Role of Single Employer Models in remote and rural health services

POSITION STATEMENT

College position

Single Employer Models (SEMs) are a key strategy toward building a strong Rural Generalist (RG) workforce and should be progressed as a policy priority.

ACRRM is committed to advancing appropriately designed SEMs and contributing to their development and delivery including for registrars and Fellowed RGs.

The College supports SEMs being provided as part of a range of employment options as befitting the diversity of RG training and practice contexts and the training and career journeys that RGs pursue.

Pay and conditions for RGs should fairly reward their skills and services and incentivise the growth of this critical workforce. RGs provide broad scope services to meet the needs of people without the ease of access to specialised services available in cities. Attaining this skillset involves training across multiple workplaces and a longer and more complex training journey than that requisite for generic General Practice Fellowship.

The SEM approach addresses key barriers to attaining this scope, most notably the inability to accumulate job entitlements across the training journey.

SEMs can also have broader benefits such as streamlining RG training and nurturing better integrated cross-services patient care.

To be effective, SEM models must:

- Include strong cooperation between participating doctors, practices, and health services in design and delivery
- Be purpose fit to the diverse contexts in which RG training and practice occur
- Ensure the training employment conditions coincide with suitably remunerated and incentivised RG careers beyond Fellowship
- Be compatible with RG training and practice standards and requirements
- Involve ACRRM in design and roll out as arbiter of professional standards for RG training and practice.

SEMs should be progressed where they can contribute positively to strong, sustainable remote and rural health services. Positive employment conditions for RGs should coincide with appropriate remuneration and conditions for all members of remote and rural healthcare teams and healthcare providers.

Supporting the RG Workforce

A strong RG workforce is a key solution to restoring sustainable health care services to rural and remote communities.

There is comprehensive evidence that rural and remote communities experience inequitable access to all medical care and especially to consultant specialist care and this access inequity is coinciding with people in these communities recording significantly worse health outcomes than their urban counterparts.[1]

The per capita number of non-GP medical specialist services received by people in outer regional areas was 25% lower than in major cities, and 59% lower for people in remote and very remote areas and lower by 9%, and 36% respectively for GP services. Similarly, per capita MBS funding for non-GP services declined by 16% for people in outer regional areas, and 59% for people in remote and very remote areas, compared to that spent on people in major cities and by 8%, and 28% respectively for GP services.[2]

RGs can maximise the breadth of medical services available locally. They also record rural retention levels without parallel across medical specialties. This is evidenced by external studies of ACRRM Fellows[3] by the outcomes of the Queensland Rural Generalist Program[4] and by the around 80% of ACRRM (RG) Fellows who are rurally-based. By contrast, for example, 12% of Fellows of RACS (FRACS) live and work rurally and for five of the nine surgical specialties, less than 5% of surgeons were based outside cities.[5, 6]

Version 1.0
Date published: March 2024
Date for review: February 2027

Fellowship as a RG confers that a doctor has attained competency to practice across a broad range of healthcare settings as appropriate to meeting the breadth of healthcare service needs of their rural and remote communities. Thus, training to this scope of practice at minimum involves considerable training time in both hospital and primary care settings and in practice typically involves complex movements between a range of settings in a range of locations to ensure all necessary skills and experience are attained.

The National Rural Generalist Taskforce Advice Paper recognised that the complexity of this training represented a barrier to doctors training to this career. A key disincentive was that RG registrars forewent the opportunity to accrue workplace benefits. Consequently, it included the following recommendation which facilitated the subsequent exploration of these models:

Recommendation 9: A mechanism for ensuring preservation of employment benefits and continuity of mentorship, for example, a "duration of training contract" by a single employer, is included in the business case for the (National Rural Generalist) Pathway.[7]

Many of the problems of complexity and entitlements associated with working across multiple employers can also apply to RGs post Fellowship. There may be opportunity for SEMs to support remote and rural workforce development by providing an attractive employment option. Additionally, SEMs have the potential to provide an RG service delivery model that can provide services in remote and rural communities that may not be able to attract or sustain private medical services.

The Model in Fellowship Training

Under SEMs, registrars maintain one employer for the duration of Fellowship training usually a jurisdictional health service. The Single Employer provides the participating registrars' salary and work entitlements, and secondment arrangements are established with the additional workplaces in which the registrar may train. In the ideal under these arrangements, training toward a Fellowship qualification as a specialist General Practitioner and RG would provide a seamless movement between hospitals, general practices and other work settings such as Aboriginal and Torres Strait Islander Medical Services or Retrieval Services.

There are a range of SEM arrangements in place across the country and it is anticipated that further variations will emerge as other states and Territories develop their own bespoke programs.

- The Murrumbidgee Model trial was established in 2020 through an agreement with the Commonwealth health department and the New South Wales (NSW) Murrumbidgee Local Health District (MLHD).

  The agreement grants a limited exemption to Section 19(2) of the Health Insurance Act 1973, which prohibits the payment of Medicare benefits where other government funding is provided for that service. The exemption allows the jurisdictional health service to be the employer of doctors who provide Medicare billed services.

  Under this model, doctors enrolled on a FACRRM or FRACGP Fellowship pathway can apply under the program. In joining the program, they are also enrolled in the NSW Rural Generalist Training Program and commit to training in locations in the Murrumbidgee region. They are employed under the state award by the MLHD. The MLHD enters an agreement with each of the participating general practices. Under these agreements, registrars' services within practices are billed to Medicare and the MLHD invoices the practice for the billable hours worked in the practice by the registrar.
- A SEM has been established in South Australia since 2022 which can be undertaken in association with ACRRM Fellowship training. The model is delivered in association with the Riverland Academy of Clinical Excellence (RACE). Participants are employed by the Riverland Mallee Coorong Local Health Network (RMCLHN) to work across both hospitals and community-based health services including private GP clinics in the region.
- A range of SEM type arrangements have been operating in Queensland for many years including the Central West Hospital and Health Service model.[7]

Community Benefits

Investment in SEM programs has the potential to benefit the community by contributing to a more coordinated approach to workforce development and delivery in the interests of people in rural and remote areas including in Aboriginal and Torres Strait Islander communities. Appropriately designed programs will foster positive collaboration between the health services in that area. The program's delivery will involve ongoing engagement and cooperation across local healthcare providers and the Fellowed RGs emerging from such programs will be doctors with a strong understanding of, and professional connections with general practices, hospitals and other health services across their regional area.

SEM programs will also build the attractiveness of RG training by offering the following registrar benefits:

- Maintaining employee entitlements and allowing their accrual over the training journey
- Minimising the duplication of the employment administrative processes
- Providing a relatively seamless training experience as they move between private practices, hospitals, and other workplaces with prioritised and/or facilitated access to hospital training placements as required
- Providing a single authority that assumes overarching responsibility for registrars' welfare as employees and takes responsibility for issues such as fatigue management and leave entitlements.

Beyond attainment of Fellowship, SEMs may provide an employment option that may increase the attractiveness of RG in remote and rural communities. It may also provide a viable medical service provision option to remote and rural communities that are unable to deliver services through market-driven processes.

Optimising Community Outcomes

There are a range of potential issues that may arise from SEMs and careful design is required to ensure the implementation and expansion of these programs leads to the best possible outcomes for rural and remote communities.

- **Managing conflicting interests**

  The Single Employer must ensure that the interests of positive, high quality training experiences, and the longer-term outcomes for building sustainable rural and remote services are not undermined by narrow or short-term organisational imperatives.

  Retaining a future workforce relies on positive training experiences, thriving local practices, and strong health service teams in rural and remote communities. It is important that all stages of the development and implementation of the SEM programs include strong engagement with rural and remote communities, the colleges, and the local practices to ensure that program determinations consider all these perspectives. Key will be a whole-of-program recognition of the shared goal of building a RG workforce to underpin strong, sustainable local services.

  These principles would apply in any SEM initiative for Fellowed doctors.

- **Mobility and flexibility**

  The terms and conditions of agreements may involve prohibitive limitations to the terms of the training including to the locations in which participants can train and practice. It is noted that the 19(2) exemption requires that training occurs in a specific location and there are potentially a range of other specifications for participation in SEM programs which may render them unattractive or unviable for many potential registrars.

  Models should incorporate flexibility to enable training that is attractive to registrars, that can accommodate their personal circumstances and allows them to meet all their training requirements.

  More broadly SEM programs including those for employment post Fellowship should seek to enable flexible arrangements to accommodate diverse work arrangements potentially across multiple locations as befits the needs and exigencies of the context.

- **Relative competitiveness of terms for registrars**

  SEMs in training programs should offer competitive terms and conditions relative to other employment models available to other trainee doctors with comparable skill sets. A principle of same pay for same work should apply.

- **Enabling training and career pathway options**

  A one size fits all approach should be avoided and alternative options should be available in RG training and practice such that SEM programs do not leave participating doctors and practices worse off.

  RG training is designed to accommodate the diversity of rural and remote communities across Australia and their associated health service models. It is unrealistic to expect any one model to be a good fit for every RG registrar or for every ACRRM accredited training practice. The best training and workforce outcomes will arise where registrars are able to pursue an employment model best suited to their individual circumstances.

  Similar principles would apply in any SEM initiative for Fellowed doctors.

- **Supporting RG practice in Fellowship Training**

  SEM initiatives should maintain their essential purpose as an enabler for RG workforce development.

  The SEM approach has been designed specifically to address the additional complexity of the RG training journey and its necessary integration of hospital and primary care training. Implemented SEMs associated with Fellowship training need to continue to address this additional complexity and particularly to ensure RGs have facilitated access to the hospital training requisite to attainment of Fellowship.

The fundamental principle remains under all circumstances that it is important to have strong, attractive, fit for purpose training pathways to accommodate the diversity of rural doctors.

Find out more

If you have any queries relating to this Position Statement, please contact us by:

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Endnotes

1 Australian Institute of Health and Welfare (AIHW) (2019). Rural and remote health. Cat. no. PHE 255. Canberra, **https://www.aihw.gov.au/reports**.

2 AIHW. (2021). Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21. Retrieved from **https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21**.

3 McGrail M, O'Sullivan B (2020). Faculties to Support General Practitioners Working Rurally at Broader Scope: A National Cross-Sectional Study of Their Value. International journal of environmental research and public health, 17(13), 4652. Retrieved from **https://doi.org/10.3390/ijerph17134652**.

4 Queensland Health (2022) Queensland Rural Generalist Pathway 2020 Data Snapshot. Accessed at January 2021. Retrieved from: **https://ruralgeneralist.qld.gov.au/about-us/**

5 RACS (2020) Rural Health Equity Strategic Action Plan: 15 December 2020. Retrieved from: **https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/interest-groups-sections/Rural-Surgery/RPT-Rural-Health-Equity-Public-FINAL.pdf**

6 Cth Aust – Dept of Health (2021) National Medical Workforce Strategy. Pg.35 Retrieved from: **https://www.health.gov.au/our-work/national-medical-workforce-strategy-2021-2031**

7 Rimmer D et al (2015). Central West Single Practice Service Model Paper presented to the Rural Medical Australia Conference, October, 2015.

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live and pay respect to their elders past present and future.