an important message about the Government 'valuing' the work of these doctors. All submissions emphasised that the largest payments should be provided to those practitioners working in MMM classifications 6 and 7.

The vast majority of individual submissions were inclined to remove the relocation incentive payments and direct these funds more generally towards recruitment activities and increased retention payments. There were a number of comments suggesting that the amount of funding available under the relocation grant was not enough to significantly influence a practitioner's decision. The data and evidence also noted that the majority of doctors who accessed the grant did not receive the second instalment. In short, the decision to relocate was multifactorial, and the removal of this element of the GPRIP was unlikely to change decision-making. It was noted, however, that early career medical practitioners (such as GP registrars and other junior doctors) may be slightly disadvantaged should this element cease.

It was acknowledged that relocation assistance was also provided to medical and other health practitioners, via a number of other avenues, including State and Territory Government, local councils; private recruitment firms and/or private practices as part of the salary and conditions negotiated prior to commencement of employment.

Meetings

The panel met formally on 1, 9, 16 and 23 December 2014 and on 8 and 13 and 20 January 2015. There were numerous other informal teleconferences and communications, between Panel members and the panel and the Department.

Stakeholder roundtable meeting

The key stakeholder roundtable meeting was held in Canberra on Tuesday 16 December 2014.

Individual consultations

The panel met a number of the organisations individually to discuss in more detail the issues raised in the stakeholder roundtable meeting or in the organisation's written submission.

Information sources

The Panel used the public discussion documents on the General Practice Rural Incentives Scheme and the MMM, that were provided on the website to guide the submission process. The panel sought greater detail from departmental officers on some issues raised in these documents, to further inform decision making.

The panel also sought and reviewed information from a range of documents and data sources including but not limited to the following references:

- The Senate Community Affairs references Committee, 2012: The factors affecting the supply of health services and medical professionals in rural area, Canberra.
- Mason J, 2013: The final report of the Review of Australian Government Health Workforce Programs.
- Australian College of Rural and Remote Medicine, May 2014: The Rural Way: Implementation of a national rural generalist pathway, Melbourne.
- Royal Australian College of General Practitioners, January 2014: The report of the New approaches to integrated rural training for medical practitioner project, Melbourne.
- Rural Doctors Association of Australia and the Australian Medical Association, 2010: *The Rural Rescue Package,* (and subsequent updates in 2012).
- Russell DJ, Humphreys JS, McGrail MR, Cameron WI and Williams, PJ, 2013: The Value of Survival Analyses for evidence-based rural medical workforce planning*, Human Resources for Health*, 11:65. Available at: http://www.human-resources-health.com/content/pdf/1478-4491-11-65.pdf
- McGrail MR & Humphreys JS, 2009: *The Index of Rural Access: an innovative integrated approach for measuring primary care access,* BMC Health Services Research, 2009, 9:124. Available at: http://www.biomedcentral.com/content/pdf/1472-6963-9-124.pdf
- Russell D, McGrail M, Humphreys JS & Wakerman J., 2012: What factors contribute most to the retention of general practitioners in rural and remote areas? *Australian Journal of Primary Health*, 18: 289-294. Available at: http://dx.doi.org/10.1071/PY11049
- Russell D, Wakerman J & Humphreys JS, 2013: What is a reasonable length of employment for health workers in Australian rural and remote health care services? *Australian Health Review*, 37:256-261.
- Sivey P, Scott A, Witt J, Joyce C & Humphreys JS, 2012: Junior doctors' preferences for specialty choice, *Journal of Health Economics*, 31(6):813-823.
- Hudson JN & May, JA, 2015: What influences doctors to work in rural locations?*, Medical Journal of Australia*, 201(1), 5-6.
- Kondalsamy-Chennakesavan S. Eley DS, Rummuthugala G, Chater AB, Toombs MR. Darshan D & Nicholson GC, 2015: Determinants of Rural practice: Positive interaction between rural background and rural undergraduate training; *Medical Journal of Australia* , 201(1), 41-61.
- Kamien M, 1998: Staying in or leaving rural practice: 1996 outcomes of rural doctors' 1986 intentions, *Medical Journal of Australia*, 169:318-321.

Data sources:

- Medical Practice in Rural and Remote Australia: National Minimum Data Set (MDS) Report, RHW, November 2013.
- Australian Bureau of Statistics: 3101.0 Australian Demographic Statistics.
- Department of Health: Medicare Benefits Division.

Themes

Modified Monash Model (MMM)

The use of the ASGC-RA for the distribution of health workforce programs was considered by the Senate Affairs Committee inquiry into the *Factors affecting the Supply of Health Services and Medical Professionals in Rural Areas* (released in August 2012). In order to address the fundamental inequities associated with the continued use of the ASGC-RA, the Senate Committee recommended its replacement with an improved fit-for-purpose classification as the basis for guiding eligibility for, and distribution of, incentives for doctors that takes account of the nature of medical practice and the context in which they operate. The Senate Committee was supportive of this alternative model proposed by Panel member, Professor John Humphreys and his colleagues from the Monash University, which draws upon findings of the *Medicine in Australia: Balancing Employment and Life* (MABEL) study.[6]

The Monash research used geo-coded data to show an association between six sentinel (professional and non-professional) indicators internationally recognised as contributing to difficulties in the recruitment and retention of rural doctors, specifically:

1. total hours worked;
2. public hospital work;
3. on-call after-hours;
4. difficulty taking time off;
5. partner employment; and
6. schooling opportunities.

The Monash classification ensures that doctors undertaking similar activities in similar settings receive appropriate incentives and support for their practice, and are differentiated from those practising in contrasting practice environments

Based on these indicators, the research showed that population size (used in conjunction with geographical location) provided a significantly better and more sensitive surrogate measure to underpin the classification scheme for distributing medical workforce incentives than the ASGC-RA.

A later review of health workforce programs examined the use of the ASGC-RA and recommended the adoption of a modified version of the model developed by the Monash University, based on the updated Australian Statistical Geography Standard (ASGS). The MMM is an evidence-based geographical classification system based on rurality and population size, in which population size is adopted as a suitable proxy reflecting the impact of the six sentinel indicators that reflect the greatest barriers affecting workforce recruitment and retention initiatives.

[6] J Humphreys, M McGrail, C M Joyce, A Scott and G Kalb, "Who should recieve recruitment and retention incentives? Improved targeting of rural doctors using medical workforce data" *Australian Journal of Rural Health* (2012) 20, 3-10

The modified model separates inner and outer regional locations (RA2 and 3) in accordance with population size. The seven categories under the proposal are:

1. RA1
2. RA2 and RA3 with population greater than 50,000
3. RA2 and RA3 with population 15,000 to 50,000
4. RA2 and RA3 with population 5,000 to 15,000
5. RA2 and RA3 with population less than 5,000
6. RA4 (remote)
7. RA5 (very remote)

The MMM incentive classes are based on standard, publically available geographies, concepts and measurements, including:

- Statistical Area 1 (SA1): is the second lowest ABS classification, varying from 2,000 square metres to many square kilometres; SA1 populations range from 0 to 7,284;
- Estimated Resident Population (ERP): is estimated by the ABS for SA1s;
- Urban Centres and Localities (UCL): geographical units that statistically describe Australian population centres with populations exceeding 200 people and created from aggregates of SA1s;
- Significant Urban Areas (SUA): include one or more UCLs whose centres are close (within 5 km) and who share the same labour market, for example, Albury-Wodonga.
- Remoteness Areas (RA): five classifications based on SA1s, using the ASGS-RA.
- 'buffer zones' of a specified distance around each town.

In reviewing the suitability of the MMM, a number of issues emerged that warranted further consideration, some of which were similar to those raised under the current ASGC-RA system. A working group, the Rural Classification Technical Working Group (Working Group), including representation from a number of rural stakeholders, was convened to assist with the finalisation of the MMM. Importantly, the broad architecture of the core classification was strongly endorsed, as was the importance of the underlying principles in order to avoid any arbitrary and *ad hoc* changes that were not justified on the basis of any evidence. As a result of its deliberations, the Working Group endorsed adoption of a series of buffer zones in order to prevent any perverse incentives to practise in small towns close to major regional areas. The proposal by the department to introduce a 'buffer' zone around inner and outer regional centres will have the effect of including small nearby towns in the same classification as the larger town.

Submissions and consultations with key stakeholders showed overwhelming support for the adoption of the MMM as the appropriate first step in reforming GPRIP.

The Panel noted comments made in a number of submissions that there should be consideration of the demands of high pressure service delivery particularly with chronic and complex cases, broader community health burden, lower socio-economic disadvantage, and the uniqueness of health service delivery to Aboriginal and Torres Strait Islander populations and communities. However, the Panel acknowledges that the MMM's population considerations, adequately

reflects a representation of these concerns in the existing sentinel indicators. Whilst some of these issues may be a significant factor in a given community, there are variable patterns of GP employment, in terms of service provision and remuneration, which do not warrant further additional sentinel indicators.

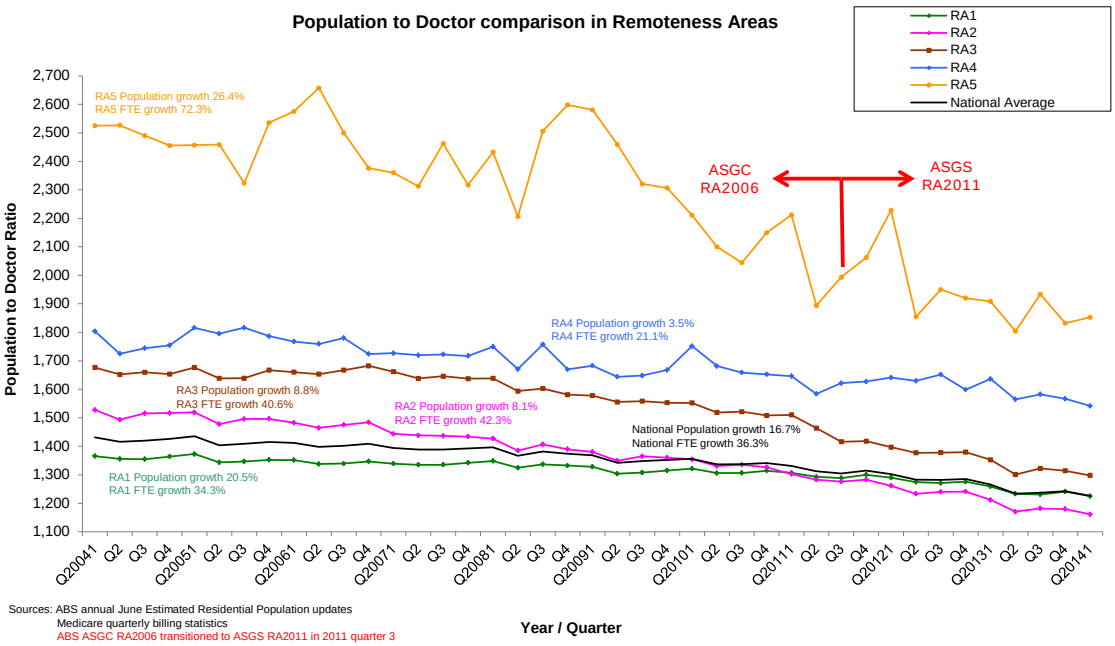
General Practice Rural Incentives Programme (GPRIP)

Since its inception in 2010, the uptake of GPRIP has exceeded expectations. However, the primary criticism of the programme has been that the centralised approach of paying incentives to doctors does not consider the workforce needs of individual communities or the differing skill level of rural doctors. Currently under GPRIP, doctors are considered to be eligible if they practise in a regional or remote area of Australia (based on the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system, defined as RA2 – RA5.

Incentives should reflect the different contexts in which rural and remote doctors practise, often characterized by working in relative isolation and not well-supported by other health services, facing difficulties in getting locum relief, high on-call, and with limited opportunities for spouses and families. The Rural Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) recognise the particular skills required by rural general practitioners and offer specialist rural skills training. It is well accepted that rural GPs are required to perform additional duties and possess additional skills, such as unsupervised procedural medicine and emergency care where rural GPs are required to have a broad range of skills and the requirement to manage the rigors of on-call and after-hours availability. The panel considered developing a two-tiered approach to incentives, with a secondary payment for more complex skills, but recognises that GPRIP is not the most effective programme for recognition of these skills. The Practice Incentive Programme – Procedural Grants component is better placed to recognise and bolster these skills, and as such, the panel recommends GPRIP funds to be redirected to this programme for rural doctors in MM3 and MM7.

Since 2010, distribution of doctors has increased into inner regional locations to the point where there is little need to continue to incentivise retention. In its submission to the panel, ACRRM stated “In particular in the current AGSC-RA 2 *(sic)* classification where most growth has occurred in the GPRIP payments, there is 2.7 doctors per 1000 population which is average by OECD standards and more than the national average for countries such as the United States and Canada. This creates an environment in which there is strong motivation for under-employed urban doctors with little interest in, or skills for, the unique demands of practice in rural communities, to provide service in the most convenient and hence least needy locations.” Under the MMM, MM2 is the category for all RA2 and RA3 locations with populations greater than 50,000, and MM3 is the category for all RA2 and RA3 locations with populations between 15,00 and 50,000. Within the current fiscal environment, priority retention should be maintained within categories MM4 to MM7.

The following graph shows the current trend for doctors per population, illustrating the significant reduction in demand for doctors in RA2.



Under the current GPRIP, eligible GPs include state-salaried doctors working in RA4 and RA5, doctors working for the Flying Doctor Service or in Aboriginal Medical Services, and GPs providing services that are not “billable”. Whilst the panel recognises the work of these medical practitioners, who were previously receiving GPRIP payments through the Flexible Payment System, the panel believes that these practitioners should seek reward through their individual employment provisions rather than through the GPRIP.

Recommendation 1

1 (a). The panel recommends that GPRIP be delivered through retention payments to doctors providing primary care services in small regional, rural and remote communities (MM 4-7). Automatic payments should continue to be administered through the Medicare system in accordance with qualifications, service obligations, geographic classification, Medicare billing and length of service

1 (b). The Panel also recognises that rural GPs often deliver additional complex care within their communities, particularly in MM 3-7, but reflecting this within GPRIP payments is not the most efficient mechanism to reward this higher level of community service. As such, the Panel strongly recommends that some funds from the existing GPRIP be redirected to existing programmes which already recognise this more complex work, such as the Practice Incentives Program (PIP) Procedural General Practitioner Payments, for the purposes of increasing payments in MM 3-7 as well as including a payment recognising unsupervised emergency department work.

The current GP retention programme is a costly measure, and, to date, there is limited evidence about the extent to which it contributes to the retention of doctors in rural practice. A recent quantitative study concluded that "The most important factors associated with the retention of rural and remote GPs…were primary income source, registrar status, hospital work and restrictions on practice location (which are linked to geographic location)."[7] It is a widely-held view by a number of medical practitioners that GPRIP payments are more recognition of service in rural locations, as well as support for additional costs incurred by rural doctors such as children's education, transport costs, or locum support. However, research shows that retention rates for primary health workers in rural and remote locations begin to decline at around 2 to 3 years of service and that provision of financial incentives at prior to these critical points could improve those retention rates and therefore continuity of care, and result in reduced recruitment costs[8].

Under the current programme, payment eligibility commences immediately with the first payment being made after 6 months for ASGC-RA locations at RA3 to RA5, and 12 months for locations classified as RA2. The Panel considered whether there should be a greater lead-in time before rural doctors are eligible for an incentive to more effectively meet the aim of a retention programme. Opinion amongst stakeholders varied greatly in relation to this factor, with the majority recommending that the incentive commence after two years and scaled over a period of ten years. After further consultation and consideration of other options, the Panel believes this option is the most equitable.

[7] Russell, DJ., McGrail, MR., Humphreys, JS., Wakerman, J. "What factors contribute most to the retention of general practitioners in rural and remote areas?" *Australian Journal of Primary Health* 18 (2012): p289.

[8] Russell, DJ., Wakerman, J & Humphreys, JS. "What is a reasonable length of employment for health workers in Australian rural and remote primary healthcare services?" *Australian Health Review* 37 (2013): p260.

The period of service on completion of qualifications is a reflection of the commitment of doctors to using their skills in delivering high quality, comprehensive primary care to local communities over and above any mandated return of service.

The Rural Doctors Association of Australia (RDAA) advised in its submission to the Panel "…there is evidence to suggest that the 2-year mark is critical in terms of longer term retention and this could also be considered as an appropriate time frame to commence retention incentive payments."

ACRRM stated " three years is a better point at which to start scaling incentives as this reflects a point at which a critical mass of rural experience and skills have been achieved."

A number of doctors currently receiving GPRIP retention incentives are mandated to work in rural practice and /or as a result of limited alternative training placement options. Whilst the Panel wishes to encourage these practitioners, it does not believe that GPRIP incentives should be payable at these points.

However, to acknowledge the work performed by these GPs, the Panel believes that the number of years of service in training or return-of-service be counted towards accrued scaling once they achieve eligibility. "[There is a] generally shorter retention of GPs working with restrictions on their practice location (52% shorter retention than those GPs with no restrictions). This is not surprising given the likelihood of either recent graduation (bonded students) or relatively recent arrival in Australia (visa restrictions)."[9]

The Panel recognised a number of practitioners are vocationally recognised but do not possess fellowship qualifications, and are regarded as eligible for incentive payments. All eligible practitioners are recognised practitioners who do not have location restrictions on where they can practice.

[9] Russell, DJ., McGrail, MR., Humphreys, JS. & Wakerman, J "What factors contribute most to the retention of general practitioners in rural and remote areas?" *Australian Journal of Primary Health* 18 (2012): p293.

Recommendation 2

The Panel notes from the available workforce retention data including median lengths of stay that a critical point in time when incoming Specialist General Practitioners leave rural medical practice is after two years of service in MM3-5 and after twelve months in more remote locations. Therefore, the Panel recommends that GPRIP payments should commence at this time point for new entrants. For GP Registrars, and other non-Fellowed doctors participating on training or workforce programmes payments should commence two years after the achievement of Fellowship for doctors continuing to practise in MM4-5 and after one year for doctors continuing to practice in MM 6-7.

The Panel recommends that doctors who are completing return-of-service obligations under the Medical Rural Bonded Scholarships Scheme and International Medical Graduates who are restricted under section 19AB of the Health Insurance Act 1973 also gain access to GPRIP incentives at those critical discretionary time points (two years after they have completed their obligations in MM4-5 and after one year in MM 6-7).

The Panel noted from the data that currently a significant number of doctors who complete their service obligations do not remain in rural areas. Accordingly, to increase retention, doctors who have contributed to rural practice during their training and/or return-of-service should receive a joint cumulative payment (taking into account their service and location over the previous five years) at the first payment point.

Currently GPRIP payments are assessed quarterly by the Department of Human Services and paid annually, initially at 6 months in RA3 to RA5 and 12 months at RA2, with annual payment points after that. The Panel, in agreement with the majority of stakeholders, supports annual payments.

Recommendation 3

The Panel recommends that after the commencement of payments, eligibility will be assessed quarterly and GPRIP incentives be paid annually.

The Panel considers the scaling differential should be based upon evidence indicating the time periods when “potential triggers to leave” may preclude optimal length of stay. Evidence suggests these critical points are after three years. And that scaling should be weighted towards MM6 and MM7 where need is greater and resources and support structures are less available.

Recommendation 4

The Panel recommends that scaling of payments continue under GPRIP in recognition of geographic location, billing amounts and period of rural service. For new entrants in MM4-5, the first payment would occur at the end of year two, a small increment at year three, and another increase to the maximum at year five. New entrants in MM6-7 would receive a first payment at year one, an increment at year three and at year five at which point the maximum would have been reached.

The current thresholds for eligibility under the GPRIP have been in force since the implementation of GPRIP’s predecessor, the Rural Retention Program (RRP), in 2000. They are a minimum of $4,000 per quarter and a maximum of

$20,000. That is, a GP is eligible for a pro-rata payment if they have eligible Medicare billing of more than $4,000 per quarter. A maximum payment is paid if billing is $20,000 or more, per quarter. These thresholds are not consistent with current GP workloads and should be updated to better inform incentive payments.

A proportion of stakeholders recognised that the minimum and maximum thresholds had not been altered since the programme's inception and that they should be adjusted upwards.

Recommendation 5

The majority of stakeholders recognised that the minimum and maximum thresholds had not been altered since the programme's inception and the overwhelming majority agreed that they should be adjusted upwards.

The Panel recommends that thresholds be adjusted upwards and levels be informed by current median workloads. The maximum thresholds should be easily achieved by a practitioner working full-time and the minimum thresholds should be easily achieved by practitioners working part-time. Finally the relativities for various levels of payments should be informed by the relative risk of retention identified in the most up-to-date available Australian research.[10]

Under the GPRIP, payments are based upon provider numbers that are location specific. This ensures that eligible services are provided to the rural community through face-to-face consultations, and require the GP to be present at the rural community. The issue as to whether a determining factor for eligibility should be whether the doctor resides in the rural communities in which they provide their services, solicited a varied response from key organisations, and reflected the breadth of rural general practice. Some individual submissions argue that incentives should encourage doctors to reside in the community in which they work, whilst others argued that some communities are too small to attract full time practitioners and rely on doctors providing outreach services.

Recommendation 6

In recognition that many doctors are providing outreach services, the Panel recommends that GPRIP payments continue to be based on the practice location, regardless of practitioner or patient address.

Currently GPs are able to have 12 months leave each 24 months to retain their year level status under GPRIP. Once a GP takes more than the allowed leave without approval, they revert back to the commencement point of their eligibility and the lowest payment point. Given the needs to ensure communities have well-rested, well-trained doctors in rural locations, this restriction could impede a doctor's work life balance, and be a cause for early departure from rural practice.

The majority of submissions acknowledge than an absence could occur for a range of personal reasons such as family needs and professional needs such as education and training that cannot be undertaken rurally.

[10] Russell et al. Human Resources for Health 2013, 11:65 http://www.human-resources-health.com/content/11/1/65

Recommendation 7

The Panel acknowledges that many rural skills are maintained for a period of time and where necessary, rural refresher courses are available for doctors who wish to return to rural practice. The Panel therefore recommends that doctors who leave rural practice for up to five years not be penalised through the loss of service status on their return to rural practice. Doctors returning to rural areas after a period of absence that is longer than five years should, however, commence GPRIP under the terms for new entrants.

Currently eligible services are listed as clinical services from the following sections of the Medicare benefits Schedule Book:

Category 1 – Professional attendances

Category 2 – Diagnostic procedures and investigations

Category 3 – Therapeutic services

Category 7 – Cleft lip and cleft palate

Eligible services do not include optometry, dentistry, pathology, and diagnostic imaging services. Bulk billing items 10990, 10991, and 10992 are also excluded.

The Panel agrees with stakeholder submissions that acceptable clinical services should remain unchanged.

Recommendation 8

The Panel recommends that the existing MBS categories for GPRIP continue unchanged. If telehealth items are considered in the future the Panel recommends that assessment for payments should be made in accordance with the doctor's physical location – not the patient location.

Under GPRIP, doctors practising in multiple locations are assessed according to the RA in which the greatest billing occurs each quarter, excluding RA-1. Therefore doctors who provide services in a number of rural categories, such as RA 3 and 5 would be paid at the rate for wherever they billed the majority of services.

The Panel considered that this policy does not fairly recognise the contribution to each area and concluded that a more transparent approach would be to calculate the payment against the proportion of service, per MM category, except where the maximum threshold has been reached in a more remote location.

Recommendation 9

The Panel recommends that equal incentives for equal work be a guide when rewarding doctors providing services in more than one location per quarter. Higher MMM categories should dominate. That is, where the maximum threshold is achieved in a single higher MMM category, the higher incentive would be paid. Where the thresholds are reached through various locations, pro-rata payments should occur to reflect the proportion of work in each location.

Since implementation of the relocation component of the GPRIP, the number of doctors relocating under the Rural Relocation Incentive Grant (RRIG) component has fallen well short of original targets. Indications are that the primary causal factors for under-achievement of the programme are possibly the strict eligibility criteria and doctors not remaining in their new location long enough to receive a relocation payment. Evidence suggests that financial incentives are not necessarily a major determining factor in consideration of relocating, and that to become a major determinant, incentive amounts would need to much higher, at least 130 per cent of annual earnings.[11]

There is cause for concern in relation to the effectiveness of the RRIG, especially regarding the validity of providing relocation payments to doctors moving from one rural area, such as Mackay, Queensland, to another similar region, such as Cairns, Queensland. Relocation from Mackay to Cairns currently attracts a relocation payment of $15,000 however this does not serve to increase the number of doctors in rural and remote locations, but rather transfers current rural services. Further, data show that the number of doctors practising in locations classified as RA2 under the ASGC-RA system has increased significantly, reducing the need to include this category within relocation payment consideration. Significantly, current data show that the majority of relocation grants approved were for movements from major cities (RA1) to inner regional (RA2).

Public submissions advised there are a number of factors influencing a doctor's choice to relocate to a rural setting including rurally-based education and training, a rural background, personal preference workforce characteristics and remuneration and the attractiveness of an additional suite of targeted incentives. One consideration as to the effectiveness of an incentive is that it is wasted if it is provided to someone who was going to relocate or stay without the incentive.[12]

Most submissions argue that the current relocation component is perhaps not as well-targeted as it needs to be, including an emphasis of matching skills to local needs, and is not an effective influence on retention. Most submissions from organisations argued that these funds would be better utilised in support of

[11] Scott, Anthony et al. "Getting Doctors into the Bush: General Practitioners' Preference for Rural Location" *Melbourne Institute Working Paper* No13/12 (2012): p2.

[12] Humphreys J et al. "Who should receive recruitment and retention incentives? Improved targeting of rural doctors using medical workforce data" *Australian Journal of Rural Health* No20 (2012): p4.

retention strategies, and is perhaps only a small factor in a doctor's motivation to relocate to a rural area.

Recommendation 10

The Panel noted concerns about the low uptake and high drop-out rates of the relocation component of GPRIP and also that various other mechanisms of support are provided to assist recruitment, such as, but not limited to those offered through Regional Training Providers, Rural Workforce Agencies, and state, territory and local governments. In view of these, the complexity of the current arrangements and the lack of impact on any lasting rural retention, the Panel recommends that funds allocated for relocation grants be redirected into retaining long-serving rural doctors.

Rural Education

At key points in their medical training and development, the structure of the training system and a lack of advanced rural positions tend to force new doctors back to the cities, where they often settle. This makes it hard for rural areas to attract a sustainable Australian-trained workforce, given that locations do not share the same staffing attraction factors, such as high quality schooling services and spousal employment opportunities, as metropolitan areas.

A recent study undertaken by the University of Queensland's Rural Clinical School[13] confirms the link between rural background and study at a rural clinical school, and specifically mentions that the duration of the rural placement /relationship are very strong indicators that these students will remain in or return to rural practice once training is complete.

Through both the public submission process and the face-to-face stakeholder consultation process, the IEP encountered strong views and support for junior doctor training in rural areas, to be a step in a truly rurally-based medical education pipeline. Options and activities such as targeted investments in rural academic centres and better regional training coordination were viewed as key steps in building the capacity of the rural training system to support students as they move through the pathway. The objective of such a programme being implemented would be to develop the capacity to create better-coordinated, flexible rural training pathways through a regionalised approach, which produces doctors who are qualified against existing professional standards, but can complete the bulk of their training based in a rural or regional location.

Building better pathways would mean that medical students can progress to fully qualified doctors, with most of their training completed outside of metropolitan areas and linked to a particular region, its health services and its community. It is recognised that development of any new pathway needs to be a shared responsibility between the Commonwealth, states and territories and the education sector and that implementation will need to occur through a series of phases to develop both training capacity and collaboration between key partners. Panel member, Dr Paul Mara has provided a case study, detailing

[13] Mja.com.au/journal/2015/202/1/determinants-rural-practice-positive-interaction-between-rural-background;-and Mja.com.au/journal/2015/202/1/what-influences-doctors-work-rural-locations

some experiences from doctors who have undertaken training at the Gundagai Medical Centre (at Appendix 2).

Recommendation 11

The Panel acknowledges the advantages gained through early and ongoing rural immersion at various training stages, and strongly recommends that the Government consider a range of options to introduce a programme that provides high quality community medicine and general practice training in rural and remote areas through extended placements for junior doctors. Prevocational training exposure should be considered as part of a coordinated rural training pipeline to fill the current gaps identified around high quality training opportunities in rural and remote Australia at prevocational career stages.

The Panel recommends that the Commonwealth take a leadership role in the prevocational junior doctor education and training by working closely with states and territories, the medical colleges, universities and local health services to ensure a sustainable system of rural prevocational training is established as part of a fully integrated and coordinated rural medical education and training pipeline.

Recommendation 12

The Panel considers that ongoing analysis and evaluation of GPRIP is vital. It recommends that an evaluation strategy be formulated at the onset of the programme, and that regular evaluation using sentinel indicators of GPRIP effectiveness be undertaken to ensure that GPRIP is achieving its objective of retaining the right doctor with the right skills to meet the needs in rural and remote communities.

Appendix 1 – Summary of Key Organisational Submissions

Submissions were sought from interested parties on the redesign of GPRIP, with the following questions put forward for consideration:

Questions about the GPRIP – Retention payments

1. Who should be eligible for GPRIP payments under the MMM?
2. When is a suitable to time to commence retention incentives?
3. How frequently should retention incentives be paid?
4. Should the current policy of scaled incentives be maintained? If scaled incentives continue, at what point should they reach a maximum?
5. Should the current minimum and maximum billing thresholds be revised?
6. Should retention payments be limited to doctors who live in rural areas?
7. How long do you think GPRIP payment levels should be maintained for doctors who take extended leave from their rural practice?
8. Do you agree with the current Medicare services that contribute to the quarterly billing calculation?
9. Do you agree with current policy to determine payment rates for doctors working in multiple locations?

Questions about the GPRIP – Relocation payments

1. Do you think that relocation grants encourage doctors to move to a rural or remote location?
2. What categories of the MMM should be deemed eligible for relocation grants?
3. Do you agree with the current eligibility criteria for relocation grants?
4. Do you think the current locum rule is fair?
5. What other strategies could be pursued to provide exposure to rural general practice for junior doctors?

The main organisational submissions received by the Panel are summarised below:

Australian College of Rural and Remote Medicine (ACRRM)

ACRRM provided a comprehensive submission that generally supports the introduction of the MMM, as better, more finely tuned instrument than the AGSC-RA based system for encouraging doctors to provide services where they are most needed. ACRRM provides extensive discussion on its preferred policy for the redesign of GPRIP. ACRRM's view is that to achieve maximum benefit for the considerable investment in the programme, it should be viewed as a contributing element to an overall strategy to properly train, nurture, and retain doctors in the rural and remote areas where they are needed.

ACRRM stated concern not only about the lack of doctors in some rural locations, but the maldistribution of doctors within locations currently classified as RA3-5, due to small rural communities having the same incentive as much larger centres within those broad categories. The wider the remuneration net is

cast, the less GPRIP can provide per doctor in the current environment, which can potentially lead to small individual payments of limited effect.

ACRRM explicitly stated that GPRIP retention payments should not be treated as an entitlement but rather as a special recognition by the Australian public and Government for the provision of important medical services to the communities in which they live and work, in order to encourage and reward continuity and longevity of service. Further, payments should be made to individual doctors and not to a business entity which employs them.

ACRRM is of the opinion that eligibility for GPRIP payments should not be based on geographic location alone, but on a set of indicators that measure the "comprehensiveness" of care provided, in addition to rurality. Incentives should also reward demonstrated continuing commitment to rural communities; recognise that rural practice extends beyond Medicare billable services; and should assist in the provision of an unbroken rural-centric training and career pipeline, by incentivising rurally interested junior doctors to continue through the pipeline.

Responses (retention):

1. ACRRM did not explicitly state which MMM categories should receive GPRIP retention incentives, but proposes that it is only one element of a multi-tiered eligibility criteria, of which GPs must meet to gain a payment. However, the ACRRM submission suggests that those MMM categories that directly correlate with AGSC-RA location 3-5 should be considered.
2. ACRRM argued that incentives should commence immediately, be scaled appropriately however, milestone payments would not apply until year two, five, or ten years of service.
3. Retrospectively and annually.
4. The general approach to scaling of incentives, ranked according to MMM classification is supported. It should be noted however, that this system has significant gaps and some additional mechanism is required to address these. It is proposed that three years is a better point to commence scaling, and ideally scaling could continue to ten years as opposed to five.
5. ACRRM stated that Medicare billing of $4,000 per quarter is reasonable. It proposed that this be minimum billing in MMM 3-7. ACRRM provided a more complicated formula for determining dollar value eligibility, related to total percentages in the MMM classification.
6. Yes, further towns in MMM 1 and 2 should not be eligible. Additionally, alternative programmes are in place to incentives locums services and do not need to be duplicated.
7. The current arrangements are generally satisfactory. However, the current 12 months should be extended to two years for GPs, and registrars enrolled in and progressing appropriately through a two year advanced specialised training programme.
8. As outlined above, current arrangements already fail to reimburse many of the very important services that are provided outside the Medicare system and this problem needs to be addressed. It is noted that separate funding arrangements are in place for some of the excluded items.
9. The general approach is supported.

Responses to questions (relocation):

1. These grants are considered a less potent and therefore less important element of the GPRIP framework. However, they may contribute positively to the recruitment of doctors in the most remote categories.
2. ACRRM states that in general, greater incentives should be available to assist doctors to relocate to the places of most acute workforce shortage and greatest need. ACRRM seeks to see additional data, before it provides any other view on this question.
3. ACRRM proposes that eligibility criteria for relocation grants be the same as retention grants for GPRIP payments.
4. The 20 day timeframe seems arbitrary and could be slightly extended without affecting the intention of the rule.

Rural exposure for junior doctors

ACRRM provided significant information on its rural and junior doctor training policy and sees it as essential that rurally-interested medical students and graduates are enabled to stay out of urban hospitals, where they are socialised to urban sub-specialties and become too clinically cautious to be comfortable with the scope of rural generalist practice. In contrast to traditional tertiary hospital junior doctor training programmes, being rurally-based during prevocational training years, enables young trainees to establish lifestyles expectations and family and social ties in that setting which is vital to rural retention.

ACRRM suggested that the Commonwealth should leverage commitments from states and territories, via COAG to have a percentage of salaried junior doctors training in rural units and to have measurable outcomes in the COAG health service agreements. Additionally, it suggested that the Commonwealth take financial responsibility for junior doctor salaries, and community practice supervision in MMM 3-7 where at least 50 per cent FTE each week for at least 20 weeks is undertaken in a community based training /service provision component.

ACCRM suggests that better selection criteria is required to recruit rurally-interested graduates and prepare and direct them to rural vocational training. It also advocates for ‘preferential selection’, which could be directed to medical graduates who have previously demonstrated their engagement with the training pipeline (ie: rural health clubs; John Flynn; and bonded scholarship programmes). Selection should also preference those already enrolled in a rural generalist Fellowship programme, or those with the advanced skills that are required in rural practice and associated with rural retention.

Australian Medical Association (AMA)

The AMA provided comments on the basis that the new MMM classification system and reforms to GPRIP will not be used to reduce overall funding to GPRIP, while acknowledging that it may be possible to use funds more effectively.

The AMA supports the MMM classification system, which appears to be strongly evidence-based, incorporating other factors such as population size in classifying rural communities. The AMA is of the view that this will allow for

better differentiation between locations which are currently considered equivalent for incentive purposes but have very different service level challenges.

The AMA acknowledged that there needs to be a redesign of GPRIP and advocated for its policy known as the '*rural workforce rescue package*', which is also supported by the RDAA. Its package provided a range of incentives including a rural isolation payment to all rural doctors and a rural procedural and emergency on-call loading.

Responses to Questions (retention):

1. All doctors in MMM 2-7, with a stronger emphasis on encouraging doctors to MMM 4-7
2. Retention incentives should be commenced after 12 months for all categories except registrars who derive benefit from the existing six month payment in the first year.
3. Retention incentives should be paid quarterly.
4. Scaling by years of service should be replaced with a flat rate, escalating to a significant lump sum bonus at five year intervals. However, in the case of registrars, scaling payments are useful to encourage rural training.
5. Consideration should be given to indexing thresholds to ensure GPRIP remains targeted to doctors who can deliver sufficient services to meet community need. If a decision is made to extend GPRIP to doctors not billing Medicare then a proxy measure of service will need to be determined.
6. GPRIP incentives should continue on the basis of practice location.
7. The AMA believes it is reasonable to allow for a leave period of up to five years before reverting to the lowest payment level, if or when a doctor returns to rural practice. A staged decrease in payment levels is also suggested. Extended leave provision to allow up-skilling should be maintained.
8. It is vital that recognition of non-Medicare hospital services delivered by GPs should be included when calculating incentive payments.
9. A more accurate assessment would be a calculation of the percentage of services provided in each location and provide incentives according. However, it is noted that this may complicate the administration of payments.

Responses (relocation):

1. It may help reduce the financial disincentive to relocating for the more remote locations however for less remote categories it barely covers the cost of moving. The AMA is of the view that relocation grants should be repaid if the doctor moves from the new area after less than five years.
2. MMM 3 -7
3. The AMA disagrees with the "OTD 10 year moratorium" and supports incentivising those who voluntarily consider a career in regional, rural and remote Australia.
4. No. The rule potentially excludes doctors genuinely interested in rural and remote practice who have used locum work to assess whether one or more locations are suitable to them to settle in permanently.

Rural exposure for junior doctors

The AMA supports the exposure of junior doctors to rural general practice, particularly before choosing a vocational pathway. Through better targeting, this will result in more efficient longer term gains by training those who are more interested in, and better suited to general practice.

The AMA recommended establishing a new programme to support pre-vocational doctors with exposure to general practice, and one that supports the placement of doctors in rural general practice, support for supervision, appropriate salaries and appropriate infrastructure. The AMA advocates for access to A1 Medicare rebates to ensure patients are treated equally regardless of whether they see a pre-vocational trainee, a GP trainee or a fully qualified GP. The AMA also advocated on the urgent need to develop regionally based models for the Specialist Training Programme. The AMA is supportive of developing regional training hubs and partnerships between rural and metropolitan hospitals/settings to provide specialist training terms.

Health Workforce Queensland (HWQ)

HWQ has developed its own methodology to identify communities in greatest need, taking into account variables that align to the MMM. HWQ currently administers components of the GPRIP and was pleased that the MMM reflects the complexity of factors that affect access to services in rural and remote Australia.

Responses to Questions (retention):

1. HWQ recommends that incentive payments begin at MM 3 with funds being distributed on an incremental sliding scale. Significantly higher payments should be retained for MM 6 and 7.
2. HWQ recommends that payments commence at six months for MM 4 -7 and after the first year in MM 3.
3. Yearly payments should be maintained
4. HWQ suggests that a crucial point is between years one and two in terms of retention and recommends a greater incentive at the end of the second year. There could also be scope to rewards doctors who have served five years or more in MM 6 and 7 locations.
5. HWQ suggests that billing thresholds should be considered, but support thresholds to include those doctors working part-time and to ensure those working in AMS' or other service settings are not disadvantaged.
6. The area where the doctor provides the service should be considered, not the area in which they reside, noting that many communities are not large enough to support a full-time practitioner.
7. Reverting back to the lowest payment level does not provide an incentive to return to rural practice post periods of leave. HWQ recommends a scaled approach on a one year to one year basis.

Responses to Questions (relocation):

1. Supported the continuation of relocation grants, but notes that it is not purely money that encourages doctors to move to a rural or remote location.
2. As per retention payments commencing at MM 3 and scaled up to MM 7.
3. Supported the current eligibility criteria.
4. Does not support the current locum rule and believes it is unfair. HWQ supports the "getting a good fit" or "try before you buy" approach.

Rural exposure for junior doctors

HWQ advocated for a clear coordinated pathway from junior training into employment as a rural doctor, arguing that the lack of such a pathway for prospective rural practitioners is a key disincentive to rural general practice. HWQ discussed the new national framework for interns and its requirement for intern terms to be taken outside a hospital. HWQ advocates for a recognised placement in a rural facility during the intern years.

HWQ strongly advocated for a rural training pipeline that exposes doctors to rural general practice as early as possible in their careers, supported through the better targeting of participants to help attract the right doctors to rural general practice.

Additionally, application criteria to join a general practice Fellowship programme should link to, or reward rural exposure and pathway programmes. It should also recognise previous university based rural health club exposure and rural junior doctor training experience when assessing candidates for rural general practice training.

National Rural Health Alliance (NRHA)

The NRHA supported the adoption of the MMM, stating it will result in a significant improvement in terms of addressing geographic maldistribution of general practitioners, but not other professions. However, it suggested that consideration of the pros and cons of the MMM is quite a separate issue from how the GPRIP might be redesigned. The NRHA noted that it is not aware of any data or other evidence on the extent to which funds expended under GPRIP have changed GP's decisions.

The NRHA advocates on behalf of its membership that a weighting be attached to inland (and Indigenous identified) communities. The NRHA argues that incentives be multi-disciplinary and apply to all professionals in remote, very remote and isolated communities and suggests that the biggest barrier is the distribution of incentives through Medicare, which is doctor-focused.

Rural exposure for junior doctors

The NRHA argued that rural exposure for prevocational doctors is an essential component of the rural training pipeline. It is essential that some form of prevocational rural exposure to general practice is maintained for the integrity of the rural training pipeline and to secure a sustainable and home-grown rural medical workforce for the future.

Royal College of General Practitioners (RACGP)

The RACGP submission provided detailed information, analysis and policy positions that it has developed and or supports, related to the rural medical workforce, particularly rural GPs, and includes options for classification systems, incentive payments and educational and training opportunities.

The RACGP agreed that the current classification system is not appropriate. However, while stating the MMM is a significant improvement on the current system, it should be enhanced and further developed to include additional indicators and flexibility, to cover a range of personal and professional issues that may or may not influence choice of practice location. The RACGP suggested that the MMM should be the first level of a three-level system to provide a much better model on which to determine rurality and disadvantage.

Responses to Questions (retention):

1. If applying the MMM or rurality measure as the sole criteria for the GPRIP it is recommended that the existing criteria be retained (MM 7 highest, MM 2 lowest).
2. Retain the existing structure.
3. First payment after 6 months for MM 3-5 and after 2 years in MM 2, with subsequent payments made yearly.
4. Retain scaling; incentives should increase up to a maximum after 5 years as per the current arrangements.
5. Yes, it is important to retain the existing $4,000-$20,000 quarterly limits, as this represents services delivered to the community. However, it is also recommended that some flexibility be built-in and billing thresholds should not discriminate against part-time workforce, and medical officers with the right of private practice and “out-reach clinic” service models.
6. It is important that there is a requirement for GPs to live close to the in which they provide services, but not necessarily within it. For example, a 50 km distance may be reasonable as commuting further may suggest that the doctor is not integrated in the community or providing after-hours services. The RFDS model should be reviewed and some flexibility provided.
7. This provision should be maintained, provided the GP practises in the location within the yearly review. However, consideration should be given to GPs who require extended leave for family or educational reasons.
8. No. There is scope for modification of the Medicare items, as Medicare billing alone may not indicate population health needs. Inclusion of a health needs assessment may be useful.
9. No. There is a need to amend this policy to reflect the remoteness of different locations, including out-reach services to surrounding areas. This enhanced scalability would provide an added incentive to service smaller communities.

Responses to Questions (relocation):

1. The RACGP referred to papers outlining a range of professional and non-professional factors influencing practice location decisions. If maintained, payments should be scaled to reward remoteness.
2. The relocation grant should apply to MMM categories 3-7. Consideration should be given to opening eligibility for this grant to registrars for the most disadvantaged areas.
3. The RACGP noted there were five eligibility criteria and any change would have implications. However, it suggested at least one be altered. Criteria should be "working towards Fellowship'. The RACGP does not in-principle support the 10 year moratorium rule, as part of its broader policy.
4. The RACGP advocated for support to be provided to locums for re-settlement in rural or remote areas. Consideration could be given to the 20 day rule, as it appears to work directly against the policy to encourage doctors to work in these underserviced areas.

Rural exposure for junior doctors

The RACGP provided its policy titled: Integrated Rural Training Pathways - A focus on prevocational years.

The RACGP argued that the positive exposure to rural general practice as early as possible in a doctor's career is a significant factor in choosing rural general practice as a vocational preference. The RACGP is of the view that a flexible and well-supported rural training pathway, inclusive of medical students and longer rural placements, would be a significant factor in both vocational choice and doctor retention but that any rural training pathway would benefit from targeted selection such as rural background, rural curriculum, ruralised assessment and rural placements, and the nurturing and support of doctors to experience training in context and to navigating the system from student through to rural practice.

The RACGP advocated for a stepped, linked programme/policy to enhance junior doctor education and training, particularly in rural areas. The main topics included:

- empowering career decision flexibility and choice;
- enabling integration-prevocational training; facilitating link to community; seamless training hubs;
- targeting, noting this is at individual's learning needs and flexibility around entry and re-entry points and part-time study/work arrangements.

The RACGP suggested that overall effort should be targeted to ensure incentives and supports are in line with a policy that provides for an easy entry, gracious exit for rural participants.

The RACGP's view is that rural exposure strategies could be pursued to expose junior doctors to rural practice and argues for implementation of its policy position.

Rural Doctors Association of Australia (RDAA)

The RDAA submission provided general principles and objectives related to the redesign of the GPRIP. It proposed that the redesign of GPRIP be as simple as possible and include robust evaluation and monitoring mechanisms.

Overall, the RDAA was supportive of the MMM noting that it would be a significant improvement. However, it stated there was a need to consider the broader maldistribution of GP skills. The RDAA noted there is a need to focus on the recruitment of the 'right' doctor and focus recruitment activities on the recruitment and retention of GPs whose skill-set matches community needs. GPs providing such services may include:

- general practice based primary care;
- VMO services at hospitals and other facilities;
- emergency and after-hours care; and possibly more advanced-skills in relevant areas such as obstetrics, mental health or Indigenous health, should be appropriately recognised and incentivised; and
- recognition and support of rural supervisors and teachers.

RDAA also argued that GPRIP provided important recognition to GPs that the services provided in regional, rural and remote communities are recognised and valued. In this regard, it urged the Panel to set clear boundaries around the scope of incentives, and to focus on what could be achieved in a practical sense to a limited financial resource to where it was most needed to have the greatest impact. The RDAA also advocated for clear definitions of practitioners and services eligible for incentive payments under a revised programme. The RDAA seeks increased coordination between all GP incentive programmes. The RDAA reiterated that rural practice is different to urban practice and stressed the need for rural exposure for prevocational doctors as an essential component in the rural training pipeline.

Responses to Questions (retention):

1. Although the areas which are in greatest need would generally be smaller towns and regional centres, the RDAA acknowledged locations within MM 3 where incentives are also warranted. The RDAA recommended the adoption of a tiered approach where geographic location and the nature of services provided are considered in determining the quantum of incentive payments.
2. RDAA recommended that commencement of payments occur at a minimum after 12 months, alternatively noting evidence that the two year mark is critical in terms of longer term retention and therefore this could be an appropriate time to commence incentive payments.
3. Payments should be annual, following the qualifying period.
4. Yes, the current policy of scaling for geographic location and length of service should be maintained. A five year maximum is realistic.
5. No. Current billing thresholds have not been reviewed for some time and should be reconsidered. However, a significant proportion of a rural GP's work may not be funded under Medicare, but this work should be recognised for the purpose of eligibility for incentive payments, noting a mechanism for measuring this work needs consideration. Part-time work also needs to be recognised as this is valuable in rural communities.

6. In the interests of longer term investment in community sustainability, as a general principle, the RDAA argued that retention payments should generally be encouraging doctors to live in the communities in which they work. However, it noted that this may not be practical in all circumstances and there are instances where 'fly in – fly out' doctors should receive retention incentives.
7. The current provisions provide a good basis. Consideration could be given to circumstances such as maternity leave and study leave for GP registrars. Scaling arrangements could also apply so that doctors working in more remote areas are able to take longer periods of extended leave, though flexibility is required.
8. The RDAA indicated that the current schedule of eligible services is satisfactory. If telehealth is to be considered so as not to produce perverse incentives or unintended consequences. The RDAA acknowledged the benefit of telehealth consultations in appropriate circumstances and in collaboration with the patient's regular rural general practice.
9. Payments should reflect out-reach work undertaken to more remote locations from rural or regional practices.

Responses to Questions (relocation):

1. While relocation payments have merit, these should not be funded at the expense of retention grants for doctors who were already living and working within the community.
2. Eligibility should be consistent with the criteria for retention grants in terms of location and service delivery
3. If such grants were to be retained, the current eligibility provisions could be streamlined so that more doctors are encouraged to apply (and that the assessment of application is simpler).

Rural exposure for junior doctors

The RDAA noted that exposure to rural general practice for junior doctors fulfilled two basic functions: providing a key linkage between graduation from medical school; and vocational training for rural general practice within the rural training pipeline. It also provided opportunities for junior doctors to experience rural general practice, which may stimulate an interest in that career choice. It would also provide an understanding of the circumstances of rural practice which was beneficial, should they pursue other specialist practice.

The RDAA believed any future pre-vocational exposure programme should be based on a set of principles which relate to: cost-effectiveness; prioritisation where there is limited funding; broad national focus under the auspices of ACRRM and RACGP and the states and territories; the promotion of primary care and rural health workforce outcomes; provide support for program hosts and supervisors; and be consistent and evaluated regularly with consistent longitudinal data so that short and long term outcomes can be measured.

Rural Doctors Workforce Agency (RDWA)

The RDWA supported the introduction of the MMM and suggested it be applied to other programmes it currently administers, adding this could improve workforce distribution. The RDWA noted the MMM should, in the first instance,

be applied to GPRIP and the Bonded Medical Places scheme. It also recommended that the Five Year OTD Scheme be retained as location specific, suggesting this would further incentivise difficult-to-recruit to locations.

The RDWA proposes that a significant distinction between MM 3, 4 and 5 is not necessary, it is more important to direct higher payments to MM 6 and 7 locations.

With respect to relocation payments, the RDWA suggested these should have a reduced administrative burden and be used as a recruitment incentive, and be incorporated into other relocation support payments administered by the RDWA, complimenting other Commonwealth funded programmes that it administers.

Rural exposure for junior doctors

The RDWA noted that the National Framework for Interns allows for terms to be taken outside the hospital environment. It proposed that a Rural Intern Term Workforce Programme should be implemented, specifically identifying a term in rural general practice.

Rural Workforce Agency Victoria (RWAV)

RWAV agreed the MMM will provide a greater level of distinction within RA categories. The use of buffer zone to determine the additional categories was viewed as appropriate, and noted the MMM was a measure of access, not a single measure of disadvantage.

RWAV did not expressly answer the questions posed, but offered a short commentary under the headings of: retention; relocation; and exposure for junior doctors to rural general practice.

RWAV stated that the majority of GPs working in rural Victoria receiving GPRIP retention payments are in RA2 and RA3 locations. The extent to which the GPRIP retention payment has been a major or deciding influence on retention in RA2 and RA3 is not clear. Once a doctor becomes eligible for a GPRIP Retention payment, the payment will be on-going provided the service (billing) level is maintained.

RWAV suggests the retention payment is most likely treated as taxable income and considered an entitlement, rather than a workforce retention incentive. In order to overcome existing problems associated with the recruitment and retention of doctors to underserviced rural and remote areas, equitable resource allocation for doctors should be based on: nature of activity and service provided by doctors in their community; and their attractiveness, both professionally and non-professionally as settings to work and live in.

It was noted there has been limited up-take of the relocation component of GPRIP and this may be the result of the strict eligibility requirements including the need to meet minimum level service (billing) requirements. Moving to a relocation support package administered by the RWAV would enable payment of the actual relocation costs incurred by a doctor and his family at the time of relocation and permit access to locum relief arrangements with associated support funds.

Rural exposure for junior doctors

RWAV argued that junior doctors should be exposed to rural general practice early in their careers to help inform career choices. This would be beneficial as part of the rural general practice training pipeline that enables better targeting of participants to help ensure that the system develops the right doctors for rural general practice.

RWAV also argued that doctors subject to s19AB of the *Health Insurance Act 1973* were required to train on the rural pathway, and on completing training and Fellowship, often move into a DWS location in the city rather than remaining in a rural area. The new National Framework for Internship allows for intern terms to be taken outside the hospital, so the concept of a 'Rural Intern Term Workforce Program' offering an intern term in rural general practice could be an option.

Appendix 2 – Junior Doctor Training in Rural Practice

Maintaining the continuum and building greater capacity – a case study by Dr Paul Mara

It is now accepted, intuitively and backed by research, that recruitment for rural practice is greatly enhanced through affirmative selection of students with a rural background and rural exposure at all levels of education and training.

Gundagai is a small rural community on the Hume Highway around 4 hours' drive from Sydney. The town has a population of around 3,000 and the only practice has a patient base of around 4,000 with over 3,000 SWPEs (Standardised whole patient equivalents). There are two practice principals in the sole practice and services provided to the community include hospital in patient and acute emergency care through the casualty and all after hours care which is maintained almost entirely by the practice doctors. The practice is a teaching practice and over many years has participated in undergraduate teaching and supervision and training of GP Registrars.

Some years ago the practice was approached by Prof Graham Richardson from Wagga Wagga Base Hospital with a vision to commence the Prevocational General Practice Placement Program in the region and allocate a PGY2 RMO to Gundagai under ten week terms.

The aim of the program was seen as having benefits for the hospital system in being able to place some of the extra doctors coming through the increased graduation from medical schools, providing exposure to community medicine in a quality teaching environment, supporting increased professional responsibility, and being exposed to rural practice.

The central organisation of the program was exceptional, and commitment shown by Prof Richardson was likewise.

Experience over five years with the Prevocational General Practice Placement Program in Gundagai did not only support this notion but had additional professional and personal benefits for established practice doctors, junior doctors, the practice and ultimately the community that were more immediate that what might have been first anticipated in terms of workforce support.

The PGPPP in Gundagai was a breath of fresh air and for the first time in over 25 years of full time rural practice providing primary care and hospital based services and teaching GP Registrars under GPET, was seen as the light at the end of the tunnel in terms of improved workforce and succession planning.

It is true to say that without the PGPPP, the professional services of the established doctors could not have been maintained and certainly not at the then current levels.

The PGPPP scheme immediately, not only improved the workforce situation in the short term, by providing an extra doctor with excellent training and skills and a willingness to provide high quality support for hospital, on call, emergency and after hours services – albeit under strict supervision requirements, but also improved immediately the professional, intellectual, economic and social capacity in the practice and indeed the community.

In addition doctors coming from a known hospital environment in the regional base hospital where they were themselves known had improved access to services when required such as for after-hours emergencies. Liaison with the referral hospitals improved significantly, and follow up of patients and feedback was more contemporaneous and worthwhile as these junior doctors could communicate more effectively with their peer colleagues than GP Registrars coming from other environments and perhaps cultures.

Systems of accreditation ensured that the practice required more sustainable and systematic educational programs and support structures that built capacity in practice systems for education of medical students and GP Registrar teaching. Interaction at all levels was promoted. Development of practice infrastructure and new services were supported through the PGPPP. Community infrastructure was required and developed for accommodation for PGPPP in addition to student accommodation and as a side effect this accommodation was able to be used for locums as well when required.

A cohort of the first PGPPP trainees became our GP Registrars, providing much needed continuity for the practice and patients.

A mini analysis of the PGPPP program in Gundagai was undertaken for the purposes of this review. All previous and current PGPPP trainees in an email survey were asked:

- tell us what you are doing now and what you see as your career goals
- tell us what you thought of your time at GMC, what professionally and personally you got out of the term
- give us some insights as to whether it influenced your career path decision
- any other comments or feedback you might make as to how the system can be better designed for the future.

In no way should this analysis be seen as definitive, but it is evident from the responses that the values we, as practice principals, placed on the programme were reflected in the comments from trainees and professional intentions.

In particular around 70 per cent of the over 30 doctors who undertook a PGPPP term in Gundagai are now either training for or practising in a rural or remote region as either a general practitioner, procedural non specialist rural doctor or trainee, or as a specialist with declared intentions of practising as a regional specialist obstetrician or paediatrician.

This compares with less than 5 per cent of GP registrars that have trained in Gundagai over 25 years, the vast majority of whom elected to do the rural training stream of GPET.

Overall, the ten week PGPPP term was rated by trainees at the completion of their placement extremely highly, even amongst those who had specialist career aspirations, established before and after the term. One doctor having assertively declared his intentions to undertake orthopaedic speciality training before and during the term, in his survey response stated:

“My time at GMC was invaluable experience allowing significant (growth in) confidence and professional development in a supportive environment. The staff and supervisors made it such an enjoyable experience that I have altered my planned career path.”

For us and these doctors, the PGPPP was not simply about getting them to become rural doctors or even GPs. To be sure, two of our PGPPP trainees are now completing their FACRRM in Gundagai and are committed to remaining in the practice and community and by this measure alone it can be seen as a success. But the programme has brought far more benefits to the practice and community, benefits that have contributed to moving from a practice with an uncertain future to one that with the PGPPP became viable and sustainable.

Perhaps these can be best expressed in some of the comments from the respondents to our mini survey:

"I found my time at GMC to be a great experience, and something that I am definitely glad I got the opportunity to do, probably more so because I did not choose a career in general practice. Although I had done various placements within general practice as a student, I found it quite a different experience as a resident, as I was able to take ownership and responsibility for my patients, and was also able to follow-up with the outcomes of various advice, treatments and referrals. It also enabled me to more fully appreciate the needs and also the limitations of GP's, the benefits of multidisciplinary care and the importance of a good discharge summary! I think the PGPPP experience provided by GMC was a great opportunity to see the scope of GP practice - from short consultations to on call and hospital visitations. This is quite a unique experience to have as a resident, and even within PGPPP terms - I know my city-based colleagues who did PGPPP terms certainly did not have those opportunities. I felt my term was very well organised, with good supervision, structured and unstructured teaching (including going back to Wagga for formal teaching) and the opportunity to see a wide range of patients."

"Although the path I chose was not that of general practice I still value the experience for the understanding of primary health care it gave me, and if I had to choose my resident terms again I would still do a PGPPP term."

"I grew up in the city and had always imagined myself as a city girl until I did a rural term in University. That made me become passionate about working in rural and regional areas and therefore I completed my internship and residency in Wagga Wagga. The PGPPP was one of the highlights of my time as a resident. It was a big learning curve to be having your own patients to look after, with fantastic supervision and great 1:1 teaching opportunities you don't get as a junior doctor. I found the on call a little scary in the beginning, but again, the support was always there, and I think it was this initial introduction to on call that has made the transition into O&G and the on call associated with it a lot easier. You hear it often, but life and the people who live in rural and regional centres are different, medicine in these areas is different, you are not spoilt with the same resources as that in the city, and your skills as a doctor, especially as a rural GP are greater- for a young doctor working in this environment, this is the bread and butter stuff that you learn and you keep with you, and I certainly learnt it in Gundagai!

Working in general practice, especially at the GMC, taught me more than clinical skills. Seeing your patients one on one and following them up strengthened my communication skills as well as my confidence. Having to see multiple patients with appointments taught me about good time management, a skill that is invaluable as any doctor, generalist or specialist, especially when

you have to run a busy antenatal clinic, a skill that you don't always acquire as a junior doctor on the wards!"

"Perhaps it may seem odd that a rural general practice term may have influenced my career path when I don't work in general practice or in a rural or regional area, however, I'd like to think my experience has contributed to the doctor I am today. In terms of my future, I want to return to the country- most likely a regional centre- to work as a specialist obstetrician/ gynaecologist. I am aware of the need there is and I am encouraged by the experience I had in Gundagai and the support I have had in the process.

I have to also mention that I enjoyed my PGPPP placement in Gundagai so much, I managed to do another PGPPP later that year at Cootamundra, which was similarly a great experience, albeit a little different!"

"On a personal level, it was very welcoming both in terms of staff and patients. I mainly grew up in Sydney, so it was the first time I'd lived in a rural township for that length of time which was fun and educational in a way."

"I felt that at Gundagai unlike many rotations, we were actually quite useful clinically and provided a service to the patients."

"Not all the PGPPP practices ran the same way. I spent time at other practices. I liked the GMC approach of adequate patient numbers, protected teaching, autonomy to see patients and present all initially then only those where I felt support needed or if making referral or invasive tests."

"My time at GMC was the first opportunity that I had experienced (in my 18months of being a medical officer to that time) to be individually responsible for a patients care. It was the first time, when I had the opportunity to sit in front of a patient and know that I would be working on the problem that they presented (whatever it may be) and working out not only what the next steps would be but making sure that those steps occurred. In contrast to the hospital where as a junior doctor very little responsibility is given and mostly enacts the plans given by senior doctors, at GMC I had the opportunity to see undifferentiated problems, make assessments and diagnosis and put plans into place. I did not however, feel unsupported in this responsibility and the ability to have access to a senior and experienced doctor in the next door room was invaluable not only in reassuring me that patients were getting safe treatment but also in developing my handover and communication skills and refining my clinical reasoning."

"Make PGPPP compulsory for all RMOs. It is inconceivable that most medical professionals can now progress from being students to sub specialist physicians or surgeons without ever spending a day actually working in a General Practice which is the place where all medical care for patients starts and finishes. We currently would not consider doctors to be properly prepared or trained if they have not ever having a surgical or emergency placement so when primary care in general practice is the lynch pin of health care, why should we consider any doctors as properly trained that have never worked in it?"

"I learnt to triage in emergencies and to begin to work out my own professional limits"

"My term at GMC was the most educational of all of my terms as a resident doctor and intern. The term provided an ideal balance of independent work, within a supervised setting, and gave the opportunity to experience a wide breadth of medicine. The term was the only opportunity I had as a resident medical officer to experience outpatient medicine. Despite working in regional, outer-metropolitan and inner-city hospitals throughout NSW, I did not have another opportunity to experience outpatient medicine until my fifth working year as a doctor, and after I had completed my specialist physician examinations. Outpatient medicine now makes up the vast majority of my practice, and my experiences through the PGPPP program were the first to highlight to me the value of preventative medicine and long-term patient care."

"Though I chose to pursue physician training, experience working in General Practice was invaluable in understanding the vital importance of a healthcare team to provide optimal patient care."

"My experience through PGPPP continues to influence the way I practice medicine, as the program allowed me to appreciate that a patient's general practitioner is the vital driver of the patient's healthcare. This has influenced the way I communicate and work with other health professionals and my patients. Through General Practice training, GP trainees have multiple opportunities to experience other medical specialties. However the PGPPP program is the only method through which trainees from other specialties can experience General Practice. As someone who was fortunate to experience this unique training perspective, I have made a point of sharing my experiences with my colleagues and junior staff."

In summary:

Benefits of the PGPPP to Gundagai Medical Centre – a practice perspective.

- Immediate workforce support and longer term real opportunities for succession planning;
- Support for a more satisfying integrated teaching and service delivery practice model in a small rural community;
- Able to sustain a higher level of service in the community including after hours, emergency and hospital based care;
- Support for capacity building within the practice at professional, clinical, infrastructure, economic levels;
- Stimulus to maintain practice facilities and development;
- Personal professional development enhanced through teaching and interaction with a wide range of junior doctors with differing skills, knowledge and perspectives;
- Improved interactions with referral hospitals, feedback and follow up of patients;
- Opportunity to meet other people and satisfaction of seeing ongoing professional growth and personal development within young colleagues; and
- Opportunity to engage junior doctors in a discussion about general and rural practice and improve their understanding of the need for high quality primary care services and challenges with delivery.