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Ms Amber Mardon
Assistant Director
Access Program Section, Rural Access Section
Health Workforce Division, Department of Health

By email: amber.mardon@health.gov.au

Dear Ms Mardon,

Re: Draft Principles of the More Doctors for Rural Australia Program

Thank you for giving the AMA the opportunity to comment on the draft principles of the More Doctors for Rural Australia Program (MDRAP) which will form the basis of MDRAP implementation guidelines.

The AMA has long argued for the Government to develop comprehensive plans to better support the provision of high-quality health care in regional, rural, and remote Australia. We agree that the current 3GA framework has not encouraged doctors to work towards fellowship, which is the end point for general practice, and that the proposed MDRAP is a workforce program that has the potential to improve health services for rural and remote communities.

While the AMA broadly supports the proposed principles (and guidelines) for the MDRAP, there are some specific sections in the draft document where the AMA has some concerns and comments. These are outlined below:

Objectives of the MDRAP

The AMA supports the aim of MDRAP as a "rural immersion workforce program" providing valuable rural general practice experience. Any program that increases exposure to rural medicine in an attempt to address the current maldistribution is commendable.

The AMA also supports the proposed core principles considered in the design of the MDRAP, namely:

- Supervision – ensuring the MDRAP has a sound supervision framework that addresses the needs of doctors working in rural and remote practices to ensure patient and doctor safety;
- Momentum – supporting doctors to consider general practice fellowship as a training endpoint;
- Quality – determining the standard for doctors who provide general practice services to the community; and

- Distribution – supporting the equitable distribution of doctors in regional, rural and remote locations.

We believe the statement regarding distribution needs further clarification in terms of what equitable distribution means in practice. There is the potential for this statement to be misinterpreted - for example, it could be interpreted as the Government wanting more control of where International Medical Graduates (IMGs) go. The AMA could not support the Government if it chose to force IMGs or other participants to move out of towns they are currently working in if that is what is envisaged.

We note the draft document only highlights that doctors on the MDRAP will be able to claim Medicare benefits at 80% for general practice items, with an expectation that the doctor will commit to join a pathway to fellowship within the defined timeframe. We believe the draft document should also clarify that:

- Being able to claim Medicare benefits at 80% for general practice items will also apply to new non-VR doctors (and they will be able to bill at 100% when they are on a pathway to Fellowship); and
- The existing non-VR workforce with access to A1 level rebates will have a five-year grandfathering period over which time current arrangements will remain in place.

The AMA is also concerned about supervision of participants. Participants in the MDRAP will require Level 1 supervision, a learning plan, online Medicare and other education. This will require significant additional effort by supervisors and we are concerned that, in the absence of appropriate financial support, practices will be unable to support this critical function.

The AMA notes that there is funding for the Rural Junior Doctor Training Innovation Fund (RJDTIF) program as well as funding for the Colleges once a participant joins the RACGP's Practice Experience Program or ACRRM's Independent Pathway. Participants on MDRAP are likely to have less general practice experience than those on a pathway, and therefore will require more supervision. Funding for supervision recognises the time and opportunity cost of supervising trainees. There is a serious chance that supervisors will not agree to participate in the MDRAP if it increases their workload and reduces their earnings.

The AMA also notes that it will not be the Colleges nor RTOs that are responsible for this cohort, but the Rural Workforce Agencies (RWAs). In this regard, there needs to be clarity about the level of educational support provided – noting that the Colleges are the current standards, training and educational setting bodies. The introduction of another organisation into the general practice endpoint pathway could cause confusion regarding roles and responsibilities.

Communication will therefore be an important factor for the success of this program. The AMA believes there is still a lot of confusion about the intent of the MDRAP, especially among those currently participating in the 3GA programs. The MDRAP will need to ensure that detailed information regarding processes, eligibility, expected outcomes etc. are communicated widely and on a regular basis.

<u>Eligibility</u>

The AMA notes doctors considered in the initial phase of the MDRAP are:

- Overseas and Australian Trained Doctors who do not have fellowship of a general practice College;
- Medical practitioners who provide locum services in areas that cannot easily attract ongoing doctors; and
- Non-VR doctors on an existing 3GA placement.

According to the draft document, in the future the MDRAP guidelines will be updated to include provisions for doctors in training.

The AMA is of the view that further clarification regarding the provision for doctors in training is needed sooner rather than later and that this should be included as part of this document. Doctors in training need certainty regarding training availability and options. Currently, there is a lot of uncertainty for doctors in training:

- due to AGPT transitioning to Colleges and non-clarity of how Colleges will run the training;
- regarding Regional Training Organisations (RTOs) going forward;
- surrounding the AGPT policy for rural generalists; and
- of what policies will eventuate from Professor Paul Worley's work on the national Rural Generalist pathway (NRGP).

These factors are likely to have contributed to decreasing applications for the AGPT program in recent years.

The AMA is of the view that the statement "In the future the MDRAP guidelines will be updated to include provisions for junior doctors" does not provide clarity or certainty for junior doctors about GP training pathways in the future. Well defined training pathways for junior doctors are required to encourage more junior doctors to apply for the program.

With regard to guidelines, the MDRAP needs to ensure that the Australian Health Practitioner Regulation Agency (AHPRA) provides clarity in terms of what is an acceptable "AHPRA Plan" and also how Plans are consistently interpreted. The MDRAP must also ensure that there are guidelines on how to complete acceptable plans as well as a good communication and education strategies for doctors needing to complete plans.

Timeframes

While the AMA supports MDRAP placements to be time-limited, there is concern about what happens if a practitioner, despite valiant attempts and efforts to get accepted into College training or an experience pathway, fails to be accepted into the pathway. The MDRAP will need to have in place a clear appeals process including clarifying grounds for appeal and extension of timeframes. There should also be a monitoring mechanism overseen by relevant stakeholders to ensure that the appeal process undertaken by the Department is fair and equitable.

Additionally, the AMA is of the view that the statement "The MDRAP will make interim provisions to ensure medical practitioners are given a genuine opportunity to progress to a fellowship pathway" is unclear and needs further clarification. Doctors need to be provided with certainty of policy and

how expectations will be fairly handled so that there is no unfair disadvantage.

The document should also clarify “Any extension may include appropriate conditions or milestones” outlining what policy or guidelines will apply.

Supervision

The AMA views supervision as one of the most important features of safe practice and a key challenge for the MDRAP and as such it must be adequately resourced.

Since the expansion of the AGPT intake to 1500 places (with a further 100 announced for the National Rural Generalist Pathway (NRGP) in the budget), RTOs have had trouble finding experienced supervisors. It will be very hard for Rural GPs to continue their own work, take on medical students and interns under the RJDTIF program and provide supervision for MDRAP.

Further, many Fellowed practitioners in rural areas are new fellows and have not had years of experience being supervisors. Infrastructure is also lacking in rural towns to take on these doctors despite the demonstrated success of recent Commonwealth Infrastructure Grants which have now dried up.

The AMA is of the view that for the purposes of clarity and certainty, the MDRAP will need to provide exact guideline examples of what is accepted as “remote supervision” and what evidence medical practitioners will be required to provide (which of course is another impost on the supervisor).

Additionally, with regard to the proposed guidelines, the AMA is also of the view that doctors with no prior GP experience will need a proper orientation program and close supervision during their initial few months (in the past this was done by rural workforce agencies and local medical boards). This should be included as an additional dot point for the proposed guidelines.

Milestones

While milestones are outlined for doctors, we believe there needs to also be some reference to evaluation of the program from the start. This should include which organisations will be responsible for the evaluation and how it will be conducted.

The AMA looks forward to continuing to work with the Department in the development of the MDRAP. Please contact Nicholas Elmitt at nelmitt@ama.com.au should you require any further information.

Yours sincerely

Ms Sally Cross
Acting Director,
GP and Workplace Policy