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AMA submission to the Department of Health and Aged Care – consultation on rural procedural programs streamline and expansion report

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General comment

The AMA welcomes the opportunity to provide feedback on the final report of the consultation and design process to streamline and expand the Rural Procedural Grants Program (RPGP) and the Practice Incentives (PIP) Procedural GP Payment.

The AMA acknowledges there is a significant need to define new program arrangements that will ensure the RPGP and PIP Procedural GP Payment are aligned with the Rural Generalist (RG) pathway, consider the recommendation of the Strengthening Medicare Taskforce, and provide better incentives for GPs working in rural areas under a College-led training model.

The AMA would like to see the new arrangements encourage a strong rural medical workforce to better meet the health needs of Australians living in rural and remote areas, particularly for access to specialised health care both procedural and non-procedural services.

Continued support for rural doctors, both to attain continuing professional development (CPD) for advanced skills and to access financial incentives, is a key component to address the ongoing maldistribution of health professionals in rural and remote Australia. In this regard, the new administrative model of the support programs must increase attraction and retention of doctors to rural, be simple to understand and to implement, and value doctors who work in rural setting.

AMA response to the consultation questions

1. What is your preferred option from those presented in the report?

A. RPGP expansion options

The AMA is in support of the moderate expansion option of RPGP to include advanced skills on Aboriginal and Torres Strait Islander health, mental health, palliative care and paediatrics (**option A1b. Moderate expansion**). These non-procedural advanced skills are currently the most needed skills in rural communities and training for these skills needs to be immediately funded. Beside these skills, some jurisdictions are in need of internal medicine specialised

skill. This could be considered as another non-procedural advanced skill for RPGP expansion. As the report points out, the challenge would be on how to recognise the advanced skills of rural GPs that have been attained and used in the non-procedural domains.

The AMA suggests the broader expansion of RPGP (option A1c) be a long-term goal as it would be appropriate to include all GP colleges defining non-procedural advanced skill areas. This expansion will involve the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) defining non-procedural advanced skills for rural GPs to be supported by RPGP based on the colleges' advanced skill training program curricula.

The expansion arrangement of RPGP can be developed by the colleges but it must be obtainable to rural GPs who choose not to gain registration as rural generalists, or who do not have a college advanced skill qualification. The demonstration that the rural GPs' expertise is being sought by hospitals or peers should be one criterion, and case audit that demonstrates workload at a higher level of skill than colleagues would be another. The colleges' CPD curricula will need to be able to accommodate these circumstances.

B. PIP Procedural GP Payment expansion options

The AMA would like to see PIP Procedural GP Payment to stay separate from Rural Procedural Grants Program (RPGP) and remain limited to procedural areas as of the current practice (**option B2. No change**). The AMA considers it important to clearly separate the issues of CPD for advanced skills and financial incentives for doctors and/or practices providing advanced skills to a rural community. PIP Procedural GP Payment program has been reportedly useful to incentivise doctors working in rural areas and support practices in rural setting.

2. <u>What features are most important to you in the revised scheme (e.g. particular advanced skills, additional incentive mechanisms, flexibilities)?</u>

Equal pay for equal work principle

While supporting the roll out of National Rural Generalist Pathway (NRGP), the AMA advises that the program delivery of NRGP must not inadvertently become another barrier to rural practice i.e., it becomes the basic requirement, and/or remuneration is structured around the qualification to the detriment of other rural GPs. Many rural GPs have vast experience and advanced skills, and have been providing advanced procedural and non-procedural care to the communities but their skills are not necessarily formally recognised.

In terms of streamlining and expanding RPGP and PIP Procedural GP Payment, the AMA is in support of providing rural loading for all clinical services, including but not limited to those provided by Rural Generalists (RGs), and is increased based on Modified Monash Model category from MMM2 to MMM7.[1]

[1] Australian Medical Association (AMA). 2018. *AMA response on the National Rural Generalist Taskforce Advice to the National Rural Health Commissioner*. Recommendation 17.

The AMA believes that incentives for doctors practicing rurally must be based on the principle of equal pay for equal work. As such, we support rural generalists given access to RPGP and PIP Procedural GP Payment and/or MBS specialist item numbers when providing clinical care in areas of accredited additional skills in principle, but with very specific conditions and caveats regarding scope of practice and credentialing arrangements for additional skills.[2] Access to the program/payment must be available to all GPs when providing clinical care in areas of accredited additional skills, not just to rural generalists. Many doctors in rural and remote settings already practice across an extended scope of medical care and that the notion of equal pay for equal work as a basic premise should apply.

While we provide in principle support, we would like the discussion of access to non-GP specialist incentives to be part of a much broader discussion about incentives for primary care, not something that is restricted to the NRGP.

The AMA encourages and supports additional qualifications for rural GPs as rural communities need access to specialised healthcare. However, the new arrangements of rural generalists and advanced specialist training must appropriately build on the current structure rather than bypassing it. The changes will need to ensure that GPs who are already providing advanced skills in rural communities must not only be disadvantaged by any changes, but are also eligible for any new funds from expansion of the program.

3. Are there any potential unintended consequences or barriers to implementation that the Department should address when considering changes to the *scheme*?

Unequal access to funding

The unintended consequence of the changing to the scheme would be to have doctors doing the same work utilising the same skills but not gaining the same funding/incentives as colleagues who have a simpler and more verifiable qualification.

The AMA is convinced that flexibility is an important feature in designing the new scheme. The principle of equal pay for equal work should be applied so that additional payments/incentives only apply when the job description requires the additional skill regardless the formal qualification of the GPs. For example, a rural generalist who provides a regular GP role would not get paid more than any other suitably qualified and experienced GP who provides the same specialist care.

Regarding funding to rural health, the pressure point rurally is funding for emergency department (ED). The AMA recommends that the scheme ensures there are no losses to emergency funding, or there will be more funding put into it to increase the incentive for rural GPs to work in ED. Rural and regional areas have been struggling to keep their ED running. If rural ED fails so do rural hospitals.

[2] Ibid. Recommendation 16.

GPs prioritising advanced specialised care rather than providing primary care

As described in the report, in some jurisdictions where there is strong support and reimbursement for rural generalists within the hospital system, there is an emerging trend for rural generalists to work in areas/hospitals where they can practice their advanced skills and spend little to no time in general practice. This situation is contrary to the broad principles embedded in the Collingrove Agreement which stated:

> *"A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team."* [3]

The AMA suggests that there must be measures in place to ensure access to non-GP specialist rebates does not create perverse incentives by driving rural generalists away from comprehensive general practice in favour of better remunerated areas of the MBS. This will be critical to ensuring that rural generalists help solve issues of workforce maldistribution and do not create new problems.

Rural practice dependence on incentives

The AMA submission to Inquiry into provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians describes potential issues could emerge when incentives are removed from general practices that have been solely relying on them. Many practices in rural areas are only viable because they recruit doctors through 19AB exemptions and receive incentive payments. Incentives have been the main source of funding that keep the practices running.

The AMA believes that incentive payment must be actual incentives on top of otherwise sustainable businesses. It is unacceptable that government funding policies now mean that general practices in regional, rural and remote locations are only viable through incentive payments. The solution to the significant impact to general practices that lost rural incentives in the shift to the Modified Monash Model (MMM) is not to reinstate incentives, but to increase meaningful funding again to general practice.

It is also important to note that focus on bulk billing rates is detrimental to the efforts to increase GP workforce. The costs of running a practice continue to outstrip the indexation of MBS rebates and GP earnings continue to significantly lag their non-GP specialist colleagues. This is detrimental to GP recruitment and, in the absence of further initiatives to improve GP remuneration will continue to impact negatively on recruitment in the sector.

[3] The Collingrove Agreement. 2018.

The AMA proposes a long-term reforms to general practice outlined in the AMA's Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform. While longer-term reforms begin to take effect, the AMA has a series of proposals for immediate consideration:[4]

- Providing support for shared networking
  Fund the establishment of networks between rural and city general practices to support non-metropolitan general practice e.g., share administration and provision of locum relief. Small geographically close practices could be incentivised to have a shared practice manager and back-office operation. For example, accounting, patient recall and health promotion activities could all be performed remotely through networked practice software. This would generate efficiencies and require minimal support from the Government. Primary Health Networks (PHNs) could coordinate this process.
- Infrastructure Grants (tax free)
  Infrastructure grants for investment in new technologies will support general practice to build on the increased productivity in general practices to access MBS funded telehealth. These grants should be tax free.
- Implementing models to ensure sustainable health workforce in rural practices through collaborations among hospitals, health services and local government
  The local governments can adopt the AMA Easy entry, gracious exit model; recognition of scope practice and remuneration; and provide family support that includes spousal employment, educational opportunities for children, childcare, subsidy for housing/relocation and/or tax relief.
- Retention payments
  Meaningful incentives for sustained long service (at least five years) would encourage GPs to remain in their communities for longer. This should be tiered by rurality and could begin in outer metropolitan areas. Incentives could also come in the form of support for upskilling, with reliable locum cover at no cost to the practice. Long-serving GPs should be supported to develop advanced skills in areas of community need, for example skin cancer surgery, ultrasound, or mental health.

4. Do you have any advice for the issues discussed around credentialling or threshold qualifications?

As stated in the AMA response on the National Rural Generalist Taskforce Advice to the National Rural Health Commissioner in 2018, we noted that the issue of defining scope of practice and credentialing will require broad ranging discussions including with the RACGP and ACRRM, specialist medical colleges, State/Territory Health Departments, Primary Health Networks, Local Hospital Networks and other relevant stakeholders. The implementation of College-led GP training model might also need to be considered in the discussion around credentialling and threshold qualification.

The AMA acknowledges that developing endorsements within the Australian Health Practitioner Regulation Agency (AHPRA) to provide a public register of the current additional

[4] Australian Medical Association (AMA). 2021. *AMA submission to Inquiry into provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians*

skills of each RG (as recommended by the Taskforce) has the potential to assist with the public transparency and support credentialing processes for the work of RG.[5] However, we note that using endorsements may put in place a requirement for more qualifications.

5. Any other related comments about the strengths and limitations of the RPGP

The AMA believes that supporting training pathway for rural GPs through the expansion of Rural Procedural Grants Programs (RPGP) will help doctors retain in rural, and enable them to provide communities access to procedural services which they can't access from the specialists. The RPGP implementation has been reportedly successful in increasing the numbers of rural GPs with procedural and emergency medicine skills to access educational activities relevant to their discipline. The purpose of this program was to maintain their skill levels and support them to continue providing these services in their rural hospital, thereby enhancing the retention of these GPs in the community.

However, the main objectives of rural medical workforce initiatives should also be to streamline medical workforce to rural and regional areas to address the workforce shortages in these settings. The AMA Rural and Remote Medical Workforce Policy's proposal on training and retention of medical practitioners are the following:

1. Investing in the rural medical training pipeline:
    a. Increase intake of medical students from a rural background to one third of new enrolments.
    b. Increase the number of medical students undertaking clinical placements in rural area to one third.
    c. Expand the Specialist Training Program to 1700 places giving priority rural and generalist training.
    d. Investment in regional teaching hospitals to ensure they have sufficient capacity to host STP-funded non-GP specialist registrars.
    e. Implement the National Rural Generalist Pathway nationally, and a commitment to ongoing funding.
    f. Encourage end-to-end rural medical training programs that provide positive rural exposure.
    g. Expand capacity for remote learning and supervision in regional/rural sites.
    h. Promotion of regional training and research teaching hospital hubs to grow non-GP specialist capacity outside metropolitan areas.
    i. Implement a Single Employer Model for GPs in Training.
    j. Encourage and support non-GP specialist medical colleges to offer more generalist training places for trainees.
2. Retention of medical practitioners:
    a. Provide rural, emergency/on call and advanced skills loadings and incentives that encourage doctors to work in rural areas and reward long service.
    b. Fund the establishment of networks between rural and city general practices to support non-metropolitan general practice e.g., share administration, provision of locum relief.

[5] National Rural Health Commissioner. 2018. *National Rural Generalist Taskforce Advice to the National Rural Health Commissioner*

c. Provide tax free infrastructure grants to rural practices to support investment in new technologies e.g., telehealth, home monitoring.
d. Provide extra funding and resources to rural and regional hospitals to support the provision of adequate facilities, improved staffing levels and flexible work arrangements, e.g., core visiting medical officers, locum relief for GPs and non-GP specialists.
e. Provide family support that includes spousal opportunities/employment, educational opportunities for children, subsidy for housing/relocation and/or tax relief.
f. Improve access to educational support for rural doctors including continuing professional development and mentoring.
g. Provide access to high-speed broadband in rural areas including the rollout of the National Broadband Network.
h. Implement models to address the market failure of small rural practices e.g., funding for local governments to adopt the AMA Easy entry, gracious exit model.

A clear transition processes

Aware that general practice training is undergoing a period of substantial change and there have been a number of reform discussions for the sector more broadly, including Strengthening Medicare Taskforce, the AMA suggests any reforms must recognise that rural GPs have made business decisions based on the current incentive programs.

The reforms will be more effective and win broader support if they are backed by appropriate transition arrangements for GPs and registrars already practicing under the current programs. For example, for PIP Procedural GP Payment recipients that might transition from being determined based on Rural, Remote and Metropolitan Area (RRMA) classification, and then changed to Modified Monash Model (MMM) classification, there should be a clear transition arrangement. The transition arrangement should be able to prevent recipients from an immediate loss of incentives.

Conclusion

The AMA suggests that new program arrangements to streamline and expand the RPGP and the PIP Procedural GP Payment into a new rural generalist GP support program for GPs with advanced skills must support all forms of rural practice and never disadvantage the current rural GPs.

The AMA supports increased incentives for doctors practicing rurally and the principle of equal pay for equal work should be the core of the new model. The new model should ensure that GPs who are already providing advanced skills in rural communities are also eligible for any new funds from expansion of the program.

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