Policy Redesign: General Practice Rural Incentive Program (GPRIP)

1. Current Arrangements

1.1 Policy Intent: Benefits and Limitations

The General Practice Rural Incentives Program (GPRIP) Scheme is a key national incentivised general practice workforce supply solution which came into effect on 1 July 2010 (2009-10 Budget). Part of the Rural Health Workforce Strategy, the program provides relocation and retention incentive payments to encourage medical practitioners to work in underserviced rural, regional and remote areas. The package effectively combined the previously separate Rural Retention Program and the Registrars Rural Incentive Payments Scheme (General Practitioner Component). A key shift was the added inclusion of a relocation incentive grant (Rural Relocation Incentive Grant) tiered to time spent in rural location against a sliding scale of rurality.

The Scheme has proven effective in terms of increasing overall supply with reported outcomes to June 2012 realising a four percent (GPs) and five percent (GP Registrars) workforce growth. The program has met higher than anticipated demand with an additional allocated $35.4 million over two years from 2013-14. Despite overall strong gains, the reliance on an ineffective classification scheme resulted in an uneven distribution of funds and inner regional bias.

These issues are well documented in the 2013 Mason Review which called for substantial program reform. Mason’s key policy finding confirmed unsustainable growth in GPRIP retention payments to inner regional areas (RA2) at a cost to areas of stronger need.

The development of an enhanced classification system with an emphasis on targeting smaller and more remote communities, which experience greater workforce need, was recommended to address the program limitations. It is envisaged that many of the geographic inconsistencies will be addressed through the recently announced rural classification system redesign or new Modified Monash Model. The Mason Review also signalled broader required reform for the GPRIP including broadening to other health professions, more local autonomy in terms of workforce planning and enabling flexibility in program application (either for relocation or retention) according to local area need.

1.2 RACGP Position: Rurality + Local Needs

The RACGP National Rural Faculty has consistently highlighted the need for reform of the ASGC-RA Remoteness Classification System. Rural retention and direct assistant payments that are differentiated by the degree of rurality or remoteness can only be effective if the model they rely upon is undisputed, both in terms of efficacy and equity.

It is clear that the success of any policy intervention relies on strong targeting, a key policy requirement which has long been undermined by a flawed rural classification system. The eligibility criteria for rural recruitment and retention strategies has been underpinned by the ASGC-RA system.

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which inadequately aligns with workforce need and has contributed to workforce maldistribution and an inefficient use of incentive funding.

However, the influence of geographical location on the provision of health services and meeting patient needs in small communities should be considered as part of a broader policy analysis. It is preferable to broaden analyses to capture local needs and assessment or additional context through pursuing a theory based, data driven approach that can estimate the efforts of demographic and community characteristics on use of (and access to) primary health care.4

It is in bringing in these stronger targeting tools, through increased assessment criteria that the GPRIP can provide for workforce results in the areas of critical need. These issues and opportunities to bring in this context, beyond rurality markers, is discussed in detail throughout the next section and forms the basis of our submission.

### 2. Policy redesign

#### 2.1 Modified Monash Model: GPRIP Considerations

It will be important, in implementing a new Modified Monash Model, to ensure a level of flexibility for enhanced scalability for areas most in need. The following sections outline the key areas that we believe should be captured in determining the distribution of the GPRIP grants.

It is clear that directing funding to those areas most in need will go a long way to addressing the current workforce distribution problem (as opposed to supply). But there needs to be flexibility to ensure broader issues associated with disadvantage and equity in access in rural areas can be factored. Therefore a method of incorporating scalability to enable adjustment for local variations of need would provide for optimum results.

It is acknowledged that the potential issues arising from using town size as a sole determinant given its reliance on the ABS UCL boundaries are still to be worked through. The required buffer zones or catchment areas (based on distances people travel to work) will be a matter for the Rural Classification Technical Working Group (RC TWG) and this issue is therefore not addressed in this submission.

##### 2.1.1 Geographic determinant: Degree of rurality

The new Modified Monash Model (proposed model) will address initial concerns around measuring rurality including the impact of remoteness on communities. It is understood that the original Monash Model’s “sentinel indicators”5 have not been retained but instead population size is used as the key determinant through seven categories (introducing two additional categories in RA2 and RA3). Further, it is understood that remoteness is captured through retaining RA 4 and 5 which is an important requirement.

Therefore the degree of rurality, as determined by the proposed model, should provide the first level in determining grant eligibility. Retaining the current mechanism of scaling of remoteness will ensure the areas hardest to fill in terms of workforce will be prioritised. However, rurality should not be the sole factor determining funding decisions but rather form part of a broader analysis which encompasses both workforce and health needs data.

The specific needs of the more disadvantaged populations and/or remote communities with specific health service needs can be captured through these additional criteria.

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The RACGP supports a system which can rely on the proposed model to assess rurality but which can be supplemented through additional criteria, for programs such as the GPRIP, which can factor important workforce and local health needs. The key considerations are:

i. Enables a degree of flexibility in terms of its application against individual programs and variations in reach.
   - The classification system should not be relied on as the sole determinant for funding decisions, instead supplementation (as outlined in point iii below) should be captured.

ii. Enables aspects of isolation and remoteness to be factored in to location indicators.
    - Continued use of town size as key classification determinant, but recognises the different health service issues caused by remoteness.

iii. Captures workforce and population data including local need and context.
    - Although complex, the model needs to capture both locational and patient needs based analysis (as well as the workforce data).

2.1.2 Enhanced scalability: Health Needs Assessment

It will be important to ensure population health issues can be factored into grant decisions through a local needs assessment criteria. A system which can enable further overlay to capture population needs analysis would provide a way to ensure more targeted funding to the more disadvantaged or remote communities or those with specific health service needs.

The use of evidenced-based health indicators, through input and cooperation of the new Primary Health Networks, might provide a way forward in ensuring Government has the required local input in making funding decisions. It would help to clarify the skill mix required in addressing need including advanced skills requirements of GPs, both procedural and non-procedural.

A further consideration for the more disadvantaged areas is caseload and time requirements which will need to be factored in when determining the areas of highest need. Simplistic doctor/patient ratios (as FTE or similar) are not a reliable measure in determining workforce requirements in the most disadvantaged populations.

2.1.3 Priority Population: Aboriginal and Torres Strait Islander Medical Workforce

The AIHW Report “Access to primary health care relative to need for Indigenous Australians” shows that across all geographic areas in Australia, the health needs of Aboriginal and Torres Strait Islander people are higher than non-Indigenous Australians, and their access to GP care is also worse. It also shows that improving access to GPs has a bigger impact for those with higher health needs. The AIHW 2012 Medical Workforce survey shows that there were 514 medical practitioners working clinically in Aboriginal Medical Services in Australia (compared with 33,000 GPs).

An incentive scheme that is purely geographically based that does not take into account the higher health needs of Aboriginal and Torres Strait Islander people, will be successful geographically, but could widen differentials in access relative to need. For this reason, we believe that specific requirements are required to recruit and retain medical professionals to work in Aboriginal and Torres Strait Islander communities, including Community Controlled Health Services. This would be a simple and effective measure to continue to help in closing the gap in health outcomes for Aboriginal and Torres Strait Islander people.

The RACGP recommends consultation with NACCHO around developing appropriate models for these requirements. Possibly the simplest way of doing this would be to move Aboriginal and Torres Strait Islander services up a level in the classification system, though the exact details could be worked on at a later date.

2.1.4 Enhanced scalability: Workforce factors

It is important to acknowledge that the required shifts to address current rates of workforce attrition will not be addressed through a single policy measure. It will be vital with increased numbers of medical students coming through that incentives accurately factor important workforce measures to ensure incentives reach the key areas of workforce need. There is a need to ensure balance so that an equalled policy emphasis is placed on supporting the existing workforce (retention) in addition to supplementation strategies (recruitment). A level of scalability throughout will help ensure appropriate incentives for the more isolated roles (both professionally and geographically).

A multifaceted approach is required, a mix of financial and non-financial incentives, to ensure the right doctor for the rural community. In terms of stronger targeting of the GPRIP incentives additional workforce scores could be based around the six sentinel indicators mapped under MABEL. These include professional factors such as hours worked, type of procedures, on-call arrangements and ability to have time off; and non-professional factors including spouse support and schooling arrangements. How well the specific location provides for these requirements could be factored into funding decisions.

2.2 GPRIP Targeted: Modified Monash + Local Needs + Workforce

To ensure the GPRIP is able to provide stronger incentives to areas of highest need, additional scalability against increased demand or need is required. The key requirements would bring in broader indicators which would include: rurality + needs assessment + workforce factors.

In terms of assessment process, the first indicator, rurality, would be provided for by the Modified Monash Model. The second and third indicators could be worked through, in consultation with the state or territory PHN, as part of the application process. A review panel could be formed in each state and territory to work through the additional local area analysis, including health needs and population assessments and importantly bring in the workforce attraction factor. The scaling or point system outlined in Table 1 below is just to illustrate the approach and has not been thoroughly tested.

Table 1: Possible GPRIP indicators (enhanced scaling)

<table>
<thead>
<tr>
<th>FIRST MEASURE: RURALITY</th>
<th>SECOND: POPULATION HEALTH + DISADVANTAGE</th>
<th>THIRD: WORKFORCE FACTORS</th>
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</thead>
<tbody>
<tr>
<td>MODIFIED MONASH MODEL</td>
<td>NEEDS ASSESSMENT</td>
<td>WORKFORCE ATTRACTION</td>
</tr>
<tr>
<td>Geographic (town size) determinant</td>
<td>Health needs assessment with input from PHNs</td>
<td>Mix of use of the six sentinel indicators mapped under MABEL</td>
</tr>
<tr>
<td>GPRIP: Retain the current mechanism of scaling of remoteness</td>
<td>Aboriginal and Torres Strait Islander communities</td>
<td></td>
</tr>
</tbody>
</table>

Table 1
Table 1: Possible GPRIP indicators (enhanced scaling)

<table>
<thead>
<tr>
<th>FIRST MEASURE: RURALITY</th>
<th>SECOND: POPULATION HEALTH + DISADVANTAGE</th>
<th>THIRD: WORKFORCE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified Monash Model [existing remoteness scale]</td>
<td>Possible indicators [maximum 12 points]</td>
<td>Possible indicators [scalability 0 to 6, max 12 points]</td>
</tr>
<tr>
<td>MM1 (RA1) [metro not prioritised]</td>
<td>0 Health needs assessment [scalability 0 to 6-low to high]</td>
<td>Professional factors:</td>
</tr>
<tr>
<td>MM2 (RA2 and RA3) [population &gt; 50,000]</td>
<td>1 Aboriginal and Torres Strait Islander community [+6]</td>
<td>Professional isolation (consider stage of career/ skill level)</td>
</tr>
<tr>
<td>MM3 (RA2 and RA3) [population 15,000-50,000]</td>
<td>2</td>
<td>Advanced Skill (type of procedures)</td>
</tr>
<tr>
<td>MM4 (RA2 and RA3) [population 5,000-15,000]</td>
<td>3</td>
<td>Work flexibility (hours and on-call)</td>
</tr>
<tr>
<td>MM5 (RA2 and RA3) [population &lt; 5,000]</td>
<td>4</td>
<td>Non-professional factors:</td>
</tr>
<tr>
<td>MM6 (RA4)</td>
<td>5</td>
<td>Spouse support (possible employment opportunity y/n)</td>
</tr>
<tr>
<td>MM7 (RA5)</td>
<td>6</td>
<td>Schooling arrangements (Does the location provide for family y/n)</td>
</tr>
</tbody>
</table>

Case Example

To illustrate the possible application of the approach for GPRIP, enabling increased scalability in addressing highest need, we use the example of a relocation incentive which would attract the highest funding allocation. For example, an RA5 location requires an experienced GP to support an Aboriginal and Torres Strait Islander Community which holds a significant disease burden and little social infrastructure or professional support.

Rurality score (6) + Needs Assessment (12) + Workforce Attraction (12) TOTAL 30 POINTS

Therefore this individual should attract the highest funding level and be prioritised in terms of allocation of funds (dispersal). This example helps to illustrate how the containment of funds for the areas of highest need could be factored in to policy design. The structure would ensure reach to those critical areas which often are the least desirable areas to fill from a workforce policy perspective.

3. IEP Discussion Paper: GPRIP Questions

3.1 Retention Payments

Q1. Who should be eligible for GPRIP payments under the Modified Monash Model?

If applying the Modified Monash Model or rurality measure as the sole eligibility criteria for the GPRIP it is recommended that the existing scalability criteria be retained based on remoteness (MM7 highest to MM2 lowest). It would be preferable to ensure an increased level of flexibility for enhanced scalability for areas most in need as outlined throughout this submission with a particular focus on MM3 and further targeting on MM4 to MM7 areas.

There is additional scope in GPRIP redesign to provide for additional flexibility to ensure stronger targeting and reach. In addition to the new Modified Monash Model geographic distribution function, which defines rurality, the Government should consider incorporating additional assessment criteria to enable adjustment for local variations bringing in important population health and workforce factors. These areas of most need must be prioritised in terms of grant dispersion and local input should be sought to determine the areas of most need (possibly through the new PHNs) and skill mix required.
Q1. **Who should be eligible? (Cont.)**

Enhanced GPRIP assessment criteria include:

(i) Modified Monash Model to capture rurality retaining existing scalability criteria (MM7 highest to MM2 lowest);
(ii) Prioritise Aboriginal and Torres Strait Islander communities and containment of proportion of funding for GPs working in this population group;
(iii) Ability to capture local needs assessment with input from PHNs or similar structure;
(iv) Ability to capture workforce factors utilising MABEL sentinel indicators with input from PHNs.

Q2. **When is a suitable time to commence retention incentives?**

Q3. **How frequently should retention incentives be paid?**

Retain the existing structure: First payment after six months in MM3-5 and after two years in MM2; and subsequent payments made yearly as per current arrangements.

Q4. **Should the current policy of scaled incentives be maintained? If scaled incentives continue, at what point should they reach a maximum?**

Retain scaling: Incentives should increase up to a maximum after five years as per the current arrangements (scaled by remoteness). Option to strengthen scalability as outlined in Section 2.

Q5. **Should the current minimum and maximum billing thresholds be revised?**

It is important to retain the existing structure minimum ($4,000 per quarter) and maximum ($20,000 per quarter) arrangements. The billings calculation for eligibility is supported in principle as it estimates the level of clinical services provided to a community. However, a purely billings-based approach risks misrepresenting and therefore excluding from the incentives program many rural GPs who provide valuable services to their rural community.

It is recommended that some flexibility be built in to ensure thresholds do not discriminate against the part-time workforce and/or GPs working within more than one rural community. For example, those based in MM3 and outreach to MM4 or 5 should be remuneration at the appropriate scale point. Further broader considerations to include the Medical Officer with Right of Private Practice (MORPP) or similar arrangement where many of their services are provided through the state health system but remain predominantly primary care providers.

Q6. **Should retention payments be limited to doctors who live in rural areas?**

It is important that there is a requirement for the GP to live close to the town they are servicing but not necessarily within it. For example, within 50km of the practice is reasonable. Commuting further than that to work suggests the doctor may not be integrating into the rural lifestyle and community; however it is quite common for rural GPs to not want to live directly in town, particularly a small town, for the sake of privacy out-of-hours.

The Royal Flying Doctor Service (RFDS) requirement should be reviewed and flexibility provided. The RFDS business model is by definition servicing rural and remote communities and they should automatically qualify for the incentive.

A further important aspect for the more remote locations relates to eHealth and how these services are captured. In these instances, for hub-and-spoke service models, where the doctor actually resides is less relevant and this aspect must be factored in to this review. A loading or time related measure should be developed to recognise eHealth coverage in these remote communities. This is particularly important as Medicare currently does not provide for these essential services, nor does it adequately provide for services more broadly with unequal treatment overall of the services provided by Aboriginal Medical Services and to Remote Indigenous populations. It is recommended that the IEP seek input specifically from the Remote Indigenous workforce in relation to the targeting of these incentives.
Q7. How long do you think GPRIP payment levels should be maintained for doctors who take extended leave from their rural practice?

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 educational or family purposes.

Q8. Do you agree with the current Medicare services that contribute to the quarterly billing calculation?

There is scope for modification as Medicare billing doesn’t necessarily reflect the need for services. In determining need the enhanced scalability model outlined at 2.1.2 Health Needs Assessment and 2.1.3 Priority Population would help to ensure more equitable treatment of the areas of highest need.

Q9. Do you agree with current policy to determine payment rates for doctors working in multiple locations?

There is a need to amend this policy to reflect the remoteness of different locations. Those providing outreach services to surrounding country towns should receive increments against remoteness. This enhanced scalability would provide an added incentive for GPs working in rural and geographically isolated areas to provide outreach services to these smaller communities.

3.2 Relocation Payments

Q1. Do you think that relocation grants encourage doctors to move to a rural or remote location?

Refer also to the discussion in the next section, 1.2 Rural Predictors, which outlines the professional and non-professional motivators which include but extend beyond financial incentives. It is understood the relocation component of GPRIP has not met expected targets with strict program eligibility rules thought to be the contributing factors to these lower than expected outcomes. The containment of grants for the most critically underserviced communities and adjusting payments accordingly would provide for stronger recruitment outcomes. The enhanced scalability discussion at 2.1.4 (page 5) could guide the decisions around stronger criteria.

Q2. What categories of the Modified Monash Model should be deemed eligible for relocation grants?

The relocation grant should apply for categories MM3 to MM7 and there should be consideration to open the grant to GP registrars. However, for Registrars in terms of the most disadvantaged areas, ensuring there is adequate professional, peer and personal support and that formal mechanisms for peer support are provided would need to be prioritised.

Q3. Do you agree with the current eligibility criteria for relocation grants?

It is noted that currently, to be eligible, doctors must be: (i) Fellowed at a recognised specialist college; (ii) be an Australian citizen or permanent resident; (iii) not have received a Relocation payment previously; (iv) in the case of overseas trained doctors, must have completed the requirements under Section 19AB of the Health Insurance Act, that is completed the 10 year moratorium; and (v) be moving to a location considered to be more rural than where they have practised during the preceding twelve months.

Therefore changes to any of the five criteria areas would depend on the changes implemented through this review process. For example, at Q2 directly above, the option to expand to registrars would require discretion around the Fellowship criteria. For this specific cohort there would be a need

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to include a ‘working toward Fellowship’ criteria instead due to time in career. The remaining criteria seem reasonable with the exception of the 10 year moratorium rule which is a part of a broader policy that the RACGP does not support.

Q4. Do you think the current locum rule is fair?

The RACGP would urge Government to support locums toward re-settlement in a rural or remote area. Consideration should be given to the twenty day rule as it seems to work directly against the desired policy outcome to encourage doctors to work in these underserviced communities.
Integrated Rural Training Pathway: A focus on prevocational years

1. Current Arrangements

1.1 Program demise: PGPP program

In shifting to the training discussion and the required primary care emphasis across the full training continuum but for the purposes of this review on prevocational years, there is broad support among members for the expansion of PGY1 and PGY2 general practice posts. Facilitating training integration from medical school to rural practice is an essential policy requirement to address maldistribution.

The recent Federal Budget signalled an end to the Prevocational General Practice Placement (PGPP) program. The program was key to enabling a flexible integrated rural training pathway experience and its cessation leaves a significant gap for junior doctors. In terms of program outputs, there is an extract of the General Practice Education and Training Limited (GPET) Annual Report 2014 relating to the take up and dispersal of the former PGPP program provided at Appendix 1.9 These tables show a consistently high rural take up thus highlighting the gap with the conclusion of the program.

The RACGP input does not seek to critique the benefits and failures of the former PGPP program but instead to detail the requirements for a new prevocational training scheme for rural areas as part of a broader strategy for a more integrated rural training pathway. The discussion in Section 2: Policy Redesign has been taken from the RACGP Report: New approaches to integrated rural training for medical practitioners (2014) and a separate briefing can be provided for the expert panel if required.

1.2 Influencing choices: Rural predictors

Preference for specialty choice is an important part of the discussion and the discrete choice experiment undertaken by Sivey et al (2012) provides some important insights against this cohort (junior doctors) including around expected future earnings and other attributes of specialty choice which suggest the need for more opportunities for procedural and academic work.10 How exposure to a positive rural placement as a student and junior doctor translates to specialty choice and retention in general practice is well documented in the literature. An early study suggested that providing an alternative setting for junior doctors, in addition to the hospital, appeared to be the catalyst for reflection and decision-making. This finding provides important evidence in supporting the need to prioritise prevocational training in policy.11

There have been many other later studies which has expanded the evidence around this key connection in enabling career choice from an undergraduate or graduate perspective which this review’s expert panel will be well across. However, a study by Walker et al (2012) that showed rural origin plus a rural clinical school (RCS) placement as the most significant predictors to practice rurally also identified a number of important broader influences. It is these professional and non-professional factors that will be most useful in terms of future policy development for this cohort (junior doctors) and for the purposes of this review. This specific study highlighted that whilst the literature points to students who undertake supported well-coordinated longer rural placements (particularly RCS placements) were more likely to take up rural careers, a broader range of factors were at play.12

12 Williamson M, Gormley A. The new rural health curriculum at Dunedin School of Medicine: how has it influenced the attitudes of medical students to a career in rural general practice? New Zealand Medical Journal 2003; 116: 1179.
The study shows there is a strong preference for rural training opportunities that provide long-term prospects for permanent, rural-based junior doctor terms, more JMO positions in rural hospitals, and greater choice for postgraduate training. But it is the broader factors that the study revealed as important influences toward rural practice and important to training design which provide the key issues in developing future policy. These include: availability of a range of incentives; community, professional and family support; long hours and availability of locums; isolation and socialisation problems associated with living rurally.13

Similar to the MABEL study’s six sentinel indicators it seems a combination of professional and non-professional factors are required. Therefore whilst financial incentives are important, responsive policy must address these key barriers and ensure rural general practice remains a viable and attractive career within the wider field of medicine. Support structures that empower and flexibility that enables choice are needed along with targeted, yet accommodating, incentives in support of rural intention.

2. Policy redesign

2.1 Empowering career decisions: Flexibility and choice

For those in their early medical career and particularly those in prevocational general practice training, flexibility and choice are essential. As decisions or orientation toward rural practice may not occur early (medical student or prevocational doctor), restrictive early entry into rural training programs can be counter-productive to achieving rural recruitment.14

Early in medical education, emphasis is needed on primary care and generalism, accompanied by targeted rural exposure strategies. Recruitment strategies for students must allow for flexibility to provide a broad and varied training experience, which meets the needs of the learner and the learner’s future community. Workforce-driven policy which imposes negative conditions, including time constraints on acquiring skills and an overemphasis on securing positions early in training, are inherently overly restrictive.15

The key issue undermining policy success is the lack of support for the trainee to navigate the system from medical school through to rural practice. Support structures that empower and flexibility that enables choice are needed along with targeted, yet accommodating, incentives in support of rural intention.16

2.2 Enabling integration: Prevocational Training

As with the GPRIP discussion, the new Modified Monash Model will ensure rurality can be factored well into incentive and program planning. However, to facilitate the required training integration (from medical school to rural practice) current incentivised schemes must similarly support integration.

Some clear policy parameters should be established in facilitating training in rural areas which include strategies that provide trainees with the flexibility to have more rural experiences or to opt out, to ensure resources are not exhausted on trainees who are not rurally inclined through coercive schemes. Working through ways that students and junior doctors who are mapping out their careers can be given positive rural experiences and high quality rural exposure is essential.16

15 to 16 Ibid.
2.2.1 Facilitating link to community

Nurturing rural intention by enabling learners to maintain a link to a specific rural community throughout their full training years is a key requirement, not only to encourage rural retention but to link training experience with service context.\(^\text{17}\)

There is a need to find more ways to provide the type of flexibility both the learner and community need. It is important to factor in the proven enablers and key motivators to rural health and clustering those known influences in order to better target individuals, but it is also vital to ensure they are nurtured and supported once captured.\(^\text{18}\)

In terms of addressing the current constraints across the full medical training continuum, it is necessary to ensure broader skill-acquisition opportunities so that they can be undertaken in the rural setting. The system is currently structured in favour of the partialist and not the generalist focus it needs, and this must be addressed. Embedding more primary care and generalist skill emphasis are required.\(^\text{19}\)

2.2.2 Seamless training: Training Hubs

The need to invest in more innovative models, including interdisciplinary training hubs to provide that community connection, and to facilitate longer terms in rural, is needed. These hubs would facilitate the networks and coordination, address current competing factors and thereby provide for more sustained rural training outcomes.\(^\text{20}\)

The hub model relies on the provision of a coordinator or career development positions which would address the current lack of focus in helping junior doctors to structure career pathways. The coordinator role would be responsible for determining the skill mix required in particular areas in response to community needs, and coordinating the generalist training pathway. The development roles would assist junior doctors in navigating this pathway and mapping their experience, matching what they want to achieve with a structured approach to achieving it.\(^\text{21}\)

2.2.3 A final note on targeting

Trainees need to have both entry and re-entry points. More flexibility around addressing an individual’s needs including family needs, part-time arrangements for young mothers, for example, is required in order to make rural a more attractive and viable option. The key influences, in terms of key motivators to rural, are, in fact, mostly weak effects unless bundled together. Rural background, rural role models, rural curriculum, ruralised assessment and rural placements brought together will work. Building quarantined places into the pipeline, while also enabling for flexibility for those seeking alternative routes is important. With effort overall to ensure incentives and supports are in line with a policy that provides for an ‘easy entry, gracious exit’ for rural.\(^\text{22}\)

3. IEP Discussion Paper: Question

3.1 Exposure Strategies

Q1. What other strategies could be pursued to provide exposure to rural general practice for junior doctors?

Invest in the strategies outlined at 2.2 (2.2.1 to 2.2.3 above) to provide for the required integration including the reinstatement of a prevocational general practice placement program to help facilitate rural training integration from medical school to rural practice. Implement the related key findings of the RACGP “New approaches to integrated rural training for medical practitioners” (NAIRTMP) project to build in to program redesign the key policy requirements to provide for more flexibility and choice into the training system including targeted and essential supports for junior doctors. A separate briefing can be arranged to brief the IEP on the findings of the NAIRTMP Project Report.

\(^{17}\) to \(^{23}\) Ibid.
**APPENDIX 1**

**Junior doctors - PGPP program**

Targets for the PGPP program require a minimum of 50% of all activity to be delivered in RA 2-5 localities - consistent with the AGPT program. For 2013 a total of 65% of PGPP program placement weeks occurred in RA 2-5 localities (2012: 66%). This figure is significantly above the target of 50% and supports the regional and rural emphasis of PGPP program placements. Significant growth in placement activity has occurred in all localities. The placement activity distribution target for the PGPP program was met in 2013.

<table>
<thead>
<tr>
<th>LOCALITY</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tbody>
<tr>
<td>RA 1</td>
<td>28%</td>
<td>32%</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>RA 2-3</td>
<td>47%</td>
<td>50%</td>
<td>51%</td>
<td>50%</td>
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<tr>
<td>RA 4-5</td>
<td>25%</td>
<td>17%</td>
<td>15%</td>
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</table>

**TABLE 3: PGPP program activity distribution by RA 2010–2013**

The distribution of PGPP program placement activity between states and territories over 2013 reflects an increasing proportion of places being undertaken in NSW (2013: 20% vs 2012: 19%) and Queensland (2013: 23% vs 2012: 20%).

<table>
<thead>
<tr>
<th>State / Territory</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
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<tr>
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<td>3%</td>
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<tr>
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<td>8%</td>
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<td>13%</td>
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</tr>
<tr>
<td>VIC</td>
<td>16%</td>
<td>18%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>WA</td>
<td>14%</td>
<td>15%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**TABLE 4: PGPP program activity distribution by state/territory 2010–2013**