

Submission to the National Medical Workforce Strategy Steering Committee – Consultation on potential solutions

17 April 2020

1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the National Medical Workforce Strategy Steering Committee (the Steering Committee) for the opportunity to provide comment on their [Proposed solutions](#) document.

The RACGP is Australia's largest general practice organisation, representing over 41,000 members working in or toward a career as a specialist general practitioner (GP).

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards and curricula for training
- maintaining the standards for quality general practice
- supporting specialist GPs in their pursuit of excellence in patient and community service.

2. RACGP position

General practice is the backbone of the primary care system, with nine in 10 Australians visiting their GP each year.¹ Evidence shows that a well-supported general practice sector will result in efficiencies for primary and secondary care, and the broader healthcare system.² Failure to invest adequately in general practice will result in continued increases in overall healthcare costs.

With more than one-third of GPs aged over 55,³ the government must invest in our future GP workforce. A decline in specialist GP numbers will have a devastating impact on the health of the nation. If patients cannot access appropriate care in the right setting at the right time from their specialist GP, the delay in care will result in poorer health outcomes, and more patients will end up in an emergency department, causing higher government expenditure.

In addition to decreasing numbers of GP trainees, the nature of the GP workforce and workload is changing:

- The average number of hours worked per week is declining.⁹
- There is an increasing proportion of female GPs⁴ – who are more likely to work part time⁴, and who also on average spend more time with their patients.¹⁰
- The Australian population is seeing an increased prevalence of chronic disease and of co-morbidities, requiring more complex care⁵ (which in turn has been shown to increase rates of burnout among doctors⁶).
- Due to this increase in complexity and comorbidity, the proportion of long consults is increasing,⁷ meaning GPs are able to see fewer patients in a standard work day.

The combination of these factors means that a greater headcount of GPs will be required to provide the same full-time equivalent (FTE) workforce in future, and a larger FTE workforce will be needed in the future.

While the current GP workforce is sufficient to meet demand – albeit with a need to re-distribute to meet areas of need – the future workforce supply is in jeopardy.

The number of medical graduates choosing to enter GP training each year has stagnated. Eligible applications for GP training have dropped by 22% since 2015. Unfilled rural training places have increased from 10% (65 places) in 2018 to 30% (201 places) in 2020. Unfilled non-rural places have also increased over the same period to 2.15% (16 places) in 2020.⁸

As discussed in the National Medical Workforce [Scoping Paper](#), there has been a significant shift toward specialisation of the medical workforce. For every new GP, there are 10 new non-GP specialists; this gap between the number of non-GP specialists and GP specialists widened from 119 in 2009, to 4271 in 2017.⁹ Even within general practice, there is now a greater focus on special interests, for example in skin cancer medicine.

The RACGP applauds the Steering Committee's acknowledgement that health systems which provide strong primary care are more effective at increasing life expectancy and reducing hospitalisations; and that therefore making general practice an attractive career choice will be an important area of focus for future workforce planning.

The reduction in the number of junior doctors applying for the Australian General Practice Training (AGPT) program has reached a critical point. New and significant investment in training GP registrars is needed. While no single change to the training program will be the 'solution', action is needed to put general practice training on equal, or greater, footing with other medical specialty training programs.

3. RACGP response to survey questions

The RACGP has addressed the majority of the potential solutions, with those not relevant to general practice noted as "no comment".

The RACGP has identified the below ten solutions as the highest priority for supporting the current and future general practice workforce:

Potential Solution 6: Develop an end-to-end incentivisation plan to increase trainee numbers in undersubscribed specialties.

Potential solution 12: Develop mechanisms to support the portability of employment benefits, enabling doctors to work across different employers, regions and/or health services throughout their careers.

Potential solution 16: Expand outreach, network models and telehealth models that provide continuity of care and are attractive to doctors.

Potential solution 20: Provide specific and adequate funding to compensate, develop and support supervisors in rural areas, including GP educators.

Potential solution 21: Continue to support national rollout of the rural generalist program.

Potential solution 35: Increase high quality exposure to generalism in medical school and the prevocational years, potentially through a competency-based transition to practice approach.

Potential solution 39: Review opportunities to reduce the ways in which the MBS fee-for-service model incentivises subspecialisation.

Potential solution 40: Consider financial incentives for doctors who choose to pursue a generalist career, especially in a rural and remote context.

Potential solution 42: Educate the community on the importance of generalist skills.

Potential solution 43: Make generalist careers more attractive and shift prestige perceptions.

3.1 Coordination between medical workforce planning stakeholders

Potential Solution 1: Establish a joint planning mechanism to guide and coordinate decision-making on the medical workforce.	-
Potential Solution 2: Develop a national medical workforce data strategy, harmonised with the priorities of the National Medical Workforce Strategy.	-
Potential Solution 3: Adopt consistent demand-and-supply modelling methodologies to form a national view of workforce planning.	-

Joint planning (1)

The RACGP supports the proposed joint planning mechanism, and the principles which would underpin joint planning. It is important that GP supervisors are included in planning to ensure that the model of supervision for GP trainees and structural supports are appropriate and well-funded.

Data strategy (2)

The RACGP supports improved data collection, management, and sharing to allow consistent demand-and-supply modelling methodologies and support future workforce planning.

Supply and demand modelling (3)

The RACGP supports the adoption of consistent methodologies to form a national view. The key components identified are appropriate, with the addition of consideration of changing work patterns, and changes to the makeup of the workforce (eg increasing numbers of female GPs and part-time GPs).

3.2 Over- and undersupply in certain specialties

Potential Solution 4: Align college decision-making about accreditation and training numbers with the data, modelling outputs and decisions of the joint planning process.	No comment
Potential Solution 5: Inform and empower medical students and junior doctors with a nationally consistent, transparent and data-based tool to help them make career decisions.	-
Potential Solution 6: Develop an end-to-end incentivisation plan to increase trainee numbers in undersubscribed specialties.	Priority

Data tool to support career decisions (5)

The RACGP supports the development of a nationally consistent, transparent and data-based tool to help medical students and junior doctors make career decisions. Medical students have limited exposure to

general practice during their study and during their subsequent junior doctor years and the RACGP advocates for stronger visibility and clarity regarding all career options for medical students.

The below commentary is in response to ideas provided in the detailed discussion of potential solution 6.

Increasing exposure to general practice early in training / study (6)

The RACGP supports the proposed steps to increase exposure to general practice rotations and increasing visible medical leadership roles to change perceptions about the specialty of general practice.

Increasing research opportunities (6)

The RACGP supports the proposal to increase research opportunities in general practice as a lever to increase the profile and prestige of the specialty. General practice research is essential to ensuring all Australians can access a high quality, effective and evidence-based primary healthcare system. General practice research will also provide evidence to underpin the development and implementation of new and innovative models of service delivery.

It is important that these research opportunities are appropriately funded to ensure sustainability.

Making general practice more financially attractive (6)

a) Incentivising GP registrar positions

GPs in training face a number of financial pressures when they transition from the hospital training environment to general practice in community settings. Inadequate remuneration, for both GP trainees and specialist GPs, is contributing to reduced interest in becoming a GP. Significant reform regarding general practice support and funding is required to ensure the sustainability of general practice and the GP workforce, both now and into the future.

The RACGP understands that salary support in Aboriginal Community Controlled Health Services resulted in improved GP registrar attraction. Further consideration and evaluation of this initiative is warranted to understand the impact and its applicability to increasing registrar attraction to mainstream general practice.

The RACGP's 2020-21 [pre-budget submission](#) outlines actions required to better support and remunerate GP registrars by:

1. Increasing the base salary for GP registrars to reduce disparity with hospital-based counterparts.
2. Matching and retaining the leave entitlements of hospital-based doctors.

It is vital that the government ensure that GPs in training are not disadvantaged, in comparison to their peers, as a result of pursuing a career as a specialist GP.

For further discussion see "single employer model" and "portability of employment benefits" in section 3.4.1.

b) Incentivising general practice as a career

The costs to provide general practice care increase year on year, and the government has not matched these increases in the patient rebates provided by the MBS. The growing gap between the cost of providing care and the Medicare rebate, combined with high external pressure for GPs to bulk bill all services, has had a significant impact on GP income and general practice sustainability.

The RACGP's [General practice: health of the nation](#) reports that GPs are more dissatisfied with their remuneration than any other aspect of their role.

The average GP's annual earnings amount to slightly more than half that of other medical specialists, and the disparity between GP and other specialist income has increased in recent years.¹⁰

c) Alternative funding methods

The RACGP's [Vision for general practice and a sustainable health care system](#) (the Vision) is a framework for excellence in healthcare and provides the solution to address a range of issues and pressures currently facing the Australian healthcare system. The Vision demonstrates how realigning funding to support internationally recognised features of high-quality general practice will facilitate the successful delivery of an equitable and sustainable healthcare system, benefiting patients, providers and funders.

3.3 Reliance on registrars to meet health service needs

Potential solution 7: Reduce the number of tasks for which hospitals require a middle-grade workforce by improving practices, systems and processes.	No comment
Potential solution 8: Ensure scopes of practice for non-medical personnel are maximised where they can reduce the reliance on a middle-grade workforce.	-
Potential solution 9: Expand specialists' roles in hospitals.	-
Potential solution 10: Define options for 'middle-grade' roles (and rename these) to attract doctors into this role and service hospital demand.	No comment

Expanding the scope of practice for non-medical personnel (8)

The RACGP urges caution on this recommendation.

There is no clear evidence that role substitution saves money or reduces the workload of doctors.¹¹ There is an increased risk of fragmentation of care, the creation of a two-tiered health system, lost opportunities for preventive healthcare interventions, and unnecessary referrals. If GPs are left with mostly complex chronic care presentations, they will be at increased risk of burnout.⁶

Moving forward with this proposed solution may require significant revision of existing medical and non-medical training models, and carries implications for a provider's legal obligation and duty of care.

GPs undertake work that no other health practitioner can do. They have to be prepared for anything that a patient may present with in their practice. They are the only medical specialists providing coordinated, patient-centred care for multi-morbid patients across the full spectrum from paediatrics and child health, to aged care and palliative care. GPs are unique in that they are clinicians, care coordinators and patient advocates, while also acting as stewards of the health and social care systems.

Expanding specialists' roles in hospitals (9)

This solution is low priority.

As previously stated, and as acknowledged in the Steering Committee's strategy framework, general practice and primary care should be a central tenant of medical workforce planning. At a time when recruitment into general practice is faltering, prioritising this solution sends the wrong message.

The RACGP instead recommends expanding the role of specialist GPs in hospitals as an important link between primary and secondary care, improving both continuity and integration of patient care. Rural generalists are likely to be able to fulfil this role in rural settings, helping to create a more sustainable health system.

3.4 Geographic maldistribution

3.4.1. Implementing innovative funding models

Potential solution 11: Consider salaried and single-employer models for rural general practitioners, with incentives to maintain service levels, access and quality.	-
Potential solution 12: Develop mechanisms to support the portability of employment benefits, enabling doctors to work across different employers, regions and/or health services throughout their careers.	Priority
Potential solution 13: Develop pooled or block-funding models for Modified Monash (MM) 4–7 (rural and remote) areas that offer greater flexibility.	-
Potential solution 14: Enable regional bodies to provide meaningful local input into workforce funding decisions.	-

Single employer model (11)

The RACGP sees the benefit of the single employer model, however there are broader implications to the workforce that must be carefully considered to avoid unintended consequences.

The results of Australian trials such as the Murrumbidgee trial, as well as international examples of this model in the healthcare workforce (such as for registrars in the UK) should be thoroughly reviewed and their broader applicability evaluated before further single-employer-models are put in place.

The RACGP has been in discussions with the Australian Department of Health and other stakeholders regarding potential single employer models to address GP registrar needs. The current proposed solution, to apply a single employer model only to the small number of rural generalist trainees (or to rural GPs, as suggested in the Steering Committee's paper), will exacerbate the problems of recruitment into the AGPT program. All registrars undertaking GP training, regardless of training location, should have the same benefits and flexibility, and all practising GPs should have access to the same employment benefits.

The RACGP recommends that a national body be established, independent of the State and Territory governments, to protect GP registrar entitlements, achieve salary parity with hospital-based registrars, and improve the attractiveness of a career in general practice.

The current proposed solution that States and the Territories be the single employer undermines the flexibility of workforce, as GP registrars would be limited to a single state which may limit opportunities for career progression.

The States and Territories do not have experience with general practice, and there is risk that they may use GP registrars as a hospital workforce solution, which may negatively affect patient access to community based services. The proposed model in the Steering Committee's paper explicitly suggests that the single employer could allow doctors to work across both hospital and community settings. GPs can be used with great effect in the hospital setting to better facilitate patient transition to and from community-based care, and to coordinate care for patients with complex needs. However, this model should be used with caution lest it negatively impact on patient access to specialist general practice care, if GPs are diverted from their core role in primary care.

The solution to employment models must be College led. It is up to the RACGP and ACRRM to design GP training programs and consider any changes to GP employment models, in collaboration with GP members and stakeholders. Supervisors and practices, as the employers of GP registrars, must be actively engaged as part of the solution, to ensure GP training places and practising GPs are well supported into the future.

Portability of employment benefits (12)

The RACGP supports allowing portability of employment benefits, and supported the idea of a third-party portability fund for GP registrars in its 2020-21 pre-budget submission. This is a solution which could provide the incentives of the single employer model while still allowing GP registrars the flexibility of moving employers and locations. Any introduced scheme should also ensure portability of benefits interstate.

As only 1 in 10 GPs are salaried employees,³ there may be benefit in considering similar models for all GPs as well. The ultimate goal should be to make general practice an attractive career overall, however addressing the first hurdle – loss of employment benefits when transitioning from the intern years to the practice settings – should be a priority. It is suggested that any new model be trialled first for registrars, to allow time for extensive consultation with RACGP members regarding their employment situations, and to consider the broader implications of making any changes.

Portability of employment benefits is particularly relevant to GP registrars, as they do not retain their employment benefits during training as they move to a new employer each rotation. Junior doctors make crucial decisions about their career based on a range of factors, including remuneration, available entitlements and their family and personal circumstances. The nature of general practice means that junior doctors lose accrued entitlements from their time in the hospital setting when transitioning to community based practice, and then do not stay in an individual practice long enough to re-accumulate those leave entitlements.

The protection of entitlements and guaranteed salaries must be offered to all registrars in GP training. If protection of entitlements and guaranteed salaries are only offered to those training as rural generalists or rural GPs, a two-tiered system will be created, dividing the profession, exacerbating AGPT recruitment issues, and undermining patient care.

The RACGP recommends that rural places be incentivised through other mechanisms, like tax benefits and grants.

A body such as a “National Entitlements Fundholder” is required, governed by the RACGP or another appropriate entity independent of the State and Territory governments, and guaranteed by the Federal Government. This body would be responsible for the maintenance and distribution of registrar entitlements while GP registrars are undertaking training.

The “National Entitlements Fundholder” would manage leave entitlements including annual leave, sick leave, extended leave, parental leave, and long service leave for GP registrars. Consideration could be given to feasibility of registrar salary top-up funding to guarantee minimum salary, ensuring base salaries are not less than their hospital registrar counterparts.

Critically, unlike other solutions proposed, this model does not involve substantive change to current employment arrangements during GP training, and as such does not involve the direct employment of GP registrars. Nevertheless, many operational details would need to be considered, and all stakeholders must be involved in the development of such a model.

Pooled funding models (13)

The RACGP supports the principle of removing bureaucratic barriers to access funding, and the intention to allow greater flexibility in the use of funding to achieve better workforce recruitment, retention, and models of care which suit community needs. Different rural communities have different healthcare provision models based on their needs, and this must be explicitly recognised. Ensuring funds are easily accessible to all rural communities in need, despite their current healthcare provision model, is important.

The RACGP sees that State and Territory governments should play a greater role in supporting general practice care for all areas, not just MM4–7. State and Territory governments will see benefits from an appropriately supported general practice system through reduced hospital use and a healthier population able to manage their health while remaining in the community. State and Territory governments can play a role in supporting high-quality general practice through:

- supporting coordinated care models between general practice and state- or territory-funded programs and services
- supporting integrated care initiatives that improve the interface between general practice, hospitals and other health services.

The RACGP’s Vision describes ways to improve the work life of health providers. This includes:

- ensuring that GPs are well recognised for the important role they play in the healthcare system
- providing systems and funding that support GPs to provide high-quality, comprehensive and patient-centred care

- funding systems which reduce burnout
- reducing administrative burdens, improving remuneration, and increasing career options (via leadership roles and research opportunities).

Improved satisfaction of GPs will also increase the attractiveness of general practice as a profession, helping to grow and sustain the future general practice workforce.

Input of regional bodies into workforce decisions (14)

Increased transparency in workforce funding decisions would be beneficial. Ensuring the GPs and other primary healthcare professionals working in rural communities have a strong voice in workforce funding decisions is essential for optimal outcomes. Registered training organisations (RTOs) should also be a major voice in local health service delivery involving GP trainees, to ensure good health outcomes are delivered without compromising training requirements.

3.4.2. Optimising service delivery models

Potential solution 15: Work with communities to set service expectations and ensure adequate workforce planning and resource allocation for rural areas.	-
Potential solution 16: Expand outreach, network models and telehealth models that provide continuity of care and are attractive to doctors.	Priority
Potential solution 17: Ensure that all rural communities and doctors have access to 24/7 specialist clinical support.	-

Working with communities (15)

The RACGP recommends that there be a defined base level of services that are recognised as a minimum level required for all communities. While we would support communities being involved in the setting of service expectations, there is an existing evidence base that can help inform these discussions.¹² It would also be helpful to allow sharing of some of the successful healthcare models that currently exist in remote and rural communities across Australia. Provided the necessary funding were available, the RACGP would be willing to work with stakeholders to create a sharing platform to promote discussion and implementation of innovative ideas and successful models.

Telehealth (16)

The RACGP supports expanding telehealth models as suggested. It is time the MBS be modernised to allow patients the ability to connect with their GP via telehealth. Medicare rebates for telehealth video consultations between patients and non-GP specialists, under limited circumstances, have been available since 2013. However, patients require the services of their usual GP much more often than non-GP specialists.

Use of technology in general practice can ensure care is accessible to all people, particularly those who experience poorer health and increased barriers to accessing health services. This often includes regional, rural and remote communities, people with mobility issues, Aboriginal and Torres Strait Islander peoples, and culturally and linguistically diverse communities.^{13,14}

A patient's eligibility to access their GP or practice using technology should not be determined by where they live, but rather their need,¹⁵ as has been demonstrated during the 2020 COVID-19 crisis. Telehealth services must be available for anyone who is not able to access their GP in person. In addition to the current pandemic situation, telehealth can benefit all patients when it is used for short follow-up appointments to explain test results, or for maintaining regular contact in chronic disease management.

The RACGP supports the facilitation of existing GP-patient relationships by encouraging care to be delivered flexibly (including the use of non-face to face care) by the patient's usual GP. The best long-term option for

achieving this is for removal of the MBS rules that stipulate that MBS consultation items can only be claimed when a patient is present in person.

Care provided to patients known to the GP via email, video consultation or over the phone can complement traditional face-to-face consultations, helping to facilitate the ongoing partnership between individual patients and their usual GP. Greater use of basic technology will allow for better-targeted and effective coordination of clinical resources to meet patient needs and facilitate the provision of acute, preventive and chronic disease care.

While face-to-face consultations should continue to be the primary means of GP and patient interaction, there are many scenarios where technology can enable more convenient and accessible healthcare delivery for patients, their regular GP and the general practice team.

Patients want flexible care with healthcare providers they know and trust. The ability to access their regular GP using technology will benefit patients by reducing wait times, travel time and costs, and absence from workplaces.

The [RACGP Technology Survey](#), conducted in October 2017, found that GPs were generally optimistic about use of telehealth, and 45% of respondents said they would use telehealth services if appropriate funding and supports were available. Data on the uptake of telehealth during the pandemic by GPs, and the impact this has had on practices will be collected by the RACGP and made publically available to inform future policy in this area. The RACGP will continue to advocate for greater use of telehealth, beyond the current pandemic environment.

24/7 specialist clinical support (17)

As mentioned for potential solution 15, the RACGP supports the idea of an evidence-based agreement of the minimum services required in a community.

It would be beneficial for a gap analysis to be carried out to identify where further support services are needed. The RACGP is very supportive of developing additional resources which allow access to specialist expertise, especially in remote communities. In rural and remote communities, innovative and effective solutions are often developed in response to a lack of resources. Dialogue with the existing service providers and community residents will be essential to ensure integration of new clinical support models as opposed to overriding existing models.

Remote supervision must meet an agreed set of standards. The RACGP endorses GP Synergy's [Remote Supervision Policy](#).

3.4.3. Expanding specialist training positions

Potential solution 18: Collaborate with specialist medical colleges to identify and resolve the barriers to accrediting more high-quality rural training positions.	-
Potential solution 19: Expand pathways that allow all or the majority of training to be completed in rural areas.	-
Potential solution 20: Provide specific and adequate funding to compensate, develop and support supervisors in rural areas, including GP educators.	Priority
Potential solution 21: Continue to support national rollout of the rural generalist program.	Priority

Accrediting more rural training positions (18)

The RACGP would support moves to resolve barriers to accrediting high quality rural training positions. Often GPs completing their Advanced Rural Skills Training (ARST) have to move to a metropolitan area to find an accredited post. This can cause disruption to their home and family life, which is a disincentive for them to later return to a rural area.

For genuine educational reasons it may be difficult to accredit a post in a rural or remote area – for example if there isn't a hospital of sufficient size to ensure the registrar would have exposure to all of the learning outcomes required to complete the ARST. It may not always be possible to resolve these barriers, and a weakening of the standards to enable rural training is not desirable. However, efforts should be made to enable the accreditation of more rural training posts, where this can be done without weakening education standards.

RACGP Rural is revising the ARST curricula to integrate ARSTs into the rural general practice setting where possible.

Expanding training pathways (19)

The RACGP supports the principle of increasing time spent training in rural areas – in medical school, in GP training, and in the training pathways of other health professionals. Evidence shows that rural undergraduate training increases the odds of working rurally, as do longer periods in rural training, and more placements.¹⁶

We support the implementation of national rural training pathways such as the [National Rural Generalist Pathway](#), which upholds the idea of rural end to end training (with the above caveat on completing the ARST).

The RACGP also supports the National Rural Health Commissioner's work on increasing access to allied health services in rural Australia.

It is important to note that while we support the increase of non-GP specialty training posts in rural areas, these cannot replace the role of the GP. Rather they are essential to ensure communities have access to an appropriate range and mix of health professionals to meet their needs.

Rural supervision (20)

Support for rural supervisors should be a priority for investment. Increased funding for compensation and support, and access to training and professional development would go a long way to supporting supervisors and increasing the number of quality training places available. Evidence shows that having a positive rural training experience is a key driver in individuals choosing to train and work in rural areas.¹⁷

Rural generalist program (21)

The RACGP recommends that the implementation of the National Rural Generalist Pathway be fully funded. It is essential that the work to develop and implement the Pathway is continued, that it is fully funded and that all key stakeholders continue to be engaged. Rural Generalists will be an important part of the solution to address disparities in health outcomes in underserved communities, including rural and remote Aboriginal and Torres Strait Islander communities.

While Rural Generalists will form a valuable part of the workforce, the skills and importance of the whole scope of GPs working in rural communities must be acknowledged. We will need to attract both rural GPs and rural generalists in order to ensure we provide our rural communities with the skills they need and meet the volume of demand.

3.4.4. Valuing rural experience

Potential solution 22: Ensure rural experience is included as a desirable selection criterion for positions, both in medical school and throughout doctors' careers.	-
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The RACGP does not support measures which compel doctors to work in rural areas; it is preferable to instead foster those who have an interest in rural practice. Measures which compel doctors to work rurally are often unsustainable.

For example, previous approaches to address the maldistribution of GPs have focused on mandating that certain GPs must work in rural communities through visa requirements or bonded places. However, evidence from both Australia and Canada shows that these policies are not wholly effective; once the 10-year period is complete, the GPs move away from rural areas.¹⁸

We should instead focus on mechanisms which would ensure registrars have a positive rural placement. This may include setting requirements for high-quality rural experience—for example, duration, location and breadth of exposure to rural medicine.

We would also support measures which highlight the value of rural GP experience and the esteem in which it is held, such as expanding the evidence base on the clinical value of rural experience.

3.4.5. Growing programs

Potential solution 23: Ensure all programs undergo outcomes-based evaluation.	No comment
Potential solution 24: Establish mechanisms for communities to share learnings on what makes programs successful.	-
Potential solution 25: Enable new and existing programs to more effectively address critical barriers and drivers for attracting doctors to rural careers.	-
Potential solution 26: Provide leadership development training and mentorship to aspiring rural trainees and future rural medical workforce champions.	-
Potential solution 27: Support practice managers through training and the creation of a central or jurisdictional 'navigation hub' for self-serve and assisted support.	-

Sharing learnings (24)

A central repository of all relevant data, studies, anecdotal evidence etc would be helpful for a variety of stakeholders including practices, RTOs, local government, state health departments and workforce programs etc.

Addressing barriers to recruitment (25)

Building on the existing evidence, sharing initiatives that are effective, and collaborating across jurisdictions are all essential in increasing the numbers of doctors choosing to train and work in rural communities.

Leadership training and mentoring (26)

While the RACGP supports the development of local networks for clinical leaders, these resources (networks to provide mentorship, support, and build skills) should be available to all GP trainees and GPs, regardless of rurality.

Practice manager support (27)

The RACGP is very supportive of greater resources for practice managers, including training and networking.

Practice managers undertake a multitude of essential tasks, including the recruitment and retention of staff. Practice managers can play a key role in helping GPs settle into a new rural practice. This is important as a range of factors, including finding a network, having a work/life balance, and lifestyle,¹⁹ are key in determining how long GPs remain in rural and remote locations.

3.4.6. Realigning medical education

Potential solution 28: Improve data collection and transparency to evaluate and support effective medical school programs that increase uptake of rural roles.	-
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The RACGP supports collecting data for the purpose of sharing and promoting ideas and programs that have been proven effective.

However, medical schools should not be financially penalised nor rewarded based on the success or otherwise of their programs.

3.4.7. Reducing reliance on locums

Potential solution 29: Standardise and cap locum pay levels and terms to rebalance usage of locums versus permanent positions.	-
Potential solution 30: Address recruitment and staffing models such as approval requirements for permanent staff recruitment, to allow hospital administrators more flexibility in recruiting doctors without the need to rely on locums.	No comment
Potential solution 31: Create incentives that encourage limiting locum use by health services.	-
Potential solution 32: Implement new locum management models.	No comment

Standardise locum pay levels (29)

Locums play an essential role in the rural workforce by filling long-term roles which can't be recruited, covering gaps while GPs seek training in metropolitan areas, covering parental leave, and providing needed skills to practices or hospitals with short term skills gaps.

Standardising locum pay levels would assist general practices to compete with state health services, and realign services to needed areas.

Any pay standardisation proposals would require extensive consultation before being introduced.

Limitations on locum use (31)

The RACGP does not see that this proposed solution is realistic for the reasons outlined in (29), and this does not take into account the use of locums outside the hospital setting. Locums are a valued and necessary part of the rural workforce. Requiring that locum use be limited would mean many communities would be deprived of needed skills and access to care.

3.4.8. Improving the distribution of IMGs

Potential solution 33: Review the IMG exemptions.	-
Potential solution 34: Document the number of IMG specialists entering under Area of Need versus District of Workforce Shortage criteria and assess the need to align these criteria.	-

IMG exemptions (33)

The RACGP supports reviewing the IMG exemptions policy to ensure the regulatory mechanisms are achieving their intended outcome.

The 10-year moratorium saw most IMGs return to urban settings once they satisfied the regulatory requirements. Often described as a two-tiered system, this arrangement places limits on the IMGs

professional development and career opportunities, while placing them in an unsupported and clinically complex environment.¹⁸

While IMGs remain an essential part of the rural GP workforce, distribution policies that can allow for self-sufficiency should remain the Strategy's key objective in the long term.

Data on IMG location (34)

The RACGP supports gathering additional data on the location of IMGs and the numbers working under each of these policies. The process for both employer and IMG must be made as clear as possible to reduce red tape; alignment of criteria may assist in this area.

3.5 Balance of generalist versus subspecialist skills

3.5.1 Structural solutions

Potential solution 35: Increase high quality exposure to generalism in medical school and the prevocational years, potentially through a competency-based transition to practice approach.	Priority
Potential solution 36: Ensure selection criteria for entry into speciality training programs reward generalist experience and do not encourage early subspecialisation.	No comment
Potential solution 37: Work with colleges to equip fellows with the right balance of generalist and subspecialist skills throughout their training and careers.	No comment
Potential solution 38: Work with medical schools to determine if there is an evidence base for using medical school selection as a potential lever to increase generalism.	No comment

Early exposure to generalism (35)

Feedback from our members strongly supports increasing exposure to general practice during medical school and prevocational years, noting the value of the Prevocational General Practice Placements Program when it was in operation. Reinstatement of a similar model to create a pipeline into general practice would be supported.

Medical schools should foster students to pursue interests in general practice, generalism, and rural placements by increasing exposure to leaders in these fields and focussing on generalist competencies as the core of medical training.

3.5.2 Market solutions

Potential solution 39: Review opportunities to reduce the ways in which the MBS fee-for-service model incentivises subspecialisation.	Priority
Potential solution 40: Consider financial incentives for doctors who choose to pursue a generalist career, especially in a rural and remote context.	Priority
Potential solution 41: Ensure that generalist skills are fostered and valued in hospital recruitment processes.	No comment
Potential solution 42: Educate the community on the importance of generalist skills.	Priority

Reduce the ways in which the MBS fee-for-service model incentivises subspecialisation (39)

The RACGP has advocated strongly for this as part of the MBS Review process.

Scheduled patient rebates for GP services are consistently undervalued when compared to those for other medical specialist consultations, even after adjusting for years in training between specialisations. The RACGP reiterates its call for a loading of at least 18.5% to be applied to all GP consultation MBS rebates to bring them to the level of other specialist consultation items. Through the MBS review, the RACGP has also called for better support to provide [wound care](#) to patients, either by providing funding through the MBS for dressings, or by changing the rules to allow GPs to more easily charge patients for dressings.

In addition, the RACGP recommends recognition of specialist GP skills and experience within the MBS. Unlike most other industries, more experienced GPs do not financially benefit from the skills and experience they gain over time. This can limit:

- general practice as a desirable vocation
- engagement with chronic or complex patients
- practice leadership and ownership.

Financial incentives for generalism (40)

Rural GPs must be remunerated appropriately for the increased risk they carry, the on-call hours, and their additional skills. GPs with procedural skills should have access to the same MBS numbers as non-GP specialists performing the same procedures (“equal pay for equal service”).

The RACGP has endorsed the National Rural Health Commissioner’s [proposal](#) around rural loading for all clinical services, including but not limited to those provided by Rural Generalist GPs.

Any financial incentive for general practice would be welcome after many years of disinvestment in the profession. It is important that incentives be applied across the full scope of general practice locations, not just in rural areas.

In addition to the previously discussed potential solutions of increasing base salary for GP registrars, increasing Medicare rebates, introducing innovative funding models, and allowing portability of employment benefits, introducing generalist loading payments and waiving HECS debts would be a welcome relief to the existing and future general practice community.

Other potential solutions may include:

- increased funding for voluntary patient enrolment, and expanding the program to all patients with chronic or complex care needs, to support continuity of care
- small business grants to support general practice infrastructure needs
- complexity loading on payments to general practices, responding to the patient profile of the practice
- research funding dedicated to general practice research, undertaken by general practitioners.

Community education (42)

The RACGP would welcome additional funding from the government to support a community education program on the value of general practice and the important role GPs play in the community and health sector.

Appropriate remuneration for the role GPs play in community education on population health issues would make this a more viable activity, and in turn increase the profile of general practice in the community. At present, this work is mostly unfunded.

3.5.3 Clinician solutions

Potential solution 43: Make generalist careers more attractive and shift prestige perceptions.	Priority
Potential solution 44: Improve professional and clinical support for generalists, especially in rural and remote locations.	-

Potential solution 45: Work with medical defence organisations, prevocational training networks and colleges to empower doctors within their generalist scopes of practice.	-
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Shift prestige perception (43)

The RACGP supports the proposed solutions aiming to shift prestige perceptions, noting that many, if not all of these actions will require additional funding. The RACGP will commit to working with government to achieve these solutions.

It is essential that trainees are exposed to positive GP experiences and impressions throughout the undergraduate and postgraduate years. This can include positive GP placements, influential role models and mentors, information on GP pathways and career opportunities, increased research into challenges faced, and support from organisations including universities, RTOs, and the specialist medical colleges.

The RACGP provides support and resources including the RACGP Future Leaders program, webinars and training workshops, networking opportunities, and awards including GP of the Year, GP Registrar of the Year, and the Medical Student Bursary award.

Support for generalists (44)

The RACGP would support improvements to professional and clinical support for remote and rural GPs. Often these professionals are isolated, and working in very different circumstances to metropolitan GPs (for example, without access to specialists for consult/referral, or in single doctor practices). Increased access to continuing professional development is essential. Currently this is often only available if the GP can travel to a major city, which can cause difficulty if a locum can't be found. More options for these GPs to ensure they can access professional development opportunities, are essential.

Empower doctors within their generalist scope of practice (45)

The RACGP supports encouraging GPs to undertake more procedural work by improving indemnity insurance packages.

However, it should be noted that a proportion of the risk that generalists face arises from the medical complaints process as administered by the Australian Health Practitioner Regulation Agency. As small businesses, general practices rely on the goodwill and word of mouth of their patients to run their business. A published tribunal decision can have the same effect on a general practice as a negative online review for any other business.

An additional barrier to practice is the complexity of Medicare item descriptors, and the stress caused by draconian compliance processes as administered by the Department of Health. The current MBS is unnecessarily complicated and GPs spend too much time trying to understand its intricacies and keep up to date with the regular amendments. Medicare compliance activities and Professional Services Reviews have also increased, with recoveries doubling in the past financial year.

GPs have traditionally borne the brunt of these compliance processes, however improved data analytics and increased staffing are driving more review of billing practices for non-GP specialists.

The RACGP has advocated for a shift from the more punitive compliance processes toward a greater focus on provider education and guidance on how to interpret the MBS.

3.6 Management of end to end training and career pathways

Potential solution 46: Create transparency for doctors throughout the training pathway.	-
Potential solution 47: Increase support for doctors to navigate and plan for their career pathway, particularly for undersupplied specialties and rural areas, and for Aboriginal and Torres Strait Islander doctors.	-
Potential solution 48: Work with colleges to increase accreditation of non-metropolitan posts through governance processes and innovative supervision approaches.	No comment
Potential solution 49: 'Right size' the training pathway.	No comment
Potential solution 50: Facilitate flexible approaches to training.	-

Support doctors to plan their career pathway (46 and 47)

Providing greater clarity on GP training and career pathways would be helpful, particularly as changes are introduced to the AGPT and if Rural Generalist Medicine is recognised as a specialised field within the specialty of general practice. As the landscape becomes more complicated it is important for all key organisations (including the RACGP) to provide as much clarity, information and advice to doctors in training as possible.

Flexible training (50)

The RACGP supports flexible training pathways and has implemented several measures including remote supervision.

Providing for maternity leave, study leave, and other leave for GP registrars continues to be a challenge in the small business environment general practice operates in. Approaches to support this are under consideration (see section 3.4.1).

This will continue to be an area of focus as AGPT transitions back to the RACGP.

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