RACP
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Working Better for Medicare Review – RACP responses

Main issues

In your view/experience, what are the main issues regarding access to primary care, GPs and/or medical specialists, and their distribution across Australia?

METROCENTRIC RECRUITMENT AND TRAINING PRACTICES

- Paucity of doctors selected from regional, rural and remote (RRR) environments at medical schooling entry.
- Most medical school positions and specialty training positions are based in metropolitan settings or require significant periods of training time to be completed in metropolitan.
- Specialty college training criteria and hospital accreditation that supports end to end RRR participation is inconsistently embedded.
- General devaluation of the enormous professional rewards of RRR practice.

Whilst this is changing at the medical school level, what needs to change is the pipeline so that post medical school, graduates can continue to train rurally and regionally.

OVERLY SIMPLISITIC CLASSIFICATION OF RURALITY

Existing frameworks based on a simplistic MMM that fails to appreciate or recognise the factors that attract or dissuade practitioners from working in a particular location. In addition, these incentives prioritise GP specialists and there is comparatively little focus on son-GP specialist medical workforce initiatives. Work life integration needs like childcare, accommodation, relocation and partner support are seldom addressed.

UNDERFUNDING OF COMMUNITY AND COLLABORATIVE CARE MODELS

Jurisdictional health services are taking an increasing role in providing community-based non-GP specialist services (e.g. Big Idea: Medical Community Virtual Consult Service - Northern Health Virtual consult service is supporting GPs to deliver specialist-level care in the community. Specialist Outreach Clinics | The RMH RMH refugee health outreach clinic. Outreach clinic brings expert cardiac care to small communities - News (nsw.gov.au) NSW health specialist cardiac outreach.) However, there are no robust funding models for collaborative care or practitioner-to-practitioner consultations. In the absence of additional incentives for non-GP specialists to develop community-based interdisciplinary services, pressure on local health services will continue to escalate.

Health services and consumers must also navigate gaps in service and funding between jurisdictional and federal funding.

INADEQUATE WORKFORCE PIPELINE MANAGEMENT

At state and territory level there is no agreed means of managing number of training and service delivery positions across public hospitals, ensuring balance of metropolitan and regional posts. This perpetuates metropolitan vs rural maldistribution. Overreliance on overseas trained transitional workforce with mechanisms like 19AB which only serve as an inequitable stop gap measure.

Positive impacts on access

How do the specific workforce distribution levers being reviewed help or support access to primary care, GPs and/or medical specialists?

Please type or paste comments specific to section 19AA here.

This is a reasonable requirement that remains relevant to ensure practitioners accessing Medicare benefits are subject to specialist College training and CPD requirements where applicable, and that Australian communities have not only access to healthcare, but also that this care is of a subject to consistent quality standards.

Please type or paste comments specific to section 19AB here.

The 19AB access to Medicare for overseas trained doctors and foreign graduates of an accredited medical school is not a mechanism that meets the needs of underserviced communities (DPA or DWS) or that of practitioners. It perpetuates a narrative of 'any doctor is better than no doctor' and places vulnerable practitioners, who often have limited understanding of Australian health care systems and culture, in the most under-supported environments for them personally with limited supervision and fewer opportunities to develop requisite clinical, communication and professional competencies. Such practitioners should rather be in better served communities and practice settings. Underserved communities deserve and need higher functioning and locally oriented GP and non-GP specialists who have a more highly developed appreciation of how to negotiate the Australian healthcare system for their patients and communities. To achieve this requires supporting and expanding initiatives to attract and retain Australian trained medical practitioners to work in underserved communities through a combination of selection to medical school and training, significant rural training and exposure in medical school, prevocational and vocational training for all specialties and incentives (financial and other supports – CPD, childcare, schooling, relocation, retention).

This system creates a two-tier system of doctors where overseas trained doctors are forced to travel to rural areas. This suggests that rural people are not entitled to the expertise of world class trained non-GP Specialists and GP-Specialists that represent those trained locally in Australia. It creates a two-tiered system in which those from overseas face requirements to work in a significantly more challenging and clinically demanding position in a rural area with potentially less supervision and support available in a metropolitan area – all while navigating an entirely new healthcare system. This expertise is often the only expertise available to people in rural and remote areas – thus leading to potentially lower standard of care than available to those in the metropolitan centres.

Please type or paste comments specific to the District of Workforce Shortage (DWS) classification here.

DWS DOES NOT READILY TRANSLATE TO ALL CLINICAL POPULATIONS/PROFESSIONS

DWS could be useful but is too blunt a tool and focuses only on overseas trained graduate specialists. To avoid provider driven Medicare based activity in overserved areas DWS should be extended to all practitioners. A focus on overseas trained specialist is counterproductive and drives the issues highlighted in association with 19AB above.

Please type or paste comments specific to the Distribution Priority Area (DPA) classification here.

Please see comments above for DWS as the same applies to General Practitioners.

Please type or paste comments specific to the Modified Monash Model (MMM) classification here.

MMM MISSES NUANCES AROUND SOCIODEMOGRAPHIC FACTORS IMPACTING CARE PROVISION

MMM is a useful tool and reasonably reflects service access. However, basing incentives only on MMM fails to recognise other issues of remoteness for practitioners in including cost and time taken in accessing local or interstate capital cities where much of the high-quality training required for CPD for GP and non-GP specialists is accessed and where international travel hubs are typically located for both holidays, families and CPD. In addition, MMM fails to address, for medical practitioners, the local cost of living and access to other factors which make a particular site or regional attractive including access to childcare and high-quality primary, secondary and tertiary education. Access to care in the urban fringe is also problematic and many communities are subject to deep inequities in access even though they live in a comparatively urban setting.

Alternative tools that could be integrated into more nuanced models of assessing workforce shortage. E.g. Workload Indicators of Staffing Need (WISN) WHO tool. Workload indicators of staffing need (WISN) (who.int) These have been used in global health context. Applying the workload indicators of staffing needs method in determining frontline health workforce staffing for primary level facilities in Rivers state Nigeria | Global Health Research and Policy | Full Text (biomedcentral.com) Also growing area of research interest in high resource settings. Assessing needs-based supply of physicians: a criteria-led methodological review of international studies in high-resource settings | BMC Health Services Research | Full Text (biomedcentral.com).

Negative impacts on access

How do the specific workforce distribution levers being reviewed hinder or limit access to primary care, GPs and/or medical specialists?

Please type or paste general comments here.

LEVERS DO NOT ADDRESS PRACTITIONERS' WELLBEING NEEDS OR COMMUNITY CARE NEEDS APPROPRIATELY

The current focus on overseas-trained doctors and foreign graduates of an accredited medical school is not a mechanism that meets the needs of underserviced communities (DPA or DWS) or that of practitioners. It perpetuates a narrative of 'any doctor is better than no doctor' and places vulnerable practitioners, who often have limited understanding of Australian health care systems and culture, in the most under-supported environments for them personally with limited supervision and fewer opportunities to develop requisite clinical, communication and professional competencies. Such practitioners should rather be in better-served communities and practice settings. Underserved communities deserve and need higher functioning and locally oriented GP and non-GP specialists who have a more highly developed appreciation of how to negotiate the Australian healthcare system for their patients and communities. To achieve this requires supporting and expanding initiatives to attract and retain Australian-trained medical practitioners to work in underserved communities through a combination of selection to medical school and training, significant rural training and exposure in medical school, prevocational and vocational training for all specialties and incentives (financial and other supports – CPD, childcare, schooling, relocation, retention).

Please type or paste comments specific to the District of Workforce Shortage (DWS) classification here.

PROCESSES FOR DETERMINING DWS SUBSPECIALTIES LACK TRANSPARENCY AND RISK MISSING AREAS OF UNMET COMMUNITY NEED

DWS subspecialities not current. These should include rheumatology, endocrinology, neurology, gastroenterology, infectious diseases, urology, ENT, paediatric surgery, orthopaedics as they are sorely lacking in public hospitals in regional, rural and remote areas. If we looked at subspecialty areas that most impact duration of hospital admission and morbidity these subspecialities would be included (https://rheumatology.org.au/Portals/2/Documents/Public/About%20the%20ARA/News%20and%20media/ARA%20Workforce%20Doc_DIGITAL_compressed.pdf?ver=2023-02-16-164318-850 Neurology Modelling accessibility of adult neurology care in Australia, 2020–2034 | BMJ Neurology Open Endocrinology Endocrinology.pdf (endocrinesociety.org.au)).

Depending on sociodemography of a location community care needs can change dramatically. Using population ratios does not reflect this level of complexity. This also extends to communities at the urban fringe and outer metropolitan growth corridors. In addition, the DWS is not updated frequently enough. It is meant to be updated every year however, the last update was July 2022.

Please type or paste comments specific to the Distribution Priority Area (DPA) classification here.

The DPA not updated frequently enough as the last update was July 2022.

Please type or paste comments specific to the Modified Monash Model (MMM) classification here.

MMM is not updated frequently enough. The last Australian census was 10th August 2021 but the update to the MMM is still in progress.

Impacts on availability of training
The workforce distribution levers being reviewed are not working to significantly increase the availability of training opportunities. Colleges would benefit from closer collaboration with Commonwealth and AMC to enable prevocational and vocational training within RRR settings as has been successfully implemented in medical schools. The training and post-vocational pipeline involves multiple stakeholders. The Department of Health and Aged Care could prioritise regional, rural and remote training opportunities through dedicated funded supervision and support programs like RVTS (rural vocational training scheme). This program can be applied to non-GP subspecialties and rolled out in any regional, rural and remote site the trainee is willing to go through remote, local and group supervision opportunities. Colleges could support accreditation of training opportunities that meet the accreditation criteria, further embed flexible training criteria, and provide best practice examples from across the sector.

The STP program could be improved so that it links these training sites with networks across the jurisdictions, improving wellbeing and supervision models. In addition, more agility is needed to manage STP positions that fall vacant.

Dedicated joint collaboration between The Department of Health and Aged Care (funding and health service engagement) and speciality colleges will truly “shift the dial” in regional, rural and remote workforce development. It is known that trainees will go where there are supported opportunities. Innovative and strategic collaborations across the sector with nurtured training opportunities are a potent solution.

How do the specific workforce distribution levers being reviewed impact the availability of training opportunities for primary care, GPs and/or medical specialists?

There is a perception that recent Medicare and health policy reviews have been weighted in favour of GP specialists. In addition, there is often inadequate representation of rural regional and remote practitioners across the MMM3 – 7 spectrum. The resultant outcome is that workforce measures often specifically target GP specialist workforce and miss key requirements for non-GP specialist workforce.

Examples include:

- the original MRBS model which was difficult to implement for non-GP specialist training.
- DWS model which does not account for majority of specialisms.
- Integrated Rural Training Pipeline (IRTP) training funding which is not possible to do while on most specialist training pathways (requires 2 of your 3 years of

advanced training to be in a rural area which is not possible on most training pathways).

Impacts on quality of practice

How do the specific workforce distribution levers being reviewed impact the quality of practice for primary care, GPs and/or medical specialists?

19AA

Supports some measure of standardisation but could do more to improve the efficiency of vocational registration.

Requiring practitioners to be registered with a delegated authority allows them to access professional development supports to enable better quality care.

19AB

Enforced practice in a particular region can have impacts on practitioner wellbeing.

Can result in a mismatch between practitioner existing and aspiring professional skillset. Better quality outcomes are delivered when practitioners are working within their optimum scope and have capacity to manage clinical risk. This includes decisions about how, when and where they practice.

Workforce classifications – DWS

Workforce classifications are inadequate as a means of dictating or driving quality of care. While it provides a numerical basis for comparison between areas it does not accurately gauge quality of care delivery.

Looking at specialties in isolation also misses the opportunity to measure and embed interdisciplinary care models. The availability of a care team is often a greater driver of patient outcomes than the availability of an individual practitioner. Newer models of assessing “thin markets” could look at evaluating access to -team-based care rather than individual craft group care. For example, a comprehensive cardiac rehabilitation plan should involve cardiologists, allied health professionals and GPs. DWS and other levers do not address this need meaningfully.

Solutions

What are possible solutions to the issues you have highlighted that could improve access to primary care, GPs and/or medical specialists? What needs to change about specific workforce distribution levers being reviewed or how they are used?

Please type or paste general comments here.

- The RACP has a Regional Rural and Remote Physician Strategy the provides many recommendations that would help provide solutions to the issues identified previously.
- Monitor and proactively adjust numbers of additional training and service delivery positions in metropolitan centres.
- Facilitate additional funding for regional, rural and remote services to build and sustain accredited training positions. Recognise that activity-based funding does not accurately reflect the complexities and challenges of providing a service in a rural or remote location.
- Increase rural medical school positions in regionally based universities with preferential acceptance of regional, rural and remote medical students e.g. CSU, Latrobe.
- Develop end-to-end selection to training policies and procedures that support participation of people from Aboriginal and Torres Strait Islander and rural backgrounds e.g. 5-point ATAR boost as for most other degrees in NSW (Understanding University Bonus Points Schemes | Matrix Education Bonus points scheme is quite well evolved and has been shown to increase inclusion and accessibility of otherwise marginalised groups. Now re-labelled adjustment schemes. Adjustment Factors | Western Sydney University)
- Facilitate training opportunities regionally or accreditation of sites with hybrid supervision e.g. Local specialist and remote specialist supervision. We need to encourage flexible supervision arrangements to shift the dial in workforce needs.
- Completely review the DWS model for funding as current set up is inadequate for non-GP specialist workforce – ensure that working group for this includes equal representation from rural and metropolitan areas and includes adult and paediatric specialities. Ensure that the new model accurately represents the challenges of working rurally including accounting for distance to medical care by hospital catchment (not ABS classification); social and medical complexity of caseload; and difficulties for incoming health workers to access services for themselves (accommodation, employment for partners, education and childcare)
- DWS models should evolve to enable assessment of access to interdisciplinary team-based care models as opposed to individual practitioner/speciality access.
- Add rural and remote loading to Medicare items according to DWS and DPS classification. If the DWS and DPS accurately represent both workforce shortage, clinical caseload complexity and local challenges for rural workforce then the Medicare rebates can accurately reward those who make the sacrifice to work in rural areas.
- Classification of rurality in a healthcare context should include basic indices such as ratio of particular specialists or non-GP specialists to population (this should be done by hospital catchment and NOT by ABS area classification as it is currently for DWS- this is one of the major shortcomings of DWS); Distance from nearest tertiary hospital; Proportion of indigenous population; Proportion of people in the lowest socioeconomic quartile; and proportion of people with poor healthcare

outcomes on key indices as this represents a clearer classification of the degree of complexity of the rural area.

- Develop and embed new funding models that reflect and support the value of community-based care and collaborative practice. That includes practitioner to practitioner consultation. This could also drive greater innovation and partnerships between metropolitan and rural services. Specialists should also be eligible for Commonwealth incentives when and where they provide community-based specialist service, whether Medicare is accessed or not.
- Develop and embed new funding models that allow for complexity of clinical caseload and distance from services in order to provide financial and other incentives to rural practitioners to move and stay in rural areas.
- Continue the Welcome program described above. Key program that makes a huge difference.