College Submission

March 2024

Feedback to the Working Better for Medicare Review

Initial Comments

ACRRM welcomes the opportunity to provide feedback to the Working Better for Medicare Review. Australians living in rural and remote communities, including First Nations communities, deserve equitable access to a high standard of healthcare commensurate with that provided to their urban counterparts. While rural and remote models of care may take different forms to those available in major cities, they should be designed and funded to ensure peoples' access to continuous, local primary medical and health professional care along with acceptable and timely access to emergency, secondary and tertiary care.

To make positive progress towards achieving these outcomes, increased investment in Rural Generalist training and supervision; Rural Generalist recognition; and initiatives to further strengthen Medicare within the rural and remote context to meet the healthcare needs and circumstances of rural and remote communities, including Aboriginal and Torres Strait Islander communities, are required.

Response to Consultation Questions

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

Australia's overall doctor to population ratio is among the highest in the OECD and many areas of medical practice are in plentiful supply or even over-supply.[1] Maldistribution of the medical workforce however, both in terms of location and specialisation, continues to result in pervasive workforce shortages across rural and remote Australia. These shortages are contributing to unacceptable inequities in terms of healthcare outcomes for the people affected by them.

The tripling of the number of Australian medical graduates has led to an oversupply of doctors in urban areas but has done little to address shortages in rural Australia. Australian trained medical graduates today are less likely to work either as general practitioners or in rural communities compared to

[1] Cth Dept of Health (2021) National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs.

graduates in previous decades and rural areas continue to remain substantially dependent on International Medical Graduates doctors, who comprise almost half of the general practitioner workforce in rural areas.[2]

This maldistribution translates to fewer staff and also lack of continuity of care where communities rely on short-term, temporary or locum practitioners. Reliable and sustainable heath care is a cornerstone to community resilience and the loss of services, or loss of trust in service provision, can create a downward spiral in terms of establishing sustainable local staff and resources.

The situation becomes increasingly fragile as the workforce ages. The average age for a GP working in a rural or remote area continues to be over 50, with an increasing number in the over-60 age group who will be looking to retire or at least reduce their workloads over the coming years. College membership figures indicate relatively low numbers in the following cohort (40-49 yrs) compared to higher numbers in younger and older age brackets. This is most likely due to a period of unsupportive rural training policies that coincided with the training years of this cohort of doctors.

There are a much larger number of members who are in the younger age groups; however the challenge is to retain the experienced doctors who are either retiring or close to retirement within the workforce for some period of time so they can continue to provide health care services and train the next generation until more workforce gaps can be filled.

The workforce maldistribution extends beyond geography, to an increasing preference for careers in specialties other than general practice and the increasing trend towards sub-specialisation. Specialist services are expensive and usually located in larger centres. They do not facilitate the delivery of the services that are most needed in rural and remote communities in a cost-effective manner; nor do they take into account the importance of providing as many services as possible, as close to home as possible, for people living in rural and remote areas.

Many rural and remote people cannot realistically access many specialist consultant medical and allied health services. This is evidenced by patterns of usage showing, compared to levels in major cities, annual utilisation of non-GP specialist services decreased by 25% in outer regional areas and 59% in remote and very remote areas.[3] This being the case, it is important that rurally-focussed healthcare professionals such as rural generalists, with scopes of practice appropriate for rural and remote contexts should be recognised and incorporated into policy, workforce modelling and planning.

Changing expectations will also impact on workforce supply and distribution into the future. The younger generation of doctors has differing priorities and lifestyle expectations to their forebears. Many are less interested in running a private business; they place a higher priority on allocating time for family and to pursue other interests. They are also aware that that private practice does not necessarily provide many of the benefits of public employment, including sick leave; designated holiday periods and time off; transferability of entitlements; and study and other professional leave.

These issues, together with the financial and workforce challenges of owing and working in private general practice, need to be addressed if the current workforce maldistribution towards specialist rather than general practice/primary care is to be rectified.

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[2] *O'Sullivan B et al (2019) Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence Hum Resour Health 17: 8*

[3] AIHW (2021) Medicare-subsidised GP, allied health and specialist healthcare across local area: 2019-20 to 2020-21.

The distinctions in the broader training and also practice context for rural doctors need to be addressed if we are to retain a rural workforce. Policies need to ensure there is a positive training context for prospective future rural doctors, but should extend beyond training, to ensuring there is a positive lifestyle outlook for a long-term rural career. If training and recruitment is to successfully attract long term rural doctors, communities need for example to be able to offer good and affordable housing, childcare and other services. Additionally, there needs to be recognition that rural doctors and other health professionals work in high-stress roles in conditions of relative isolation from professional colleagues, and as such need to have access to strong professional and pastoral support.

At the training level, for example, the Medical Board's national Medical Training Survey found that ACRRM registrars surveyed (who were rurally based, and nearly all of whom reported interest in rural careers), compared to RACGP registrars surveyed, reported around 10% lower satisfaction with access to internet and other training resources and facilities, were 10% more likely to report working excessive hours and more likely to report that their wellbeing was impacted by excessive work.[4]

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

Section 19AB Health Insurance Act 1973

As identified in the National Medical Workforce Strategy, the provision of essential medical services in many rural and remote areas continues to rely heavily on active recruitment of doctors from overseas usually through recruitment policies which specify their practice in areas of service shortage.

Studies based on the MABEL dataset have found that Australian trained medical graduates today are less likely to work either as General Practitioners (GPs) or in rural communities compared to graduates of the 1970s and 1980s.

ACRRM acknowledges and values the significant contribution that International Medical Graduates (IMGs) have made, and continue to make, in providing essential medical services to rural and remote communities. These areas continue to remain substantially dependent on these doctors, comprising 36-38% of all GPs in small rural centres.[5] More recent studies have found that IMGs compared to Australian trained medical graduates were significantly more likely to be working in rural and remote areas and to be working as a general practitioner. The vast majority however (approximately 75%) were practising in urban areas. [6] The greater likelihood of IMGs practising rurally is likely to be strongly influenced by government policies which facilitate attainment of visas and registration to immigrating doctors who practice in an area of need, including the requirement upon most IMGs to work in an area of workforce need for a period of 10 years to be able to provide Medicare billable services. Concerningly, IMGs based in rural and remote areas are significantly more likely to be recent graduates, suggesting that many may be relocating to cities at the end of obligatory terms.[7]

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[4] Medical Board of Australia and Ahpra, Medical Training Survey

[5] O'Sullivan B et al (2019) Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence *Hum Resour Health* 17: 8

[6] Yeomans N. D. (2022). Demographics and distribution of Australia's medical immigrant workforce. *Journal of migration and health*, *5*, 100109. https://doi.org/10.1016/j.jmh.2022.100109

[7] Yeomans N. D. (2022). Demographics and distribution of Australia's medical immigrant workforce. *Journal of migration and health*, *5*, 100109. https://doi.org/10.1016/j.jmh.2022.100109

Distribution Priority Area (DPA) and District of Workforce Shortage (DWS) classifications

The DPA scheme provides a recent example of changes to government policies having severe perverse impacts on rural workforce. The DPA program facilitated employment of IMG doctors in the most hard-to-recruit areas in MM3-7 by conferring exemptions to them to provide MBS billable services. To address relatively minor workforce shortages in MM2 and outer urban areas, the scheme was extended last year to support employment in these areas. Within a short space of time, this triggered significant movement of IMG doctors out of MM3-7 to take up positions in MM1-2 and has made it substantially harder to recruit to MM3-7 vacancies.[8]

The DPA and DWS programs would benefit from incorporating consideration not just of workforce need but also the appropriate model of care for each rural area. For example, areas seeking a general practitioner, may need a general practitioner with a specific skill set. Likewise, an area applying for a specialist obstetrician may be better served by a Rural Generalist who can provide general practice services as well as obstetric services.

The College would strongly argue its position as put forward in a range of submissions and public statements, that the DPA scheme should return to its former framework in which only practices in MMM3-7 classifications were eligible under the scheme with facility for consideration of exceptional circumstances where appropriate.

Modified Monash Model (MMM) classification

The College supports the Modified Monash Model (MMM) as an administratively efficient mechanism to proportionately support practice and compensate for the additional personal and financial costs associated with practice in isolated locations. ACRRM acknowledges the considerable scholarship that underpins the model's validity and the significant input of rural doctors and communities who informed it, however it is recognised that the MMM system will not perfectly reflect need and there may be requirements for additional mechanisms to accommodate outliers. We consider however that any unfairly classified professionals and practices can and should be dealt with on an exceptional basis, and under such arrangements the vast bulk of funding will be appropriately targeted to reflect needs. We would be strongly opposed to any efforts to dismantle the MMM structure which has enabled major improvements to the effective allocation of funding and support and see significant risk that an alternative framework would lead to worsening rather than improvement to equity.

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

Training opportunities for General Practitioners and Rural Generalist in particular, are reliant on access to highly qualified and supported supervisors. All strategies to increase the interest in, and uptake of, careers in rural generalism and general practice are dependent on the availability of accredited and appropriately

[8] Sparke C (2023) '800 open job ads 'a sign of rural doctor crisis' *Australian Doctor.* 21 Feb 2023 https://www.ausdoc.com.au/news/800-open-job-ads-a-sign-of-rural-doctor-crisis/

skilled and experienced supervisors for registrars who are undertaking the general practice placement component of their training.

Therefore, any of the distribution levers as outlined in the scope of this review, have the potential to impact on training opportunities, if they result in changes to the availability of suitable supervisors.

ACRRM is committed to providing high quality, contextually-based training for its registrars and strong support for its accredited supervisors. The College believes that the future Rural Generalist workforce should be trained by current Rural Generalists as much as possible. This includes the key training periods which are undertaken in rural general practice and other primary care settings.

There are a number of challenges associated with the recruitment of supervisors. The rural workforce is ageing and while there is a strong cohort of emerging Fellows, there may be shortfalls associated with the retirement of existing supervisors before the new influx is ready to replace them.

The challenges of rural and remote general practice have increased over time, with increased imposts in workload and associated implications for practitioner wellbeing, administrative burden, and practice costs which have not been adequately reimbursed through MBS and other funding arrangements. There is an intrinsic undervaluing of the clinical consultant role of the supervisor in private and community clinics, relative to non-GP specialist consultants performing similar roles in hospitals. This is particularly relevant in rural and remote areas where the supervisor is one of few readily available clinical consultants.

In some cases, the ongoing challenges are resulting in supervisor retirement or scaling down of activities earlier than previously anticipated, with the associated inability to take on the additional work and responsibility required of registrar supervision. This includes the necessary professional development which often requires time away for the earning capacity of general practice.

From a rural generalist perspective, there are additional challenges in terms of competition with non-GP specialist registrars for Advanced Skills training places, particularly in regional hospitals where many RG trainees would be seeking to undertake their AST training.

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

Recent changes to the DWA have made it impossible for some remote locations to attract doctors, who are instead choosing to move to DWS locations in urban centres. This has negatively impacted the quality of care and critical mass for safe, quality training capacity in many rural areas.

In addition, the DWA/DWS moratorium, while positive, has resulted in unintended consequences. It is noted that IMGs on moratorium who don't have specialist qualifications need to train without any support in the way that AGPT and other specialist trainees are supported. This is especially problematic where these doctors have left social networks in former country and come from a different culture to Australia and are practicing in rural and remote areas with minimal medical professionals locally available to support them. This presents an opportunity to optimise potential for these doctors to become highly-skilled registered GPs and RGs who stay rural longer, by strengthening the Fellowship training and support and engagement with training programs for these doctors.

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?

The Rural Generalist Model of Care

Many rural and remote people cannot realistically access many specialist consultant medical and allied health services. This is evidenced by patterns of usage showing, compared to levels in major cities, annual utilisation of non-GP specialist services decreased by 25% in outer regional areas and 59% in remote and very remote areas.[9] This being the case, it is important that need for alternative 'rural' professionals with scopes of practice appropriate for rural and remote contexts should be recognised and incorporated into workforce modelling and planning.

ACRRM contends that the Rural Generalist (RG) model of care is a key strategy in delivering the best possible healthcare services in rural and remote communities, including maximising the care that can be provided locally.

The joint application for recognition of Rural Generalist Medicine as a specialist field within general practice is now well advanced and a final determination by the Health Ministers' Committee is likely to be made in 2024. Should this be successful, this recognition would provide a consistent and clear basis for MBS item numbers and industrial awards which recognise the distinct training, assessment and professional development associated with the Rural Generalist scope. It is essential that the key role in rural service provision of Rural Generalists, their nationally accredited scope of practice, and the opportunity to recruit doctors with these skills, is incorporated into planning and modelling.

International Medical Graduates

The provision of essential medical services in many rural and remote areas continues to rely heavily on active recruitment of doctors from overseas, usually through recruitment policies which specify their practice in areas of service shortage.

Review of DPA and DWS - the expansion of the Distribution Priority Areas (DPA) scheme in 2022 to address proportionately smaller workforce shortages in MM2-1 areas triggered significant movement of IMG doctors out of MM3-7 and has made it substantially harder to recruit to MM3-7 vacancies.[10] These new classifications are resulting in a movement of IMGSs away from rural and remote areas and in to outer metro/inner regional areas.

Supporting Specialist IMG training through College-led training - it is imperative that workforce strategies and policies integrate meaningfully to ensure Australian Graduates, Foreign Graduates of Australian Medical Schools (FGAMS), and IMGs are well supported to meet the needs of our rural, remote and Indigenous communities in Australia. Far more needs to be done to ensure IMG and FGAMs receive more equitable financial, personal, and professional support to succeed and thrive in rural medical careers.

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[9] AIHW (2021) Medicare-subsidised GP, allied health and specialist healthcare across local area: 2019-20 to 2020-21.
[10] Sparke C (2023) '800 open job ads 'a sign of rural doctor crisis' *Australian Doctor.* 21 Feb 2023 https://www.ausdoc.com.au/news/800-open-job-ads-a-sign-of-rural-doctor-crisis/

Current policy settings that exclude FGAMS and IMGs from applying to access commonwealth-funded general practice training positions on the Australian General Practice Training Program and Rural Generalist Training Schemes should be urgently revised to remove barriers to rural training and support while they work to achieve Fellowship.

To avoid duplication and to harness the opportunity to integrate SIMGs into their local professional networks, we would strongly recommend that the targeted resources and initiatives associated with this Recommendation build on the resources and programs already being delivered by ACRRM and other Colleges.

ACRRM has a well-trained pool of experienced and expert rural doctor SIMG assessors, pragmatic and highly efficient assessment pathways in terms of both time and cost for applicants. We have developed and publish contemporary lists of comparable authority programs (CAPs) and qualifications that we consider to be substantially equivalent to our own Fellowship. We also have robust processes for reconsideration, review and appeal that are available to candidates if required.

Our College SIMG assessment process is deliberately designed as a single, integrated, assessment of suitability for specialist medical registration and suitability for conferral of Fellowship, The proposed transition to AMC-based assessment for registration purposes would therefore introduce a need for candidates to undergo subsequent additional assessments, administrative duplication and cost to subsequently apply to the College for Fellowship to attain professional and peer recognition within Australia.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is **the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care**. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

ACRRM has more than 5000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

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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.