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Royal Australian College *of* General Practitioners

RACGP Rural GP Summit report

Alice Springs, 26 February 2020

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RACGP Rural GP Summit report

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Acknowledgement

This report on the 2020 RACGP Rural GP Summit was prepared for the RACGP by Dr Brendan Grabau (Brendan Grabau & Associates). The event was facilitated by Dr Grabau on Wednesday 26 February 2020 in Alice Springs.

The RACGP held the summit to collaborate with rural health organisations and develop a unified vision to address the distribution of the general practitioner workforce throughout Australia. It was attended by stakeholders from Aboriginal and Torres Strait Islander Community Controlled Health Services, state/territory and federal governments, rural clinical schools, Primary Health Networks, rural generalist programs, regional training hubs, RACGP Rural faculty, RACGP GPs in Training faculty, General Practice Registrars Australia, Rural Doctors Association of Australia, rural workforce organisations and training organisations. The focus was on finding solutions for the future.

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Contents

Executive summary

Australia's persistent maldistribution of medical practitioners means people living in rural and remote communities often struggle to access the healthcare they need. A range of strategies, policy reforms, and government-driven incentives and initiatives have been introduced, aiming to attract and retain general practitioners (GPs) to these communities. However, though some of these initiatives have had a positive impact, many communities still do not have appropriate access to GP services.

To overcome long-standing disparities, rural health reform must lead to increased support for GPs and their communities, and address current barriers to recruitment and retention. Central to The Royal Australian College of General Practitioners' (RACGP's) key aims is ensuring that rural general practice has adequate capacity and that members and GPs in training (GPiTs) have access to appropriate training, professional development and support in rural and remote communities.

It is for this reason that the RACGP hosted a Rural GP Summit in Alice Springs on 26 February 2020. The purpose of the event was to explore key issues of rural workforce distribution and, importantly, identify practical solutions that could be implemented by the RACGP to enable GPs to provide the highest-quality care to rural and remote communities.

The RACGP invited a diverse group of individuals and organisations with expertise and experience in the delivery of general practice services across different jurisdictions. These key stakeholders were asked to collectively help the RACGP identify existing challenges and roadblocks related to rural workforce distribution; and to develop ideas and solutions for the RACGP to consider with the overall aim to establish a well-trained, well-supported and sustainable GP workforce in rural and remote Australia.

Thirty-one issues were initially identified and were prioritised by participants through a comprehensive process (Appendix 1) that distilled the list to seven key issues or themes:

1. Prevocational rotation through rural general practice – 'try before you buy', filling the gap left by the removal of the Prevocational General Practice Placements Program (PGPPP)
2. Flexibility of training models to suit the rural context
3. Financial incentives to attract more GPs to rural and remote areas
4. Implementing evidence that supports effective healthcare models in remote and rural Australia, along with appropriate advocacy
5. Appropriate matching of GPs to community needs, with suitable infrastructure support to sustain training
6. Advocating for a review of tiered billings/Medicare Benefits Schedule (MBS) payments for GPs in remote and rural settings
7. A collaborative advocacy role between the RACGP and training organisations to better support the rural and remote workforce

There was consensus that these seven issues were the most urgent and, if addressed by the RACGP, were likely to have the greatest positive impact on the rural GP workforce.

Participants formed six groups (five within the room, one online), and each was assigned an issue (the online group was assigned two issues) and instructed to explore the elements of their specific issue to start identifying possible solutions.

Each group presented their findings and offered recommendations. They were then asked to apply a variation (PPESTER; refer to page 5) on the PESTEL (political, economic, social, technological, environmental and legal) framework, an analytical tool used to identify key drivers of change in a strategic environment, to refine their solutions and recommendations.

The 27 solutions and recommendations arising from this process are listed below.

Solutions and recommendations

That the RACGP:

- Advocate for a mandatory (core) term in community-based general practice (preferably remote and rural) in the pre-vocational years, specifically for junior doctors considering a career in general practice.
- Analyse state, territory and Commonwealth initiatives that replaced the PGPPP, and consider if a similar program could be implemented to facilitate 'rural' exposure to general practice for junior doctors.

- Advocate for more university remote and rural general practice exposure in undergraduate and graduate medical courses.
- Create a 'sister rural and remote practice program' (linking metropolitan practices with rural and remote practices) so that GPs can locum at their sister practice and experience remote and rural general practice.
- Advocate for provision of rural and remote accommodation that supports those training in these communities.
- Facilitate the temporary transfer of GPiTs between training organisations for the purpose of seeking training in rural and remote communities.
- Consider two application processes for the Australian General Practice Training (AGPT) Program per year. It was also suggested that one recruitment process could potentially be for rural and remote areas.
- As a medium-term solution, consider developing a policy framework for RACGP training that provides enhanced scope and autonomy for training organisations to make local decisions on local issues – particularly for rural and remote placements – that are in the best interests of communities and the needs of GPiTs and supervisors.
- As a longer-term goal, consider competency-based medical education and training (CBME) as part of the RACGP's curriculum and training program review.
- Consider developing a range of tailored incentives and retention packages on a sliding scale for rural and remote GPs.
- Consider recruitment strategies targeted at areas where GP services are not usually available and where workforce retention is poor.
- Consider enhancing formal and informal mentoring networks across rural and remote areas, including improved access to continuing professional development (CPD).
- Advocate for a third party to facilitate employment entitlements (this would prevent people from being locked into state or territory systems).
- Synthesise the available evidence into clear briefings for stakeholders to access, commencing with a policy brief outlining the potential cost savings of preferred healthcare models across different rural and remote settings in Australia.
- Present the evidence and advocate to the federal government for different healthcare models.
- Distribute the findings and policy from this work widely (one-page, three-page and 25-page versions) as part of a promotion strategy affirming the message that the RACGP supports rural and remote communities and GPs who live and work in these communities.
- Commit to the policy by affirming the RACGP's support for rural and remote GPs and communities.
- Advocate for community health needs by undertaking genuine community engagement and match the right GPs to the right place.
- Develop a clear strategy to support rural and remote GPs who are most vulnerable or at risk of fatigue and burnout.
- Advocate for appropriate infrastructure that contributes to a sense of belonging, with consideration of the needs of the GP, their family, and their social and educational needs.
- Consider undertaking a cost–benefit analysis, along with some financial modelling of a sliding-scale or tiered MBS rebate in rural and remote settings.
- Consider developing a range of other strategies aimed at incentivising existing rural and remote GPs.
- Continue a dialogue with both the federal and state/territory governments, advocating on behalf of existing rural and remote GPs for development of a range of enhanced incentives as a retention strategy.
- Work collaboratively with training organisations to address flexible training arrangements, particularly for GPiTs in rural and remote locations.
- Investigate mechanisms for protection and portability of GPiT entitlements.
- Continue dialogue with federal and state/territory governments, advocating on behalf of rural-based GPiTs by investigating the feasibility of a single-employer or similar model.
- Consider a dedicated marketing campaign focused on recruitment pathways and targeting rural and remote students, highlighting the benefits of returning to contribute to their community.

Each of these solutions and recommendations is discussed in further detail in the body of this report.

Introduction

Australians living in rural and remote regions are not afforded the same access to comprehensive general practitioner (GP) care as those living in urban areas. This inequity can lead to poorer health outcomes for those who most need care. Attracting and retaining GPs to many rural and remote locations is a key barrier to the provision of essential GP services in these communities.

The distribution of GPs in rural and remote areas is grounded in recruiting GPs to these areas, convincing them to stay, and retaining existing rural GPs before they become fatigued and disheartened. Recruitment and retention strategies have been the subject of policy reform and have included initiatives ranging from increases in medical school student positions through to the development of specific rural GP incentive programs.

Measures to address rural GP workforce issues, particularly incentives and initiatives to recruit and retain rural and remote GPs, are now well embedded across all levels of government. But though some measures have positively impacted the situation, significant aspects require new thinking.

The Royal Australian College of General Practitioners (RACGP) believes that to overcome long-standing rural disparities, rural health reform must lead to increased support for GPs and their communities and must address current barriers to recruitment and retention. It is clear that any future strategies must be comprehensive, well targeted and informed by the experiences of those 'on the ground' if they are to successfully address the complex and unique requirements specific to rural and remote communities.

A more responsive and better-coordinated health system in the future must foster rural innovation, improve access to high-quality healthcare, provide for better coordination, and reduce duplication and gaps. Central to the RACGP's key aims is ensuring that rural general practice has adequate capacity and that members and GPiTs in rural and remote communities have access to appropriate training, professional development and support.

RACGP Rural is committed to addressing rural disadvantage, with efforts focused on developing and implementing strategies that lead to more equitable access to healthcare throughout Australia, irrespective of an individual's postcode. Responding to current and emerging pressures in rural and remote Australia is a central focus for the RACGP.

The RACGP Rural GP Summit, held in Alice Springs on 26 February 2020, explored issues of rural workforce distribution and, importantly, identified practical solutions that can be implemented by the RACGP to enable GPs to provide the highest-quality care to rural and remote communities.

To help identify existing challenges of, and obstacles to, appropriate rural workforce distribution and to develop ideas and solutions, the RACGP invited participation from a diverse group of individuals and organisations with expertise and experience in the delivery of general practice services across different jurisdictions.

The RACGP's strategy for the summit was to engage with, and listen to, the thoughts, perspectives and ideas from the different stakeholders who work in conjunction with the RACGP to deliver GP training in rural and remote Australia. The RACGP also developed an agenda that would foster collaboration and problem solving, culminating in practical actions to deliver positive and sustainable change.

Attendees

Approximately 100 participants attended the summit, representing the following organisations:

- Australian Aboriginal and Torres Strait Islander health Community Controlled Health Services
- State, territory and federal governments
- Rural clinical schools
- Primary Health Networks (PHNs)
- Rural generalist programs
- Regional training hubs
- General Practice Registrars Australia (GPRA)
- General Practice Students Network (GPSN)
- Rural Doctors Association of Australia (RDAA)
- Rural workforce agencies
- Remote Vocational Training Scheme (RVTS) and Regional Training Organisations (RTOs)
- RACGP Rural and RACGP GPs in Training faculties
- RACGP Board members, senior management and staff

The summit was streamed live for those who were unable to attend in person. Up to 20 participants joined the summit remotely, including some RACGP staff. Online participants were able to pose questions as well as access virtual presentations.

The process undertaken at the summit is included in Appendix 1.

Presentations

The summit began with short presentations from six GPs. Each speaker outlined their unique rural perspective and the key issues and obstacles they have encountered working as a rural or remote GP. The presenters were:

- Dr James Robinson – GP in training from Huonville, Tasmania, with an interest in becoming a rural generalist
- Dr Melanie Matthews – new Fellow of the Royal Australian College of General Practitioners (FRACGP) and Fellow of Advanced Rural General Practice (FARGP) from Darwin, working between Darwin and the remote Aboriginal community of Maningrida, Northern Territory
- Dr Michael Clements – FRACGP, FARGP from Townsville, Queensland
- Associate Professor John Kramer – FRACGP, experienced GP supervisor from Woolgoolga, New South Wales
- Dr Sam Heard – FRACGP, working as a GP in Aboriginal communities in the Northern Territory
- Dr Ken Wanguhu – FRACGP, FARGP from Waikerie, South Australia, who practises as a rural generalist with additional skills in obstetrics, anaesthetics and emergency medicine

Key themes and issues that emerged during each presentation were recorded. A total of 31 issues were identified – these are included in Appendix 2.

A prioritisation process (Appendix 1) distilled the list to seven key issues or themes:

1. Prevocational rotation through rural general practice (‘try before you buy’) to fill the gap after discontinuation of the Prevocational General Practice Placements Program (PGPPP)
2. Flexibility of training models to suit the rural context
3. Financial incentives to attract more GPs to rural and remote areas
4. Implementing evidence that supports effective healthcare models in remote and rural Australia, along with appropriate advocacy
5. Appropriate matching of GPs to community needs, with suitable infrastructure support to sustain training

6. Advocating for a review of tiered billings/Medicare Benefits Schedule (MBS) payments for GPs in rural and remote settings
7. A collaborative advocacy role between the RACGP and training organisations to better support the rural and remote workforce

Participants divided into six groups (five within the room, one online). Each group within the room was assigned one issue, while the online group was assigned two issues. Each group was instructed to explore and unpack the elements of their specific issue and to commence preliminary identification of possible solutions. They were then asked to present their findings and offer recommendations within a 10-minute presentation.

Each group was asked to apply the PPESTER framework in consideration of their particular issue. The PPESTER framework, a variation on the PESTEL (political, economic, social, technological, environmental and legal) framework, is an analytical tool used to identify key drivers of change in a strategic environment. The framework was introduced so that groups would consider a wide-ranging set of stakeholders and factors that might affect operation of a specific solution. PPESTER impacts are:

- **P**rofessional – GP professional needs; wellbeing for GPs and their families
- **P**olitical – federal policy position and imperatives
- **E**conomic – funding models and implications; impact on funding for other programs
- **S**ocial – rural and remote community and patient needs
- **T**echnological – evolving technologies to optimise efficiency
- **E**nvironmental – end users, being GPiTs, supervisors and GPs; resources and support processes for learners/teachers
- **R**egulatory – jurisdictional impacts; employment regulations; cross-border issues

Groups were then asked to refine their solutions and recommendations and make a brief presentation of their recommendations. Each presentation comprised a clear articulation of the problem, the preferred proposed solution/s, an analysis of the strengths and weaknesses of the proposal, and a consideration of risk and financial viability.

Groups were also instructed to consider stakeholders, funding models, rural and remote community needs, and how the proposed solution/s supports a rural GP workforce from an operational perspective.

The proposals are described below.

Proposals

Issue 1. Prevocational rotation through rural general practice ('try before you buy') to fill the gap after discontinuation of the Prevocational General Practice Placements Program (PGPPP)

The group tasked with this issue discussed the importance of creating a positive rural GP experience, whether in student or prevocational years. Melanie Matthews had only eight weeks' exposure to general practice throughout her undergraduate medical degree. Various members of the group identified how the PGPPP had benefitted them.

The PGPPP was a prevocational training program designed to enhance junior doctors' understanding of primary health care and encourage them to take up general practice as a career. The PGPPP was introduced at a time when there was not enough demand for GP training places, and attracting hospital doctors into a career in general practice was necessary. The PGPPP was defunded at the conclusion of 2014, with its funding redirected to expand Australian General Practice Training (AGPT) Program training places from 1200 to 1500 new places in 2015.

The group identified that after defunding, no national replacement programs were initiated. The result was a lost opportunity to showcase general practice as a career for junior doctors. Importantly, rural PGPPP placements of 10 weeks provided junior doctors with a taste of rural general practice. Both Melanie Matthews and James Robinson reported a positive and meaningful rural GP experience that had a huge impact on their career choice. While acknowledging that that there was significant cost associated with running the PGPPP, having a rural GP experience early is important either during prevocational training or during medical school.

The group proposed that the RACGP consider a range of strategies:

- Explore the possibility of a mandatory 10-week GP rotation in the first two postgraduate years, with a shared funding arrangement between government, local government health services, PHNs (which offer a range of auxiliary services such as child minding) and the community.
- Require all general pathway AGPT Program applicants to complete a rural rotation.
- Acknowledge the anomalies of Modified Monash Model (MMM) geographical classification.
- Advocate for the provision of rural and remote accommodation that supports those training in these communities.
- Facilitate the temporary transfer of GPiTs between training organisations for the purpose of seeking training in rural and remote communities.

Solutions and recommendations

- That the RACGP advocate for a mandatory (core) term in community-based general practice (preferably rural and remote) in the prevocational years specifically for junior doctors considering general practice as a career.
- That the RACGP analyse state and federal initiatives that replaced the PGPPP and consider if a similar program could be implemented for facilitating 'rural' exposure to general practice for junior doctors.
- That the RACGP advocate for more university remote and rural general practice exposure in undergraduate/graduate medical courses.
- That the RACGP create a 'sister rural and remote practice program' (linking up metropolitan practices with remote and rural practices) so that GPs can locum at their sister practice and experience rural and remote general practice. This should be a collaborative process shared with training organisations.
- That the RACGP advocate for provision of rural and remote accommodation that supports those training in these communities.
- That the RACGP facilitates the temporary transfer of GPiTs between training organisations for the purpose of training in remote and rural communities.

Issue 2: Flexibility of training models to suit the rural context

This group was tasked with addressing issues associated with applying greater flexibility of the training model and associated policies. The consensus was that existing RACGP training policies are restrictive, particularly with regard to rural GP placements. Specific issues included the need to move towards an outcomes-based training program rather than a program tied to time requirements (tick-box based). This is often problematic in rural locations because of 'input' requirements that cannot be easily fulfilled. It was suggested that the RACGP consider a competency-based program when it undertakes its next curriculum review.

The group indicated that a review of policies was required because some policies – for example, leave flexibility for GPiTs, diversity of practice (two-practice rule) in rural areas, critical incident monitoring and models of supervision – are no longer workable. Participants also raised some concerns surrounding a national selection process, as they believed that local knowledge was important in matching a GPiT with a supervisor.

It was suggested that training organisations needed more flexibility in decision making, given their local knowledge and understanding of their context and environment. A flexible approach could be developed through a policy framework that afforded training organisations the ability to enact local solutions to local problems within the policy framework.

The group acknowledged that a flexible policy framework required clear parameters and further discussion between the RACGP and training organisations. It also acknowledged that a flexible approach was not in line with Commonwealth workforce initiatives. Further, it suggested that the RACGP consider multiple selection processes outside the annual recruitment cycle, and also consider at least a twice-yearly recruitment cycle and even a rolling entry cycle for the future.

Solutions and recommendations

- That the RACGP consider two selection recruitment processes for the AGPT Program per year. It was also suggested that one recruitment process could potentially select solely for rural and remote areas.
- That as medium-term solution, the RACGP consider developing a policy framework for RACGP training that provides enhanced scope and autonomy for training organisations to make

local decisions on local issues, particularly those that that serve the best interests of rural and remote communities and the needs of GPiTs and supervisors. Furthermore, that this process includes identification and removal of redundant policies.

- That the RACGP, as a long-term goal, consider competency-based medical education and training (CBME) as part of its curriculum and training program review.

Issue 3: Financial incentives to attract more GPs to rural and remote areas

This group explored financial and other incentives that could potentially attract more GPs to rural and remote settings.

The maldistribution and challenges associated with attracting GPs to rural and remote locations in Australia are often addressed through financial incentives or rewards in a recruitment strategy, but these might not be effective for long-term retention. Though financial incentives are acknowledged as a motivator, they should not be considered in isolation. Other factors include:

- financial/economic (remuneration, salary packaging and benefits)
- support of the profession
- professional/organisational support
- social (housing, spouse/partner employment, child care, schools, education, lifestyle and community affiliation).

In regards to retention, GPs may leave a rural location because of poor financial supports but also because of inadequate housing, excessive workload, excessive travel, personal security concerns and issues with leave and locum access.

Solutions and recommendations

- That the RACGP consider developing a range of incentives and retention packages tailored on a sliding scale for rural and remote GPs. The incentives and packages should have parity with other specialties. It was proposed that payments could be based on a sliding scale or gradient through MBS payments to GPs. Higher rates of payments should be made to GPs who live and work in remote areas. Payments should also increase for rural GPs with extra or additional skills. Furthermore, that the RACGP continue to advocate for rural GPs with the federal government.
- That the RACGP consider recruitment strategies that are targeted towards areas where GP services are not generally available and where workforce retention is poor. Along with appropriate incentive programs, extra consideration could be made for GPs with families, tailoring campaigns to ensure sufficient emphasis is placed on availability of educational opportunities, social supports, family support networks and employment opportunities for partners.
- That the RACGP consider enhancing formal and informal mentoring networks across rural and remote areas. Access to CPD could be explored and mechanisms for enhancement identified. Improved access to a range of CPD delivery modalities could ensure a sense of connection with the RACGP. Consideration could be given to the increased use of technology to further enhance the availability of CPD and positively impact recruitment and retention.
- That the RACGP advocate for a third party to facilitate employment entitlements (this would prevent people from being locked into state and territory systems). Further, that the RACGP consider advocating for a transparent, independent concierge service to provide easy access to entitlements and incentives for those working in remote and rural areas.

Issue 4: Implementing evidence that supports effective healthcare models in rural and remote Australia, along with appropriate advocacy

There was a shared perception that the RACGP's current messaging around its role in rural and remote Australia is unclear and confusing. The confusion lies in whether the role of the college is to develop and maintain training standards or to manage workforce distribution on behalf of the federal government.

The group acknowledged that RACGP had a role in both and can play a critical role in advocating for rural and remote healthcare. Therefore, it was agreed that the RACGP make a clear commitment to rural and remote general practice by affirming that the RACGP trains and supports GPs who are fit for purpose anywhere in Australia. The group suggested that the RACGP continue to build upon its message that general practice is a specialty for all Australians, no matter their postcode.

Adequate evidence exists to support the implementation of variable healthcare models across rural and remote areas that facilitate equity and access

for all Australians. It was suggested that the RACGP synthesise the existing evidence and develop a range of strategies tailored for healthcare in different rural and remote settings, with the recognition that a 'one size fits all' approach does not work.

The group contended that there was 'significant market failure in MMM 3–7 regions' and that new funding models need to be developed. Participants further agreed that a fee-for-service model may not be appropriate in all areas. This is a critical issue for some of the country's more remote communities and requires thoughtful and timely consideration and advocacy by the RACGP with the federal government.

Solutions and recommendations

- That the RACGP synthesise the evidence into clear briefings for stakeholders to access, commencing with a policy brief outlining the potential cost savings of preferred healthcare models across different rural and remote settings in Australia. This should highlight the economic, social and community value of providing effective GP healthcare in remote and rural areas.
- That the RACGP present the evidence to, and advocate for, the federal government to consider different healthcare models.
- That the RACGP distribute its findings and policy widely (in one-page, three-page and 25-page versions) as part of a promotion strategy affirming the message that it supports rural and remote communities and GPs who live and work in these communities.
- That the RACGP commit to the policy by affirming its support for rural and remote GPs and communities.

Issue 5: Appropriate matching of GPs to community needs, with suitable infrastructure support to sustain training

Initially, this issue was presented by the group as being about appropriate infrastructure support for rural GPiTs.

However, upon further reflection and discussion, it became clear that the underlying issue was the concern that some communities do not necessarily view all efforts to support GP training in rural communities to be for the benefit of their community, rather simply for the advantage of the GP undertaking training.

It is therefore considered essential that health delivery must be, and be seen to be, for the direct benefit of the patient and community more broadly. Positive community perceptions, 'winning hearts and minds' should factor in all future planning and investments in supporting sustainable GP training in rural and remote locations.

This sentiment comes on the back of so much publicly known data that clearly demonstrate the significant health inequalities across Australia. The group believed that the RACGP can play an even greater role in advocating for the community's needs. Suggestions included undertaking community profiling to gain a better understanding of the community needs from a doctor/heath perspective. For example, RACGP could conduct a community profile analysis in an agricultural area to determine the demographics of the area, and proximity of other services to other communities, to determine how the community can be helped by the GP.

It was also suggested that the RACGP could take a more community-centred approach and engage with the community when developing training and other infrastructure. Promoting the interests of the community ahead of the medical profession is likely to draw the positive attention of governments, which may be interested in partnering with the RACGP, particularly if there is genuine community engagement.

Solutions and recommendations

- That the RACGP advocate for community health needs by undertaking genuine community engagement and match the right GPs to the right place. The RACGP could support the development of comprehensive town profiles so that GPs are well matched to the community.
- That the RACGP develop a clear strategy to support rural and remote GPs who are most vulnerable or at risk of fatigue and burnout. Further, that the RACGP, in conjunction with training organisations, considers strategies to better sustain training environments, including enhanced supervisor support and training.
- That the RACGP advocate for appropriate infrastructure that contributes to a sense of belonging, with consideration of the needs of the GP, the GP's family, and their social and educational needs.

Issue 6: Advocating for review of tiered billings/Medicare Benefits Schedule (MBS) payments for GPs in rural and remote settings (online group)

The online group proposed that the RACGP advocate for different, tiered or sliding scales for billing and MBS rebates for rural and remote GPs, based on geography (eg MMM status) rather than practitioner qualification. The group indicated that patients in rural and remote communities experience greater disadvantage because of hardship and lack of access, leading to inequity of healthcare services.

They proposed that this approach could enhance retention of existing GPs while potentially attracting more GPs to rural and remote communities. GPs at the summit indicated that there was little incentive to remain in rural settings as it was becoming more difficult to maintain a viable business, particularly for solo practitioners. Rural doctor fatigue and burnout is a major risk factor for many rural GPs. It is important that a two-tiered system does not exist in any geographical region by increasing rebates for standard MBS numbers for those with additional rural qualifications (eg FARGP/AGPT Rural Generalist [AGPT RG]), as this would disadvantage the majority of rural GPs and could have an overall negative impact on rural doctor burnout and retention.

Solutions and recommendations

- That the RACGP consider undertaking a cost–benefit analysis along with financial modelling of a sliding-scale or tiered MBS rebate in rural and remote settings, based on geography and community need.
- While acknowledging that there are inherent difficulties with operationalising the above model, that the RACGP consider developing a range of other strategies aimed at incentivising existing rural and remote GPs. There are potential flow-on benefits of attracting more GPs to rural and remote areas if appropriate incentives are in place.
- That the RACGP continue a dialogue with both federal and state/territory governments to advocate on behalf of rural GPs to develop a range of enhanced incentives as a retention strategy for existing rural and remote GPs (including those without additional qualifications or skills).

Issue 7: A collaborative advocacy role between the RACGP and training organisations to better support the rural and remote workforce (online group)

The online group also considered a range of issues that affect GPiTs who train in rural and remote locations. These issues included:

- Lack of flexibility for GPiTs, especially the inability to transfer between practices and training locations (intra- and -interstate).
- The benefits of a single-employer model to protect entitlements such as holiday pay, maternity and parental leave, particularly when transferring between practices or moving from a state- or territory-based system to another.
- Creating an immersion in rural and remote general practice at intern and medical school levels as a strategy for attracting more people to the diversity offered in rural and remote general practice.
- Lack of a dedicated marketing and promotions approach targeting rural and remote general practice, emphasising the rewards.
- Confusion around the boundaries of the current MMM system for determining rurality and remoteness in Australia. The group argued that the boundaries are unclear and that they do not align with existing Distribution Priority Area (DPA) classifications. They also argued that information about DPA classification was not current. This issue is addressed by another group.

Solutions and recommendations

- That the RACGP work collaboratively with training organisations to address flexible training arrangements, particularly for GPiTs in rural locations (this issue was addressed more fully by another group, and is discussed in further detail earlier in this report).
- That the RACGP investigate mechanisms for protection and portability of GPiT entitlements. The group requested that the RACGP consider developing a range of strategies that could ease some of the obstacles and restrictions that present for rural GPiTs. Resolution of some of these issues could attract more GPiTs to rural and remote areas while easing the burden that existing GPiTs currently face.

- That the single-employer model warranted further exploration as a potential instrument for managing GPiT employment entitlements. That the RACGP continue its dialogue with the federal, state and territory governments to advocate on behalf of rural-based GPiTs with respect to entitlements by investigating the feasibility of a single-employer or similar model.
- That the RACGP consider a dedicated marketing and promotion campaign with a focus on recruitment pathways, targeting remote and rural students and highlighting the benefits of returning to contribute to their community. This involves an acknowledgment of rural background and its impact on career choice, and encourages the long-term development of home-grown practitioners. Future marketing strategies could highlight the benefits of lifestyle and geographic location, but should remain down-to-earth and grounded in the reality of life in a rural or remote setting. This is a fine balance between attracting candidates on one hand and managing their expectations on the other.

Appendix 1: Summit process

Session 1 – Welcome and setting the scene

The summit commenced with an Acknowledgement of Country from Mrs Doris Stewart (from the Arrente people). The summit was officially opened by Associate Professor Ayman Shenouda, Royal Australian College of General Practitioners (RACGP) Vice-President and Chair, RACGP Rural. Dr Genevieve Yates, General Manager Education Services at RACGP, and Dr Stephen Lambert, General Manager Fellowship Pathways at the RACGP, also welcomed participants.

Participants were advised of the housekeeping requirements and of the rules of engagement for the day:

- The RACGP established the Rural GP Summit to listen to the thoughts and suggestions of invited guests. Discussion of key issues in the form of respectful debate was welcomed, as was constructive feedback. However, the summit would not be a forum for individual or personal criticism of past or present decisions, including those of specific individuals.
- The intent of the day was to be focused on the future and identify solutions.
- Participants were encouraged to be aware, inclusive and respectful of online attendees.

Session 2 – Unique stakeholder challenges and insights

The summit began with short presentations from six general practitioners (GPs). Each speaker outlined their unique rural perspective and the key issues and obstacles they have encountered working as a rural or remote GP. The presenters were:

- Dr James Robinson – GP in training from Huonville, Tasmania, with an interest in becoming a rural generalist
- Dr Melanie Matthews – new Fellow of the Royal Australian College of General Practitioners (FRACGP) and Fellow of Advanced Rural General Practice (FARGP) from Darwin, working between Darwin and the remote Aboriginal community of Maningrida, Northern Territory
- Dr Michael Clements – FRACGP, FARGP from Townsville, Queensland
- Associate Professor John Kramer – FRACGP, experienced GP supervisor from Woolgoolga, New South Wales
- Dr Sam Heard – FRACGP, working as a GP in Aboriginal communities in the Northern Territory
- Dr Ken Wanguhu – FRACGP, FARGP from Waikerie, South Australia, who practises as a rural generalist with additional skills in obstetrics, anaesthetics and emergency medicine

Key themes and issues that emerged during each presentation were recorded. All participants had the opportunity to ask clarifying questions at the end of each presentation. To capture as many issues as possible, participants were also asked if they had additional issues and themes that needed to be considered from an organisational or jurisdictional perspective. Themes and issues were recorded on large sheets of paper that were distributed around the room. A total of 31 issues were identified – these are included in Appendix 2.

Participants were then provided with three stickers and invited to place one sticker against an issue that they saw as critical. This prioritisation process distilled the list to seven key issues or themes:

1. Prevocational rotation through rural general practice ('try before you buy') to fill the gap after discontinuation of the Prevocational General Practice Placements Program (PGPPP)
2. Flexibility of training models to suit the rural context
3. Financial incentives to attract more GPs to rural and remote areas
4. Implementing evidence that supports effective healthcare models in remote and rural Australia, along with appropriate advocacy
5. Appropriate matching of GPs to community needs, with suitable infrastructure support to sustain training
6. Advocating for a review of tiered billings/Medicare Benefits Schedule (MBS) payments for GPs in remote and rural settings
7. A collaborative advocacy role between the RACGP and training organisations to better support the rural and remote workforce

The focus for the rest of the day was on these seven issues. The remaining 24 issues have been recorded

and can potentially be explored at a later date, as a number of the additional issues are likely to affect key solutions.

Session 3 – Key issues/themes for improving national rural workforce distribution

Participants were divided into six groups – five groups within the room and one online. The five groups in the room were assigned one issue each, while the online group was assigned two issues.

Group	Issue
Online	Advocating for a review of tiered billings/ MBS payments for GPs in remote and rural settings A collaborative advocacy role between the RACGP and training organisations to better support the rural workforce
1	Prevocational rotation through rural general practice ('try before you buy') to fill the gap after discontinuation of the PGPPP
2	Flexibility of training models to suit the rural context
3	Financial incentives to attract more GPs to rural and remote areas
4	Implementing evidence that supports effective healthcare models in remote and rural Australia, along with appropriate advocacy
5	Appropriate matching of GPs to community needs, with suitable infrastructure support to sustain training

Each group was instructed to explore and unpack the elements of their specific issue and commence preliminary identification of solutions. Each was asked to present its findings and offer recommendations with a 10-minute presentation. Each group was asked to select a presenter who remained with the group throughout the session. Other group members were given the opportunity to move to other groups throughout the session, enabling the group to capture different perspectives.

To help develop solutions to issues, groups were asked to apply the PPESTER framework: professional, political, economic, social, technological, environmental and regulatory factors or impacts.

The PPESTER framework is a variation on the PESTEL (political, economic, social, technological, environmental and legal) framework, an analytical tool used to identify key drivers of strategic change.

The framework was introduced so that groups would consider a wide-ranging set of stakeholders and other factors that may affect the operation of a specific solution. PPESTER impacts include:

- **P**rofessional – GP professional needs; wellbeing for GPs and their families
- **P**olitical – federal policy position and imperatives
- **E**conomic – funding models and implications; impact on funding for other programs
- **S**ocial – rural and remote community and patient needs
- **T**echnological – evolving technologies to optimise efficiency
- **E**nvironmental – end users, being GPiTs, supervisors and GPs; resources and support processes for learners/teachers
- **R**egulatory – jurisdictional impacts; employment regulations; cross-border issues

Participants in each group were offered the opportunity to switch between issues.

Session 4 – Report back to large group

Each group presented its findings. The online group presented first. Audience participation was encouraged at the conclusion of each presentation. When presentations ended, the audience was asked if there were additional issues or concerns not captured in group presentations. None were identified. At the conclusion of the session, Associate Professor Ayman Shenouda made an announcement on the future of RACGP's rural training, reaffirming the college's commitment to rural and remote general practice through the development of a rural generalist Fellowship and the strengthening of existing rural pathways, including the FARGP.

He advised that the RACGP had been working with the Department of Health to improve the flexibility in the AGPT Rural Generalist (AGPT RG) training policy to make it more attractive to those interested in pursuing a career in rural or remote general practice, with flexible opt-in/opt-out movement between rural streams to allow trainees time to understand which training pathway is right for them.

He confirmed the RACGP's commitment to working closely in partnership with the Remote Vocational Training Scheme and Regional Training Organisations to deliver rural training, including the strengthened FARGP qualification and the AGPT RG program.

Specific details were to be finalised and made available over the coming months.

Session 5 – Development of key solutions and recommendations

Groups were asked to further refine their solutions and recommendations. Each was asked to work for a further 30 minutes before making a brief presentation of their recommendations. They were asked to articulate the problem, present their preferred solution and identify the strengths and weaknesses of their proposal. Groups were also asked to consider risk and its financial viability. And, they were asked to consider the following in developing their proposal:

- The stakeholders – direct and indirect
- How the solution will be funded and what policy decisions funding bodies will need to make
- The needs of rural and remote communities and how the proposed solution addresses these
- Operationalisation – how the solution supports a rural GP workforce

Each group presented their proposals. Participants were invited to comment and ask clarifying questions following each presentation.

Wrap-up and conclusion

The summit concluded with a commitment from the RACGP to explore and consider the issues raised. Further, the RACGP agreed that the current report, outlining actions and outcomes from the day, would be circulated to all participants. The issues and solutions identified from the summit will help create a blueprint that will inform the RACGP in its wide-ranging consultations and deliberations with all stakeholders in progressing the agenda to ensure Australia has a well-trained, well-supported and sustainable GP workforce in rural and remote Australia. The RACGP committed to keeping all participants informed and updated on its progress over the coming months.

Appendix 2: Issues identified

During initial discussions, the following 31 issues were identified.

- **Access to infrastructure:** to provide a place where rural general practitioners (GPs) can raise their families, with adequate access to schools for children and to social supports
- **Financial incentives:** pay and transferability of entitlements, reimbursements for costs associated with travel; housing subsidies and government payments that enable more GPiTs to train in rural and remote locations
- **Costs of training and access to more training resources:** costs associated with relocation, attending workshops, including flights, and associated costs of attending exams
- **Marketing:** encouraging rural and remote populations to do general practice
- **Education and training:** compulsory rotation – immersive experience in rural and remote general practice for all junior medical officers before entering the Australian General Practice Training (AGPT) Program; 'try before you buy' and similar to the now defunct Prevocational General Practice Placements Program (PGPPP) for exposure to the profession
- **Pastoral:** support for young people who have or want to have families
- **Trainee support:** enhanced pastoral care/support for GPiTs rotating through rural and remote settings
- **Education and training:** enhanced support for supervisors in rural and remote areas
- **Standards:** review of standards and education requirements that don't necessarily fit the rural reality
- **Advocacy:** valuing and demonstrating the worth of the rural GP to the government and for purposes of recruitment – showing the benefits that GPs bring
- **Recruitment and retention:** better programs for attracting GPs and supervisors to rural and remote Australia
- **Flexibility:** varying supervision models (such as remote supervision) to suit rural practice
- **Billing and Medicare rebates:** difficulty making a decent living – impact on choosing the profession and on provision of appropriate care
- **Education and training:** being full-time equivalent and the change to a more part-time model of GPiTs
- **International medical graduate (IMG) workforce:** still a reliance on IMG workforce – comprises approximately 50% of the rural workforce
- **Education and training – generational changes:** expectations of GPiTs have changed
- **Monash Medical Model (MMM):** categories/ boundaries don't always reflect areas of need
- **Policy:** considerations of training policy and the multiple-practice rule, along with its impact on rural communities
- **Advocacy:** lack of rural voice for building and changing policy – RACGP to advocate
- **Role of the RACGP:** training a workforce to work rurally? Or training rural generalists?
- **Workforce:** building workforce capacity and services in Aboriginal and Torres Strait Islander health
- **Effective healthcare:** developing a policy brief of the compiled evidence of the cost savings of effective healthcare models and delivery in rural and remote areas
- **Marketing:** a more nuanced marketing and advertising campaign that promotes the pros of being a GP in rural areas
- **Patient focus:** determine what is the RACGP's role in advocating for the best outcomes for patients
- **Education and training:** flexibility of training models
- **Research:** promotion on value of rural GPs for the economy and the community
- **Education and training:** getting training and support right for being an 'extreme generalist'
- **RACGP support:** supporting rural generalism
- **Workforce:** the fly-in, fly-out model to develop skills and positively impact workforce
- **Education and training:** mentoring for support, recruitment and retention of supervisors
- **Advocacy:** a more prominent role for training organisations and the RACGP in advocating for a rural workforce with governments and other stakeholders

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