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Dear Mr Meredyth,

**Re: Rural Procedural Training Programs – Reform Options**

Thank you for giving the AMA the opportunity to comment on the reform options for the Rural Procedural Training Programs. The AMA noted that the Department is seeking feedback on the high-level direction proposed for the two programs in which:

- *Rural Procedural Grants Program* (RPGP) – the Department suggests that the RPGP should be maintained in close to its current form. Potential reforms include increasing the scope of program (within the current notional funding allocation) to include investment in GP emergency mental health training.
- *General Practitioner Procedural Training Support Program* (GPPTSP) – reforms options for the GPPTSP include: Option 1, better targeting the program and aligning administration with colleges' responsibility for the qualifications being obtained. Option 2 ceasing the GPPTSP and redirecting funding towards enhancing the rural training pathway and providing more junior doctors with exposure to rural generalist care settings.

General Comment

Reform options for the Rural Procedural Training Programs should be viewed in the context of overall efforts to attract and retain doctors (and the availability of GPs with advanced skills) in rural areas.

Although Australia currently has an adequate supply of doctors nationally, there remains a significant medical workforce shortage in rural areas.[1] Many locally trained doctors are choosing not to work in rural areas and nearly 76% of graduating domestic students reported living in capital cities in the Medical Students Outcome Database Survey (MSOD).[2] Research has shown

[1] According to *Australia's Health 2016* (pg47), the number of full-time equivalent medical practitioners per 100,000 people in 2014 in major cities was 437, compared to 292 in inner regional areas, 272 in outer regional areas, and 264 in both remote and very remote areas.

[2] Medical Schools Outcomes Database National Data Report 2015, http://www.medicaldeans.org.au/wp-content/uploads/Medical-Students-Workforce-Survey-Report-FINAL-14102015.pdf

that although GPs are more likely to practice in rural locations than other specialisations, the growth in the non-GP specialist medical workforce has outstripped the growth in GP numbers so that non-GP specialists now make up a larger proportion of the overall medical workforce. The rural medical workforce is also heavily reliant on internationally trained medical graduates.[3]

Importantly, the debate should not be just about numbers, it is also about the right skill mix. Rural medical practice requires individuals to possess a broad range of different skills – with primary care practitioners representing the backbone of rural health care. The number of GP proceduralists, or generalists, working across rural and remote Australia has been steadily declining. In 2002, almost a quarter of the Australian rural and remote general practice workforce consisted of GP proceduralists. By 2014, this figure had fallen to just under 10 per cent.[4]

Successive Federal Governments have introduced a range of initiatives in a bid to attract and retain doctors in rural areas. While some gains have been made,[5] the geographical mal-distribution of doctors persists, and the sustainability of some rural health services remain under threat.

Evidence to date points to a number of elements that can positively affect the recruitment and retention of doctors in rural areas. These include proper medical infrastructure, a strong training experience, and access to community and professional resources, and continuing medical education (which are essential to the provision of a rewarding professional and personal experience) and the opportunity to maintain and update skills. This view is supported by the 2016 AMA Rural Health Issues Survey in which rural doctors indicated that establishing more integrated programs to allow rural doctors to maintain and upgrade their procedural skills as one of the key priorities.

In this context, the AMA has strongly supported the Rural Procedural Training Programs. We believe the two programs (the RPGP and GPPTSP) not only enable rural GPs to maintain and upskill in the specific procedural skills supported through the grants, they also impact positively on the overall efforts by the Government to attract and retain GPs in rural areas.

In commenting on the proposed reform options, the AMA noted that there have been some changes to the context in which the procedural training programs since the Nous Review was finalised, particularly the establishment of the National Rural Health Commissioner and the recent Budget announcements in the Stronger Rural Health Package and that the Department's proposed reform options reflect these changes to the operating environment.

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[3] McGrail, Matthew R., and Russell, Deborah J., 'Australia's rural medical workforce: Supply from its medical schools against career stage, gender and rural-origin', *Australian Journal of Rural Health*, 5:1, November 2016.

[4] Rural Health Workforce Australia National Minimum Data Set (MDS), Reports 2012, 2013 and 2014, http://www.rhwa.org.au/fact-sheets--research---workforce-data

[5] There were 9,158 GPs recorded as working in rural and remote Australian in 2016, a 5.8% increase compared to the previous reporting period. For more see Rural Health Workforce Australia (2017), 'Medical practice in rural and remote Australia: Combined Rural Workforce Agencies National Minimum Data Set report as at 30 November 2016', Melbourne: RHWA, https://www.rwav.com.au/wp-content/uploads/2016-National-MDS-Report-30-November-2016.pdf

Proposed reform to the Rural Procedural Grants Program

Rural communities need more GPs with advanced skills and the RPGP is/has been an important initiative to support rural GPs to maintain and upskill in the specific procedural skills supported through the grants. It has been shown to deliver valuable outcomes for rural and remote communities.[6]

The AMA supports the proposed reform to maintain the RPGP close to its current form including to retain a separate uncapped entitlement component for rural doctors with a procedural skillset. The continuation of the program will ensure that rural procedural GPs are able to access a subsidy (so long as they undertake a course certified by one of the colleges) and, will also support the maintenance of safe practice.

With regard to proposed skills maintenance reform to better target/clarify the policy objectives of the RPGP:

- *Refocus the program to VRGPs with tighter criteria for locum eligibility*

  The AMA supports refocusing of the RPGP program to VRGPs to better target the policy objectives while keeping the program administratively simple.

  While there may be scope to tighten locum criteria the process needs to be simplified and clarified and care needs to be taken not to discourage locums as procedurally skilled and credentialled locums are scarce and we should be working hard to keep them credentialled.

- *Use the MMM classification system of remoteness to determine eligibility and only allow VRGPs and locums in MMM3-7 to access the program*

  The AMA supports the MMM as being the most appropriate measure of rurality, although it is important that proposed changes are properly modelled, and transition arrangements protect existing recipients. The AMA also support re-targeting of the program to focus on VRGPs and locums in MMM 3-7.

- *Implement risk management controls to minimize "double dipping" by VRGPs and the exclusion of GP registrar as per eligibility criteria*

  The AMA supports changing processes to prevent "double dipping" that exclude GPs accessing similar specific support for costs associated with procedural upskilling through state-based programs or other Commonwealth programs. As highlighted above, the AMA supports re-targeting of the program to focus on the VRGPs.

- *Implement a face-to-face requirement for at least the practical assessment of the procedural skills*

  The delivery of online education and assessment is now a recognised part of medical education. If the Department is concerned about the quality of some of these courses, then the AMA would suggest that it should explore some sort of quality control process to ensure that courses meet relevant professional standards.

[6] The Department of Health (2017) Review of the RPGP and GPPPTSP: Evaluation Report

- *Implement the requirement for local hospital support to ensure there is a local need for the skills*

  There is a strong argument that an assessment of community needs in rural Australia should drive the Commonwealth investment in education and training for practitioners in all health disciplines. In this context the AMA would support the move to implement the requirement for local hospital support to ensure there is a local need for the skills.

- *Consider options for scaled payments so MMM 5-7 areas receive higher levels of funding*

  The AMA supports scaled payment so MMM 5-7 areas receive higher levels of funding (as rural GPs must travel further, hence higher travel and associated costs) similar to other Government programs. The RPGP should also incorporate an extra day's payment for doctors in MMM 5-7 as they lose this time to travel to and from their upskilling courses. Payment should be indexed to account for raising costs.

- *Increase program scope to include emergency mental health courses to address community need, identified skills gaps and stakeholder concerns*

  Improved access to mental health services is an important priority for the rural and remote communities and the AMA supports the move to include emergency mental health courses as part of the program. GPs in rural and remote areas are often the principal point of contact to provide continuing care in communities. This training will support the increasing need for GPs to be able to deal with acute mental health emergencies that have an increasing prevalence in rural and remote communities. Ideally, the expansion of support to mental health training should be funded via further investment in the program.

<u>Proposed reform to the General Practitioner Procedural Training Support Program</u>

The AMA supports Option 1 and strongly opposed to the redirection of funding into the Rural Junior Doctor Training Innovation Fund (RJDTIF) as suggested by Option 2.

While the AMA acknowledges the impact of an oversupply of specialist obstetricians on the uptake of the program, the low uptake of the current program may also be the result of the difficulty faced by GPs in leaving their practice for a year and surviving financially. The quantum of money available, added to the salary at the training location, will likely fall short of the loss of usual income and other associated costs.

With regard to the proposed upskilling reforms:

- *Refocus the program eligibility to established VRGPs only*

  As with the RPGP, the AMA supports refocusing of the GPPTSP program to VRGPs to better target the policy objectives while keeping the program administratively simple.

- *Use the MMM classification system of remoteness to determine eligibility and only allow VRGPs in MMM 3-7 to access the program.*

  The AMA supports the use of the MMM classification of remoteness to determine eligibility provided that the MMM is consistent with the purposes and intent of the design of the GPPTSP and that appropriate transition arrangements are in place. The AMA also supports re-targeting of the program for VRGPs in MMM 3-7.

- *In consultation with the Colleges, consider the options for scaled payments so MMM 5-7 areas receive higher levels of funding*

  The AMA supports consideration of the options for scaled payments so MMM 5-7 areas receive higher levels of funding.

- *Streamline program administration by delivering future funding through the specialist training program*

  The AMA supports streamlining of program administration by delivering future funding through the specialist training program as long as funding for the program is guaranteed and eligible rural GPs will not be disadvantaged or over burdened by excessive red tape.

- *Ensure the link between the program and the provision of maternity services is understood by stakeholders and applicants*

  According to AMA Council of Rural doctors, while the RPGP program is well understood among rural doctors, many have less experience/knowledge of the GPPTSP (perhaps one of the reasons for the low uptake of the program). The AMA therefore, would support any move to better promote the GPPTSP to eligible rural GPs and to ensure the link between the program and the provision of maternity services is understood by stakeholders and applicants.

- *Align administration with the Colleges who have ownership and responsibility for the qualification being obtained. Maintain RANCZOG for obstetrics, change from ACRRM to ANZA for Anaesthetics*

  It is important that Colleges continue to cooperate in the administration and promotion of these programs and, to that extent, the AMA would see this an issue that should be negotiated with the relevant Colleges.

The AMA looks forward to being invited to further assist the Department in the development of a new program guidelines. If you have any questions, in the first instance please contact Dr Moe Mahat on (02) 6270 5445 or mmahat@ama.com.au.

Yours sincerely

Dr Tony Bartone
President