Australian Government
Department of Health

The provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

Submission from the Department of Health to the Senate Standing Committee on Community Affairs

15 October 2021

Contents

List of acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training Program
Ahpra	Australian Health Practitioner Regulation Agency
AHRGWES	Allied Health Rural Generalist Workforce and Education Scheme
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
AMDS	Approved Medical Deputising Service Program
AML Alliance	Australian Medicare Local Alliance
AMS	Aboriginal Medical Service
ANAO	Australian National Audit Office
ASGS	Australian Statistical Geography Standard
ASGS-RA	Australian Statistical Geography Standard – Remoteness Areas
ASL	Active Script List
ASPSS	Administrative Support to Pharmacy Schools Scheme
ATSIHPOS	Aboriginal and Torres Strait Islander Health Professional Organisations
BMP	Bonded Medical Places Scheme
BNC	Building Nurse Capacity
BTOS	Broad Types of Service
CDMHA	Chronic Disease Management and Healthy Ageing
CGS	Commonwealth Grant Scheme
COAG	Council of Australian Governments
CPD	Continuing Professional Development
CPMC	Council of Presidents of Medical Colleges
CSP	Commonwealth Supported Places
DESE	Department of Education, Skills and Employment
DIDO	Drive-In Drive Out
DOP	Date of Processing
DPA	Distribution Priority Areas
DVA	Department of Veterans Affairs
DWG	Distribution Working Group
DWS	District of Workforce Shortage
eMHprac	e-Mental Health in Practice
ePIP	Practice Incentive Program eHealth Incentive
FGAMS	Foreign Graduate of Accredited Medical Schools
FIFO	Fly-In Fly-Out
FTE	full time equivalent
GCfAHPC	Greater Choice for At Home Palliative Care
GP	General Practitioner
GPET	General Practice Education and Training Ltd
GPFTE	GP full-time equivalent

GPPTSP	General Practitioner Procedural Training Support Program
GPRIP	General Practice Rural Incentives Program
HeaDS UPP	Health Demand and Supply Utilisation Patterns Planning
HIA	Health Insurance Act 1973
HIAS	Health Information Advice Service
HIF	Health Innovation Fund
HWA	Health Workforce Australia
HWC	Health Workforce Certificate
HWNA	Health Workforce Needs Assessment
IAHP	Indigenous Australians' Health Program
IAR	Initial Assessment and Referral
IHWT	Indigenous Health Workforce Traineeships program
IIARP	Intern Incentive Allowance for Rural Pharmacies
IMG	International Medical Graduate
IP	Independent Pathway
IRTP	Integrated Rural Training Pathway
JDTP	Junior Doctor Training Program
JFPDP	John Flynn Prevocational Doctor Program
JFPP	John Flynn Placement Program
KPI	Key performance indicator
LHD	Local Health District
LHN	Local Hospital Network
LIME	Leaders in Indigenous Medical Education Network
MBA	Medical Board of Australia
MBS	Medicare Benefits Schedule
MDANZ	Medical Deans Australia and New Zealand
MDMSN	Murray Darling Medical Schools Network
MISS	Medical Indemnity support Scheme
MM	Modified Monash category
MMM	Modified Monash Model
MoU	Memorandum of Understanding
MPS	Multi-Purpose Service Program
MRGTP	Murrumbidgee Rural Generalist Training Pathway
MYEFO	Mid-Year Economic and Fiscal Outlook
NCoA	National Commission of Audit
NDHS	National Digital Health Strategy
NDIS	National Disability Insurance Scheme
NGPA	National General Practice Accreditation
NHHRC	National Health and Hospitals Reform Commission
NHRA	National Health Reform Agreement
NHS	National Health Service
NHSD	National Health Services Directory
NiPHC	Nursing in Primary Health Care Program
NMWS	National Medical Workforce Strategy

NNMEAN	National Nursing and Midwifery Education Advisory Network
non-VR	non-vocationally recognised
Non-VR FSP	Non-Vocationally Recognised Fellowship Support Program
NP	Nurse Practitioner
NRAS	National Registration and Accreditation Scheme
NRGP	National Rural Generalist Pathway
NRHSN	National Rural Health Student Network
NSW RDN	New South Wales Rural Doctors Network
OMOMPS	Outer Metropolitan Other Medical Practitioners Program
OMPs	Other Medical Practitioners programs
PBS	Pharmaceutical Benefits Scheme
PCCGs	Patient Centred Co-commissioning Groups
PEP	Practice Experience Program
PGPPP	Prevocational General Practice Placement Program
PGY	post graduate year
PHC	IAHP Primary Health Care program
PHN	Primary Health Care Networks
PIP	Practice Incentives Program
PNIP	Practice Nurse Incentive Program
PRIMM	Primary care Rural Innovative Multidisciplinary Models
PSR	Professional Services Review scheme
PSS	Premium Support Scheme
RA	Remoteness Area (ASGS-RA)
RACF	Residential Aged Care Facilities
RACGP	Royal Australian College of General Practitioners
rBBI	rural Bulk Billing Incentive
RCS	Rural Clinical School
RCTWG	Rural Classification Technical Working Group
RFDS	Royal Flying Doctor Service
RG	Rural Generalist
RGTS	Rural Generalist Training Scheme
RHC	Rural Health Clubs
RHMT	Rural Health Multidisciplinary Training Program
RHOF	Rural Health Outreach Fund
RHWSA	Rural Health Workforce Support Activity
RITA	Rural Intern Training Allowance
RJDTIF	Rural Junior Doctor Training Innovation Fund
RLAP	Rural Locum Assistance Program
RoSO	Return of Service Obligation
RPGP	Rural Procedural Grants Program
RPLO	Rural Pharmacy Liaison Officer program
RPMA	Regional Pharmacy Maintenance Allowance
RPSMS	Rural Pharmacy Scholarship Mentor Scheme
RPSPA	Rural Pharmacy Student Placement Allowance

RPSS	Rural Pharmacy Scholarship Scheme
RRMA	Rural, Remote and Metropolitan Area
RTH	Regional Training Hubs
RTO	Regional Training Organisations
RTP	Regional Training Providers
RVTS	Remote Vocational Training Scheme
RWA	Rural Workforce Agency
SRHS	Stronger Rural Health Strategy
STP	Specialist Training Program
TPP	Transition to Practice Program
TSPR	Training and Professional Support for the Remote Health Workforce
UDRH	University Departments of Rural Health
VOS	Visiting Optometrists Scheme
VPR	Voluntary Patient Registration
VR	Vocationally Recognised
WIP	Workforce Incentive Program

Introduction

The Department of Health welcomes the opportunity to make a submission to the *Senate Standing Committee on Community Affairs* inquiry into the provision of General Practitioner (GP) and related primary health services to outer metropolitan, rural and regional Australians, with a particular focus on the current state of services in these locations, the impact of current and former government reforms on services in these locations, and the impact of the COVID-19 pandemic on doctor shortages in these locations.

This submission addresses the inquiry's terms of reference in respect of the Australian Government's roles and responsibilities in supporting the provision of services by general practitioners (GP) and other primary care service providers to outer metropolitan, rural, and regional Australians. This is inclusive of primary care system management and support, primary health care policy and funding.

Definition and scope of primary health care in Australia

Primary care is the front line of Australia's heath care system. It is usually the first contact a person has with the health system. Primary care refers to health care services delivered without needing a referral from another health professional. Effective and accessible primary care aims to keep the community healthy and supports people to manage chronic or complex conditions at home or in a community setting. By keeping people healthy, effective primary care can reduce hospital admissions, reduce visits to emergency departments and reduce the demand on other specialist services.

Primary care is provided in a range of settings, including in a person's home, in general practices, community health centres, local government, and non-government service settings, such as Aboriginal Community Controlled Health Services (ACCHS).

Primary care services are wide ranging and include prevention and health screening, early intervention, treatment and management of illness. Services may target specific population groups such as older people, mothers and children, young people, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, refugees, people from culturally and linguistically diverse backgrounds, and people from low socio-economic backgrounds. Primary health care services may also target specific conditions and health care needs, like sexual health, drug and alcohol treatment, oral health, cardiovascular disease, asthma, diabetes, mental health, and obesity.

The mix of primary health care services and how they are delivered can and should vary depending on the location and community needs. The way services are delivered in a large city may be different to how they are delivered in small rural or remote communities. For example, GPs in rural areas may be qualified to provide additional services such as obstetrics or anaesthetics care – services that would be provided by another specialist doctor in a metropolitan setting. Very remote communities may use a combination of telehealth and visiting (outreach) primary health care professionals.

There may also be variations in the way services are structured because of other factors such as population characteristics, socio-economic circumstances, infrastructure, health status, and workforce mix and availability.

Commonwealth role in primary health care

The Australian Government (the Government) and Department of Health does not employ GPs or other primary health care professionals and does not directly deliver health services. Most primary health care professionals work in private businesses – for example around 82% of GPs, 34% of primary care nurses and 72.7% of allied health professionals work in group or solo practice, while over 91% of pharmacists work in community pharmacy. Some primary care professionals are employed by the states and territories, in settings such as hospitals and community health services. For more information on where primary care professionals work, refer to the section titled 'Practice settings'.

Although the Government does not employ primary health care professionals, it makes substantial investments to support a primary health care system to keep Australians healthy and reduce demand for hospital services. There are a wide range of programs across the Australian Government supporting primary health care and the workforce that delivers primary care services. Within the Health portfolio, primary care is supported through Medicare and other funding programs such as the Indigenous Australians' Health Program and Community Pharmacy Agreements, by subsidising the cost of services and service delivery organisations, providing incentives for primary care professionals, subsidising the costs of medications, funding training programs, and investing in mechanisms to improve primary health care system management. Key aspects of primary health care funding within the Australian Government's responsibilities include:

- *Medicare Benefits Schedule (MBS).* The Government funds a wide range of primary care services through Medicare. The MBS provides financial assistance to patients, in the form of Medicare rebates, for the cost of a range of primary care services, meaning patients can access many medical, diagnostic and allied health services for free or at a subsidised cost.
- *Pharmaceutical Benefits Scheme (PBS).* The PBS subsidises the cost of medicine for most medical conditions. This means Australians with a wide range of medical conditions receive affordable access to medicines.[1,2]
- *Health workforce*. In 2020-21, the Government provided $1.5 billion in funding for health workforce and training programs[3]. This includes targeted incentives and

1 Service Australia, Pharmaceuticals Benefits Scheme, https://www.servicesaustralia.gov.au/individuals/services/medicare/pharmaceutical-benefits-scheme
2 Department of Health Annual Report 2019-20, https://www.health.gov.au/sites/default/files/documents/2020/11/department-of-health-annual-report-2019-20.pdf
3 Australian Department of Health, Budget 2021-22: Portfolio Budget Statements, https://www.health.gov.au/resources/publications/budget-2021-22-portfolio-budget-statements.

programs to support a better distributed primary care workforce and funding for training. The Government is also responsible for a range of workforce classification systems and regulations designed to achieve a better distributed workforce.

- *Primary Health Care Networks (PHNs).* The Government funds a network of regionally-based PHNs, which work to reorient and reform the primary health care system by taking a patient-centred approach to medical services in their regions. They commission services based on local needs, work closely with local providers to build workforce capacity and quality of care, and work to integrate service delivery. PHNs make decisions independent of government.[4]

- *Aged Care.* The Commonwealth government is responsible for the aged care system and is responding to recommendations made in the recent Royal Commission into Aged Care Quality and Safety.[5] Funding is provided for residential aged care and to support people to remain in their own homes. The latter access primary care under the same arrangements as the general population, including higher rebates for services provided after hours and at the patient's home. There are specific MBS item rebates available for some health professionals to deliver primary care services to residents in aged care facilities.

- *Indigenous Health*. Through the Indigenous Australians' Health Program (IAHP), the Government funds a range of activities that aim to provide Aboriginal and Torres Strait Islander people with access to effective high-quality, culturally appropriate primary health care services in urban, regional, rural and remote locations across Australia. The IAHP's primary health care activity provides grants for primary care services, including services delivered by ACCHSs, as well as mainstream services across the health system. Through a Direction issued by the Minister for Health under section 19(2) of the *Health Insurance Act 1973* (HIA), ACCHSs can access Medicare billing while receiving primary health care funding through the IAHP. In 2019-20, ACCHS claimed $116.3 million in Medicare benefits. See Appendix B: List of Primary Care Programs for more information on the IAHP.

- *National Health Reform Agreement (NHRA).* Through this agreement, the Government contributes funds to the states and territories for public hospital services, including services in emergency departments, outpatient clinics and community health settings. Under the NHRA, the Commonwealth, states and territories are jointly responsible for identifying rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes. The Health Innovation Fund (HIF) provides funding for trials that are consistent with the NHRA. These aim

4 Department of Health, Fact Sheet Primary Health Networks, https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Networks
5 Aged Care Royal Commission Final Report, *https://agedcare.royalcommission.gov.au/publications/final-report accessed 28 Aug 21*

to ensure equitable access of health services, including primary health services, to all Australian's regardless of their geographical location.

- *Veterans' Affairs.* The Government provides funding for veterans' health through the Department of Veterans' Affairs (DVA). In 2018-19, DVA spent $1.3 billion on primary health care[6]. This is not covered in the Department of Health submission.

- *National Disability Insurance Scheme (NDIS).* The NDIS funds allied health and other therapy needed because of a person's disability, including occupational therapy, speech therapy or physiotherapy[7]. The Department's *Disability Support for Older Australians Program* delivers specialist services to vulnerable older people with disability aged 65 years and over (50 years and over for Indigenous people) who are not eligible for the NDIS. These are not covered in the Department of Health's submission.

- *Department of Education, Skills and Employment (DESE).* Students gain their primary health professional qualifications at universities. Most undergraduate domestic students will access a Commonwealth supported place, meaning the cost of a student's degree is covered in part by the government through the Commonwealth Grant Scheme (CGS). The subsidy amount is based on the student's field of study. After graduation students choose their subsequent practice in primary, secondary and/or tertiary levels of care. Universities can choose how many courses and Commonwealth supported places they offer in nursing, midwifery, pharmacy and allied health disciplines within their CGS funding. The number of Commonwealth supported places is capped for medicine. There are no caps on medical places at universities that do not access the CGS.

State and territory government role

State and territory governments also make significant contributions to primary health care. In 2017-18, they spent $10 billion on primary care[8]. State and territories fund and provide a range of community health services, including prevention and health promotion services and services that help maintain community health and wellbeing. Some of these community health services include primary health care services such as screening programs, dental clinics and mental health services.

The Commonwealth and States have a shared responsibility to ensure that all parts of the system operate in a coordinated and integrated way for the benefit of all Australians. Through the NRHA, governments have committed to working together on system-wide

6 AIHW, 'Health expenditure Australia 2018-19', *Health and welfare expenditure series number 66*, catalogue number HWE 80, AIHW, Australian Government 2020; and AIHW, 'Data tables: Health expenditure Australia 2018-19 – Supplementary tables, available: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2018-19/data. Accessed 25 August 2021.
7 National Disability Insurance Agency, Health, https://www.ndis.gov.au/understanding/ndis-and-other-government-services/health.
8 AIHW, 'Australia's health 2020: data insights', *Australia's Health Series 17,* catalogue number AUS 231, AIHW, Australian Government 2020.

policy and local, regional and State level primary health care planning. This commitment recognises the impact of primary care services on the use of hospitals and other State-funded services. Coordination across governments also aims to improve coordination of care for patients and address service gaps[9].

Definition of regional, rural and remote

The Modified Monash Model

The Department uses the Modified Monash Model (MMM) geographical classification system. The MMM measures remoteness on a scale of Modified Monash (MM) category MM1 to MM7. On this scale, MM1 is a major city and MM7 is very remote.

Introduction of the MMM

The MMM system categorises metropolitan, regional, rural and remote areas according to both geographical remoteness (as defined by the Australian Bureau of Statistics (ABS) Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA)) and town size.

The MMM categories are:

Table 1: MMM category descriptions and examples

MM category	Description[10]
MM1	Metropolitan areas – accounts for 70% of Australia's population All areas categorised ASGS-RA1
MM2	Regional centres Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are in, or within a 20km drive of a town with over 50,000 residents For example: Ballarat, Mackay, Toowoomba, Kiama, Albury, Bunbury
MM3	Large rural towns ASGS-RA 2 and ASGS-RA 3 areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents For example: Dubbo, Lismore, Yeppoon, Busselton
MM4	Medium rural towns ASGS-RA 2 and ASGS-RA 3 areas that are not MM 2 or MM 3, and are in, or within a 10km drive of a town with between 5,000 to 15,000

[9] Department of Health, 2020-25 National Health Reform Agreement p74, https://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

10 Note: Examples in this table use the MMM 2019 update.

	For example: Port Augusta, Charters Towers, Moree
MM5	Small rural towns
	All remaining ASGS-RA 2 and ASGS-RA 3 areas
	For example: Mount Buller, Moruya, Renmark, Condamine
MM6	Remote communities (ASGS-RA4), remote islands less than 5km offshore
	For example: Cape Tribulation, Lightening Ridge, Alice Springs, Mallacoota, Port Hedland, Bruny Island
MM7	Very remote communities (ASGS-RA5) and remote islands more than 5km offshore
	For example: Longreach, Coober Pedy, Thursday Island

Every location in Australia is categorised from MM1 to MM7. The MMM is updated after each ABS Census to ensure that the latest available data determines each location's MM classification. A map showing the current MMM classification of every address in Australia is available on the DoctorConnect website: www.doctorconnect.gov.au.

Outer metropolitan areas

The DoctorConnect website displays the 2014 inner and outer metropolitan classification system, which is based on ABS ASGS 2011 geographies. Under this system, all ASGS-RA1 locations are classified as inner or outer metropolitan. This is because outer metropolitan areas have previously been recognised as having some different characteristics than inner metropolitan areas.

General Practice Catchments

The MMM classification gives an overview of a region's characteristics, and how this affects the demand and supply of health workers. In order to target GP workforce programs more specifically, the Department developed GP catchments to show and then analyse in more detail how local communities access GP services. GP Catchment geographical classifications were devised for use in the Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP Tool)[11].

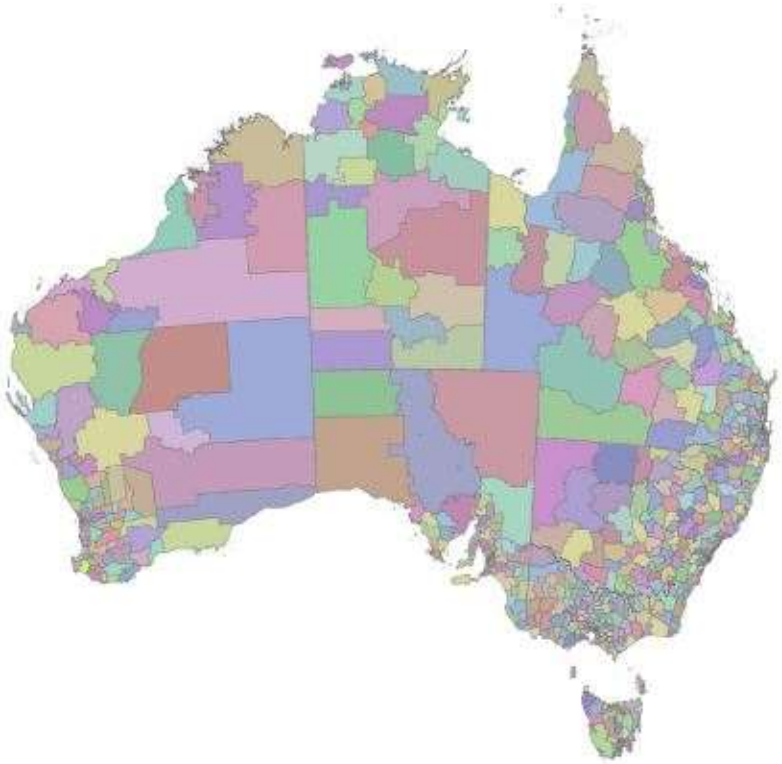
The GP Catchments were constructed using the ABS Australian Statistical Geography Standard (ASGS) 2016, along with five years' worth of Medicare data, and demographic data such as the ABS Australian Population Grid and Residential Mesh Blocks 2016.

A total of 829 non-overlapping GP Catchments were formed by aggregating sub-catchments, taking into account a number of factors including:

[11] GP Catchments, Health Workforce Division Newsletter Edition 2, 1 March 2019 https://www1.health.gov.au/internet/main/publishing.nsf/Content/workforce-ENewsletter-edition-2 Accessed 8 September 2021

- patient flows using MBS patient and provider data over a five-year period
- population demographics, e.g. population size and distribution
- GP workforce, e.g. location and number of GPs
- GP infrastructure, e.g. location and number of practices
- accessibility, e.g. catchment size, travel distance and road networks
- topography, e.g. mountain ranges, national parks, water bodies, islands
- recognition of other boundaries, e.g. state and territory borders, local government areas.

Figure 1: GP Catchments Map[12]



Caption: *The new GP Catchment geographical classifications, shown, will add further dimension to the supply and demand modelling for primary health workforce and services planning.*

[12] Department of Health. Available: https://www.health.gov.au/sites/default/files/download-pdf_1.pdf

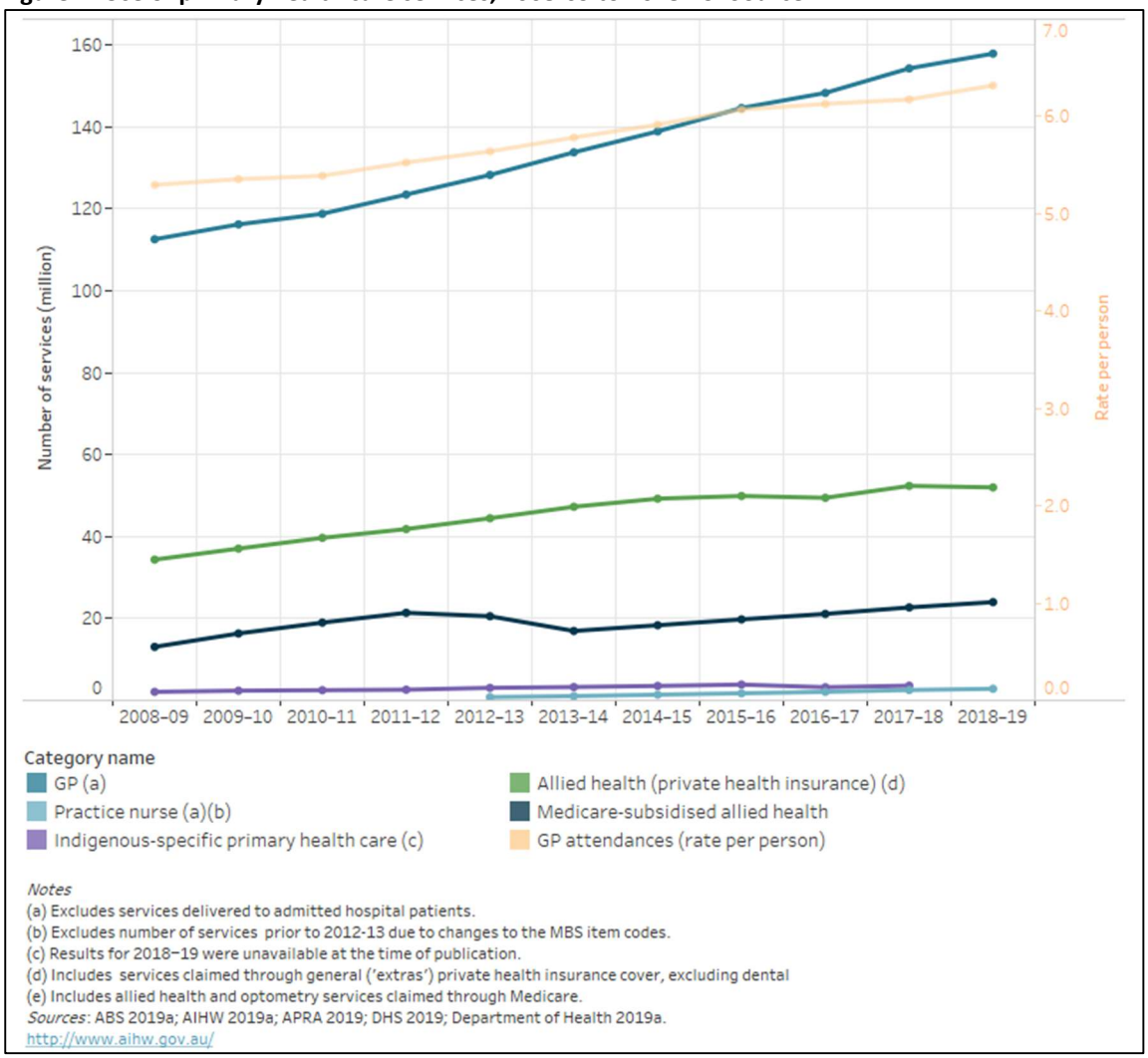
Terms of Reference Part A: Current state of outer metropolitan, rural and regional GPs and related services – Current state data

GPs are the most frequently accessed primary care professionals. However they are only one part of the primary care team. Effective primary care, particularly in rural and remote areas, relies on multidisciplinary teams working together, including GPs, pharmacists, nurses, midwives and allied health professionals.

According to the Australian Institute of Health and Welfare (AIHW), primary health care services represent a high proportion of health care services in Australia. In 2018–19, 83% of Australians aged 15 and over reported at least one GP visit in the previous 12 months, and half (49%) visited a dentist, hygienist or dental specialist[13]. Over the 10 years to 2018–19, the rate of primary health care services claimed per person increased, as shown in Figure 2.

13 ABS (2019) cited in Australian Institute of Health and Welfare (2020), 'Australia's health: Snapshots'. Available: www.aihw.gov.au/reports/australias-health/primary-health-care

Figure 2: Use of primary health care services, 2008-09 to 2018-19. Source: AIHW

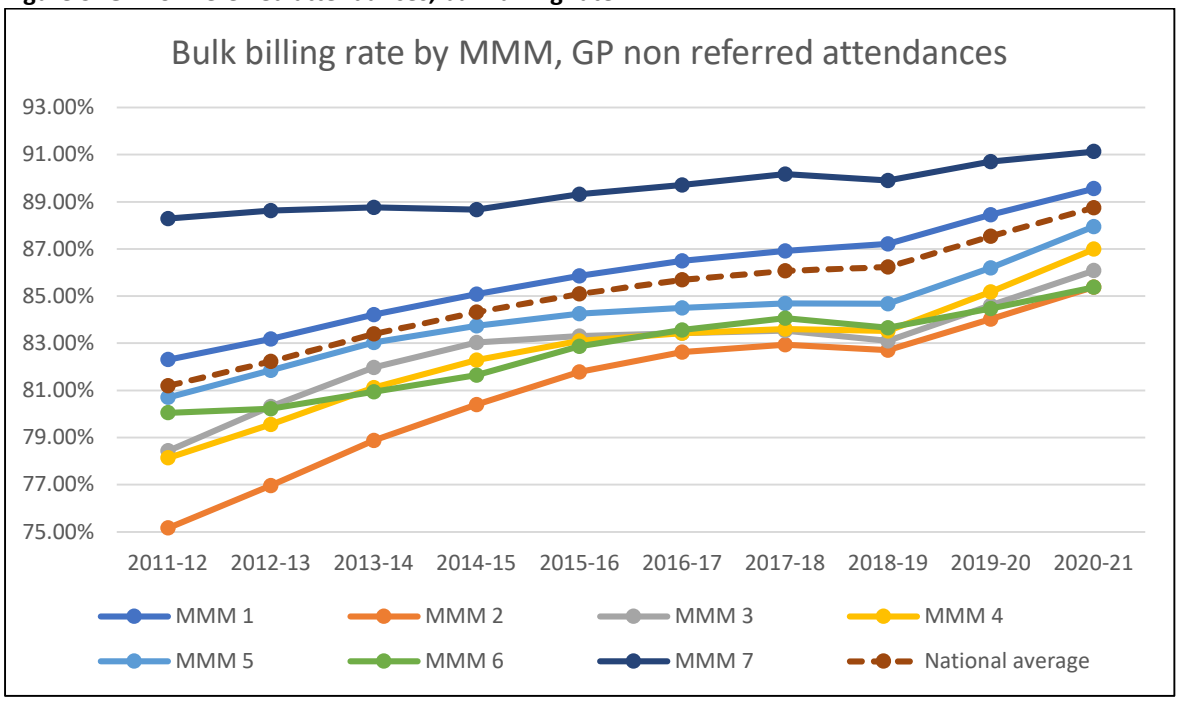


Bulk billing occurs when a patient does not need to pay any out of pocket costs for a health professional's services at the time of service. Instead, the health professional accepts the Medicare benefit as full payment for the service, and the patient assigns their Medicare benefit to the health professional.

Figure 3 shows the bulk billing rate for GP non-referred attendances by MM. In 2020-21, the bulk billing national average was 88.75%. The bulk billing rate was highest in MM7 locations at 91.14%, indicating that more patients in MM7 are receiving GP primary care services at no direct cost to themselves at the time of their consultation, compared with other MMs in Australia. Many services in MM7 are run by state governments or receive funding as Aboriginal Medical Services (AMS).

Figure 3 also shows that over the last decade, bulk billing rates for GP non-referred attendances have increased in every MM across Australia, with growth of 10.22 percentage points in MM2, followed by 8.86 percentage points in MM4.

Figure 3: GP non-referred attendances, bulk billing rate[14]



Expenditure

The Government makes significant investments in primary health care. In 2017−18 primary health care accounted for over one-third (34% or $63.4 billion) of Australia's total health expenditure[15].

In the period 2007–08 and 2017−18, Australian Government expenditure on primary health care grew 3.3% each year in real terms—an increase of $7.8 billion over the decade[16]. By 2018-19 the Commonwealth's direct spend on primary health care services was $28.2 billion, comprising more than one-third (34.9%) of the Commonwealth's health budget, including[17]:

- $10.3 billion in subsidised medicines through the PBS
- $10 billion on unreferred medical services, mostly GP visits
- $2.4 billion in spending on other primary health care professional services

14 Data shown are: total bulk billing rates for GP non-referred attendances, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average). It is noted that telehealth services introduced in March 2020 as part of the response to the COVID-19 pandemic initially included a bulk billing requirement for valid claims. This requirement ceased on 1 October 2020.
15 AIHW, 'Health Expenditure, 2017-18' *Health and welfare expenditure series number 65,* catalogue number HWE 77, AIHW, Australian Government 2019
16 AIHW, 'Health Expenditure, 2017-18' *Health and welfare expenditure series number 65,* catalogue number HWE 77, AIHW, Australian Government 2019
17 Note, the below figures do not include the Government's investments in workforce training and incentives, PHNs, funding for non-MBS primary health care services provided via grants (for example primary care services delivered via the Royal Flying Doctor Service (RFDS)

- $1.6 billion in dental services
- $1.8 billion in community health[18].

Australia's primary care workforce

Delivery of primary care services relies on a highly skilled and accessible workforce. Health professionals who provide primary care include GPs, nurses (including general practice nurses, community nurses, maternal and child health nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers and practitioners.

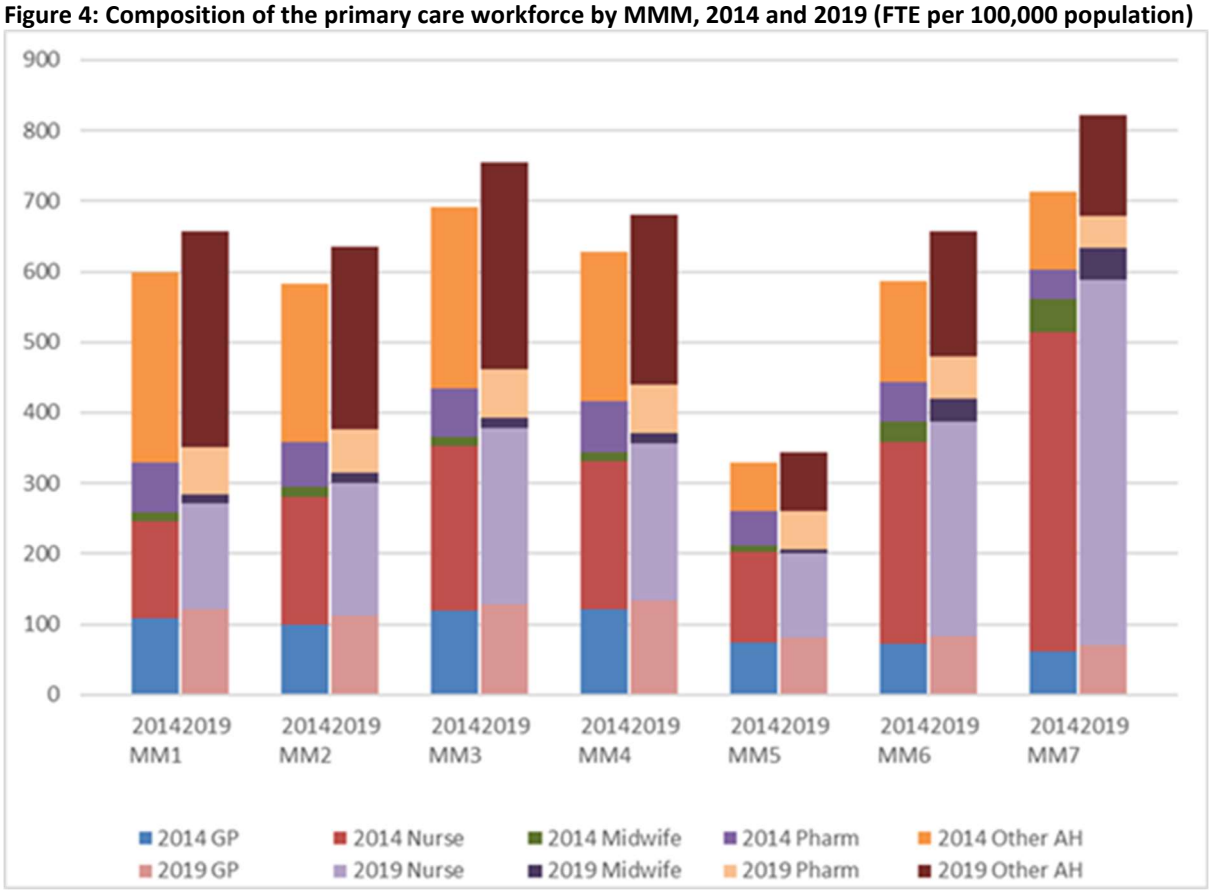
Australia's primary care workforce grew from 134,794 full time equivalent (FTE) in 2014 to 159,801 FTE in 2019[19]. The workforce has grown at a faster rate than population growth across all professions - GPs, nursing, pharmacy and other registered allied health professions.

A key objective for the Government is to have a well distributed primary care workforce able to provide services tailored to community needs, as close to home as possible. There is a particular focus on improving the distribution of the primary care workforce outside of metropolitan locations.

Figure 4 shows that the distribution and mix of health professionals varies with remoteness. In general, there is a small decrease in the number of GPs and allied health professionals in remote and very remote communities that tends to be offset by an increase in the nursing workforce.

18 AIHW (2020), 'Health expenditure Australia 2018-19', *Health and welfare expenditure series number 66*, catalogue number HWE 80, AIHW, Australian Government 2020AIHW Canberra; and. AIHW, 'Data tables: Health expenditure Australia 2018-19 – Supplementary tables, available: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2018-19/data. Accessed 25 August 2021.
19 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

Figure 4: Composition of the primary care workforce by MMM, 2014 and 2019 (FTE per 100,000 population)



GP workforce

Australia's primary care GP workforce grew from 24,737 FTE doctors in 2014 to 29,419 in 2020[20]. This represents an annual growth of 2.9%, compared to an increase in population of 1.5% annually. In 2014 there was an average of 105 FTE GP for every 100,000 people. By 2020, the national average had grown to 114, although this varies geographically[21]. It is not possible to attribute this growth to any single factor, however prior to this the Government had implemented initiatives to provide early exposure to primary care. Subsequently, the Government expanded the number of Australian General Practice Training (AGPT) Program places in 2015 in response to demand. See the section titled 'Investing in a rural training pathway beyond university' for more information.

The number of GPs in New South Wales, Western Australia, South Australia and the Australian Capital Territory decreased over the most recent period (2019 to 2020) however

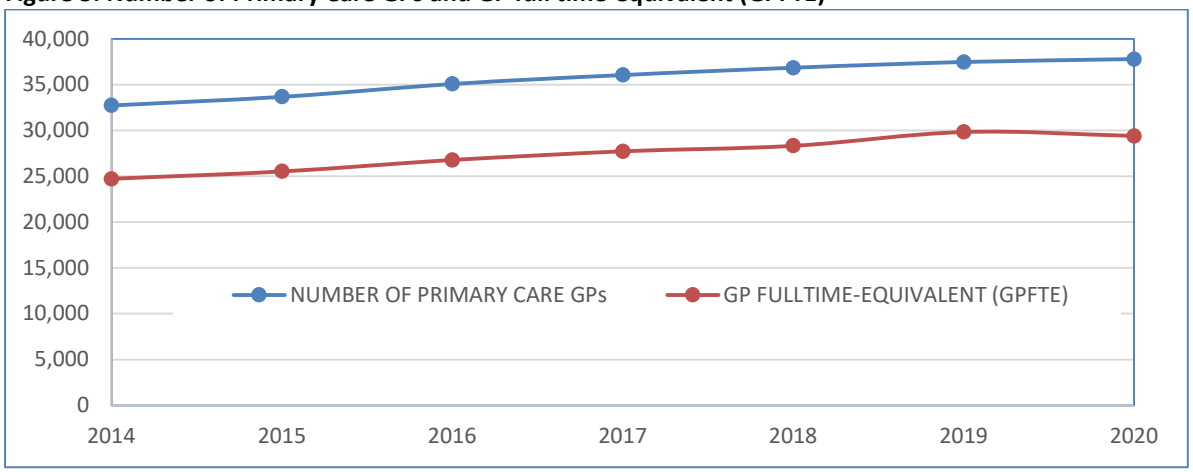
20 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.
21 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.

Western Australia and Australian Capital Territory had an increase in GP FTE. In the Northern Territory, the number of GPs has been decreasing since 2017[22].

An increasing proportion of doctors working as general practitioners have specialist GP qualifications. In 2014 there were 5,581 (17%) non-vocationally recognised (non-VR) GPs out of a total GP workforce of 32,739. In 2020 the number of non-VR doctors had decreased by 1715 to 3866 (10%) out of a total GP workforce of 37,785. This change is in line with the Australian government policy to support all doctors working as GPs to gain specialist qualification.

Non-VR doctors are encouraged to apply for training with the Australian College of Rural and Remote Medicine (ACRRM) or the Royal Australian College of General Practitioners (RACGP), through fully funded or subsidised programs.

Figure 5: Number of Primary Care GPs and GP full time-equivalent (GPFTE)[23]



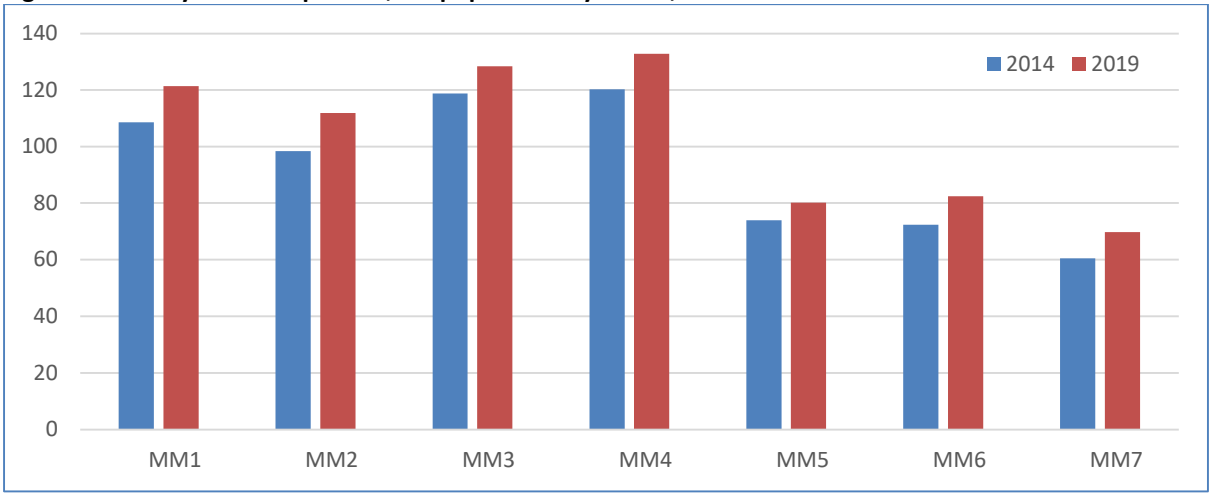
The distribution of GPs varies. The number of GPFTE per 100,000 population generally increases with remoteness up to MM 4 locations, as their roles are broader and include public health, hospital and emergency work. The number then decreases significantly in smaller remote and very remote towns.

The number of GPs in MM 3-5 and MM 7 areas decreased over the most recent period (2019 to 2020). In MM 6 areas, the number of GPs has been decreasing since 2018.

Figure 6 demonstrates the impact of town size and remoteness. MM 5 locations are small rural towns with a population between 1,000 and 5,000. MM 6 locations are remote communities whose larger populations may support group practice and Aboriginal Medical Services.

[22] Department of Health (2021), General Practice Workforce providing Primary Care services in Australia, https://hwd.health.gov.au/resources/data/gp-primarycare.html.
23 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

Figure 6: Primary Care GPs per 100,000 population by MMM, 2014 and 2019[24]



Doctors learn to become GPs through work providing patient care as registrars in supervised general practice. In 2020 GP registrars were just under 10% of the GP workforce (3,774 out of 37,780). The total number of GP registrars billing Medicare increased from 2,830 in 2014 to 3,774 in 2020, with a peak in 2019 of 3,916.

From 2015 to 2020, there was a reduction in the number of eligible applicants to the AGPT. In 2015 there were 2,458 eligible applicants with a final 1,561 accepting, but in 2020 there were 1,908 eligible applicants and a final 1,329 acceptances. There was improvement in 2021, with 2,138 eligible applicants and 1,434 acceptances leaving only 66 places unfilled, compared to 171 in 2020.

The Government's policy that over 50% of GP registrars work in MM 2-7 areas, means that GP registrars form a higher proportion of the workforce in rural areas. The AGPT also influences distribution of registrars undertaking the General Pathway by requiring them to complete 12 months in either a MM2-7 or outer metro location, or an AMS.

Reliance on International Medical Graduates

Australia is reliant on doctors whose initial qualification was obtained overseas to provide primary care. Between 2014 and 2020, the GPFTE for International Medical Graduates (IMGs) has been growing at a faster rate (4.3%) compared to Australian/New Zealand trained graduates (1.6%). The GPFTE for IMGs has increased from 48.2% of total GPFTE in 2014 to 52% in 2020. In 2020, more than half (15,311 GP headcount) of the primary care GP workforce had obtained their initial medical qualifications overseas[25].

24 Regional Population statistics for 2020 have not been released yet, so data for 2019 is presented here instead. Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.
25 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

Nursing and Midwifery workforce

Nurses and midwives are critical to the delivery of high-quality primary health care services in outer metropolitan, rural and regional Australia. They work within and independently of general practice as:

- Registered and enrolled nurses
- Nurse Practitioners (NP)
- Midwives

Registered and enrolled nurses deliver women's health, men's health, aged care, Aboriginal and Torres Strait Islander health, maternal and child health, infection control, immunisations, chronic disease management including cardiovascular, asthma and diabetes care, cancer management, mental health, health promotion, population health, wound management, and illness prevention.

NPs are registered nurses endorsed as an NP by the Nursing and Midwifery Board of Australia. Compared to registered nurses, NPs practice at an advanced level and within an expanded scope of practice. NPs can practice independently and work collaboratively in multi-professional environments. They have the experience, expertise and authority to diagnose, prescribe some medicines and treat people of all ages with a variety of acute or chronic health conditions. NPs often work in areas of no or little medical coverage.

Midwives work in partnership with their clients to give the necessary support, care and advice during pregnancy, labour and the postpartum period. They also provide care for newborns and infants. This care includes preventative measures, the promotion of normal birth, the detection of complications in the pregnant person and infant, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. Midwives also provide health counselling and education, not only for the pregnant person, but also within the family and the community.

Most midwives are employed by state or territory health services. A privately practicing midwife is a midwife who works as a sole practitioner, in partnership or in a self-employed model. Like other midwives, privately practicing midwives practise in many settings including the home, community, hospitals, clinics or health units including ACCHSs.

The primary care nursing workforce has grown, from 36,445 FTE nurses in 2014 to 41,953 in 2019[26]. This represents an annual growth of 2.9%, compared to an annual increase in population of 1.6%. In 2014 there was an average of 155 FTE primary care nurses for every

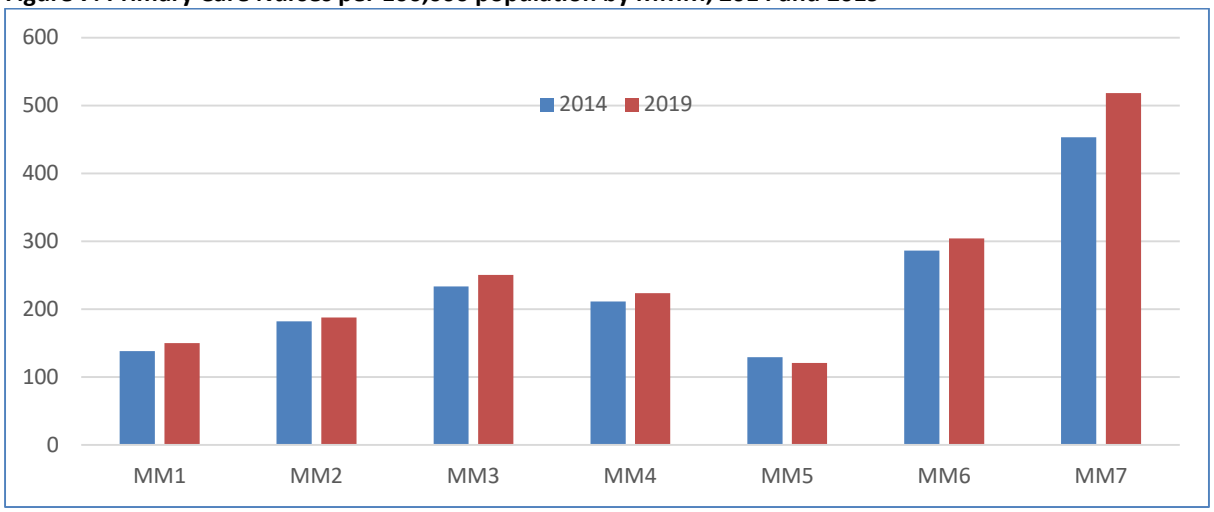
26 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

100,000 people nationally. By 2019, this average had grown to 165, although this varies by geography[27].

The number of FTE primary care nurses per 100,000 population generally increases with remoteness. Remote area nurses are the main providers of primary care in very remote towns. Their roles are broad and include providing acute and chronic disease management, public health, after-hours and emergency work in collaboration with Aboriginal health workers. Increasing numbers of remote area nurses have postgraduate qualifications gained whilst working. Many are sponsored or have scholarships to study from state, territory or Commonwealth governments. Remote area nurses are supported with visits from medical officers who also provide virtual on-call advice services between visits.

Figure 7 demonstrates the impact of town size and remoteness. MM 5 locations are small rural towns with a population between 1,000 and 5,000. MM 6 locations are remote communities whose larger populations may support group practice and AMSs.

Figure 7: Primary Care Nurses per 100,000 population by MMM, 2014 and 2019[28]



The majority of Australia's primary care nursing workforce is domestically trained. In 2019, more than 85% (35,931 FTE) of primary care nurses had obtained their initial qualifications in Australia or New Zealand[29].

The primary care midwifery workforce has also increased from 2,916 FTE midwives in 2014 to 3,277 in 2019. This represents an annual growth of 2.0%, compared to an annual increase

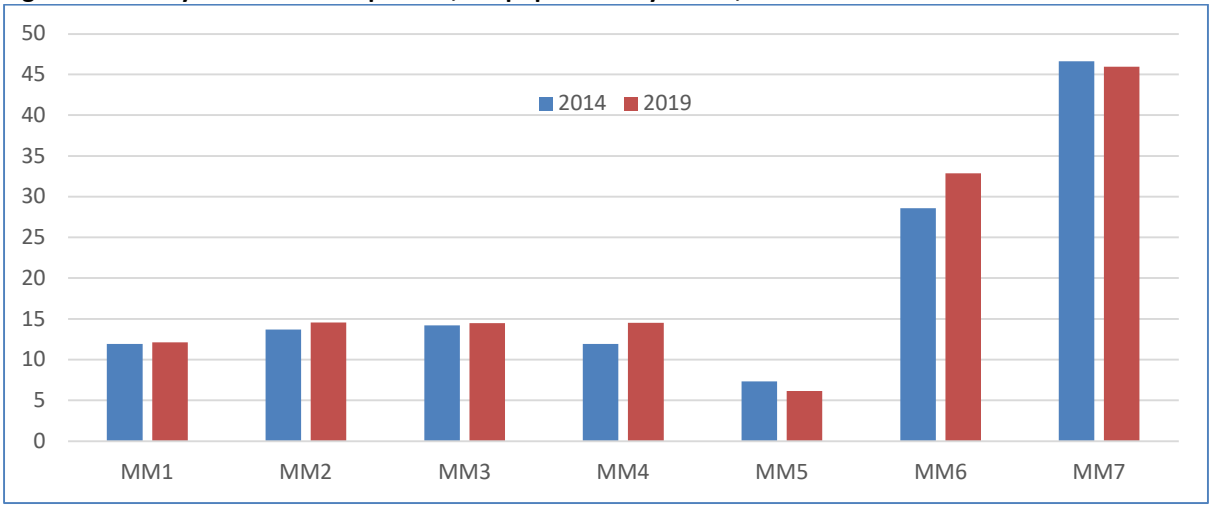
27 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.
28 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.
29 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

in population of 1.6%. In 2014 there was an average of 12.4 FTE primary care midwives for every 100,000 people nationally. And this average had grown to 12.7, although this varies by geography significantly.

Similar to the pattern observed with primary care nurses, the number of FTE midwives per 100,000 population generally increases with remoteness.

Figure 8 demonstrates the impact of town size and remoteness in FTE. MM 5 locations are small rural towns with a population between 1,000 and 5,000. MM 6 locations are remote communities and MM 7 are very remote communities.

Figure 8: Primary Care Midwives per 100,000 population by MMM, 2014 and 2019



Allied health workforce

There is no nationally agreed definition of *allied health*. Generally, in Australia, the Government recognises a group as an allied health profession if there is:

- a university level qualification of Australian Qualification Framework level 7 or higher that is accredited by a relevant national accreditation body;
- a national professional organisation with clearly defined membership criteria;
- clear national entry level competency standards and assessment processes;
- autonomy of practice; and
- a defined scope of practice.

The allied health sector is a large and diverse group, with the largest professions including psychology, physiotherapy, and occupational therapy. Allied health professionals are a critical part of the primary care team, alongside doctors and nurses. They provide a broad range of diagnostic, technical, and therapeutic health services to improve independence, health and wellbeing.

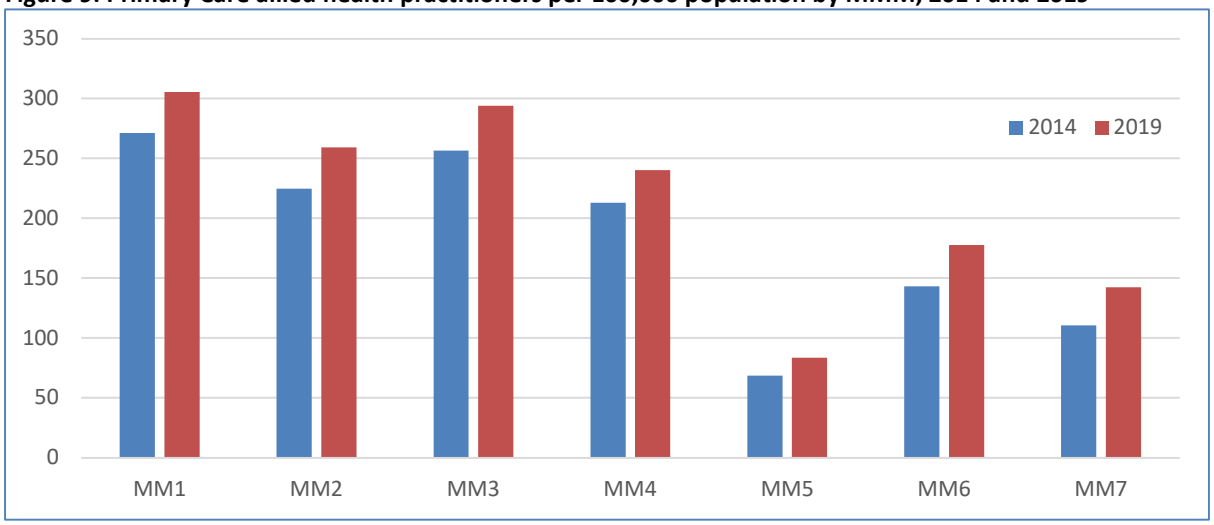
Allied health practitioners comprise 20% of the health workforce and deliver over 200 million services per year. There are close to 200,000 registered allied health professionals in Australia, split across nationally and self-regulated workforces.

Allied health is a rapidly growing part of Australia's health workforce, with the number of registered professionals growing each year. Demand for allied health professionals is expected to grow further over the next decade, as Australia's population changes. This is especially true for rural and remote Australia, as currently, allied health professionals are concentrated around major urban areas.

Australia's registered primary care allied health professions (excluding pharmacists) has grown rapidly, from 57,745 FTE professionals in 2014 to 71,098 in 2019[30]. This represents an annual growth of 4.2%, compared to an increase in population of 1.6% annually. In 2015 there was an average of 246 FTE allied health for every 100,000 people. By 2019, this average had grown to 280[31].

The distribution of allied health professionals generally decreases with remoteness. The number of fulltime-equivalent allied health professionals per 100,000 population decreases slightly with remoteness up to MM 4 locations, then decreases sharply in smaller remote and very remote towns.

Figure 9: Primary Care allied health practitioners per 100,000 population by MMM, 2014 and 2019[32]



30 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.
31 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.
32 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.

The majority of Australia's allied health workforce is domestically trained. In 2019, more than 85% (60,170 FTE) of allied health professionals had obtained their initial qualifications in Australia or New Zealand[33].

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners

Aboriginal and/or Torres Strait Islander Health Worker is an Aboriginal and/or Torres Strait Islander person who has gained a Certificate II or higher qualification in Aboriginal and/or Torres Strait Islander Primary Health Care from the Health (HLT) training package.[34]

Aboriginal and Torres Strait Islander Health Practitioners are registered healthcare practitioners who provide clinical services and patient care with a focus on culturally safe practice for Aboriginal and Torres Strait Islander people. They work collaboratively within multidisciplinary healthcare teams to achieve better health outcomes for Aboriginal and Torres Strait Islander people and communities and play a key role in facilitating relationships between Aboriginal and Torres Strait Islander patients and other health practitioners. To gain registration, practitioners must complete a minimum 12-month Certificate IV program of study approved by the Aboriginal and Torres Strait Islander Health Practice Board of Australia.[35]

Between 2015 and 2019, the total number of Aboriginal and Torres Strait Islander Health Practitioners with general registration increased by 22.0% from 514 to 670 (a compound annual growth rate of 6.9%). The number of employed Aboriginal and Torres Strait Islander Health Practitioners ('workforce') increased 15.8% from 451 to 549 over the same period (a compound annual growth rate of 5.0%).[36]

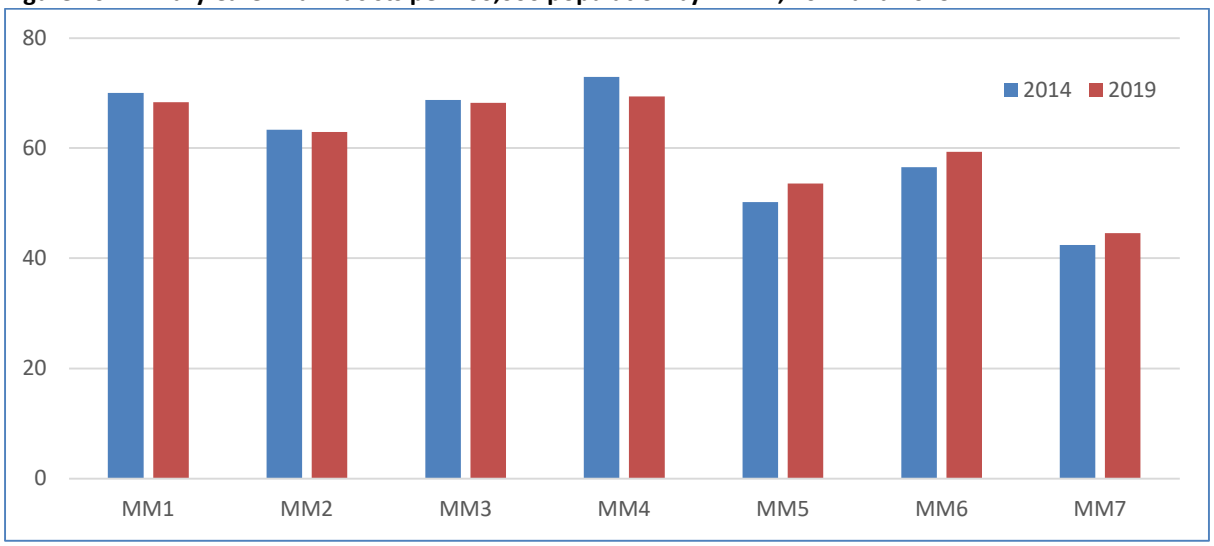
Pharmacy workforce

Australia's primary care pharmacist workforce has grown, from 15,868 FTE pharmacists in 2014 to 16,896 in 2019[37]. This represents an annual growth of 1.3%, compared to an increase in population of 1.6% annually. In 2014 there was an average of 67.6 FTE primary care pharmacists for every 100,000 people. By 2019, this average had decreased slightly to 66.6 FTE for every 100,000 people[38].

33 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.
34 National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners website, https://www.naatsihwp.org.au/what-atsi-health-workers-and-health-practitioners-do
35 Department of Health, National Health Workforce Data Set (NHWDS) Factsheet – Allied Health 2019 factsheet-alld-atsi-health-practitioners-2019.pdf
36 Ibid
37 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.
38 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.

The distribution of primary care pharmacists is relatively consistent across Australia. The number of fulltime-equivalent pharmacists per 100,000 population is between 62 to 74 for MM1 to MM 4 with locations in MM5 & 7 having the lower rates but they have increase from 2014 numbers[39].

Figure 10: Primary Care Pharmacists per 100,000 population by MMM, 2014 and 2019[40]



As with nursing and allied health, the majority of Australia's pharmacist workforce is domestically trained. In 2019, more than 87% (14,779 FTE) of pharmacists had obtained their initial qualifications in Australia or New Zealand[41].

Practice settings

GPs[42]

Nearly three quarters of primary care GPs work in group private practice - 25,611 GPFTE (73%), a further 3,149 GPFTE (9%) work in solo private practices, and around 8% (3,066 GPFTE) indicate they work in hospitals. Six percent of GPs work in Aboriginal and Torres Strait Islander medical services, outpatient services, locum private practice, community health services and the defence forces (combined). The remaining 3% work in either

39 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.
40 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health; Estimated Resident Population (ERP), Australian Bureau of Statistics. Data prepared: 19 August 2021.
41 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.
42 All data derived from Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

residential mental health, aged care facilities, commercial services, public health units and government, correctional facilities, and education facilities.

Nursing[43]

The majority of primary care nurses work in community health care services - 19,508 FTE (46.5%). A further 9,211 FTE (22%) work in GP practices, while 5,024 FTE (12%) list their workplace as private practice.

Smaller numbers of primary care nurses have their main job in hospitals, Aboriginal and Torres Strait Islander medical services, and education facilities (11.7% combined)[44].

Nurses also work in outpatient services, residential health care, public health units and government, correctional facilities, commercial services, the defence forces and locum private practice make up the remaining 7.9%[45].

Midwife[46]

The majority of primary care midwives work in group midwifery practice 1,032 FTE (31.5%). A further 834 FTE (25.4%) work in community health care services, and 354 FTE (10.8%) list their workplace as 'other'.

Smaller numbers of midwives have their main job in Aboriginal and Torres Strait Islander medical services, and education facilities (14.7% combined)[47].

Midwives also work in other government departments or agencies, independent private practice, specialist (O&G) practice, GP practice, commercial services, correctional services, and defence forces (the remaining 17.6%[48]).

Allied health[49]

Most primary care allied health professionals work in group private practice - 31,072 FTE (43.7%). A further 20,606 FTE (29%) work in solo private practices, while the remaining

43 All data derived from Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.
44 Note: This statistic includes nurses who have their main job in hospitals. These nurses would not normally be considered to be working in primary care.
45 Note: This statistic includes nurses who provide outpatient services. These nurses would not normally be considered to be working in primary care.
46 All data derived from Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.
47 Note: This statistic includes midwives.
48 Note: This statistic includes.
49 Data drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

7,667 FTE (10.7%) work in community health services. Smaller numbers of allied health professionals have their main job in residential care, disability service and public clinics (11.1% combined). The remaining 5.4% work in either locum private practice, Aboriginal and Torres Strait Islander medical services, domiciliary service, and educational facilities.

Pharmacy[50]

Primary care pharmacists in Australia work predominantly in community pharmacy - 15,438 FTE (91.4%).

The remainder 1,458 FTE (8.6%) work in medical centres, private practice, residential health care and Aboriginal and Torres Strait Islander medical services.

Remuneration

The primary health care workforce is funded from a range of different Commonwealth, state and territory sources, private health insurance and patient fees. The workplace setting affects the remuneration and business model in which the workforce operates.

Many primary health care providers who work in private practice are funded through fee-for-service arrangements, which usually comprises patient fees, Medicare or private health insurance. Providers may also receive funding through specific programs or incentives available to them through Commonwealth or state governments. For example, the Workforce Incentive Program (WIP) Practice Stream encourages multidisciplinary and team-based models of care by providing financial incentives to general practices to engage a range of health professionals, and the Practice Incentives Program (PIP) encourages general practices to continue providing quality care, enhance capacity, and improve access and health outcomes for patients. For more information on the WIP and the PIP see Appendix B: List of Primary Care Programs.

Medicare provides rebates for a range of services delivered by GPs, nurse practitioners, midwives and allied health providers. When a patient receives a Medicare-subsidised primary care service, they receive a rebate from the Government to contribute to the costs of the privately provided health service. The patient may need to pay an out-of-pocket cost if there is a gap between the fee that the primary health care professional charges and the MBS rebate amount.

While allied health has most often been delivered in private practice settings with a combination of out-of-pocket fees and private health insurance general treatment benefits, according to AIHW the number of patients receiving Medicare-subsidised allied health services in a non-hospital setting has grown markedly—from 5.6 million in 2008–09 (25% of

50 drawn from: Medicare Benefits Schedule (MBS): Claims, Provider and Patient Demographics Data, Australian Government Department of Human Services; National Health Workforce Dataset (NHWDS), Australian Health Practitioner Regulation Agency and the Australian Government Department of Health. Data prepared: 19 August 2021.

people) to 9 million in 2017–18 (37% of people)[51]. While demand factors such as increasing chronic disease will represent some of this growth, this also reflects the Government introducing new Medicare subsidised allied health rebates, such as the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative introduced in 2006 to support treatment of mental health conditions.

Providers may find private, fee-for-service practices challenging in smaller communities, particularly if the population is not large enough to sustain a private business. Therefore, the very rural and remote workforce is more likely to be employed in government block funded community or other block funding arrangements. Examples include the Primary Health Care Activity within the IAHP, which provides grants for health providers to deliver culturally appropriate primary health care services for Aboriginal and Torres Strait Islander people (see Appendix B: List of Primary Care Programs), and primary care professionals employed by the Royal Flying Doctor Service (RFDS) to deliver emergency and visiting services in remote and very remote communities.[52]

Recent policy reforms support and encourage doctors working in general practice to achieve specialist GP qualifications. Doctors without specialist status attract a lower Medicare rebate but can apply for support to gain Fellowship and become eligible for higher rebates whilst studying.

51 Australian Institute of Health and Welfare (2020), 'Australia's health: Snapshots'. Available: www.aihw.gov.au/reports/australias-health/allied-health-and-dental-services
52 Department of Health, Primary Health Care Activity, https://www.health.gov.au/initiatives-and-programs/primary-health-care-activity.

Current state of outer metropolitan, rural and regional GPs primary care and related services – Current state challenges

Attracting a medical primary care workforce

GPs are vital to delivering high-quality primary health care. General practice is the most accessed form of health care in Australia, with almost 90% of the population seeing a GP each year[53]. The continuity of care that can be provided by GPs is also associated with reduced hospital admissions and increased life expectancy[54].

Despite the critical role of GPs, consultations to develop a National Medical Workforce Strategy (NMWS) indicated that Australian students and doctors are preferring careers in non-GP specialty and sub-specialty practice rather than in general practice and other generalist practice[55].

The number of eligible applications from doctors applying for the fully funded AGPT general practice training places has declined over the last five years, from 2,318 applications in 2016 to 1,908 applications in 2020. In 2021, 2,138 eligible applications were received. [56]

In 2017 an application fee for GP training was introduced. The subsequent drop in the number of doctors applying for training, was accompanied by fewer candidates withdrawing after receiving an offer of a place on a different specialty's program. It was concluded that the fee impacted more on the overall number of applicants than on the number taking up training places.

There has also been an overall decline in the number of medical students expressing interest in a general practice career at graduation, from 17.8% in 2015 to 15.2% in 2019[57]. This trend needs to be reversed and a greater emphasis placed on growing the GP workforce. The draft NMWS articulates plans to increase the proportion of Australian trained doctors who choose to become GPs.

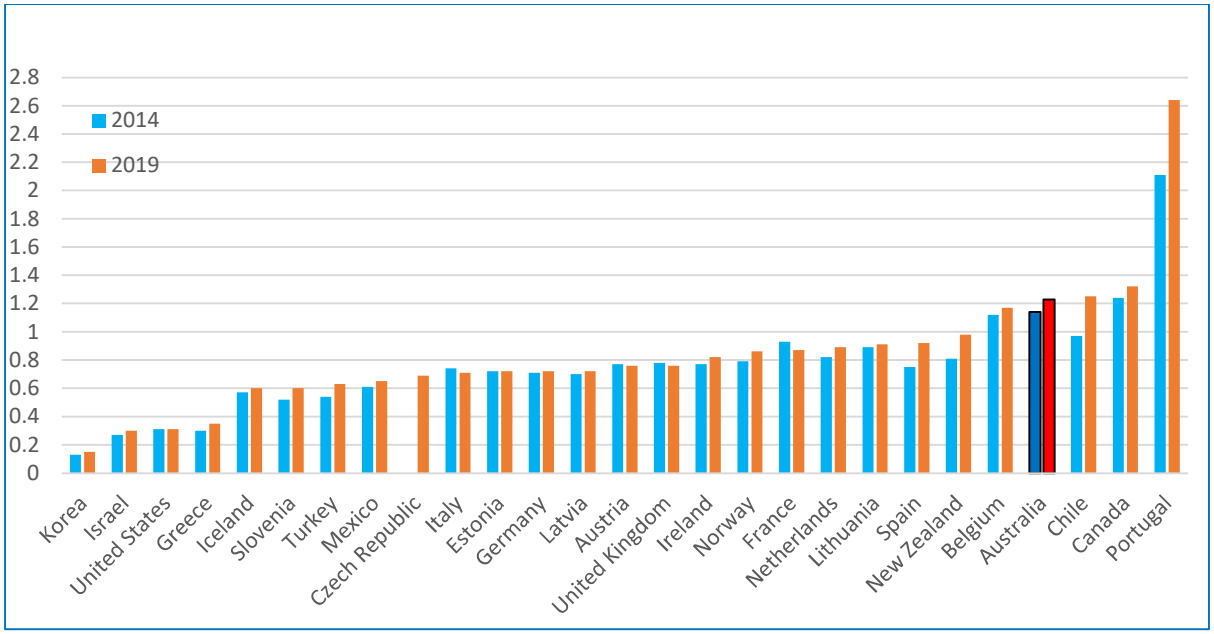
53 The Royal Australian College of General Practitioners (RACGP), 'General Practice: Health of a Nation 2020', General Practice: Health of the Nation, RACGP, 2020, accessed 12 May 2021.
54 D Gray, P Evans, K Sweeney, P Lings, D Seamark, C Seamark, M Dixon and N Bradley, 'Towards a theory of continuity of care', Journal of the Royal Society of Medicine, 2003, 96(4):160–6, doi:10.1258/jrsm.96.4; I Barker, A Steventon and S Deeny, 'Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data', BMJ, 2017, 356:j84, doi: 10.1136/bmj.j84; O Maarsingh, Y Henry, P van de Van and D Deeg, 'Continuity of care in primary care and association with survival in older people: a 17-year prospective cohort study', British Journal of General Practice, 2016, 66(649):531–9, doi: 10.3399/bjgp16X686101.
55 Australian Department of Health, National Medical Workforce Strategy 2021-2031, Australian Government 2021.
56 These applications refer to Commonwealth-funded programs only, including the Australian General Practice Training Program.
57 Medical Deans Australia and New Zealand, 'National Data Report 2020: 2015–2019 data from final year students at Australian medical schools', Medical Deans Australia and New Zealand website, 2020, accessed 23 April 2021.

Australia is not alone in these challenges. The United Kingdom's National Health Service (NHS) Long Term Plan aims to shift from a dominance of highly specialised roles in the medical workforce, to more generalist ones and build a better balance across specialties[58].

Canada appears to have had greater success in striking a balance between generalists and specialists. In 2019, data indicated that 53% of Canada's medical workforce were family physicians, while 48% worked in other specialities[59].

As Figure 11 shows, Australia has a high number of General Practitioners per 1,000 population when compared with other OECD countries.

Figure 11: General Practitioners (headcount) density per 1,000 population, OECD countries, 2014 and 2019[60]



Ongoing workforce maldistribution

People living in rural and remote areas of Australia experience poorer health outcomes, higher rates of chronic disease and lower life expectancy than those living in metropolitan areas. They also face access barriers such as the requirement to travel significant distances to access health care. These issues are exacerbated by the uneven workforce distribution, which leads to poor access and usage of health services.

Medicare data shows that in 2018–19, the number of non-hospital non-referred attendances per person, such as GP visits, were lower in *Remote* and *Very remote* areas (4.8

58 NHS (2019), The NHS Long Term Plan, United Kingdom. Available: www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf. Accessed: 2 September 2021
59 Source: CMA Masterfile, January 2019, Canadian Medical Association
60 Data extracted from OECD stats (Health Care Resources: Physicians by categories)

and 3.6 per person respectively), compared with in *Outer regional* areas (6.0 per person), *Inner regional* areas and *Major cities* (6.4 per person for each area)[61].

Despite efforts to increase the workforce in rural and remote Australia, there is an ongoing shortage of GPs and other primary health care professionals in some communities. Locums provide important cover for short-term leave in hospitals and primary care settings, filling immediate service needs and providing specialist outreach services. While data is limited, the NMWS consultations indicated there is a general view that growing over-reliance on international medical graduates and locums poses risks to continuity and quality of care, cultural appropriateness of care and longer-term workforce sustainability.

Outer metropolitan service gaps exist

It is easier to attract and retain primary health care professionals in metropolitan, outer metropolitan and larger regional centres. These areas offer access to a range of educational institutions for children, more employment opportunities for partners, opportunities for professional support and ongoing development.

However, outer metropolitan areas are different from inner metropolitan areas. Factors that can impact primary health care supply and demand in outer metropolitan areas include:

- marked increases in new housing and population;
- access to transport and infrastructure, including public hospitals with maternity services, lagging behind population growth;
- lower numbers of GPs; and
- higher numbers of people who first language is not English, including refugees and recent migrants.

There remains an opportunity to adjust incentives and distribution policies to better support disadvantaged pockets in outer metropolitan areas. The 2021 review of the Distribution Priority Areas (DPA) provides an opportunity to examine how the current methodology is working in response to circumstances such as unmet demand, changes in population or changes in services. See 'Updating the DPA' for more information.

Changing models of care

Changing models of care, including the impact of technology, can have a profound impact on the mix and structure of services. This can include new opportunities for making services

61 Australian Department of Health (2019), Annual Medicare Statistics. Referenced in Australian Institute of Health and Welfare (2020), 'Australia's health: Snapshots'. Available: www.aihw.gov.au/reports/australias-health/rural-and-remote-health. Accessed 20 August 2021. Note: This data uses the Australian Standard Geographical Classification – Remoteness classification (AGSC-RA). The categories map to the MMM as follows: MM7 (Very remote), MM6 (Remote), MMM3-5 (Outer Regional), MM2-5 (Inner Regional); MM1 (Major cities). The variations reflect that the MMM also incorporates town size into its calculation.

accessible to more remote communities, and opportunities to support remote clinical supervision and training. In other cases, new treatments and interventions may reduce the need for some services.

Developments in digital technology can enable non-traditional models of care, faster patient access to diagnosis and treatment, and more information for health care providers. Decision support software, electronic referrals and requests for tests and prescribing support are all currently being considered or rolled out in Australia.

The pace of change can also present challenges. Policymakers are challenged to keep pace with changes, training content must be updated to reflect new approaches and the primary care workforce must continually adapt their approach and skills.

Rural, regional and remote workforce retention

The NMWS consultations indicated that there is a stigma around medical practice outside metropolitan areas, including perceptions of sub-standard practice, limited resources and potential isolation[62]. A literature review by the National Rural Health Commissioner found that professional isolation and high workloads are predictors of rural allied health workforce turnover[63].

The rural, regional and remote workforce often work in a wider range of settings and to the broadest possible scope. For example, a rural GP may also work in the local hospital providing emergency or other additional services, as well as providing after hours care.

While there are clearly challenges to some rural practice, there are also career and lifestyle benefits including clinical variety, greater autonomy and being part of a close community. These benefits need to be promoted to encourage primary care practice beyond Australia's major cities and larger regional centres.

Improving primary care workforce data

There is no single consolidated source of primary health care workforce data, although significant progress has been made regarding GP data. This means that different data sets and methodologies are used by stakeholders to understand workforce supply, predict demand and undertake planning.

The problem spans all elements of the primary care workforce. The NMWS Scoping Framework identified this as a factor impacting medical workforce planning[64], while the National Rural Health Commissioner identified this as a factor impacting allied health

62 Australian Department of Health, 'National Medical Workforce Strategy 2021-203'1, Australian Government 2021.
63 National Rural Health Commissioner, 'Review of rural allied health evidence to inform policy development for addressing access, distribution and quality', Australian Government 2020.
64 Australian Department of Health, 'National Medical Workforce Strategy: Scoping Framework, July 2019', Australian Government 2019.

workforce planning[65] and recommended the development of a national allied health data strategy and allied health minimum dataset[66].

Work is already underway to begin addressing this challenge and is covered in sections titled 'Improved data usage to identify areas of workforce shortage' and 'Developing a NMWS'.

65 National Rural Health Commissioner, 'Review of rural allied health evidence to inform policy development for addressing access, distribution and quality', Australian Government 2020.
66 National Rural Health Commissioner, 'Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia: June 2020', Australian Government 2020.

Terms of Reference B: Government reforms and their impact on GPs

The Commonwealth government has introduced programs and policies to improve access to and the distribution of the entire primary care workforce.

Workforce reviews 2012-2015

In the period 2012-15, significant reviews focused on the rural health workforce highlighted that the most significant health workforce issue, particularly in general practice, was maldistribution of the workforce, particularly in rural and remote areas and some outer metropolitan areas.

The reviews highlighted that the service models and workforce skills required in small rural or very remote communities differ markedly from larger regional towns, with increasing rurality requiring multi-skilled primary care professionals able to provide primary care, aged care, acute care and procedural services. They also argued for a shift in distribution systems, from a focus on workforce numbers to a more nuanced focus on community needs.

Key themes also included need to focus on generalist skills, team-based care using all professions across the primary care workforce, and capacity building through rural training and supervision. Some of the major reviews include:

- Senate Standing Committee on Community Affairs (2012). The factors affecting the supply of health services and medical professionals in rural areas.
- House of Representatives Standing Committee on Health and Ageing (2012). *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors.*
- Review of Australian Government Health Workforce Programs (2013). Chaired by Jennifer Mason.
- Independent Expert Panel (2015). Report on the redesign of the General Practice Rural Incentives Program.

The findings set the scene for reform in the coming years, with a number of consistent findings and recommendations leading to the introduction of the MMM and DPA; introduction of joined-up rural training opportunities; reform of early career exposure to primary care for junior doctors; creation of the National Rural Health Commissioner Office; improvements to incentive programs; and a focus on rural generalism.

Changes to distribution mechanisms

The House of Representatives Standing Committee on Health and Ageing initiated a review into the registration processes and support for overseas trained doctors (referred to in this submission as IMGs) in 2010. The Committee was a response to Australia's ongoing reliance on IMGs. The report expressed reservations about the distribution mechanisms under

section 19AB of the *Health Insurance Act 1973* (HIA), but recommended maintaining these mechanisms as a way of providing a regional, rural and remote workforce until Australia was no longer reliant on IMGs to meet workforce needs.

Section 19AB of the HIA

Section 19AB(1) of HIA was introduced on 1 January 1997, and is one of the Government's key levers to target inequality in the distribution of medical services. It does this by diverting IMGs and foreign graduates of an accredited medical school (FGAMS) to the rural and remote areas that most need them.

Doctors[67] are subject to 19AB for ten years (known as the ten-year moratorium) from the date of their first Australian medical registration. These doctors can provide services eligible for Medicare rebates only in a DPA for GPs or a District of Workforce Shortage (DWS) for specialists. There is no restriction on practise in salaried positions such as public hospitals, where services do not attract Medicare rebates.

Exemptions to Section 19AB

Section 19AB(3) allows for exemptions to the operation of s19AB(1). It is possible for a doctor subject to 19AB(1) to avoid location restrictions, and work outside of a DPA or DWS in certain circumstances.

The section 19AB(3) exemption provision was originally included to accommodate limited circumstances, such as the migration of an eminent doctor or researchers with adjunct clinical practice, or for teaching purposes where clinical practice is necessary to the role[68].

Since 2012, the Health Insurance (Section 19AB Exemptions Guidelines) Determination 2019 (Guidelines) have referenced exemptions that have broadened the circumstances in which an exemption to section 19AB(1) can be granted. Grounds for an exemption currently includes, but is not limited to, if the applicant doctor:

- is seeking to work in the after-hours period;
- is seeking to work in a short-term locum employment engagement (6 months);
- holds an academic appointment with an Australian medical school (can be unpaid);
- is replacing another restricted doctor at a non-DPA/DWS practice (within 12 months);
- entered employment negotiations with a practice while the local area was a DPA/DWS (even if status changes thereafter); and
- is married to a skilled migrant or another registered doctor who has full Medicare access and is seeking employment near their partner.

67 In this context, 'doctor' refers to specialist GPs and other specialists.
68 *Health Insurance Amendment Bill (NO. 2) 1996*, Explanatory Memoranda, Australasian Legal Information Institute. http://classic.austlii.edu.au/cgi-bin/sinodisp/au/legis/cth/bill_em/hiab21996281/memo2.html

An application for an exemption is assessed in line with the Guidelines, which provide the detail and framework for exemptions.

The Department's 2020-21 data shows that the top five exemption types approved (as a percentage of all exemptions approved to practise in a non-DPA/DWS) were in the following areas:

- Training programs (combined) – 28%
- Specialists in acute shortage – 16.3%
- Locum – 13.8%
- Assistance at Operations – 13.7%
- Approved Medical Deputising Service (AMDS) Program (after hours) – 7.7%.

The high proportion of locum exemptions granted demonstrates a possible dependence on the use of locums by practices in a non-DPA/DWS location. Consultations to develop a NMWS have identified the requirement to better understand locum use and move away from over-reliance on locums, particularly where used in lieu of permanent staff.

Introduction of the MMM

The Mason Review (2013) and the Senate Standing Committee on Community Affairs (2012) both recommended reforming the rural classification system used to determine eligibility for incentives by moving to a modified version of a system developed at Monash University. This work became a major policy priority.

Work to implement a new rural classification system responded to concerns that the use of the ABS's ASGS-RA system was disadvantaging some small rural communities across Australia, in particular towns in inner and outer regional Australia. There were particular concerns about small communities receiving the same classification as larger, better serviced communities.

The MMM replaced the ASGS-RA classification system as a means of directing incentive payments. This was in response to concerns that the ASGS-RA would achieve better outcomes if overlaid with other measures impacting on access to health services, such as proximity to a town.

In 2015, the MMM classification system was introduced to better target health workforce programs. It is a contemporary and objective approach for classifying the remoteness of a location, based on town size and the ASGS-RA. The system:

- Builds on geographic data with statistical data.
- Provides a more nuanced classification for towns in the AGSC-RA Inner and Outer Regional Categories (MM2-MM5).

- Recognises differences between isolated small towns, in comparison with small towns that are accessible to and serviced by larger towns.
- Recognises the challenges attracting health professionals to more remote and smaller communities, providing a suitable basis for directing incentives.

The MMM is based on research by Professor John Humphreys and colleagues from Monash University using ASGS Remoteness areas, and then further dividing regional Australia into categories based on the size of the local town or city[69]. The MMM was modified through stakeholder consultation, including the Mason Review and the Rural Classification Technical Working Group (RCTWG).

Following the introduction of the MMM in 2015, the RCTWG met to consider whether the parameters and usage of the MMM were meeting the needs of rural communities, including whether buffer zones around large cities accurately reflected the functional service areas of those cities. As a result of discussions, the RCTWG supported the structure of the MMM.

The MMM is a consistent and well-understood system supported by the best available evidence. It is the model preferred by health sector stakeholders, although the decision to use the MMM remains with individual programs. Consequently, some programs (for example the Practice Incentives Program) have not yet transitioned to the MMM and continue to use other classification systems, such as the Rural, Remote and Metropolitan Area (RRMA) classification system, which based on 1991 Census data. The MMM is also used by other government departments.

The system is regularly updated to incorporate the latest available data. The last update occurred in 2019, incorporating 2016 Census data. Updated data can result in some areas being reclassified, most often due to outlying towns being absorbed by urban expansion. While this can result in reclassified locations receiving reduced incentives, regularly updating classifications is an important way of ensuring that incentives and programs to support primary care services in regional, rural and remote areas are correctly targeted.

'Appendix A: Incentives and support for GP practices by MM' contains a list of programs using the MMM.

Issues related to use of the MMM

The MMM is a geographic and data-based classification system. It does not have any discretionary elements and the Department is not able to change a location's MMM classification. This means that individual programs using the system need to review their program parameters if use of the MMM system is not producing desired outcomes.

69 Humphreys, J; McGrail, M; Joyce, C; Scott, A (2012), *Who should receive recruitment and retention incentives? Improved targeting of rural doctors using medical workforce data,* Australian Journal of Rural Health 20(1): 3-10. Available: www.researchgate.net/publication/221752917_Who_should_receive_recruitment_and_retention_incentives_Improved_targeting_of_rural_doctors_using_medical_workforce_data

For example, in 2016 two MM6 towns had their incentive payments under the General Practice Rural Incentives Program (GPRIP) – now called the Workforce Incentive Program-Doctor Stream – increased to levels equivalent to an MM7 location. This was a temporary program-based decision, in response to recommendations by the RCTWG, in recognition of individual difficulties attracting doctors to the area. Note that both towns continued to be correctly classified as MM6[70].

The DPA

DPA system

The DPA system is used to distribute GPs subject to location restrictions to work in areas where there are GP service shortfalls, and helps to compare relative shortages of GPs between communities, as most communities appear to self-identify that they have a shortage of GPs. The DPA compares the actual level of GP services provided to a population with the level of services that the same community should receive, if it had access to a benchmark level of services.

The DPA considers the level of services that should be received by taking into account the community's composition, including gender, age demographics and socio-economic status. This is because these factors are social determinants of health that drive a community's service needs up and down.

There are currently some automatic 'rules' under the DPA:

- MM1 inner metropolitan areas are automatically classified as non-DPA
- MM5-7 areas are automatically deemed DPA
- All of the Northern Territory is automatically deemed DPA.

The DPA was introduced in 2019, replacing the previously used DWS for general practice. The methodology changed from a simple GP-to-population ratio (DWS) to a more accurate picture of the services received by patients living in a catchment, taking account of demographics and socio-economic factors (DPA).

The DPA system compares the GP services received by the population of a GP Catchment against a benchmark level of access, taking into consideration the demographics of the individual GP Catchment. If a GP Catchment has less access to GP services than the benchmark, the area will be classified as DPA. Alternatively, if a GP Catchment has greater access to GP services than the benchmark, the area will be classified non-DPA.

The Distribution Priority Area benchmark is the average level of primary care services delivered to patients living in MM2 areas across the country. The level of service in a GP catchment is compared to the MM2 benchmark. Weightings for socioeconomic status, age

70 Questions in writing, "Modified Monash Model (Question 821), 25 October 2017. Available: https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22chamber/hansardr/70925501-1175-42e6-9bca-2765dbecf673/0309%22. Accessed: 25 August 2021.

and gender are applied to account for how the GP catchment's population varies to the MM2 average, as these affect populations' needs for GP services

DPA status does not guarantee a doctor, but it means practices in DPA areas can recruit doctors subject to location restrictions such as new entrant international medical graduates and Australian bonded doctors with return of service obligations.

DPA and outer metropolitan areas

The inner and outer metropolitan classification system is used in conjunction with the DPA indicator to identify outer metropolitan areas experiencing GP service shortfalls.

Outer metropolitan areas experiencing service shortfalls are able to be classified as a DPA. For example, Terrey Hills is part of the Sydney outer metropolitan area and is an MM1 DPA location. Outer metropolitan practices located in a DPA can recruit doctors subject to location restrictions such as new entrant international medical graduates and Australian bonded doctors with return of service obligations.

Concerns with the introduction of the DPA

Since its introduction in 2019, some doctors, concerned community members and representatives have raised concerns about the non-DPA status of their area. Concerns have included citing non-DPA status as the reason that GPs are unable to be recruited and as the reason services in their area are unavailable to patients.

Concerns have been raised that the current methodology does not contemporaneously reflect local circumstances, such as unmet demand, changes in population or reductions in Medicare services.

Areas concerned about their DPA classification can seek a review by an independent expert group. Requests are reviewed against transparent and publicly available principles:

- *Changes to health workforce.* The area can demonstrate an unexpected large change to the health workforce, resulting in a substantial drop in health services.
- *Patient demographics.* The majority of the patient cohort is within a demographic that is underserviced, or requires a specialised nature of service.
- *Absence of services.* The area can demonstrate difficulties in recruiting or retaining medical practitioners at a scale that is markedly different to similar communities.
- *Changes to the health system.* The impact of hospital closure in area (due to state-based funding) or an unexpected sharp increase in population.
- *Support by the Rural Workforce Agency (RWA).* Any request for exceptional circumstances consideration must be supported by the relevant RWA.

Updating the DPA

The DPA is updated annually on 1 July. The DPA classification of an area can change when there has been a significant shift in access to health care since the previous annual update. This might be due to changes in the workforce, or in the size or makeup of the population.

If an area loses DPA status, doctors who hold an existing exemption under section 19AB of the HIA can continue to practise at their location provided they continue to meet the conditions of their exemption. In addition, doctors already in employment negotiations with a practice prior to a status change will still be eligible for an exemption if they provide documentary evidence of this with their application.

The last DPA update came into effect on 1 July 2021. This latest update considers the impacts of COVID-19 on healthcare access, including the data impacts of temporary telehealth items in areas that experienced significant lockdown periods, such as Victoria.

The update also included data for each area that shows the level above the national benchmark where an area is non-DPA.

The DPA classification for each location in Australia is available via the Health Workforce Locator Map on the DoctorConnect website (www.doctorconnect.gov.au).

For more information on the review of the DPA's operation see the section 'Distribution Working Group and DPA review'.

Training reforms: creating rural primary care training opportunities

The Department has had a long-term focus on using education and training programs to improve health workforce distribution. Research demonstrates that providing medical students with training in rural areas increases the likelihood they will practise in rural areas upon graduation[7172].

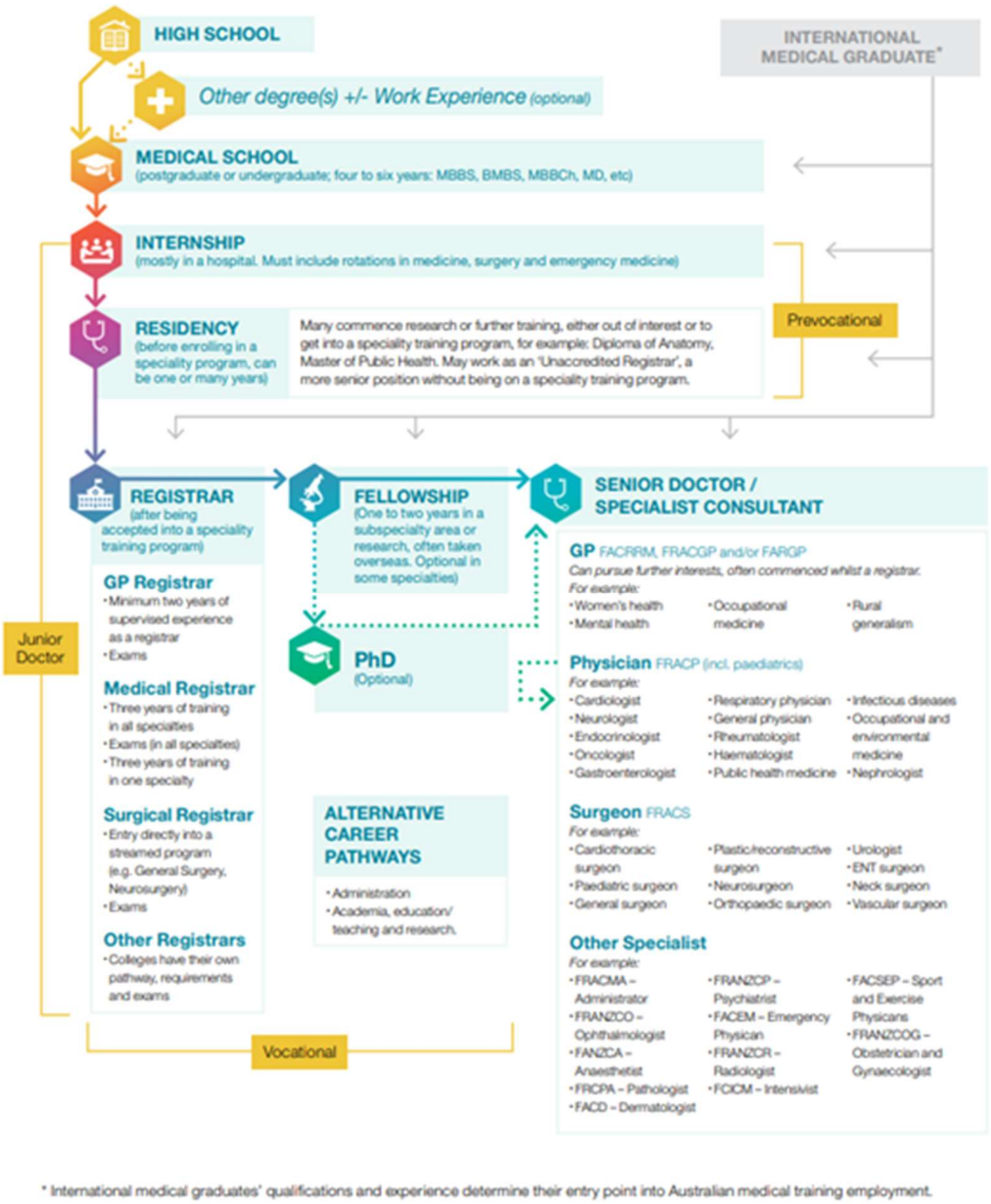
- Two years spent at a Rural Clinical School (RCS), rather than one year, doubles the probability of rural medical specialist practise.
- Rural background interacts with RCS attendance to further increase the probability of rural medical practice.
- Attending an RCS is an independent predictor of longer-term specialist rural practice (GP or other specialty).
- GPs with rural backgrounds and rural experience during their medical education are more likely to practise in rural areas.
- GPs who have completed any form of rural placement or training program are more likely to work in rural practices, regardless of whether they have a rural or metropolitan background[73].

71 Kwan MMS, Kondalsamy-Chennakesavan S, Ranmuthugala G, Toombs M, Nicholson GC (2017) The rural pipeline to longer-term rural practice: General practitioners and specialists, PLoS ONE, July 7, 2017
72 O'Sullivan B, McGrail M, Russell D, Walker J, Chambers H, Major L, Langham R. (2018) Duration and setting of rural immersion during the medical degree relates to rural work outcome, Med Educ. 2018 Aug;52(8):803-815. doi: 10.1111/medu.13578. Epub 2018 Apr 19
73 Ogden J, Preston S, Partanen RL, Ostini R, Coxeter P (2020) Recruiting and retaining general practitioners in rural practice: systematic review and meta-analysis of rural pipeline effects, MJA 213 (5) 7 September 2020

Due to the long training timeframes required for many primary care professionals to become fully qualified for independent practice, policy changes targeting the training system can take many years to impact service delivery in the community. For example, registered nurses or midwives can require 3-4 years of full-time study before entering the workforce. For GPs, their medical degree can take 4-6 years, followed by a 12-month compulsory internship and 3-5 years of further training to become a specialist GP.

Figure 12 shows Australian medical training pathways, including the pathway to become a specialist GP. GP specialist training is further described in Appendix E: Australian General Practice Training.

Figure 12: Australian Medical Training Pathways



Source: Adapted from Australian Medical Association (AMA). 'How to become a doctor'

Investing in rural university experiences

Regionalisation of medical schools

Concerns over a shortage of doctors and their distribution, led to an expansion of the number of medical schools. Since the early 2000s, increases in commencing medical Commonwealth Supported Places (CSPs) have been accompanied by health portfolio measures aimed at improving medical workforce distribution. This has included the introduction, from the early 2000s, of bonding schemes where a certain number, or proportion, of medical students in CSPs are offered a CSP that has a return of service obligation to work in areas of workforce shortage. For more information about bonded schemes, see section titled 'Enhancements to Bonded Medical Program'Enhancements to Bonded Medical Program

Some initiatives and measures were introduced through Council of Australian Government (COAG) decisions, including the last Commonwealth-state agreed increases in medical CSPs in 2006. Eleven universities graduated 1,335 doctors in 2006, and 19 universities graduated 2,777 doctors in 2012 and 3,637 doctors in 2019. A further three universities have recently begun offering medical degrees, but as of 2021 are yet to graduate their first medical students.[74].

Medical schools have traditionally been co-located with major teaching hospitals in capital cities. Their graduates learn to provide excellent care in similar settings, but are less prepared for work in rural primary care. To address this the Commonwealth and some jurisdictions, for example the NT, have invested in regional medical schools whose focus is on graduating doctors to work in their region. Two universities offer their medical school programs solely in regional areas: James Cook University based at Townsville; and University of Tasmania at Hobart (all of Tasmania is considered regional).

James Cook University was established in 2000 in northern Queensland with scope for new clinical training activity across local hospitals and other health service providers. It has published a body of evidence to support its claim of being Australia's most successful university in producing graduates who go on to rural and regional careers.

A further five universities offer their medical school programs in both a major city, and a regional location:

- Monash University: Melbourne (Remoteness Areas (RA)1), Churchill, Gippsland, Victoria (RA2);
- University of New South Wales: Sydney (RA1), Port Macquarie, New South Wales (RA2);
- Flinders University: Adelaide (RA1), Darwin (RA3);

74 Medical Deans of Australia and New Zealand (MDANZ), Student Statistics Table, https://medicaldeans.org.au/data/ accessed 8 September 2021

- University of Newcastle (UoN)/University of New England (UNE) – Joint Medical Program (JMP): Newcastle (RA1)75, Armidale (RA2); and
- University of Wollongong: Wollongong (RA1), Nowra (RA2).

The Commonwealth's $74.4 million investment (over four years) in the Murray-Darling Medical Schools Network (MDMSN) is enabling medical students to undertake the majority of their training in the Murray-Darling region of NSW and Victoria. Each year, from 2022, around 145 students per year will commence their medical school training, through the five rurally based medical school programs. For more information on the MDMSN see the section titled 'MDMSN'.Enhancements to Bonded Medical Program

Rural clinical placements

The Government has invested in RCSs and University Departments of Rural Health (UDRH) since the late 1990s. RCSs offer rurally based clinical education and training for medical students. RCSs offer placements of varying duration, with longer-term placements of a year or more common among students in more advanced stages of their medical degrees. A total of 21 RCSs were established between 2000 and 2015. Universities with more than one RCS consolidated these over time, resulting in a total of 19 RCS.

The UDRH program provides non-metropolitan education and training opportunities, including placements, to students across a range of health disciplines, including nursing, midwifery, dentistry, pharmacy, medicine and allied health. Its objective is to improve access to appropriate health services in rural and remote communities by promoting the education, training and professional support of Australia's rural health workforce. UDRHs also provide education, training and support for local health professionals and conduct research into rural and remote health issues, rural workforce development and service delivery models.

Since 2009-10, both programs have been part of the Rural Health Multidisciplinary Training Program (RHMT). Recent reforms and outcomes achieved by the RHMT program are outlined in the section titled 'R'.

The John Flynn Placement Program (JFPP) was another element of the strategy to provide rural primary care training opportunities. Originally referred to as the John Flynn Scholarship Scheme, it was established in 1997 as part of the long term strategy to attract more doctors to practise in remote and rural Australia and improve the quality of health care in these areas.

Initially the John Flynn Scholarship Scheme was delivered by universities. Since 2000, the JFPP has been managed by a national administrator, with three administrators carrying out this role over this time. The JFPP has offered medical students rural experience and

[75] University of Newcastle is also in the planning stages for transitioning 30 existing allocation of medical CSPs from their Newcastle (Callaghan) campus to a new campus in Gosford (RA1) to the full medical program from a new location.

connection to rural community through placements of two weeks each year over three or four years working alongside a rural doctor.

Although popular with students the JFPP has had high attrition rates, ranging between 20% - 30% for many years. Since becoming administrator in 2017, the Consortium of Rural Workforce Agencies (through a funding agreement with Health Workforce Queensland) have been addressing the attrition rate by supporting students to complete placements. While program data for 2020 and 2021 reflect the significant impact of the COVID-19 restrictions and border closures, preliminary analysis of the data indicates an increase in the number of combined placements (where a JFPP placement and a university clinical placement are undertaken together) credited to later-year students. This correlates with the competing priorities students face with university clinical placements and the heavy workloads in later years.

The RHMT program and the more recently established MDMSN (see section titled 'MDMSN') have become the key programs for supporting medical students to undertake medical education and training in rural Australia.

Through the RHMT program and the MDMSN, there are now many more opportunities for medical students to experience rural training than there were when JFPP commenced in 1997. Also, through the RHMT program, funding is provided to support both the National Rural Health Student Network (NRHSN) and 28 university Rural Health Clubs (RHCs) around Australia. The NRHSN is a national, rural health focused, multidisciplinary student network representing medical, nursing, and allied health students from the RHCs.

NRHSN and the RHCs promote rural health careers and encourage students who are interested in practising rural health care. The RHCs host a range of events and activities that provide rural health experiences and build relevant skills and knowledge. The activities also provide opportunities for professional inter-disciplinary learning as well as a social base for students interested in rural health.

In the 2021-22 Budget, the Government announced funding from the JFPP would be redirected further down the medical training pipeline to expand rural training opportunities for prevocational junior doctors. The new John Flynn Prevocational Doctor Program (JFPDP) will target prevocational doctors (postgraduate year (PYG) 1 – 5), supporting an additional 360 prevocational doctors to undertake rotations in rural primary care settings, and provide them with an opportunity to live and work in rural communities while they complete their medical training. The majority of intern and prevocational and vocational training positions are in public hospitals in metropolitan areas, meaning that rural interest and connections are frequently lost. The JFPDP is intended to provide rural training opportunities and exposure to a career in general practice for the next generation of doctors and to ensure the supply of junior doctor positions in primary care settings better meets projected demand in rural areas.

Information about further reform and investment announced in the 2021-22 Budget is in the section titled 'Further reform and investment: J'.

Investing in a rural training pathway beyond university

The 2013 Mason Review highlighted that the investment in rural university training was compromised by a lack of rural training opportunities after graduation, commencing with compulsory internship years for doctors which were primarily undertaken in metropolitan settings. Mason observed that the lack of a clear pathway from undergraduate rural training into employment as a rural doctor as a key reason why students who are interested in rural health are regularly lost to the metropolitan health system.

As part of the 2015-16 Mid-Year Economic and Fiscal Outlook (MYEFO), the Government announced the Integrated Rural Training Pathway (IRTP), comprising three linked components:

- The formation of up to 30 regional training hubs;
- A new rural junior doctor training innovation fund (RJDTIF) to deliver general practice rotations for junior doctors training in rural areas; and
- Support for 100 places on the Specialist Training Program (STP) targeted to rural areas.

Regional Training Hubs (RTHs) were introduced as a new element of the RHMT in 2017 to join up rural training pathways. Their role included support to doctors to complete as much of their specialist training as possible in rural and regional areas, supporting students to undertake early career rural training, supporting health services to accredit new training posts and supporting local health professionals to become clinical supervisors.

Early exposure to primary care for junior doctors

The Prevocational General Practice Placement Program (PGPPP) was established as a training program under section 3GA of the HIA in 2005. The program provided short-term, voluntary, supervised placements in general practice settings for junior (prevocational) doctors. The program aimed to encourage junior doctors to consider general practice and/or rural and remote medicine as a career option, by providing early career exposure to primary care. It provided:

- Funding to hospitals to compensate them for releasing junior medical staff to do primary care rotations, and 'back-fill' their temporarily vacant positions;
- Funding for junior doctors' salary; and
- Funding for the clinical supervision needed for junior doctors starting out in general practice. GP supervisors observed PGPPP participants and reviewed each of their patients with them, so ensuring patient safety and active learning through practice for junior doctors.

The PGPPP was initially run by the GP colleges, but then it was transferred into General Practice Education and Training Ltd (GPET) in 2010 and was administered by the Regional Training Providers (RTP) for 380 placements per year. RTPs arranged placements and

oversaw their quality. Practices were encouraged to develop as vertically integrated teaching sites and many welcomed ex-PGPPP juniors back as GP registrars in subsequent years. From 2011, GPET was asked to arrange 910 placements per year[76].

The Mason review in 2013 found that PGPPP cost an annual equivalent of $218,000 per trainee, compared with around $60,000 a year to train a general practice registrar under the AGPT program[77].

Therefore, when demand for AGPT places grew, the funding from PGPPP was redirected to significantly expand AGPT training places. From 1 January 2015, the number of AGPT training places was increased from 1,200 to 1,500 per year.

However, the Mason Review (2013) considered early career primary care experiences as key to an integrated rural training pathway. Mason and Independent Expert Panel (2015) both recommended implementing a more cost effective and sustainable approach for providing such early career primary care experiences to junior doctors.

As a result, the RJDTIF replaced the PPGPPP. The RJDTIF was welcomed by those practices involved but does not provide the same level of funding to enable GP supervisors to provide such intensive supervision of juniors. It is limited to rural areas and at present provides places for fewer doctors. In response to advocacy regarding the importance of junior doctor experience in general practice, more places are being funded.

Information about further reform and investment announced in the 2021-22 Budget is in the section titled ‘Further reform and investment: J’.

Other training reforms

Transition to College-led training

In the 2014–15 budget, the *Rebuilding general practice education and training to deliver more GPs* measure closed GPET, transferring its functions to the Department of Health. It also increased the number of GP training places to 1,500 places by reallocating PGPPP places, as outlined as above. In 2017, Minister Hunt announced that the responsibility for Commonwealth funded GP training programs would transfer from the Department to the GP colleges (the ACRRM and the RACGP) by 2022 with transition support for the GP colleges funded in 2018 as part of the 2018–19 Budget Measure *Stronger Rural Health – Training - Streamlining General Practice to produce Australian trained general practitioner where they are needed*.

There has been an increased number of registrars training in MM2-7 areas given the requirement under the AGPT that 50 per cent of training is undertaken in MM2 – 7 areas. The map provided at Appendix H: Active Trainees 2019 shows the placement of registrars across Australia in 2019.

[76] Auditor-General (2011),”Audit Report No. 34 2010-11 Performance Audit: General Practice Education and Training Limited”, Australian National Audit Office, Commonwealth of Australia
[77] Mason, J (2013) Review of Australian Government Health Workforce Programs, Chapter 3.

Despite increased training in rural and remote areas, this has not led to a retention of AGPT registrars to these areas after training.

Figure 13: MBS Services in rural location (MM3+), before and after fellowship (2011 – 2018)

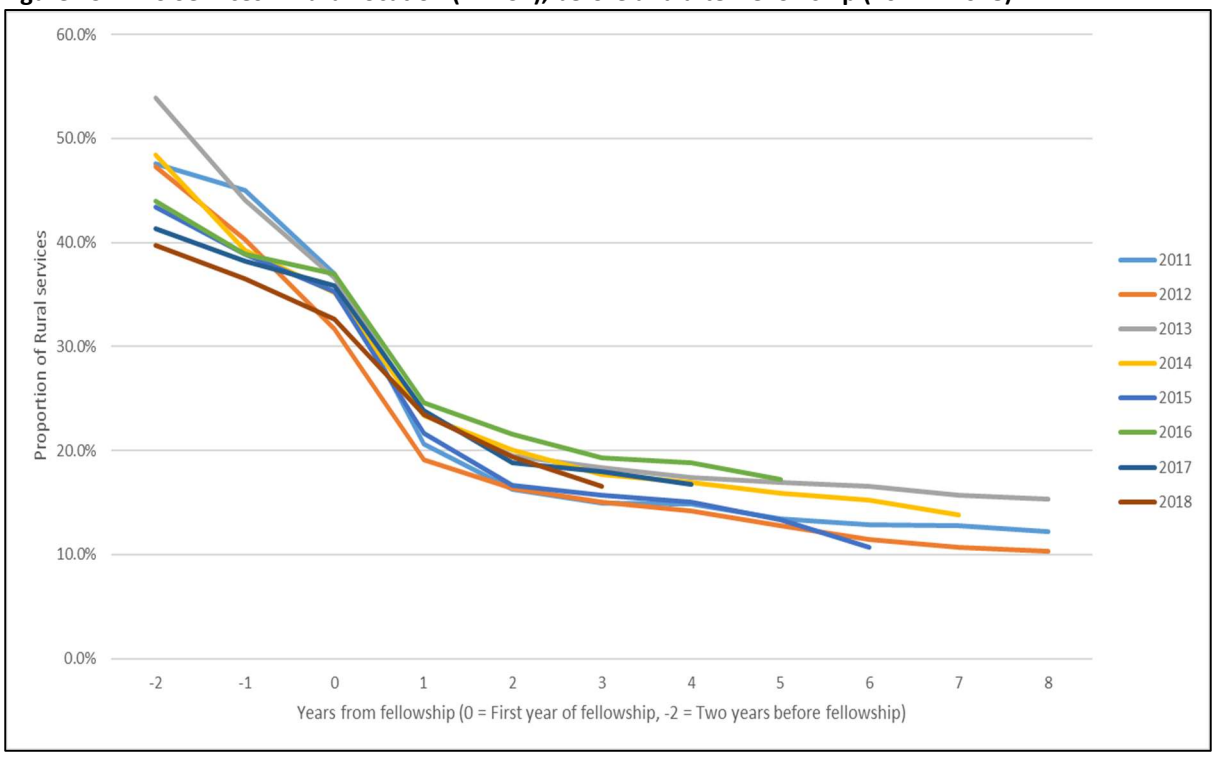
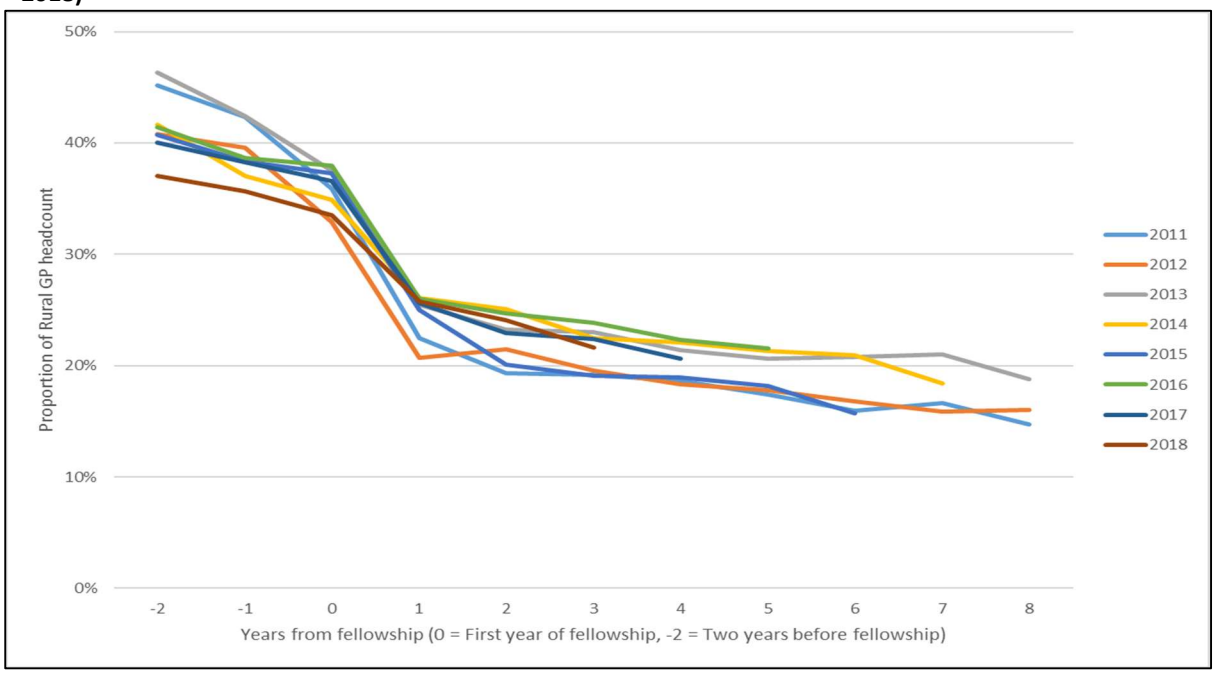


Figure 14: Headcount (based on Primary MMM) in rural location (MM3+), before and after fellowship (2011 – 2018)



AGPT is currently delivered through a network of Regional Training Organisations (RTOs) contracted directly by the Department. At the start of the 2021 training year, the AGPT had 5,457 registrars training towards GP fellowship qualifications. The 2021 funding for the AGPT program includes approximately $192 million p.a. that is provided to RTOs, and a

further $8 million paid to the GP Colleges to fund transition activities. The transition of the AGPT to a college-led model will bring general practice into alignment with other medical speciality colleges who have responsibility for their medical education and training.

Transition to a college-led training model provides opportunity to reform the GP training system. A GP training outcomes framework has been developed through sector consultation and outlines the outcomes expected for the community's significant investment in GP training. The training sector has also been instrumental in progressing work towards a nationally consistent payments model which seeks to achieve transparency and consistency for the payments made to registrars, supervisors and training practices. The model aims to encourage training in rural and remote locations by tiering payments for training undertaken in these regions and provide funding to registrars to assist with increased training costs.

The Government has been working closely with the GP Colleges – ACRRM and RACGP – on the transition to a college-led model. To date the Department has successfully transitioned the marketing, selection, education research and administration of the policies for the AGPT program to the GP colleges[78].

Training and programs targeting outer metropolitan areas

The Government has introduced a number of programs to increase the primary care medical workforce in outer metropolitan areas.

GP trainees on the general pathway of the AGPT program are required to work in outer metropolitan areas or AMSs as part of their training, while bonded medical scholars participating in some schemes can complete their return of service obligations by working in outer metropolitan areas.

The Outer Metropolitan Other Medical Practitioners Program (OMOMPS) allowed non-vocationally recognised GPs working in outer metropolitan areas to receive Medicare rebates at the higher vocationally recognised rate. The program was closed to new participants from 1 January 2019, to encourage doctors to attain fellowship.

Other approaches to primary care

Primary care in smaller hospitals: Section 19(2) Exemption Initiative

Many patients in small rural and remote towns have limited access to primary health care services. Where a community is not able to sustain private practices, many rural and remote public hospitals have employed medical officers to make traditional GP services available.

The COAG Section 19(2) Exemption Initiative – *Improving Access to Primary Care in Rural and Remote Areas* (the Initiative), introduced in February 2006, supports the provision of primary health care delivered in rural and remote public hospitals and health services in

[78] Department of Health, Transition to College-Led Training Advisory Committee Communiques, https://www.health.gov.au/committees-and-groups/transition-to-college-led-training-advisory-committee#communiques

small communities by granting states and territories conditional access to Commonwealth funding through the MBS for eligible services by approved eligible sites.

Services that can be provided under the Initiative include professional non-admitted, non-referred services (including eligible nursing and midwifery services) and eligible allied health and dental services. The Initiative seeks to assist with the challenges in attracting and retaining an adequate primary health care workforce, including nurses, in these areas.

Eligible sites must be located in areas 5 to 7 of the MMM classification system and must provide written evidence of consent and support from:

- the local PHN;
- local General Practitioners and health professionals; and
- the relevant state or territory government.

Participating jurisdictions each enter into a bilateral Memorandum of Understanding (MoU) with the Commonwealth and submit applications for sites based on participation criteria. Operational plans are developed in consultation with primary healthcare providers and participating jurisdictions are required to submit an annual report on each site's activities to the Department.

All jurisdictions participate except Tasmania. As at 18 August 2021, there are currently 126 active sites.

An independent evaluation of the Initiative commenced in December 2020 and is currently being reviewed through a consultation with participating jurisdictions.

The recommendations of the evaluation, subject to Ministerial agreement, are expected to inform the development of the new MoU with jurisdictions, noting the current MoU expires on 31 December 2021.

Outreach services for smaller communities

While policy efforts are primarily focused on supporting primary health care professionals to live and work in regional, rural and remote Australia, the Government recognises that in very remote locations, visiting services may be the most viable (and in some cases only) way to deliver health care.

The RFDS

The Government has funded the RFDS since the 1930s. The RFDS program aims to support people living, working and travelling in rural and remote areas of Australia by ensuring access to emergency primary aeromedical evacuations and other essential primary health care services where there are few or no other services.

It delivers sustainable, flexible, effective and efficient services to people in areas beyond the normal medical infrastructure in locations of market failure by providing access to:

- Primary Aeromedical Evacuations
- Primary Health Clinics, including GP, nursing and allied health services

- Remote Consultations (via telephone / videoconference link)
- Medical Chests (containing essential emergency medical supplies).

More information on funding provided to the RFDS as part of the Stronger Rural Health Strategy is available in section 'Delivering care in very remote locations - '.

Rural Health Outreach Fund

The Rural Health Outreach Fund (RHOF) aims to improve access to GPs and other medical specialists, allied and other health providers in rural, regional and remote areas of Australia by funding outreach activities that are prioritised according to community needs. The RHOF increases the range of services available in communities by removing the financial disincentives that create barriers to outreach service provision, including subsidising the costs of travel, facility hire, and equipment leasing.

In 2019-20, 206,797 patients used RHOF services. The Government is investing $115.11 million in the program over four years from 2020-21 to 2023-24.

There are four health priorities under the RHOF: maternity and paediatric health, eye health, mental health and support for chronic disease management. The RHOF is administered by jurisdictional fund-holder organisations, which are responsible for needs assessment, service planning and delivery of outreach health services.

RHOF fundholders plan and prioritise service delivery in consultation with a wide range of stakeholders in an Advisory Forum. Each Advisory Forum evaluates all proposals presented by the fundholder and endorses those proposals that meet both the priorities of the RHOF and the needs of the proposed locations.

The RHOF supports a service delivery model that includes a multidisciplinary team-based approach in delivering services. Multidisciplinary teams may consist of GPs and other specialists, allied health professionals, midwives, and nurses. It should be noted that the RHOF's scope includes, but it not limited to, primary care.

The RHOF was announced in the 2011-12 Budget, with funding coming from the consolidation of five ongoing programs into a larger, flexible program. This consolidation aimed to cut red tape for grant holders, increase flexibility, and more efficiently provide evidence-based funding for the delivery of health outcomes in the community.

An evaluation of the RHOF is currently being undertaken. It is expected to be completed in mid-2023.

The Government also funds outreach services to deliver optometric services in remote and very remote locations. See Appendix B: List of Primary Care Programs for a description of the Visiting Optometrists Scheme.

Workforce relief: Rural Locum Assistance Program

Allowing the health workforce to take breaks for recreation or professional development is essential to maintaining high quality and sustainable services. For rural primary care

professionals, taking a break can be particularly difficult, as limited numbers of health professionals may leave patients unable to access services.

The Rural Locum Assistance Program (RLAP) enhances the ability of nurses, allied health professionals, general practitioners and specialists to take leave or undertake continuing professional development (CPD) by providing targeted locum support in MM2-7 locations.

An additional $25.1 million (GST exclusive) over three years was announced as part of the 2021-22 Budget to expand the RLAP to provide rural and regional aged care providers with access to a highly skilled surge workforce to ensure continuity of care and strong clinical leadership. This announcement also included an incentive scheme for permanent aged care placements to increase staff retention in regional and remote areas. It is expected that these services will be available in early 2022.

The intended outcomes of the RLAP aged care program are:

- rural and remote aged care consumers experience continuity of care and clinical leadership;
- rural and remote aged care providers experiencing high turnover or sudden departures of staff are able to:
    - access a temporary surge workforce while they recruit; and/or
    - attract permanent staff
- new staff are available, suitable, and well prepared to undertake a locum placement or permanent relocation.

In 2020-21, there were a total of 752 locum placements. These placements accounted for 14,566 locum days across Australia. Most locum placements were for nurses (565), followed by allied health (114). There were 36 locum placements were for GP obstetricians and GP anaesthetists.

This compares to 746 placements in 2019-20, which accounted for 13,280 locum days across Australia. In 2019-20, the program funded:

- 11,192 nursing and midwifery locum days
- 1,501 allied health locum days
- 176 GP obstetrician locum days
- 221 GP anaesthetist locum days
- 190 specialist obstetrician/anaesthetist locum days[79].

The RLAP is an ongoing program with an annual appropriation of more than $11 million. The program commenced on 1 April 2016 and consolidated three separate programs. The programs were consolidated to reduce the number of funded organisations and associated

79 Elements of the RLAP, such as obstetrics and anaesthetics, extend beyond primary care.

overheads and to reduce administrative red tape for doctors, specialists and allied health professionals that own and operate businesses in rural Australia seeking locum services.

An evaluation of the program is planned for 2021-22.

After hours primary care

After hours primary health care is used by people whose health condition cannot wait for treatment in regular hours and is an important part of a high quality health care system. It should not be a substitute for primary health care that could otherwise occur 'in hours'.

Across the country, availability and access to after hours services varies considerably, with different arrangements across PHNs, states and territories. Both the Commonwealth and states/territories invest considerable resources to meet after hours demand and reduce pressure on hospital emergency departments.

In urban areas GPs may provide on-call services for their own patients, particularly those who are being palliated through their final stages of life. The majority of medical after hours care is delivered by medical deputising services or through after hours clinics, although some of the services report that this model now may be changing following the introduction of widely used Medicare telehealth items in 2020. Most primary care nursing and allied health professionals provide services during regular hours not after hours. Similar arrangements occur in large regional centres.

In rural areas GPs are usually expected to provide after hours care for patients of their practice, those in residential aged care facilities and via a roster for the rural hospital's emergency department. Nurses staff small rural hospitals and triage patients deciding whether to call in the local GP. There are examples of paramedics being employed to be the first responders to urgent after hours primary care as well as more serious emergencies.

In very remote areas, calls are usually taken by remote area nurses with off-site medical back-up. In serious emergencies medical staff who happen to be onsite are called in to assist.

Commonwealth after hours funding arrangements include different MBS rebates for antisocial hours, the PIP After Hours Incentive, funding for PHNs to support locally tailored after hours services, and the Healthdirect After Hours GP helpline, supported by a Nurse Triage Helpline providing people with 24/7 access to health information and advice.

PIP After Hours Incentive[80]

The PIP After Hours Incentive supports general practices to provide patients with appropriate access to after hours care. The PIP After Hours Incentive has five payment levels, and is available to eligible general practices registered for the PIP.

Practices in rural and remote areas are able to claim the highest tier of support if the practice provides after hours care to their patients in the complete after hours period (hours

80 Department of Health, After Hours Primary Health Care, https://www1.health.gov.au/internet/main/publishing.nsf/Content/primary-ahphc.

outside of 8am to 6pm weeknights; hours outside of 8am to 12pm Saturdays; and all day Sundays and public holidays).

PHN After Hours Program

The PHN After Hours Program supports PHNs to plan, coordinate, support and commission population-based after hours health care services. The program focusses on addressing gaps in after hours service provision and improving service integration in communities. In 2021-22 the Government is providing $71 million to 31 PHNs to address after hours primary health care needs in their regions.

This aims to reduce reliance on Emergency Departments during the after hours period. Approaches adopted by PHNs, particularly in outer metro, regional and rural areas, include:

- funding urgent-care centres or after hours clinics in areas where there is little or no service provision;
- improving patient pathways and streamlining systems to direct patients to appropriate care;
- providing support to medical deputizing services to make it viable for them to operate outside of major urban areas; and
- supporting alternative service providers, such as pharmacies, to extend their hours.

Healthdirect After Hours GP advice and support line

The After Hours GP helpline is funded by the Government and was established in 2011. The helpline is a telehealth service, offering GP telephone advice and diagnostic services to the general public; and is accessed through the Health Information Advice Service (HIAS) Nurse Triage Line. These helplines are complemented by the Pregnancy Birth and Baby service which provides information to expecting parents and parents of children from birth to 5 years of age, via maternal child health nurses who are also midwives. These Healthdirect services draw on information from the National Health Services Directory (NHSD), and directs callers to the most appropriate local services, including alternatives to visiting emergency departments in major cities.

The call lines are supported by digital tools such as the Healthdirect website, symptom checker, service finder and Healthdirect app to help people make informed health decisions.

The After Hours GP helpline provides support to those who seek after hours medical advice and aims to ensure unnecessary presentations to hospital emergency departments, and to better enable integration with other primary care services.

AMDS program[81]

The AMDS program allows GPs to deputise after-hours care for their patients to alternate service providers. Approved participants are granted access to Medicare rebates for

81 Department of Health, Approved Medical Deputising Service (AMDS) Program, https://www1.health.gov.au/internet/main/publishing.nsf/Content/approved-medical-deputising-service

providing primary care to patients in their home, or in residential aged care facilities through an AMDS provider. This care availability can reduce the need for patients to attend an emergency department for after-hours care.

The AMDS program also offers non-VR doctors the opportunity to gain general practice experience and doctors restricted under section 19AB of the HIA the opportunity to provide Medicare eligible services in non-DPA areas. Participants are granted access to Medicare benefits for providing deputising services to the community through an AMDS.

High quality, efficient and responsive primary care: reforms to governance and delivery structures

The efficient delivery and governance of primary care is challenged by the mechanisms of funding and the allocation of responsibilities. Primary care professionals are mostly employed or self-employed in private practice. As such they can choose where, when and how they wish to work. Their responsibilities are to ensure their practice is up to date and within the expected standards set by the profession.

High quality care through regulation of health professions

Health professional regulators seek to ensure the community receives high quality, safe and responsive care. They are responsible for checking practitioners qualifications, ability to communicate in English, professional indemnity, criminal history and continuing professional development. Reforms to the way health professions are regulated have been implemented since 2009 to improve access and quality.

Health professional registration

The National Registration and Accreditation Scheme (NRAS) was established through an intergovernmental agreement and a system of applied laws where jurisdictions apply one nationally agreed law, with modifications necessary for the efficient application of the Scheme. The National Law is hosted in Queensland and is implemented largely by reference legislation in each state and territory.

Prior to the commencement of the NRAS, the regulation of medical practitioners was managed by each state individually. Jurisdictions convened their own registration bodies and administered separate regulation of the medical profession. This created gaps where practitioners were expected to seek registration in multiple jurisdictions based on their practise habits and characteristics. This impost was costly to practitioners working in border towns or those who travelled extensively in rural and remote communities. State based registration also meant that regulators needed to share information about individual practitioners in order to ensure patient safety.

The *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* was signed by all heads of government in 2008 and the *Health Practitioner Regulation National Law* was implemented in each jurisdiction commencing in 2009, formally establishing the National Scheme.

The Australian Health Practitioner Regulation Agency (Ahpra) provides support to the national boards in administering the NRAS. The Objectives of the National Scheme are:

a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction;
c) to facilitate the provision of high quality education and training of health practitioners;
d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The scheme started in 2010 and now covers 15 professions[82]:

- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners
- chiropractors
- dental practitioners
- medical radiation practitioners
- medical practitioners
- nurses and midwives
- occupational therapists
- optometrists
- osteopaths
- paramedics
- pharmacists
- physiotherapists
- podiatrists
- psychologists.

82 Department of Health, National Registration and Accreditation Scheme, National Registration and Accreditation Scheme. Available: https://www.health.gov.au/initiatives-and-programs/national-registration-and-accreditation-scheme.

Requirements for continuing professional development

Each profession sets out the expected standards for CPD. For doctors the changes to be introduced are more specific on the types of activity that are required, but it is mostly up to their professional judgement which topics or content to cover.

GP colleges set out requirements for continuing membership. RACGP members must demonstrate competency in cardio-pulmonary resuscitation every three years. ACRRM requires members to provide evidence of advanced resuscitation skills, and there are specific requirements for doctors who have qualifications in procedural skills such as obstetrics and gynaecology, anaesthetics and surgery to maintain their competency.

Key changes in the Medical Board of Australia's (MBA) revised CPD registration standard include the exemption of interns and second year postgraduate (PGY2) doctors from CPD requirements, counting participation in specialist training programs as CPD activities, mandating at least half of the minimum CPD activities be focused on reviewing performance and measuring outcomes and the introduction of CPD Homes.

The introduction of CPD Homes will allow medical practitioners to participate in CPD programs offered outside of their specialist college. This measure will provide health practitioners with greater choice and the flexibility to seek CPD programs more relevant to their particular scope of practice. All CPD Homes must be approved by the Australian Medical Council and may include universities and other medical education providers.

Professions outside Ahpra

Multiple primary care professional groups are not part of NRAS. Some of these, such as speech pathology and social work, work in teams alongside the registered health professions. A larger cohort work more independently and offer services that are valued by patients, but do not, or have not been assessed, as meeting the criteria for effectiveness set by allopathic medicine. Examples in this group are naturopathy, homeopathy, massage therapy, myofascial therapy and Ayurveda.

In 2015 COAG agreed to the terms of the first National Code of Conduct, also referred to as the National Code or code-regulation regime. Its purpose is to protect the public by setting minimum standards of conduct and practice for all unregistered health care workers who provide a health service. It sets national standards against which disciplinary action can be taken and if necessary a prohibition order issued, in circumstances where a health care worker's continued practice presents a serious risk to public health and safety. Each state and territory is responsible for implementation of the National Code of Conduct.[83]

Professional indemnity

It is a condition of health professional registration for practitioners to have professional indemnity insurance in case of a claim against them of negligence. Insurers offer education to try to improve practitioners' practice and reduce their risk of claims. In most cases this

83 Health Council, National Code of Conduct for health care workers, https://www.coaghealthcouncil.gov.au/NationalCodeOfConductForHealthCareWorkers.

operates as a voluntary system. Practitioners who have recurrent claims or a poor claims history can be directed to education in order to maintain their insurance. Very occasionally a practitioner with a high claims history will be unable to find insurance, in which case their registration is ceased.

Unrestricted license to trade

Once health professionals have met the requirements for qualification of their profession, are registered with Ahpra, and indemnified, most health professionals are free to practice in any geographic location.

The exceptions to this are:

- Bonded medical scholars;
- International medical graduates and foreign graduates of accredited medical schools within the first ten years following their medical registration in Australia and subject to 19AB (see section titled 'Section 19AB of the ' for more information on 19AB);
- Community pharmacists; and
- GP trainees.

Ongoing debate: Government levers to influence location of practice

The idea of rural Medicare provider numbers has long been suggested as a mechanism to correct the maldistribution of the GP workforce. Under this system, provider numbers would only be available to allow practitioners to provide Medicare-eligible services in a specified rural geography. Analysis of MBS data within GP catchments in HeaDS UPP reveals GPs tend to work in more affluent areas. For example, in MM1 areas of South Australia, there are 12.2 GP services claimed to MBS per capita in the catchment of Norwood, Payneham and St Peters, and a GP full time equivalent (per 100,000 population) of 219.1. This compares with the 4.1 GP services claimed to MBS per capita in the catchment of West Torrens (just south of the airport) and a 70.9 GP full time equivalent.

Proponents of geographical provider numbers argue that this policy would direct GPs to the areas of Australia most in need. Doctors would be unable to obtain a Medicare provider number to work in areas that were already well supplied. Instead, they could choose not to work in an area of medicine that is dependent on MBS access, or would move to areas where they could work and their patients could access MBS rebates.

There are financial and health benefits from preventing practitioners from setting up in areas that are already well-serviced. The MBS is uncapped and there are concerns that oversupply of practitioners leads to more services being delivered but with diminishing returns in improved health outcomes for investment. At worst oversupply leads to over-servicing, over-diagnosis and over-treatment which causes patients harm, whilst leaving other patients without access to essential services, leading to higher morbidity and preventable hospital admissions.

Further consideration would need to be given as to whether Medicare legislation could restrict the issuing of provider numbers to certain locations, noting that Medicare provides rebates to *patients* to assist with the costs of medical services. It does not provide payments to doctors, except where the patient assigns their Medicare benefit to a doctor (bulk billed services). There may be significant practical and legal issues in implementing such a policy.

Comparable initiatives have been used without success in provinces across Canada, where a government decision to apply restrictions on billing numbers across urban and rural regions within a Canadian province was reversed, and the focus of health workforce programs shifted to a rural recruitment strategy and better resources for doctors. Decades of evidence from Australian government funded rural workforce programs indicates that the most successful outcomes are delivered by providing well supported, positive training and working experiences in rural communities, rather than mandating rural work.

As a consequence, the Government's current policy is to encourage Australian trained doctors to choose to live and work in less serviced areas through:

- Teaching and training doctors in underserved areas, giving them the skills and supports needed for future work in such areas under supervision
- Incentives for doctors and their partners/families to settle in underserved areas.

Reforms to increase quality and efficiency of service delivery

A large proportion of GPs' income, and the costs they generate through referrals, prescriptions, pathology and diagnostic imaging are met by the Commonwealth government through revenue derived from taxation. The Commonwealth seeks to ensure its funding provides equitable access to quality care, but tries to achieve this through influencing independent professionals.

Primary care health professionals work in four main business models:

- AMSs that employ health professionals in their clinics;
- Small private business, usually owned and managed by a health professional;
- Larger corporate businesses; and
- Government run clinics.

The degree of professional autonomy varies in each business model. AMSs have key performance indicators set by the funding government department. Employed health professionals are expected to work within the remit of their own profession and follow protocols and guidelines set by the AMS to achieve their performance targets. A similar mix of professional autonomy and organisational oversight is seen in government run clinics.

The twin aims for small private businesses and corporate practices are excellent professional care and business viability. This can lead to business decisions to focus on more financially rewarding aspects of practice, and reduction of work that can run at a loss for the

clinic, such as visiting elderly patients at home. The degree of clinical governance in small private and larger corporate practices varies, ranging from complete professional independence to close scrutiny of practitioner billing and practice, with some practitioners being set billing targets and others being audited for the quality of care in certain conditions.

The next section describes key Commonwealth initiatives designed to influence the quality and efficiency of service delivery by a sector largely made up of private businesses.

Influencing quality and efficiency through the MBS

The MBS sets fees for individual medical services, including a description of the service the item provides a rebate for. The schedule is informed by the best available evidence of effectiveness of different clinical activity. General practices are private businesses and have different models of care for their patients and will have different patterns of MBS billing.

Similarly, optometrists claim MBS items for their services in screening people for eye diseases and making recommendations regarding their treatment, and prescriptions for refractive errors.

In recognition that it is possible for practitioners to focus their MBS claims on financial, rather than clinical grounds, the Department runs a range of initiatives such as education, targeted campaigns and audits. The Department also runs the Professional Services Review (PSR) Scheme. The PSR protects patients and the community from the risks associated with inappropriate practice, and protects the Commonwealth from having to meet the cost of medical / health services provided as a result of inappropriate practice. This includes inappropriate practice resulting in payment of an MBS rebate.

Ongoing MBS reforms to influence safety, quality and efficiency

Reforms to the MBS continue to be an important way to influence the quality and efficiency of care.

The Government has long recognised the capability of telehealth services to contribute to improved access to care, and health outcomes of patients. Since 2011, the Government has gradually increased the range of MBS telehealth services available, specifically for video conferencing to support:

- consultations by specialists, consultant physicians and psychiatrists for patients: residing outside major cities; within aged care facilities; and of AMSs (introduced in 2011);
- patients clinically at their end of video consultations with specialists or consultant physicians when the patient does not live in a metropolitan area (2011); and
- GP and allied mental health services for patients in rural or remote locations (2017), or in areas affected by natural disaster (2019).

For information about telehealth items introduced in response to the COVID-19 pandemic, refer to the section titled ‘Telehealth reforms’.

Between 2015 and 2020, the MBS Review Taskforce looked at more than 5,700 MBS items, including primary care items, to see if they needed to be amended, updated or removed. It identified services that were obsolete, outdated or potentially unsafe[84].

The taskforce completed its work on 30 June 2020. It has sent almost 1,400 recommendations to the Government for consideration.

The Government began responding to taskforce recommendations in 2016. Through Budget cycles it has progressively announced changes to the MBS arising from taskforce recommendations. As at July 2021, the Government has:

- agreed to 811 taskforce recommendations
- implemented more than 580 recommendations, involving changes to over 3,000 MBS items.

Recent primary care changes announced in the 2021-22 Budget include new case conferencing items for allied health professionals who participate in case conferences organised by a patient's GP.

[84] Department of Health, Medicare Benefits Schedule (MBS) Review, https://www.health.gov.au/initiatives-and-programs/mbs-review

Medicare rebate indexation

An indexation pause was introduced in the 2013–14 Budget until July 2014, to realign the indexation of MBS fees to the financial year in line with many other Government programs. In MYEFO 2014–15, the pause on indexation was extended.

Timeline of indexation pause and reintroducing annual indexation for MBS items[85]

2013-14 Budget: Indexation pause from November 2013 to June 2014, to align MBS indexation with other Government indexation

2014-15 Budget: Specialist and allied health fee indexation paused from 1 July 2014 to 1 July 2016

2014-15 MYEFO: Indexation of all MBS fees paused until 1 July 2018

2016-17 Budget: Indexation of all MBS schedule fees paused until 1 July 2020

2017-18 Budget: Phased reintroduction of MBS fee indexation

- 1 July 2017: GP bulk billing incentives
- 1 July 2018: standard GP consults and specialist attendances
- 1 July 2019: procedures and therapeutic services, allied health

2019-20 Budget:

- Indexation of other GP services brought forward a year (from 1 July 2020 to 1 July 2019)
- Indexation of targeted diagnostic imaging services

1 July 2017: GP bulk billing incentives indexed

1 July 2018: Standard GP consultations and specialist attendances indexed

1 July 2019: Procedures and therapeutic services, allied health indexed

1 July 2019: All GP services indexed

1 July 2020: Targeted diagnostic imaging services indexed

In the 2017-18 Budget the Government announced a $1 billion commitment to the phased re-introduction of indexation of MBS rebates.

Indexation commenced on 1 July 2017 with increases to GP bulk-billing incentives and on 1 July 2018 for standard GP consultations and specialist attendances. These items have been indexed on 1 July in every year since then. Specialist procedures, allied health services and all other GP services were indexed from 1 July 2019. Diagnostic imaging fees for targeted items have included annual indexation since 1 July 2020. The diagnostic imaging items that have been targeted for indexation represent more than 90% of diagnostic imaging service volume.

The following figures and tables present MBS data for the last decade on measures that provide insight on any impacts of changes to annual indexation of MBS claims, noting that this is one of many factors that may influence price, access and providers' and patients' behaviour. Additional related MBS data is also included in Appendix C: MBS data relating to changes to annual indexation of MBS items

All MBS - Benefits per service

Data shown are: total MBS benefits per service for all BTOS, based on date of processing (DOP), financial year (2011-12 to 2020-21) and per patient MMM region (1-7, and National Average)

Figure 18: Average MBS benefit per service by MMM

85 2013-14 Budget: p177, https://archive.budget.gov.au/2013-14/bp2/BP2_consolidated.pdf
2014-15 Budget: p139, https://archive.budget.gov.au/2014-15/bp2/BP2_consolidated.pdf
2014-15 MYEFO, p166: https://archive.budget.gov.au/2014-15/myefo/MYEFO_2014-15.pdf
2016-17 Budget, p108: https://archive.budget.gov.au/2016-17/bp2/BP2_consolidated.pdf
2017-18 Budget, p109: https://archive.budget.gov.au/2016-17/bp2/BP2_consolidated.pdf
2019-20 Budget, p89: https://archive.budget.gov.au/2019-20/bp2/download/bp2.pdf
MBS Indexation schedule:
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-MedicareIndexationSchedule

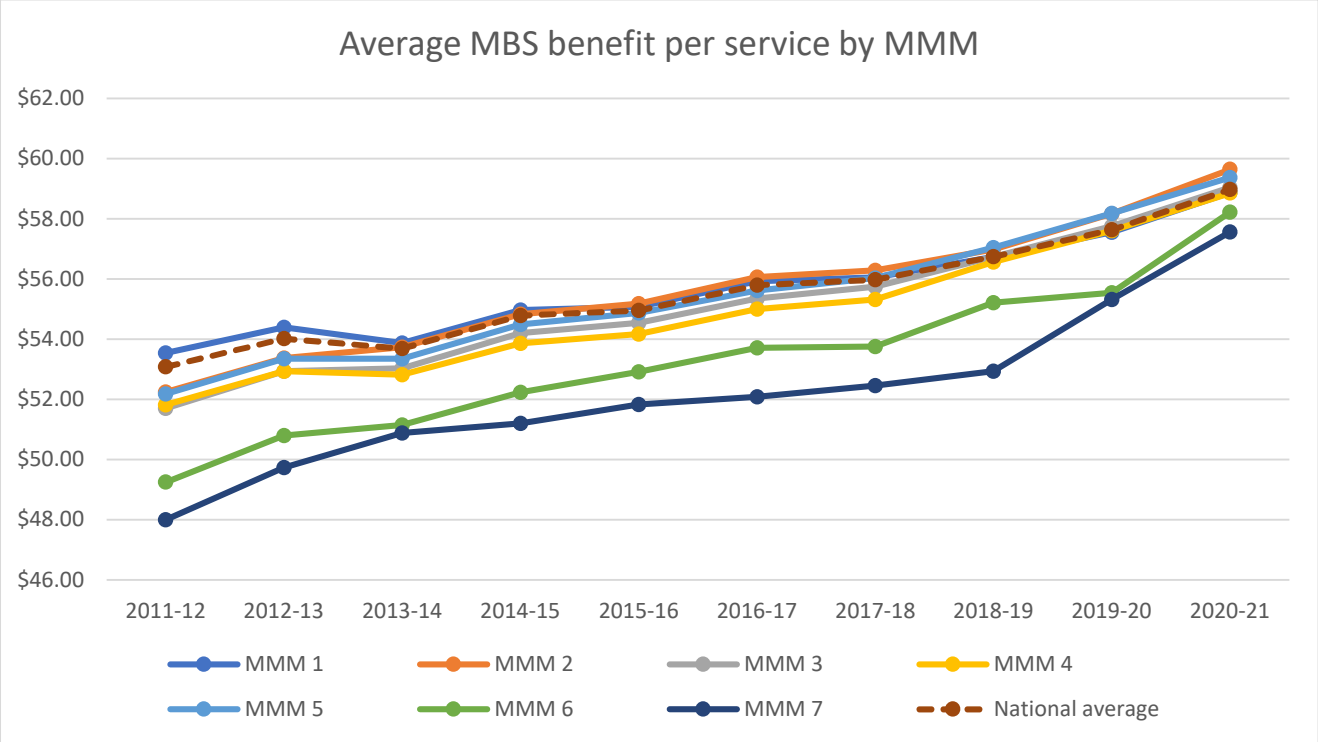


Table 5: Average MBS benefit per service by MMM

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	$53.54	$52.25	$51.70	$51.82	$52.18	$49.25	$48.00	$53.08
2012-13	$54.39	$53.37	$52.94	$52.93	$53.35	$50.79	$49.74	$54.02
2013-14	$53.87	$53.73	$53.03	$52.81	$53.35	$51.15	$50.88	$53.69
2014-15	$54.97	$54.82	$54.20	$53.85	$54.49	$52.23	$51.20	$54.78
2015-16	$55.07	$55.18	$54.54	$54.17	$54.87	$52.91	$51.83	$54.96
2016-17	$55.92	$56.07	$55.35	$54.99	$55.61	$53.71	$52.09	$55.80
2017-18	$56.05	$56.29	$55.74	$55.32	$56.03	$53.75	$52.46	$55.98
2018-19	$56.74	$56.97	$56.73	$56.56	$57.04	$55.21	$52.93	$56.74
2019-20	$57.55	$58.17	$57.76	$57.60	$58.18	$55.54	$55.31	$57.64
2020-21	$58.88	$59.64	$59.04	$58.86	$59.37	$58.22	$57.57	$58.98

GP non-referred attendances - Benefits per service

Data shown are: total MBS benefits per service for GP non-referred attendances, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average)

Figure 19*:* Average MBS benefits per service for GP non-referred attendances

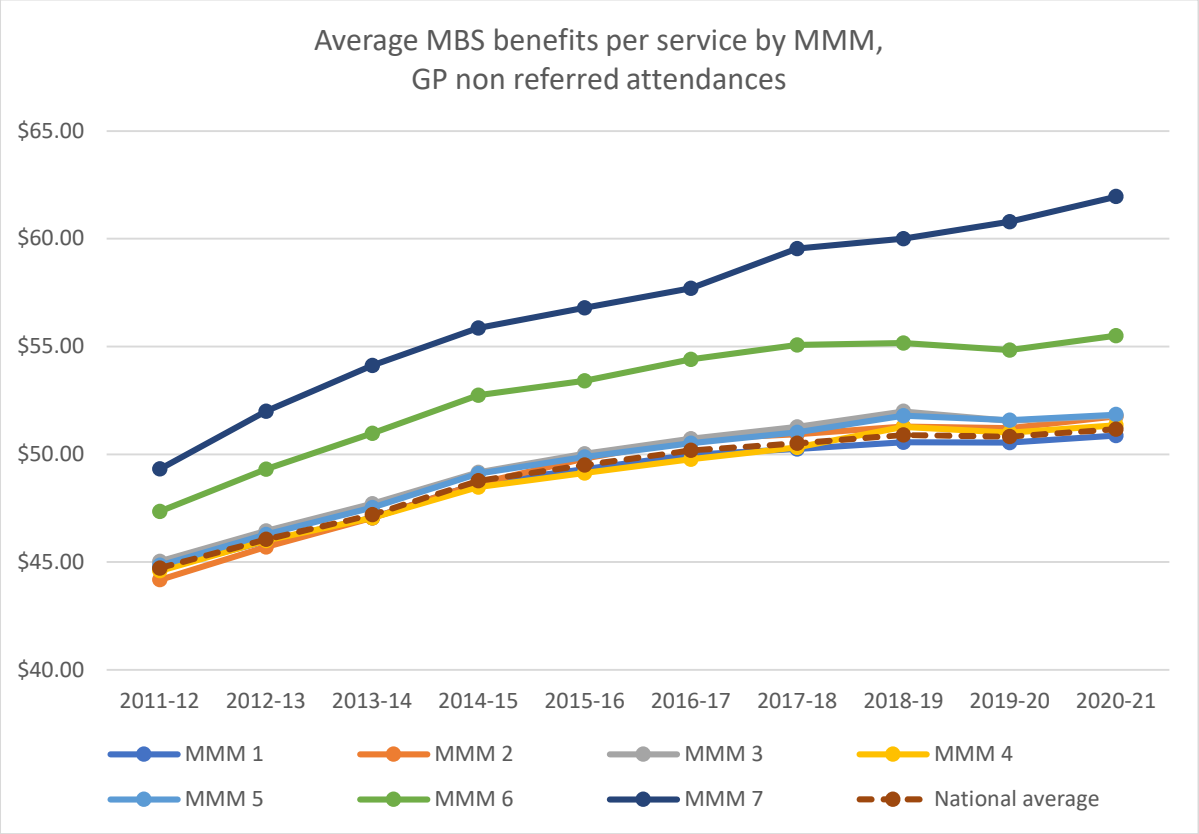


Table 6: Average MBS benefits per service for GP non-referred attendances

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	$44.70	$44.19	$45.04	$44.60	$44.85	$47.35	$49.32	$44.73
2012-13	$45.97	$45.71	$46.44	$46.00	$46.28	$49.31	$52.00	$46.06
2013-14	$47.05	$47.06	$47.71	$47.06	$47.54	$50.98	$54.12	$47.20
2014-15	$48.64	$48.64	$49.17	$48.47	$49.10	$52.74	$55.86	$48.77
2015-16	$49.32	$49.79	$50.03	$49.13	$49.88	$53.42	$56.80	$49.51
2016-17	$49.97	$50.70	$50.72	$49.77	$50.51	$54.41	$57.71	$50.19
2017-18	$50.25	$50.93	$51.27	$50.32	$51.01	$55.07	$59.55	$50.51
2018-19	$50.56	$51.28	$51.99	$51.27	$51.79	$55.16	$60.01	$50.90
2019-20	$50.55	$51.21	$51.55	$51.00	$51.59	$54.83	$60.79	$50.83
2020-21	$50.87	$51.76	$51.79	$51.35	$51.85	$55.51	$61.96	$51.17

GP non-referred attendances - Bulk billing rate

Data shown are: total bulk billing rates for GP non-referred attendances, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average). It is noted that telehealth services introduced in March 2020 as part of the response to the COVID-19 pandemic initially included a bulk billing requirement for valid claims. This requirement ceased on 1 October 2020.

Figure 20*:* Bulk billing rates for GP non-referred attendances

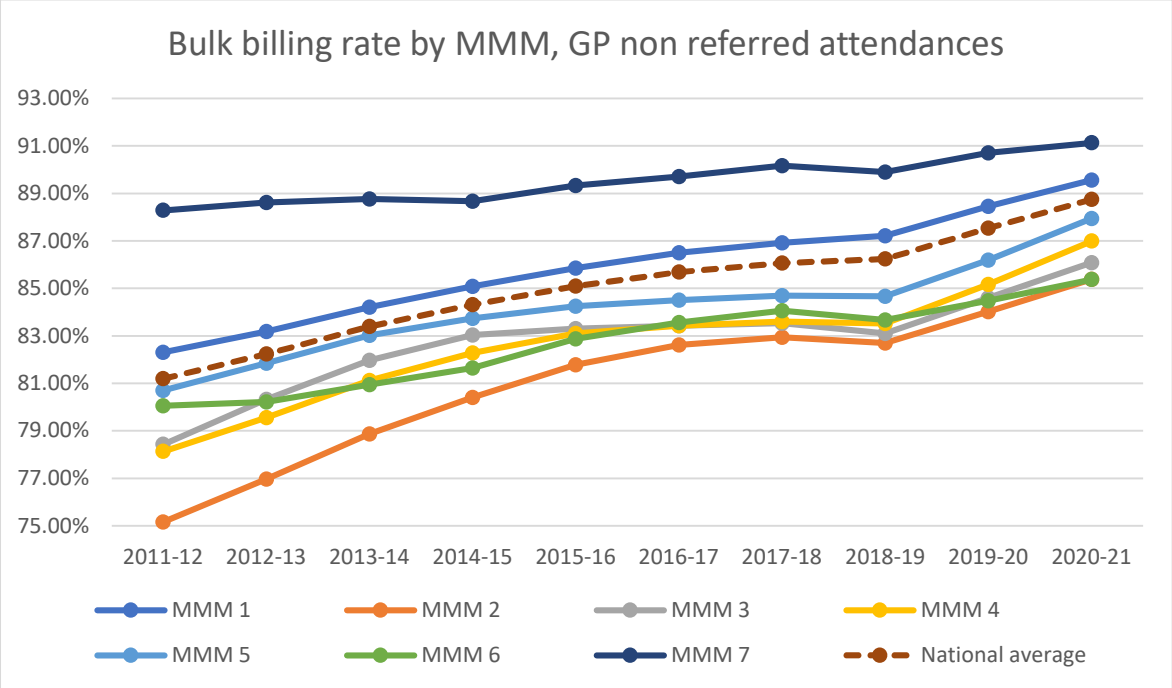


Table 7*:* GP non-referred attendances bulk billing rates

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	82.31%	75.17%	78.44%	78.14%	80.71%	80.06%	88.29%	81.20%
2012-13	83.18%	76.96%	80.32%	79.56%	81.85%	80.22%	88.62%	82.23%
2013-14	84.21%	78.87%	81.98%	81.12%	83.03%	80.94%	88.76%	83.40%
2014-15	85.08%	80.40%	83.03%	82.29%	83.74%	81.64%	88.67%	84.32%
2015-16	85.85%	81.79%	83.30%	83.10%	84.25%	82.87%	89.32%	85.10%
2016-17	86.50%	82.62%	83.43%	83.42%	84.50%	83.56%	89.72%	85.69%
2017-18	86.92%	82.94%	83.53%	83.61%	84.69%	84.07%	90.17%	86.07%
2018-19	87.22%	82.70%	83.11%	83.52%	84.67%	83.66%	89.90%	86.24%
2019-20	88.46%	84.03%	84.60%	85.17%	86.20%	84.47%	90.71%	87.54%
2020-21	89.56%	85.39%	86.09%	87.00%	87.95%	85.38%	91.14%	88.75%

GP non-referred attendances - Average out of pocket for services that are not bulk billed

Data shown are: average out of pocket rates for out-of-hospital patients who are charged a co-payment for GP non-referred attendances, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average)

Figure 21: Average out of pocket for GP non-referred attendances where a copayment is charged

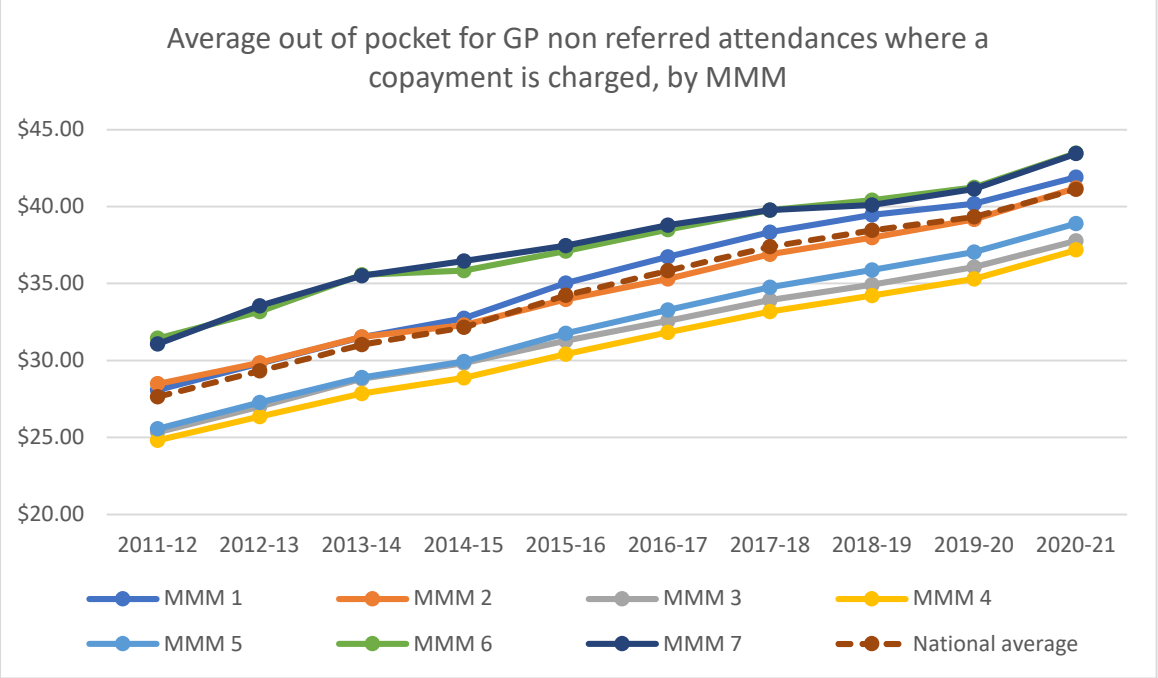


Table 8: Average out of pocket for GP non-referred attendances where a copayment is charged

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	$28.09	$28.48	$25.35	$24.82	$25.57	$31.45	$31.08	$27.65
2012-13	$29.80	$29.84	$27.00	$26.35	$27.26	$33.16	$33.56	$29.32
2013-14	$31.50	$31.53	$28.81	$27.84	$28.88	$35.57	$35.50	$31.03
2014-15	$32.73	$32.30	$29.83	$28.87	$29.93	$35.83	$36.46	$32.16
2015-16	$35.03	$33.97	$31.28	$30.40	$31.76	$37.11	$37.45	$34.24
2016-17	$36.74	$35.29	$32.58	$31.82	$33.28	$38.50	$38.80	$35.83
2017-18	$38.33	$36.89	$33.93	$33.17	$34.76	$39.77	$39.77	$37.39
2018-19	$39.45	$37.99	$34.92	$34.22	$35.87	$40.41	$40.10	$38.46
2019-20	$40.19	$39.16	$36.07	$35.29	$37.04	$41.24	$41.14	$39.33
2020-21	$41.91	$41.20	$37.77	$37.18	$38.90	$43.48	$43.44	$41.12

MBS services per patient by MMM region

Data shown are: average MBS service per patient for all MBS services and patients by MMM region and national average, per DOP financial year (2011-12 to 2020-21). The following figures and tables are based on total counts of MBS claims, noting that patients may appear in multiple MMM regions per year.

Figure 22: Average number of MBS services per patient

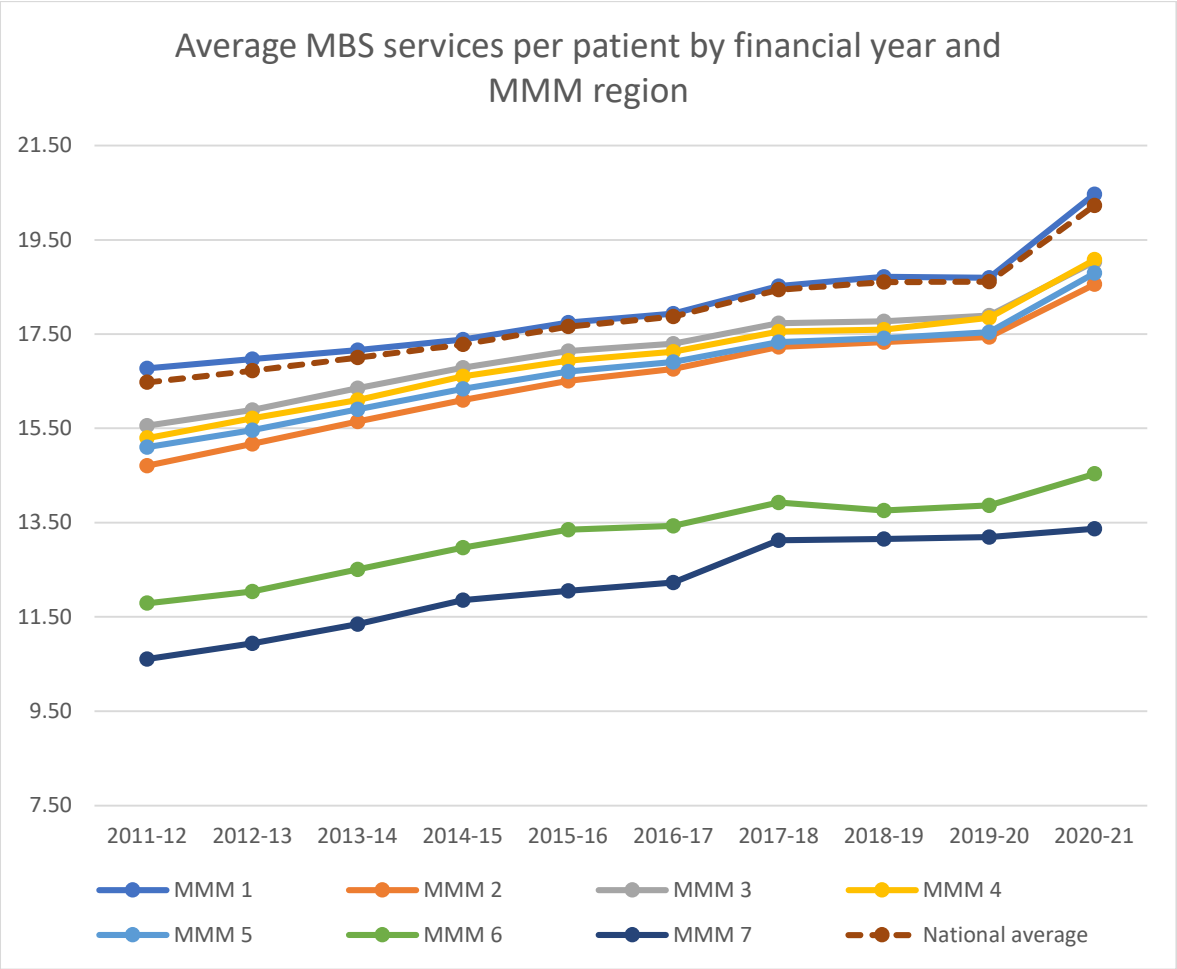


Table 9: Average MBS services per patient

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	16.77	14.71	15.56	15.30	15.10	11.79	10.61	16.48
2012-13	16.97	15.17	15.89	15.71	15.46	12.04	10.94	16.73
2013-14	17.16	15.64	16.35	16.10	15.91	12.51	11.35	17.01
2014-15	17.39	16.10	16.79	16.60	16.34	12.97	11.85	17.28
2015-16	17.75	16.51	17.14	16.94	16.71	13.35	12.06	17.67
2016-17	17.93	16.76	17.30	17.13	16.91	13.43	12.23	17.87
2017-18	18.52	17.23	17.73	17.56	17.33	13.93	13.13	18.44
2018-19	18.71	17.33	17.77	17.60	17.41	13.76	13.16	18.61
2019-20	18.70	17.44	17.89	17.85	17.54	13.86	13.20	18.61
2020-21	20.47	18.56	19.04	19.08	18.80	14.54	13.37	20.23

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Impact on bulk billing rates – all MBS items

Figure 15 and **Error! Reference source not found.** show bulk billing rates for all MBS items[86]. The data shows an overall increase in all MBS bulk billing rates across all MM areas from 2011-12 to 2020-21 with no significant change or impact on trends during the indexation pause. Figure 3 shows the overall bulk billing rate by MM category for GP non-referred attendances. This shows an increase in bulk billing across all MM areas over time.

It is noted that telehealth services introduced in March 2020 as part of the response to the COVID-19 pandemic initially included a bulk billing requirement for valid claims. This requirement ceased for specialist and allied telehealth services in April 2020, but GPs were required to bulk bill their telehealth services for nominated patient groups with increased vulnerability to COVID-19 until 30 September 2020.

Figure 15: All MBS bulk billing rates by MMM

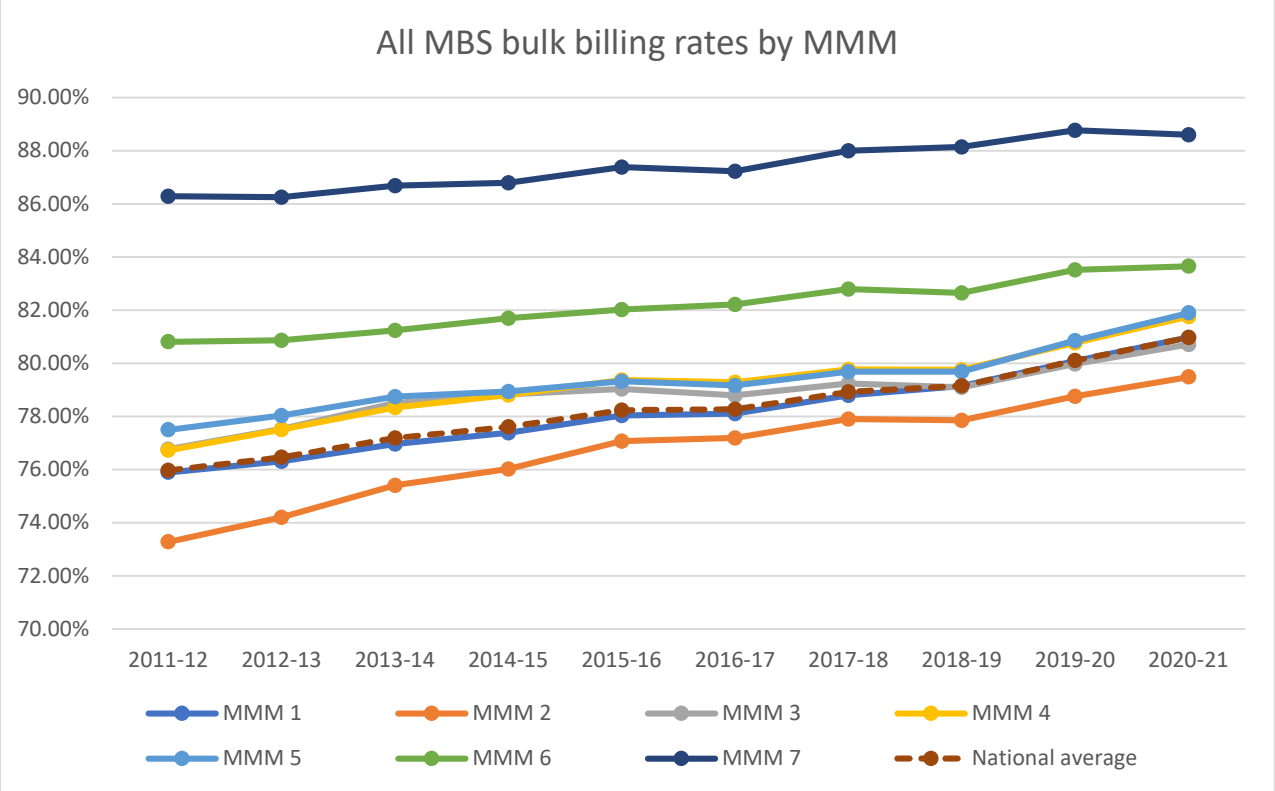


Table 2*:* All MBS bulk billing rates

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	75.90%	73.29%	76.78%	76.73%	77.50%	80.82%	86.29%	75.97%
2012-13	76.31%	74.20%	77.53%	77.51%	78.04%	80.86%	86.25%	76.46%
2013-14	76.96%	75.41%	78.51%	78.33%	78.74%	81.24%	86.68%	77.19%

[86] Data shown are: total bulk billing rates for all BTOS, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average).

2014-15	77.39%	76.02%	78.83%	78.81%	78.94%	81.70%	86.79%	77.61%
2015-16	78.03%	77.07%	79.04%	79.37%	79.33%	82.02%	87.38%	78.24%
2016-17	78.11%	77.19%	78.79%	79.29%	79.17%	82.21%	87.23%	78.28%
2017-18	78.79%	77.90%	79.24%	79.77%	79.69%	82.80%	88.00%	78.92%
2018-19	79.14%	77.85%	79.09%	79.76%	79.69%	82.65%	88.14%	79.16%
2019-20	80.08%	78.76%	79.97%	80.77%	80.85%	83.52%	88.77%	80.11%
2020-21	80.97%	79.49%	80.71%	81.76%	81.90%	83.66%	88.60%	80.97%

In the 2021-22 Budget, the Government invested $65.8 million over four years to improve the value of the rural Bulk Billing Incentive (rBBI) in rural and remote (MM 3-7) medical practice. This will encourage delivery of medical services without additional out of pocket costs for patients in rural and remote areas. Refer to the section titled 'rBBI', for more information.

Impact on average out of pocket costs (services that are not bulk billed)

Figure 16 and **Error! Reference source not found.** show the out of pocket costs charged to patients who were not bulk billed[87]. The MBS average out of pocket costs steadily increased from 2011-12 to 2021-21, with no significant correlation with either the indexation pause or reintroduction of indexation.

[87] Data shown are: average out of pocket rates for out-of-hospital patients who are charged a co-payment for all MBS BTOS, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average).

Figure 16: All MBS average out of pocket cost

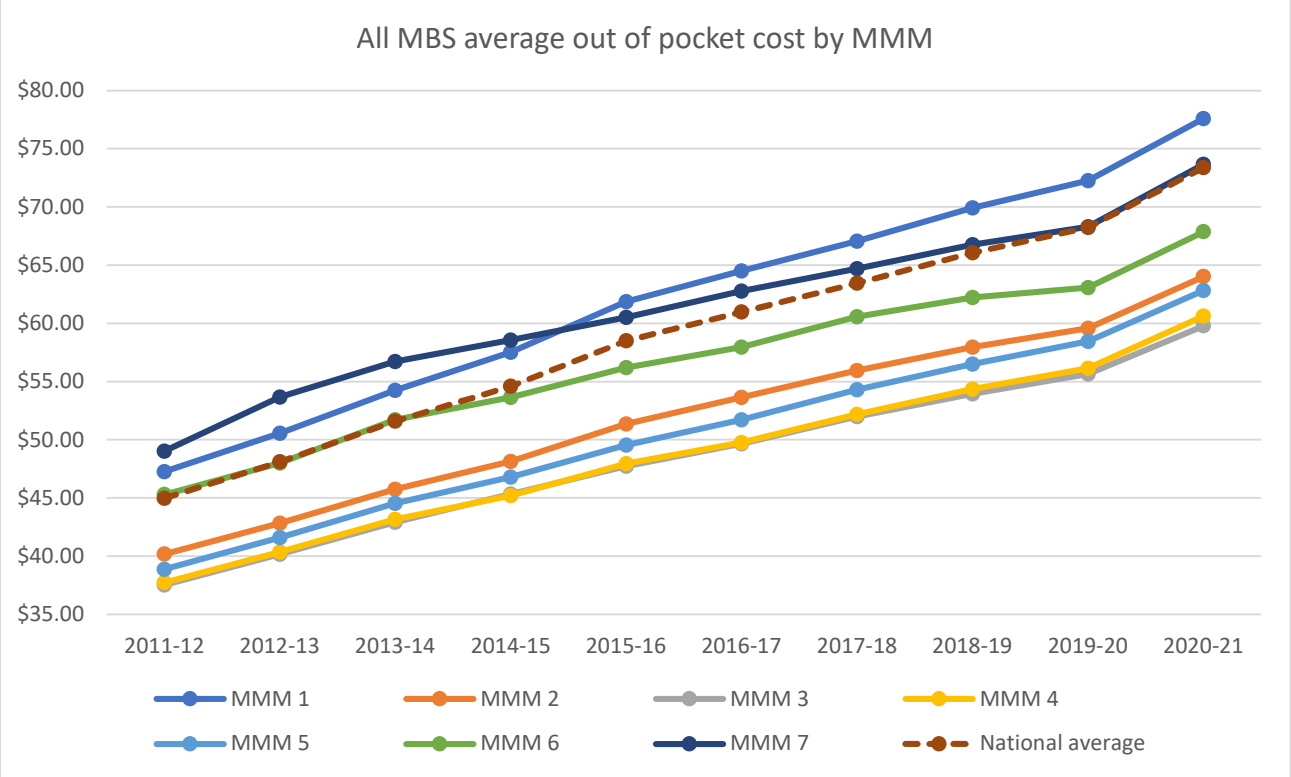


Table 3: All MBS average out of pocket cost

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	$47.26	$40.19	$37.53	$37.75	$38.89	$45.30	$49.02	$44.98
2012-13	$50.55	$42.84	$40.16	$40.36	$41.60	$47.99	$53.68	$48.12
2013-14	$54.25	$45.76	$42.91	$43.17	$44.54	$51.70	$56.71	$51.61
2014-15	$57.53	$48.13	$45.33	$45.19	$46.80	$53.64	$58.55	$54.60
2015-16	$61.86	$51.35	$47.74	$47.94	$49.53	$56.21	$60.52	$58.49
2016-17	$64.51	$53.63	$49.66	$49.76	$51.70	$57.96	$62.78	$60.97
2017-18	$67.05	$55.94	$51.98	$52.17	$54.30	$60.56	$64.68	$63.47
2018-19	$69.93	$57.95	$53.96	$54.35	$56.50	$62.20	$66.77	$66.08
2019-20	$72.27	$59.59	$55.63	$56.14	$58.46	$63.08	$68.29	$68.24
2020-21	$77.60	$64.03	$59.79	$60.63	$62.83	$67.88	$73.67	$73.39

Reforms to promote multidisciplinary care

Reforming the MBS

The introduction of *Enhanced Primary Care items,* such as chronic disease management plans, was designed to promote multidisciplinary primary care, and enable patients to benefit from each profession's skills. In some practices this funding has created opportunities for true collaboration between disciplines. In others, the independence of each practice, means that patients commute between different locations for their care without a sense of a team surrounding and working with them.

AMSs are able to use their block funding to provide such 'wrap around' services. Innovative funding models are being trialled in rural NSW to see if similar successes can be achieved by pooling resources in specific locations. See the section titled 'Innovative and multidisciplinary models of care' and 'Innovative Employment Models Trials: Remote Vocational Training Scheme' for more information.

GP Super Clinics

GP Super Clinics were announced in 2007 as 'one stop shops' for primary care services, promoting team-work and multidisciplinary care by housing all health professionals within one building.

The localities of the GP Super Clinics were based on criteria relating to need. The program provided grant funds to the value of $181.7 million for the construction or refurbishment of existing infrastructure for the first 36 GP Super Clinics, across 37 localities.

There was a further allocation of $370.2 million in 2010 for 28 new GP Super Clinics.

The primary, and in many cases, sole use of the program funding was for capital infrastructure that provided an environment where the operators of the GP Super Clinics were then required to provide services to meet the ten objectives of the program for a 20-year period. The GP Super Clinics Program does not fund the ongoing service provision and the Australian Government does not own or operate the GP Super Clinics.

While there was not a prescriptive model for GP Super Clinics, there were a number of core characteristics which the Commonwealth expected each funded clinic to demonstrate:

- GP Super Clinics will provide their patients with well integrated multidisciplinary patient centred care.
- GP Super Clinics will be responsive to local community needs and priorities, including the needs of Aboriginal and Torres Strait Islander peoples and older Australians in Residential Aged Care Facilities and community based settings.
- GP Super Clinics will provide accessible, culturally appropriate and affordable care to their patients.
- GP Super Clinics will provide support for preventive care.
- GP Super Clinics will demonstrate efficient and effective use of Information Technology.
- GP Super Clinics will provide a working environment and conditions which attract and retain their workforce.
- GP Super Clinics will be centres of high-quality best practice care.
- Post establishment, GP Super Clinics will operate with viable, sustainable and efficient business models.
- GP Super Clinics will support the future primary care workforce.
- GP Super Clinics will integrate with local programs and initiatives.

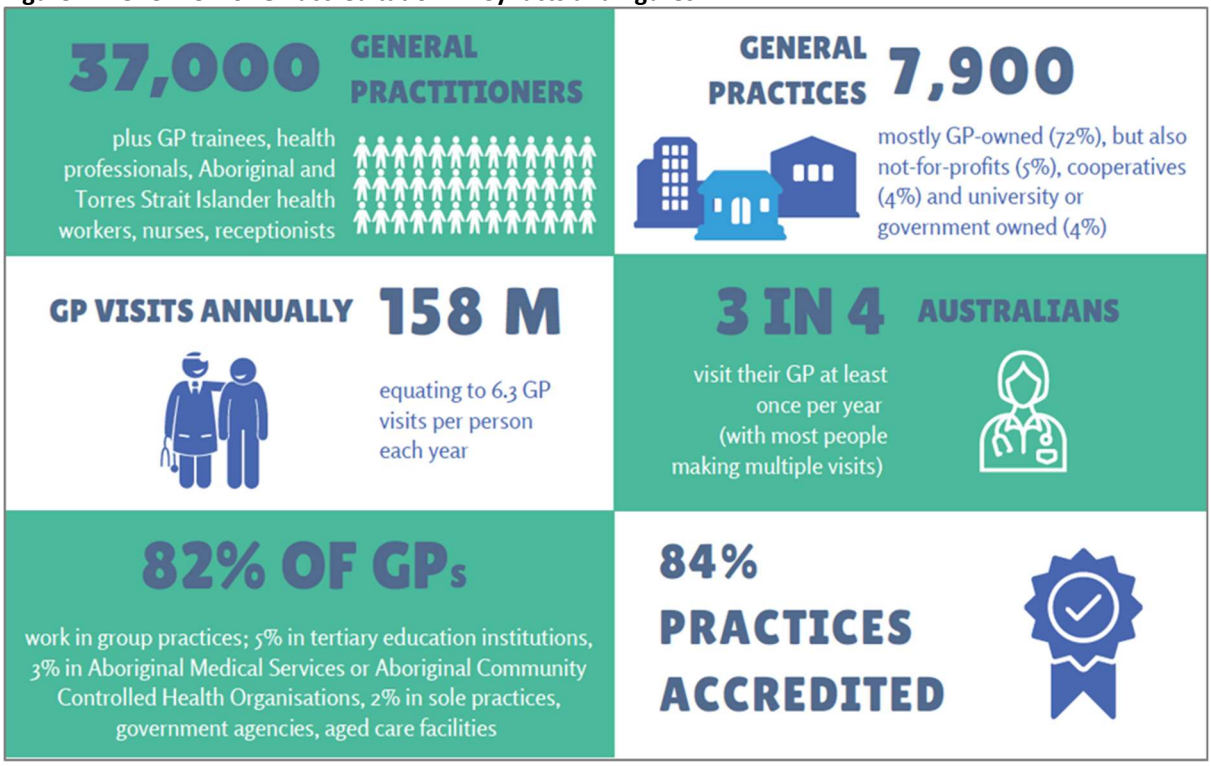
Consan Pty Ltd were engaged to evaluate the 2007-2008 phase of the GP Super Clinic program[88]. Their report and the government's response is available on the Department of Health website. The program of sixty clinics continues to be managed by the Department but no new clinics have been started since 2014.

The program provided many communities with welcome new facilities, but creating multi-disciplinary teams proved complex owing to their different employment and funding arrangements. In some cases, there were complications before infrastructure was built, with the implication that the 'one size fits all' approach required more nuancing to local circumstances.

Promoting quality care through accreditation

General practice accreditation is voluntary in Australia, however Government programs are used to encourage accreditation. It is used to demonstrate a practice's commitment to quality assurance, continuous improvement and the provision of safe and quality care to patients.

Figure 17: Overview of GP accreditation – key facts and figures[89]



Accreditation was introduced as an eligibility criterion for the PIP in 1999. Following an audit of the PIP in 2010, the Australian National Audit Office (ANAO) recommended that the Department build capability to understand the effectiveness of the PIP (including through

88 Department of Health, Evaluation of the GP Super Clinics Program 2007-2008, https://www1.health.gov.au/internet/main/publishing.nsf/Content/gpsuperclinics-pubs-eval

89 Taken from Review of general practice accreditation arrangements - Consultation Paper, https://consultations.health.gov.au/primary-health-networks-strategy-branch/review-of-general-practice-accreditation-arrangeme/

the development of an evaluation strategy and implementation of annual public reporting) and develop a mechanism to inform itself of the quality of general practice accreditation[90].

In line with these recommendations, the Australian Commission on Safety and Quality in Healthcare (the Commission) partnered with the RACGP to develop a model accreditation scheme for general practices in Australia. This model evolved over years of consultation and became the National General Practice Accreditation (NGPA) Scheme, which commenced on 1 January 2017.

The NGPA Scheme is administered by the Commission against the Standards for General Practice developed and maintained by the RACGP.

Whilst accreditation is voluntary it is a mandatory requirement to participate in the PIP.

Practices pay an accrediting agency registered under the NGPA to be assessed against the RACGP Standards. This system enables practices to benchmark against their peers, and national standards, and receive financial incentives. A separate process of educational accreditation occurs for teaching practices.

The Department has engaged mpconsulting to undertake an independent and comprehensive review of general practice accreditation arrangements (the Review). The Review is examining current arrangements for accreditation of general practices under the Scheme and the various training accreditation frameworks (to the extent these intersect with the Scheme).

The focus of the Review is understanding the barriers and incentives for general practices participating in accreditation and areas for improvement for both metropolitan and rural and remote practices.

The Review commenced in July 2021 with the active consultation phase closing on 8 September 2021. The draft review report is due to the Department on 7 October 2021 with the final report due on 20 October 2021.

Structures to support regional, rural and remote care: RWAs

The Government funds Rural Workforce Agencies (RWAs) in each state and the Northern Territory to deliver a range of activities aimed at improving the access, quality and sustainability of the regional, rural and remote health workforce.

They work with local practices, communities and other organisations to ensure that rural Australia is served by a skilled, well-supported health workforce. Under the MMM, RWAs primarily support locations classified as MM 2-7, and AMSs and ACCHS in MM 1-7 locations.

RWAs were established in 1998-99 to promote and facilitate the supply, recruitment, retention, education and support and distribution of GPs in rural and remote areas. Activities undertaken by RWAs include helping communities to recruit GPs, assisting with

90 Australian National Audit Office (ANAO), September 2010, Audit Report No.5 2010–11 Performance Audit – Practice Incentives Program for the Department of Health and Ageing, and Medicare Australia, https://www.anao.gov.au/work/performance-audit/practice-incentives-program.

locum placements, promoting rural careers and facilitating rural exposure for students/junior doctors/GP registrars, offering professional development and upskilling grants, providing workforce planning and advice, offering practice management support, assisting IMGs (including with registration, immigration and securing Medicare provider numbers), and supporting their families with fitting into a new community.

RWA activities

Since 2017, RWAs have been funded to deliver the Rural Health Workforce Support Activity (RHWSA). Under this program, RWAs work to improve the access, quality and sustainability of the regional, rural and remote health workforce through three program elements:

- Access (Health Workforce Access Program): will improve access and continuity of access to essential primary health care, particularly in priority areas, through a jurisdictional workforce assessment process involving health workforce stakeholders.
- Quality of access (Improving Workforce Quality Program): will build local health workforce capability with a view to ensuring communities can access the right health professional at the right time, reducing the reliance on non-vocationally recognised service providers in rural communities.
- Future planning (Building a Sustainable Workforce Program): will grow the sustainability and supply of the health workforce with a view to strengthening the long-term access to appropriately qualified health professionals.

RWAs also administer a range of related programs on behalf of the Australian Government, including MDRAP, the Workforce Incentive Program's flexible payment scheme, and a range of grants, scholarships and bursaries.

A key element of the RHWSA is the establishment of Health Workforce Stakeholder Groups, who develop a shared understanding of rural workforce needs and develop strategies to best meet those needs. At a minimum, Stakeholder Groups ensure RWA activities are prioritised to the areas of greatest need, and complement, rather than duplicate, other organisations' efforts.

Stakeholder Groups include representatives from RTOs, PHNs, RHOF fundholders, Specialist Training Program providers, Rural Clinical Schools, Regional Training Hubs, State Health Departments, and Aboriginal and Torres Strait Islander Health Peak Bodies.

RWAs complete an annual Health Workforce Needs Assessment (HWNA) in consultation with their jurisdictional Stakeholder Group to identify towns requiring support, and prioritise efforts. RWAs use the HWNA to develop an Activity Work Plan and provide performance reports every six months.

Review of RWAs

In March 2020, the Department commissioned a review of the RHWSA program to inform future design, funding and implementation of the program. Key findings included[91]:

- The HWNA process is critical in identifying areas of need and understanding what support could be provided for specific locations. A key strength was identified to be the focus on community needs and challenges. This focus allows agencies to collaborate to address a common issue rather than focus on pursuing their own organisational agenda.
    - In some jurisdictions, there may be an opportunity for a more place-based approach, and a greater focus on sustainability.
- The RHWSA resulted in the recruitment of 714 and 659 health professionals to rural Australia in 2017-18 and 2018-19, respectively.
- RWAs are increasingly focusing on improving access to health professional and para-professional roles outside of the medical workforce. This is in-line with the increasing focus building multidisciplinary teams that use all elements of the primary health care workforce to deliver primary health care.
    - In 2017-18 and 2018-19, across four RWAs, 471 placements were for GPs, and 418 of the placements were for allied health and nursing professionals.
- Some short-term improvements have been demonstrated, particularly for workforce access and quality, however this is difficult to attribute solely to the RHWSA program.

The findings of the KPMG review of the RHWSA in 2020 identified the need for improvements including in national governance and accountability for the RHWSA. The Minister for Health agreed that the recommendations of this review be accepted and implemented in a staged way, including that there be a single grant and holder for the RHWSA and MDRAP. This will streamline administration and ensure that rural workforce support activities are improved in accordance with the review outcomes and national coordination and governance is improved.

As a result, this grant is being provided to General Practice Workforce Incorporated, as the nominated single grant holder and National Coordination Lead for two programs, the RHWSA and the MDRAP Support Package. Under this grant RWAs will support the administrator in delivering these programs within their jurisdictions.

[91] KPMG (2020) "Rural Health Workforce Support Activity, Department of Health: Final Report". Available: https://www.health.gov.au/resources/publications/review-of-the-rural-health-workforce-support-activity-program. Accessed: 1 September 2021.

An independent champion for rural care: National Rural Health Commissioner Office

In 2017, the Government established the Office of the National Rural Health Commissioner to independently and impartially improve rural health policies, and champion the cause of rural practice. The establishment of the Office was in recognition of the inequitable access to health services and poorer health outcomes of rural Australians.

The rural health workforce and communities living in rural and remote areas were intended to benefit from the introduction of the Commissioner's Office by placing rural and remote issues at the forefront of government decision making. The Commissioner's Office was also intended to advise on better targeting interventions to support access to services and quality of services.

Following from previous reviews recommending a focus on generalist skills, the Commissioner's first responsibility was to provide advice on developing a National Rural Generalist Pathway (NRGP), a medical training pathway to attract, retain and support GPs with the skills to provide primary care, emergency and other specialist services to communities in regional, rural and remote areas. See the section titled 'Towards a NRGP' for more information.

The Commissioner was later tasked with providing advice on improving access to allied health primary care services.

Two eminent rural generalist doctors have held the role since the Office was established. In 2021, the Government extended and expanded the Office, including adding two Deputy Commissioners who offer expertise in nursing and allied health. This recognises that these workforces are critical to providing comprehensive primary care in regional, rural and remote communities.

An early priority for the expanded Office is to support the Government's ongoing rural response to COVID-19 and to advise on the impact on the health workforce in regional, rural and remote communities.

The Commissioner also provides advice on the roll out of the NRGP, as well as work with ACRRM and RACGP towards recognition of Rural Generalist Medicine as a distinct field of general practice by the Medical Board of Australia and the Australian Medical Council.

The Commissioner is working with regions to support the development of 'trial-ready' localised innovative models of care through the Primary care Rural Innovative Multidisciplinary Models (PRIMM) grants. See the section titled 'Innovative and multidisciplinary models of care' for more information.[92]

Reforms to establish structures promoting regionally tailored primary care

Divisions of General Practice

In 1993 the General Practice Working Group, a tripartite group made up of the RACGP, the AMA and the government, was given the task to investigate, develop and recommend

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proposals for general practice reform. The Division Steering Group was responsible for facilitating the development of, and the allocating the funding for, divisions of general practice throughout Australia.

Concerns were raised that divisions of general practice perpetuated the medico-centric approach to primary care, and there was a need for a broader focus on primary care (beyond general practice), including engaging with non-GP primary care systems and providers. Some divisions broadened to become Divisions of Primary Health Care.

Medicare Locals

As part of the 2011 COAG National Health Reform Agreement (NHRA), the Commonwealth Government ceased funding Divisions of General Practice and instead introduced Medicare Locals. Key staff and infrastructure transferred from Divisions of General Practice into the Medical Local where possible. Medicare Local's remit was to improve coordination and integration of primary health care in local communities, address service gaps, and make it easier for patients to navigate their local health care system.

The establishment of Medicare Locals across Australia was one of the key reforms under the NHRA. The NHRA formed the basis for the then Government's implementation of the recommendations made by the National Health and Hospitals Reform Commission (NHHRC).

Formed in 2008, the NHHRC was created to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term. The NHHRC's June 2009 report provided the foundation for the NHRA and health funding announced by the Government in 2011.

Medicare Locals were established as not-for-profit companies in three 'tranches' in July 2011 (19 Medicare Locals), January 2012 (18) and July 2012 (24). The Commonwealth also established the Australian Medicare Local Alliance (AML Alliance) in July 2012 as the peak body to support the network of 61 Medicare Locals. Under the NHRA, the Commonwealth Government had responsibility for the establishment of the Medicare Locals. The Medicare Locals were funded with $1.8 billion over five years from 2011-12 to 2015-16.

Medicare Locals were expected to fully engage with the primary health care sector, communities, the ACCHS sector, and Local Hospital Networks (LHNs)[93]. Their establishment was built on the foundations of Divisions of General Practice and many key staff switched to work within the new organisations.

Medicare Locals focused on integration of services and joint Commonwealth and State government planning for service delivery and access. They were responsible for encouraging collaboration between health care professionals, undertaking population health planning and, in many cases, providing services.

[93] Depending on the jurisdiction, LHNs may also be referred to as Local Health Networks, Local Health Districts or Hospital and Health Services.

A *Review of Medicare Locals* found that many Medicare Locals were unclear about their purpose, leading to inconsistent outcomes, and variability in scope and delivery of activities. The review recommended the creation of a new network of primary health focused organisations with clear performance expectations, flexibility to respond to regional and local context, and required to operate as efficient and effective entities[94].

Establishment of PHN network

On 1 July 2015, the Australian Government established 31 PHNs as independent primary health care organisations, located throughout Australia. PHNs work to reorient and reform the primary health care system by taking a patient-centred approach to medical services in their regions. They have three main roles:

- They commission health services to meet the identified and prioritised needs of people in their regions and address identified gaps in primary health care. This may include working with others in the community to plan and deliver innovative services that meet specific health needs.
- Through practice support, they work closely with general practitioners (GPs) and other health professionals to build health workforce capacity and the delivery of high-quality care.
- They work collaboratively within their regions to integrate health services at the local level to create a better experience for patients, encourage better use of health resources, and eliminate service duplication.

The role of PHNs is to commission, rather than provide services. It is the key difference between Medicare Locals and PHNs, and represents a fundamental shift in the way primary health care services are planned for and funded at the regional level.

Commissioning is a strategic, evidence-based approach to planning and procuring new health services or changing existing health services, where required. PHNs target and prioritise health services to meet the identified needs of the local community in a continuous cycle of improvement.

This process is focused on outcomes that boost the efficiency, effectiveness and coordination in primary health care and is centred on the health needs of patients. It is informed by detailed assessments of the regional population's health needs, a market analysis of local health care services, and evaluation of the quality and performance of commissioned services. This ensures that services are prioritised and located in areas where they are most needed.

PHNs work collaboratively within their communities. They have GP-led Clinical Councils and Community Advisory Committees which ensure that clinicians and the community have input into decisions about primary health care services.

94 Department of Health, Review of Medicare Locals, https://www1.health.gov.au/internet/main/publishing.nsf/Content/review-medicare-locals-final-report

PHNs also work to connect different elements of the health system so that patients are more likely to receive the right care, in the right place, and at the right time. PHNs develop partnerships that bring together different health providers and state and territory-based health authorities to create a more holistic system of care. Integrated health services are:

- Centred on the needs of the patient
- Effective and efficient
- Make the best use of health funding.

Additionally, PHNs provide education, training and support as a key part of strengthening Australia's primary health care system. They support general practitioners, their office staff and other health professionals to improve their efficiency, effectiveness and coordination of care. Practice support activities may include quality improvement initiatives, designing improved models of care, accreditation support, data analysis and MBS billing support.

Reforms to support efficient primary care bureaucracy

In February 2014, a National Commission of Audit (NCoA) recommended the abolition of two health bureaucracy bodies, Health Workforce Australia (HWA) and GPET. The NCoA specifically recommended consolidating the functions of both bodies within the Department[95].

The former GPET was a Commonwealth company established in 2001 to fund and oversee vocational general practice training in Australia. In this capacity, GPET managed the AGPT on behalf of the Government.

Accordingly, GPET's function transferred to the Department from 1 January 2015. The Department is now working towards College-led training. Refer to the section titled 'Transition to College-led training' for more information.

The former HWA was established under the 2008 COAG National Partnership on Health Workforce Reform to expand clinical training places for health students, increase the capacity of the health system to provide quality clinical training, embed the use of simulated learning, and promote health workforce innovation.

In establishing HWA, the original intent was that states and territories would also contribute funding for clinical training, but this did not occur, with jurisdictions deciding to make 'in-kind' contributions instead. The Commonwealth remained the sole funder of HWA. It was funded via agreements with the Commonwealth Department of Health.

The National Partnership Agreement expired on 30 June 2013 and the closure of HWA was announced in the 2014-15 Budget under the Smaller Government–More Efficient Health Workforce Development measure. HWA's functions were consolidated into the Department of Health including:

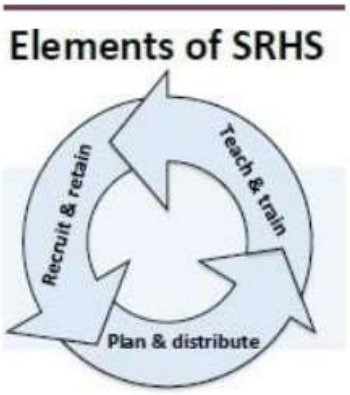
95 Commonwealth of Australia, Towards Responsible Government – The Report of the National Commission of Audit – Phase One, https://australianpolitics.com/downloads/budgets/2014/14-05-01_commission-of-audit-report1_phase1.pdf.

- Workforce Data Modelling and Projections. Work to develop long range models of supply and demand continues in the Department, with the ongoing development of the HeaDS UPP tool and workforce planning progressed through the ongoing development of a NMWS.
- Clinical Training Fund. This was a program supporting undergraduate clinical training places, clinical supervisors and simulated learning environments. The program was ceased at MYEFO 2015-16, with funding refocused supporting training through the expanded RHMT program. Refer to the section titled ‘
- Investing in a rural training pathway beyond university’ for more information.

Terms of Reference B: Government reforms and their impact on GPs - A Stronger Rural Health Strategy

The $550 million Stronger Rural Health Strategy (SRHS) is the current focal point for building a sustainable, high quality health workforce that is distributed across the country according to community need. Announced as part of the 2018-19 Budget, the SRHS is a comprehensive package of initiatives that aims to address health workforce quality, distribution and planning issues, particularly in rural and remote communities.

The SRHS acknowledges that addressing the issues of quality, distribution and planning of Australia's health workforce has been a longstanding challenge. It presents a strategic and forward-thinking approach, which includes structural reform to address these longstanding issues and build a health workforce that can meet the demands of the future. It delivers interventions across three critical areas: teaching; training; recruitment and retention.



The SRHS uses all levers available to government, spanning regulation, training and incentives to meet the challenge of redistributing the workforce. Its mix of incentives, targeted funding and bonding arrangements to give doctors more opportunities to train and practice in rural and remote Australia. It also supports a stronger role for nurses and allied health professionals in the delivery of more multidisciplinary, team-based models of primary health care.

As at 31 May 2021, the SRHS measures have:

- Increased the number of GPs in regional, rural and remote areas by more than 750. The SRHS aims to deliver 1,300 GPs by the end of 2022 and 4,000 GPs by the end of 2028.
- Increased the number of full-time equivalent nurses in regional, rural and remote areas by more than 1000 from 2016 to 2019. The SRHS aims to deliver 1,200 nurses in these areas by the end of 2022, and 3,000 nurses by the end of 2028.

Increased GP services per capita from 6.3 in 2018 to 6.4 in 2019.

The Government is about to commence the first of three planned evaluations of the SRHS to help inform ways of improving the quality, distribution and planning of the Australian health workforce to better meet the needs of the community and deliver a sustainable, well distributed health workforce, especially in regional, rural, and remote areas. Complementing this process are program specific evaluations underpinning some of the programs in support of primary health services in regional, rural and remote areas.

Teach

Research has shown that people who study and train regionally are more likely to live and work regionally. Under the SRHS, the Government has funded teaching and training

programs to provide more opportunities for students to gain rural education and clinical training experience. Investing in the education of primary health care professionals in regional, rural and remote locations improves the quality of the workforce, assists in workforce distribution, and provides valuable services to these communities through a service learning model.

Several SRHS initiatives, in particular those relating to teaching and training, deliver structural reforms. The outcome of such reforms are medium to long term in nature. It will take time before their full impact is realised.

Rural teaching and education: Train in the regions – stay in the regions

The *train in the regions – stay in the regions* element of the SRHS builds on existing investments in rural teaching through the RHMT program by establishing the MDMSN. This element also adds two new participants to the RHMT program.

MDMSN

The $74.4 million investment over four years in the MDMSN is establishing a series of five rurally based medical school programs in the Murray-Darling region of New South Wales and Victoria to provide end-to-end medical training in rural areas. The MDMSN aims to improve the future distribution of the medical workforce and promote general practice as a career choice. Specifically, the MDMSN aims to:

- Maximise opportunities to support school leavers and graduate-entry students with a rural background, and to attract those with an interest, intention and aptitude for practising in rural and regional areas once qualified;
- 'Flip' the current model of medical training with the majority of training to be regionally based and rotations to metropolitan areas for specialist immersions kept to a minimum;
- Improve the distribution of the medical workforce through the establishment of rurally based medical school programs;
- The network will provide students with the option of studying and training in more than 20 regional and rural communities. The MDMSN will enable the end-to-end rural medical training model to be tested. Outcomes will be monitored closely to inform future government direction.

The Network includes:

- The University of New South Wales (Wagga Wagga)
- The University of Sydney (Dubbo)
- Charles Sturt University in partnership with Western Sydney University (Orange)
- Monash University (Bendigo, Mildura)
- University of Melbourne (Shepparton), with a pathway for undergraduate students from La Trobe University (Bendigo, Wodonga).

A sixth university – La Trobe University – has been funded to establish a feeder degree in the rural locations of Bendigo and Wodonga. This is providing a pathway for 15 commencing students each year into the new University of Melbourne Doctor of Medicine (Rural) program based at Shepparton, commencing in 2022.

This end-to-end approach to rural training will work with complementary SRHS initiatives to improve workforce distribution.

Results

From 2022, around 145 students per year will commence their medical school training in CSPs. They will undertake the majority of their degree training in the MDMSN regional, rural and remote locations. Time spent in metropolitan areas will be minimised. To date:

- As of 1 July 2019, all capital works agreements were in place for establishing the MDMSN. The program has refurbished La Trobe's Bendigo and Albury-Wodonga campuses (2019-20) to support undergraduate pathway into medicine under MDMSN.
- Three of the five new medical schools commenced their first students in February 2021. The remaining two schools will welcome their first students in early 2022.

RHMT

The RHMT program, operating for over 20 years, supports medical and allied health students to undertake rural training through a network of rural clinical schools, university departments of rural health, dental faculties offering extended rural placements and the Northern Territory Medical Program. For early history of the RHMT, refer to the section titled 'Source: Adapted from Australian Medical Association (AMA). 'How to become a doctor'

Investing in rural university experiences'.

Since 2017, it includes 26 regional training hubs tasked with building medical training pathways within a region and guiding students and trainees through these pathways.

In 2019, as part of the SRHS, two additional universities joined the RHMT program - Curtin University (for medicine) and La Trobe University (for nursing and allied health).

In the 2020 Budget, a further $50.3 million was announced to expand the RHMT program. The four elements of the package are:

- Funding for one new UDRH in one of the known rural geographic gaps identified in the national evaluation of the RHMT program.
- Funding five projects to increase training in rural and remote settings (MM 3-7 regions).
- Funding five projects in aged care services to provide dedicated teaching spaces and manage the training of nursing and allied health students.

- Funding for a feasibility study to identify best approaches to increase dental and oral health training in regional areas.

The $50.3 million package provides for capital works grants and project funding. The capital works grants will invest funding for student accommodation at rural training sites and building works to add teaching facilities to aged care services. This new element supports the Government's priority of ensuring better health outcomes in smaller rural communities, especially for the most vulnerable.

Results

In 2019, RHMT-funded universities facilitated 346 six-month rural medical placements and 1,443 twelve-month placements. There were also 4,800 short-term medical placements, which total more than 18,600 rural placement weeks.

In late 2019, the Department requested data from universities on the clinical setting of all medical placements provided through the RHMT Program following concerns in the GP training sector that changes to the training targets under the RHMT program had resulted in a decrease in medical student placements in general practice.

The data provided showed that under the RHMT Program, from 2015 to 2018:

- The number of short-term placements in GP practices increased by 5.2%.
- The average short-term GP placement length remained consistent at 4.2 weeks.
- The proportion of GP placements relative to all short-term medical RHMT placements fluctuated year on year and overall decreased slightly, from 38% to 36%.
- The number of long-term GP placements increased by 5.4%.

Eleven universities also provided written comments on the trends in RHMT medical placement settings over the four-year period. Universities were clear the commitment to providing GP placements had not decreased since 2015, and that GP placements remained a priority. However, universities found it more difficult to find practices and clinicians willing and/or able to take on medical students because of a range of pressures, including increased registrar numbers and a preference for long-term placements.

Appendix I: RHMT Program sites (RCS, UDRH and RTH) includes maps showing RCS, UDRH and RTH sites.

Evaluation of the RHMT and further investment

The Department of Health commissioned KBC Australia to undertake a 12-month evaluation of the RHMT program. The evaluation found that the RHMT program has successfully supported the provision of rural training experiences for students across a wide range of health disciplines for the past two decades, demonstrating the capacity of universities to provide students with high quality clinical training outside metropolitan locations.

KBC Australia determined that the RHMT program is an appropriate response and important contributor to addressing rural health workforce shortages while contributing to the social

and economic strength of rural communities, including immediate benefits to local health service delivery.

While noting that many external factors influence where health professionals work, the evaluation found strong evidence of the positive impact of longer-term rural medical placements on rural workforce outcomes.

The evaluation also found the RCS and UDRH Research Network has been instrumental in progressing research in rural and remote health, rural health workforce, rural health service delivery and rural training.

The evaluators put forward 29 program-level recommendations. Most of the recommendations can be implemented by amending the program framework, program parameters and funding agreement. However there are a number of recommendations that are currently beyond the scope of the program. These recognise that with program maturity comes the opportunity to expand the program's remit.

The 2020-2021 Budget announced *Guaranteeing Medicare – Rural Health Multidisciplinary Training Infrastructure measure,* which supports two recommendations from the evaluation, for implementation over the next three years. This measure provides an emphasis on the allied health workforce. It expands the UDRH network to locations where there are geographic gaps in the delivery of multidisciplinary placements (recommendation 25). It also provides opportunities for universities to expand placement activity in smaller communities; as well as placements in community and non-acute care settings (recommendation 14).

Train

The training element of the SRHS focuses on providing early career experiences and rural training experience after completing university qualifications. Supporting primary care professionals to remain outside metropolitan areas after completing their studies aims to increase the number of primary health care professionals who choose to live and practise rurally. There is also a focus on growing the Aboriginal and Torres Strait Islander health workforce and an investment in a culturally competent workforce.

Significant investments and structural reforms have been made to MBS payments and GP training to support and incentivise doctors in primary health care to train to become specialist GPs, and thus improve the quality of the GP workforce. This is particularly important for regional, rural and remote communities where there has historically been a higher numbers of non-VR doctors delivering services.

Early rural primary care experiences: Junior Doctor Training Program

The junior doctor years are a key point in deciding which medical career path to take. The Government has had an ongoing strategy of providing cost effective and sustainable exposure to rural medicine and general practice for aspiring rural doctors.

The Junior Doctor Training Program (JDTP)-RJDTIF supports rural primary care rotations for rurally based post graduate year (PGY) 1 and 2 junior doctors, building on existing state and

territory rural training networks. The program delivers a similar experience to the earlier PGPPP, outlined in the section titled 'Early exposure to primary care for junior doctors'.

The program was expanded in 2020 to include PGY2 doctors, with 275 rotations funded for 2020 to provide PGY1 and PGY2 doctors with an experience in a rural primary care setting. This is the first-year rotations were available for PGY2 junior doctors and organisations reported some challenges filling rotations with PGY2 junior doctors. The program is also expanding as part of the NRGP and this is addressed in the section '**Error! Reference source not found.**'.

Results

The JDTP-RJDITF was successfully expanded to include second year postgraduate doctors for the first time in 2020 with support for up to 100 new accredited rural primary care rotations.

Between 2018 and 2020, 552 rural primary care rotations in MM 2-7 for interns and PGY2s in accredited training facilities were delivered under the JDTP-RJDITF program.

In 2019-20, PGY1 intern key performance indicator (KPI) targets were met, with 115 interns undertaking accredited training. Additionally, around 85 PGY2-3s were funded to undertake an accredited training placement with at least one rural rotation in MM 2-7 location.

Further reform and investment: JFPDP

As part of the 2021-22 Budget, the Government supported investment of $12.4 million to expand opportunities for early career doctors to work in rural communities while they complete their medical training through the new JFPDP.

The measure consolidates existing funding for RDJTIF (Core and Rural Generalist (RG) programs) and will increase rural primary care rotations from 440 (110 FTE) in 2022, to 800 (200 FTE) by 2025. It also expands eligibility for the JFPDP to prevocational doctors in their first five postgraduate years and delivers new rural primary care rotations for metropolitan hospital-based early-career doctors.

The JFPDP will incrementally increase rural primary care rotations for hospital-based prevocational doctors in rural areas from 440 rotations (110 FTE) in 2022 to 800 rotations (200 FTE) by 2025. This is an increase of an additional 360 hospital-based junior doctors to experience rural general practice, which is designed to encourage a greater uptake of rural placements.

The high demand among early-career doctors for rural placements results in almost 100% of rural internships being filled. An additional 360 early-career doctors will experience rural general practice, through the JFPDP, provide opportunities to live and work in rural communities.

The program will commence from 1 January 2023 with current RJDTIF and RG arrangements continuing until 31 December 2022. The Department has commenced engagement with stakeholders to ensure the implementation of the program is well informed and value for money.

MDRAP

The MDRAP supports doctors to gain primary care experience in rural areas and provides them with enough experience to decide whether to pursue a career in general practice. The MDRAP commenced on 29 April 2019 and took the place of several existing workforce programs under Section 3GA of the HIA, which were closed to new entrants. These previous Section 3GA programs allowed non-VR doctors to perform professional services with access to Medicare, and without attaining fellowship for long periods of time[96].

The MDRAP provides an avenue for medical practitioners to gain experience before being accepted into a college fellowship program. The program is open to Australian and international medical graduates.

Working with the RWAs in each State and the Northern Territory, each MDRAP participant is assessed for experience and development needs. The program provides access to foundational education modules (through the GP Colleges) and sets doctors up in a practice where they can be supported with supervision. This helps MDRAP doctors gain the experience required to support transition to a formal fellowship pathway such as the AGPT or the Remote Vocational Training Scheme (RVTS).

The MDRAP has a maximum participation time of two years within which participants are required to join a college-led fellowship program. This timeframe can be extended to a maximum of four years under exceptional circumstances.

The MDRAP Support Package was implemented in April 2020, to address stakeholder concerns regarding training and supervision support for non-VR doctors on MDRAP. The Support Package provides funding for clinical supervision and education for MDRAP doctors, helping to ensure the safe delivery of medical services and high standards of quality care.

The MDRAP Support Package is administered by the RWAs, with funding of $10 million in 2019-20 and $20 million per year over the next three years – total funding of $70 million. While the initial funding calculation allowed for 300 doctors, the RWAs indicate that judicious assessment of supervision needs may see this funding able to support more doctors than initially expected. The current funding agreement with the RWAs is in place until the end of 2020-21. A further grant opportunity is in development to finalise funding for the final two years of the Support Package.

The RWAs are responsible for disbursing funding, with payments either direct to practices (for supervision payments), reimbursed to doctors (for educational costs), and to other education and training providers as agreed.

Results

As of 31 July 2021, there were 406 participants enrolled in the Program to gain rural clinical experience.

96 The Rural Locum Relief Program (RLRP), the Special Approved Placements Program (SAPP) and the Other Medical Practitioners (OMPs) programs closed in the first half of 2019.

The MDRAP is achieving its objective of encouraging non-VR doctors to pursue GP careers and join a training pathway. Since the program's inception more than 140 doctors have moved from MDRAP to a formal fellowship training pathway, with approximately 40 doctors achieving Fellowship (as at 31 July 2021).

Recognising GP skill and experience

On 1 July 2018, a new MBS item structure for GPs was introduced to encourage all primary care doctors to qualify as specialist GPs and become Vocationally Recognised (VR) practitioners. This identifies non-VR doctors as a distinct group for MBS GP item claiming purposes. The changes:

- Ensure that MBS fees payable reflect recognised levels of qualification. Non-VR doctors can claim 80 percent of the amount claimable by their fully qualified counterparts.
- Reward and incentivise investment in postgraduate specialist qualifications.

Streamlined GP training and fellowship program

From 1 January 2019, GP training arrangements were streamlined and new fellowship support programs introduced to support doctors to become specialist GPs. These arrangements included the consolidation of a range of existing programs under a broader GP fellowship program, with multiple training pathways, administered by both GP Colleges - ACRRM and RACGP.

The streamlined GP training and fellowship program includes:

- AGPT
- RVTS
- The new Non-Vocationally Recognised Fellowship Support Program (Non-VR FSP)
- The RACGP Practice Experience Program (PEP) and ACCRM Independent Pathway (IP).

The $42 million Non-VR FSP provides a subsidy to assist non-VR medical practitioners to gain fellowship and vocational registration as a general practitioner on either the PEP or IP.

While the Non-VR FSP is not a rurally targeted program, both the IP and PEP are primarily delivered to participants in Modified Monash (MM) 2-7 locations. This encourages non-VR doctors to move into regional, rural and remote areas to access these training programs, as well as ensuring that the non-VR workforce in regional, rural and remote Australia are supported to achieve fellowship.

Results

- In 2020, 50% of GP training was occurring MM 2-7 locations, with 6,200 trainees in total (up from 5,354 in the 2017 baseline year).

- In 2019, 29,553 (79%) of GPs providing primary care services were either VR with a fellowship qualification from RACGP or ACRRM or vocationally registered on the Vocational Register for General Practice. This represents a 2% increase from 28,324 (77%) in 2018. Also, in 2019:
    - All states and territories experienced growth in VR GPs in primary care compared to previous years both in cities and regions.
    - MM 2-7 areas recorded slightly higher VR GP growth rate (5.5%) compared to cities (5.4%).
    - VR GPs in primary care increased in MM 2-7 areas at a rate stronger than in the previous year (5.5% compared to 5.2%).
    - MM 2-7 areas in Western Australia (8.0%), Queensland (6.7%), New South Wales (5.6%), and Victoria (5.4%) recorded a stronger VR GP growth rate in 2019 compared to the previous year.
- As at July 2021, there were 972 participants working towards fellowship and receiving a Non-VR FSP subsidy. Since commencement, 45 participants have been supported to achieve fellowship. The rate of achieving fellowship is expected to increase towards the end of the program when participants have had time to complete their training.
- The Non-VR FSP was recently extended to 30 June 2023, to align with the Other Medical Practitioners (OMPs) programs grandfathering period. The Department has also approved more flexible use of the subsidy funding, such as for exam support and remediation, to better support participants to successfully achieve fellowship.

Growing the Aboriginal and Torres Strait Island Workforce

The SRHS has continued and expanded support for Aboriginal and Torres Strait Islander Health Professional Organisations (ATSIHPOs) to increase the number of people in the Indigenous health workforce and support them in their careers.Under the SRHS, the Government is providing $33.4 million over four years to support and develop the growing Aboriginal and Torres Strait Islander health workforce and to increase the cultural capability of the broader health workforce, to support better care of Aboriginal and Torres Strait Islander people.

Results

Data shows that there has been growth of capacity in ATSIHPOs which will enable them to provide support to a growing Aboriginal and Torres Strait Islander health workforce. There has also been increased involvement of ATSIHPOs in providing professional and educational support, national leadership, partnerships and support across multiple sectors.

- ATSIHPO memberships were up by 83% in 2019 compared to 2017. They delivered 29 cultural safety training programs in 2019.

- 95 mentoring relationships in place between Aboriginal and Torres Strait Islander health workers and ATSIHPOs in 2019-20.
- 36 professional development opportunities were provided to Aboriginal and Torres Strait Islander health workers in 2019-20.

Recruit and Retain

Improving the distribution of the health workforce to areas most in need is a key imperative of the SRHS. The Strategy includes initiatives to improve the Department's ability to identify areas experiencing primary care workforce and service shortages. It also strengthens regulatory provisions to distribute the GP workforce to areas most in need of primary health care services.

The SRHS includes initiatives to improve the supply and distribution of health workers in regional, rural and remote areas through integrating incentives and geographic classification systems.

Together, these initiatives aim to ensure that the supply and distribution of the workforce are calibrated to match the current and forecast health workforce needs.

Improved data usage to identify areas of workforce shortage

A new workforce planning tool called HeaDS UPP has been developed to increase availability of data and assist with health workforce planning. HeaDS UPP provides a single, integrated quality source of health workforce and services data to:

- Measure and analyse the health services needs of a community,
- Plan the workforce required to meet that need, and
- Identify the gaps in the current health workforce.

HeaDS UPP improves consistency and reliability of data analytics. It provides improved geospatial analysis and data visualisation capability by integrating the latest geospatial information from different systems and other health workforce data.

HeaDS UPP provides sophisticated and comprehensive evidence using the geographic catchments (outlined earlier in this submission) to reflect where people live and where they access health services, as well as where health practitioners and services are located (see Figure 1 for a map of GP catchments). While HeaDS UPP's current focus is GPs providing primary care services, the ultimate goal is to develop a whole of health workforce planning tool that includes medical specialists, nursing and allied health.

The evidence base built through the development of HeaDS UPP will be used to better inform policies and programs aimed at improving the distribution of the health workforce and improving access to health service.

HeaDS UPP is available to government and non-government organisations involved in health workforce planning. Health workforce planning encompasses different levels of government

and a range of agencies and stakeholders responsible for planning, managing and operating Australia's health system. By providing a secure, reliable and accessible shared interface, HeaDS UPP increases collaboration among national, state and local planning professionals.

HeaDS UPP will be complemented by the HeaDS UPP Scenario Planner, which will provide an advanced capability to test the impact of different scenarios on workforce supply to inform health workforce and service planning decisions. The HeaDS UPP Scenario Planner will generate health workforce redistribution scenarios up to 30 years into the future. Users will be able to factor in changes to key entry and exit variables, such as training pipelines, retirement ages, and movement of providers between areas. Users will have an improved capability to explore different policy options and recruitment approaches aimed at improving the availability of primary health care services. Development of HeaDS UPP Scenario Planner will continue through to mid-2022, with a beta version expected by the end of 2021.

Results to date

A live version of HeaDS UPP was released on 5 December 2019. Access is gradually being rolled-out to organisations involved in health workforce planning, including RWAs, PHNs, GP medical colleges, RTOs, and State and Territory health departments. Additional organisations will continue to be provided access as needed.

As at 30 June 2021, there were:

- 209 HeaDS UPP users (164 external to Department of Health)
- 14 datasets integrated into the tool.

Visas for GPs Program

The Visas for GPs Program commenced on 11 March 2019 to manage growth in the medical workforce by regulating the number of IMGs in well-serviced metropolitan areas, and directing them to areas of workforce shortage in regional, rural and remote Australia, classified as MM 2-7 locations and which are also DPAs.

The program does not cut expenditure or services, rather it slows the projected oversupply of doctors and reduces unnecessary growth in areas that currently have higher than average access to primary health care services.

To achieve this, a new requirement was introduced for employers seeking to recruit an IMG. In select occupations (General Medical Practitioner, Resident Medical Officer and Medical Practitioners not elsewhere classified), employers must obtain a Health Workforce Certificate (HWC) from an RWA as part of the Employer Sponsored visa nomination process. HWCs are only issued where there is an identified need to fill an additional primary health care position in a given location.

RWAs conduct position assessments using the Department's assessment tool and are responsible for issuing HWCs. The assessment tool uses an evidence-based approach to identify genuine need for additional primary health care services in a GP catchment where

patients are accessing general practice services. This is based on characteristics of the GP catchment including: the number of dedicated GPs in the catchment; GP over-capacity; service complexity; the level of socio-economic disadvantage; the types of services available; and the demographics of patients and providers. The assessment tool assists in identifying areas of greatest need by comparing primary health care services delivered in areas with similar populations.

The program aimed to reduce IMGs entering primary health care by 200 in 2018-19, 355 in 2019-20, 2020-21 and 2021-22 and 155 in 2022-23. The program only limits the number of overseas trained doctors in well-serviced capital cities and metropolitan areas. It does not limit the number of IMGs working in hospital-based positions or limit overseas trained non-GP medical specialists.

The program works in tandem with distribution policy tools including section 19AB of the HIA. Section 19AB4 of the HIA improves the geographic distribution of IMGs by linking MBS access to their work in DPA locations for general practice and DWS for all other specialties. However, being eligible for section 19AB exemptions does not automatically equate to eligibility for a HWC, as section 19AB exemptions are independent of the HWC assessment process and of the Visas for GPs program.

Results to date

Since commencement, the Visas for GPs program has achieved its dual policy objectives of reducing the intake of the IMGs entering the primary health care system and redirecting them to regional, rural and remote areas of Australia.

The program has seen:

- A reduction of around 350 IMGs entering the primary health care system in 2020-21. The total reduction target in 2020-21 was 355 compared to baseline (2017-18) levels.
- An increasing proportion of IMGs directed to MM 2-7 areas to work in primary health care (from a baseline of 29% in 2017-18):
    - 362 (59% of total) in 2020-21
    - 411 (53% of total) in 2019-20
    - 163 (35% of total) in 2018-19.

Enhancements to Bonded Medical Program

The Government's Bonded Programs have been in operation since 2001. The statutory Bonded Medical Program (the program) commenced on 1 January 2020. Up to that point, there were two legacy schemes - the Medical Rural Bonded Scholarship Scheme and the Bonded Medical Places (BMP) Scheme – which are both now closed to new entrants.

The program provides students a CSP in a medical course at an Australian university in return for a commitment to work in eligible regional, rural and remote areas for a specified period after completion of their medical course. This commitment is referred to as a Return of Service Obligation (RoSO).

Legacy scheme participants can request to opt in to the program. Since 1 January 2020, all successful new medical student applicants have entered the program directly.

The program is a critical component of the SRHS to ensure that the Australian trained medical workforce is well-distributed, flexible and targeted to areas of most need. The Department acknowledges the commitment made by participants to regional, rural and remote Australia.

The key features of the program are:

- a standard three (3) year RoSO to be completed over an eighteen (18) year period. NB: Participants of the BMP Scheme 2016-2019 cohort who have a twelve (12) month RoSO will keep this under the new arrangement;
- replacement of the individual contract/deed of agreement approach of legacy schemes with a statutory scheme;
- a Program specific web portal, the Bonded Return of Service System to provide self-service management of RoSO;
- a wider range of options as to when, where and how participants can complete their RoSO within the Program's time frame and requirements. 18 months can be completed pre-fellowship and 18 months completed post fellowship. RoSO can be non-continuous, full or part-time work, and fly-in/fly-out work in eligible locations may be counted towards RoSO;
- more choice and more locations with participants able to complete their RoSO in MMM 2-7 locations, and in DPAs for General Practitioners or in a DWS for Specialists for their medical speciality; and
- no restrictions on working in areas which are not eligible for RoSO during the 18-year period.

To avoid unintended impacts on participants, in June 2020, opt ins to the statutory program for legacy scheme participants were placed on hold while the Department clarified the Program completion timeframes and other aspects of the opt in process.

On 16 March 2021, the Department emailed more than 2000 individuals in the legacy programs advising them of issues that arose during the early implementation of the program and offering them a choice to opt into the new statutory program or to remain in their legacy scheme.

The Department is continuing to progress individual cases for and to minimise any impacts for affected individuals. These issues are outlined in more detail in the monthly updates that the Department is posting on its website[97].

Progressing cases involves understanding each individual participant's circumstances and any actions taken since the individual was not correctly bonded under the statutory

[97] Department of Health, The Bonded Medical Program, https://www1.health.gov.au/internet/main/publishing.nsf/Content/reformed-bonded-programs

program during 2020. Managing cases on a no disadvantage basis also requires thorough assessment of both recent and historic actions. Information on the process is detailed in the July 2021 Update[98].

The Department is prioritising those individuals who opted into the new program but were not correctly bonded, thought that they had completed their obligations and exited the program. Resolution of these cases is progressing well.

In addition, the Department has commenced allocating cases for individuals who opted into the program but were not correctly bonded and still need to complete their RoSO. A case manager will work with the affected individual to understand their personal circumstances and tailor a solution.

The Department also recognises there are many individuals who expressed their interest to opt in during 2020 and await a response. These cases will also be progressed.

rBBI

The rBBI provides extra funding to GPs who accept assignment of the patient's MBS rebate as full payment for their services. The rBBIs were aligned to the MMM 2019 on 1 January 2020 to better support rural and remote service delivery. This alignment ensured the higher incentives were correctly targeted to practitioners working in regional, rural and remote areas, rather than in metropolitan areas or larger towns.

Eligibility for rBBIs is now based on a bulk-billed service being provided in a MM 2-7 area. The implementation was delayed from 1 July 2019 to 1 January 2020 to allow practices (particularly those in metropolitan areas no longer eligible for the incentives) time to adjust their business models. The delay reduced the initially forecast savings by around $25.9 million.

In the 2021-22 Budget, the Government announced a $65.8 million investment to implement a progressive incentive schedule that increases bulk billing payments for doctors in remote areas and rural towns.

These changes aim to improve access to quality health services for rural and remote Australians by reducing out-of-pocket costs for patients and improving the viability of primary care services in their communities.

Scaling the rBBI will better recognise that doctors in rural and remote areas face higher operating costs, smaller patient populations, increased complexity in patient care, and carry a greater burden of responsibility for the healthcare needs of people living in these communities.

From 1 January 2022, the rBBI will progressively increase from the current rate of 150% of the bulk billing incentive in metropolitan areas as classified under the MMM to:

[98] Ibid

- 160% for GPs in MM 3–4, large (population 15,000 to 50,000 residents) and medium (population 5,000 to 15,000) rural towns
- 170% in MM 5, small rural towns (population up to 5,000)
- 180% in MM 6, remote areas, and
- 190% in MM 7, very remote areas.

Workforce Incentives Program

The Workforce Incentive Program (WIP) improves access to quality medical, nursing and allied health services and team-based care in regional, rural and remote areas. The program has two streams, the Doctor Stream and the Practice Stream (PNIP). The WIP replaced the General Practice Rural Incentives Program for doctors and the Practice Nurse Incentive Program for employed practice staff.

The WIP provides financial incentives of more than $500 million per year. More than 8,000 doctors and 5,600 practices receive incentives under the WIP each year.

Doctor Stream

The WIP – Doctor Stream provides targeted financial incentives to encourage doctors to deliver services in rural and remote areas (MM 3-7 locations). Participating doctors receive direct payments for delivering eligible primary care services in an eligible location. Payments are based on how long a doctor has been part of the program, and increase for more remote locations, encouraging ongoing service in eligible locations.

Table 4 shows the maximum annual payments available to medical practitioners across each MM category at each Year Level. A participant's Year Level refers to the duration of their active service within the program[99].

Table 4: Maximum annual incentive payment amounts

Location (MM)	Year 1	Year 2	Year 3	Year 4	Year 5 plus
MM 3	$0	$4,500	$7,500	$7,500	$12,000
MM 4	$0	$8,000	$13,000	$13,000	$18,000
MM 5	$0	$12,000	$17,000	$17,000	$23,000
MM 6	$16,000	$16,000	$25,000	$25,000	$35,000
MM 7	$25,000	$25,000	$35,000	$35,000	$60,000

Note: The MM 3 category in the table also includes participants on approved training pathways undertaking selected approved training in MM 1 and MM 2 locations.

[99] Department of Health, Workforce Incentive Program guidelines, https://www.health.gov.au/resources/publications/workforce-incentive-program-guidelines.

In 2020-21, $122 million in payments were made through the Doctor Stream to 8,317 medical practitioners.

Practice Stream

The WIP – Practice Stream commenced on 1 February 2020. The Practice Stream helps general practices across Australia with the cost of employing nurses, Aboriginal and Torres Strait Islander health practitioners and health workers, and a range of allied health professionals to work in the practice.

It encourages multidisciplinary and team-based models of care, giving practices the flexibility to consider the needs of their community when determining which health professionals to engage in the practice. This is helping practices to meet the increasingly complex health needs of people living with chronic and complex conditions.

Eligible practices in all locations can receive incentives of up to $125,000 per year, depending on the practice size and hours worked by professionals in the practice. A rural loading between 20% and 50% is applied to incentive payments to practices depending on level of remoteness.

Results

In 2019—20, there was a 6.2% increase in medical practitioners receiving incentives under WIP-Doctor Stream:

- 2019-20 – 8,292 (>8,000 target)

As at 2 November 2020, there were 5,604 approved practices participating in the WIP-Practice Stream and a steady growth in practice participation over time:

- 2019-20 – 5,542 (>5,000 target)
- 2018-19 – 5,393 (4,100*target)[100]
- 2017-18 – 5,166 (4,100*target).

Delivering care in very remote locations - RFDS

The SRHS included an additional $84.1 million over four years from 2018-19 to 2021-22 to increase the availability of dental services, provide new mental health services and ensure availability of emergency aeromedical evacuations. This funding is part of the $327.2 million that the RFDS will receive over the same period.Rural Health Outreach Fund

Results

The RFDS funding is supporting an increase in primary care (dental and mental health services) through the SRHS, including:

- 19,933 dental health services in the six months covering Jul-Dec 2020. In the full 2019-20 year, the RFDS provided 43,456 dental health services.

100 2018-19 and 2017-18 targets refer to the former PNIP program

- 6,534 mental health services in the six months covering Jul-Dec 2020. In the full 2019-20 year, the RFDS provided 9,857 mental health services.

Educating the nurse of the future

In 2019, an independent review of nursing education considered factors that affect early career workforce participation and articulation of future career pathways. The review made 26 recommendations for the educational preparation required for nurses to meet the future health, aged care, and disability needs of Australians.

Results

The Educating the Nurse of the Future report was provided to Government in September 2019.

The majority of the recommendations are directed to the nursing profession and are outside the direct responsibilities of the Commonwealth Department of Health or DESE. Both Departments will work closely with the Nursing and Midwifery Board of Australia, Ahpra, the Australian Nursing and Midwifery Accreditation Council and jurisdictions through the National Nursing and Midwifery Education Advisory Network (NNMEAN) to implement the recommendations.

There is an intersection between a number of recommendations and other reviews in the health sector including the Accreditation Systems Review and the Royal Commission into Aged Care Quality and Safety. The NNMEAN will monitor implementation of overlapping recommendations to ensure alignment.

The Government supported recommendations relevant to the Department of Health:

- To protect the public, assistants in nursing (whatever their job title) should have mandated education, English language, and probity requirements, which are accredited, assessed and enforced by a robust quality-assurance regime.
- The Department should review the RHMT program guidelines to ensure that nursing education gains the benefits of longer regional placements, interdisciplinary training, and travel subsidies.
- The Department should fund a national campaign designed to attract under-represented groups to nursing. NNMEAN should oversee the campaign and ensure that key stakeholders are engaged in its development and conduct.
- The Department should sponsor research aimed at determining the ideal mix of online and face-to-face teaching as well as how best to integrate simulation and clinical placements.
- The NNMEAN should be given responsibility for monitoring the realisation of this review's recommendations.
- The Government should consider commissioning a follow-up review after four years, with the aim of assessing the progress in implementing the recommendations contained in this report.

Strengthening the role of nurses in primary health care

Under the SRHS, the Australian Primary Health Care Nurses Association is funded $8 million over four years from 2018-19 – 2021-22 to deliver the Nursing in Primary Health Care (NiPHC) Program.

The NiPHC program aims to increase the capacity of the primary health care nursing workforce, model innovative nurse-led models of care, and influence recruitment and retention of primary care nurses in regional, rural and remote areas through investment in education and training for the nursing workforce. The three components to the NiPHC program are:

- The Transition to Practice Program (TPP), which aims to recruit up to 150 nurses in total across the four-year funding period. Each nurse will be supported to transition into primary health care via a 12-month program, which includes education and mentor support;
- Building Nurse Capacity (BNC) clinics, which aims to recruit and support 35 primary health care organisations to implement nurse-delivered team-based models of care; and
- Chronic Disease Management and Healthy Ageing workshops (CDMHA), which aims to deliver one day evidence-based training workshops on the management of chronic diseases and healthy ageing for nurses working in primary health care.

The initiative's distribution targets (up to 150 nurses over four years with up to 75 nurses (50%) in rural/remote areas) influences the recruitment and retention of nurses in regional rural, remote areas through training in MM locations.

Results

The NiPHC initiative is delivering the distribution outcome for the nurses in primary care although the target numbers are relatively small.

As at 31 December 2020, 149 nurses have participated in the TPP. At at 31 December 2020, 60 of 149 (40%) nurses recruited under the TPP are in rural and remote (MM 3-7) locations.

Retention in primary health care following participation in the TPP has been high. After six months, 61% of the 36 Tranche 1 transitioning nurse survey respondents remained in primary health care (as at 31 December 2020).

The BNC project is being delivered in 2 tranches:

- 18 BNC clinics participated in Tranche 1 (Feb 2019-July 2020), with one clinic exiting the project early and three not completing the program due to COVID-19.
- 14 completed the program.
- 7 of the 18 clinics (39%) were located in rural and remote (MM 3-7) locations.

As at 31 December 2020, 18 CDMHA professional development workshops have been delivered (12 face-to-face, and 6 online). Of the 12 face-to-face workshops, 3 were delivered in rural and remote areas (MM3-7).

Rural Generalism

The 2012 Senate Standing Committee on Community Affairs report had recommended considering an expansion of the rural generalist model, where rural GPs provide primary care, as well as emergency and other specialist skills to the community. The 2013 Mason Review emphasised the need to focus on generalist skills.

By 2018, the concept of rural generalism had been gaining momentum for around 10 years, however it was used in a wide variety of contexts and had multiple meanings. The key concept of rural generalism was based on the concept that in smaller rural towns, community needs could be best met by GPs having extra skills in areas such as mental health, palliative care, obstetrics and anaesthetics. In cities, these services would be provided by a non-GP specialist.

The Office of the National Rural Health Commissioner (the Commissioner) was established to provide advice to Government on the development of a NRGP (the Pathway). In early 2018, the Commissioner brokered the first step towards a Pathway with the Collingrove Agreement, which for the first time established a national definition of a rural generalist doctor.

Under the Collingrove Agreement, rural generalists are doctors trained to meet the specific needs of rural and remote communities by providing comprehensive general practice and emergency care and required components of other medical specialist care in hospital and/or community settings as part of a rural healthcare team.

Towards a NRGP

In December 2018, the Commissioner presented 19 recommendations to Government for implementation of a dedicated medical training pathway to attract, retain and support rural generalists. By investing in a rural generalist workforce, regional, rural and remote communities will have access to a broader range of locally available medical services, supporting these communities to access the right care, in the right place, at the right time, as close to home as possible.

In response, the 2019-20 Budget provided $62.2 million over four years to commence the development of the National Pathway. This funds three core initiatives:

- An application to the MBA for subspecialty recognition of Rural Generalist Medicine within the specialty of General Practice
- Establishment or expansion of Coordination Units for rural generalist training
- An expansion of the RJDTIF.

Recognition of Rural Generalist Medicine will provide a nationally consistent training framework and scope of practice for rural generalists, as well as recognition for the skills

and knowledge of doctors who provide advanced or secondary level services in rural and remote communities. The GP Colleges submitted a revised application to the MBA on 5 July 2021.

Coordination Units aim to improve workforce supply by coordinating the training pipeline for rural generalists and develop a strong link between hospital and primary care training.

The RJDTIF RG expansion provides up to 200 new rural primary care rotations per calendar year to support PGY 1 & 2 junior doctors interested in or on the Pathway. Rotations will be delivered by the Coordination Units who have the responsibility of managing the new rural primary care rotations.

The 2019-20 Budget provided funding for the recommendations from the Commissioner that could be progressed immediately by the Commonwealth. The remaining recommendations require joint commitments from the Commonwealth, state and territory governments and key stakeholders.

Results

Due to the multi-year timeframes involved in training as a rural generalist, the Pathway represents medium to long term investments in rural primary care. To date, key progress includes:

- Coordination Units have been established to provide localised support for trainees in navigating the end-to-end training requirements for rural generalism and post-fellowship support.
- Funding agreements are in place with Coordination Units in all states and the Northern Territory until 30 June 2023. As of 17 August 2021, the Department has executed grant agreements with six Coordination Units for RJDTIF primary care rotations: Tasmania, Queensland, Northern Territory, Western Australia, Victoria and South Australia. New South Wales is yet to execute its grant agreement.
- The primary care rotations will be incorporated into the new JFPDP from 1 January 2021.

Rural Generalist Training Scheme

The SRHS included funding of $49.7m (GST excl) over four years for the Rural Generalist Training Scheme (RGTS). The RGTS was established in February 2021 and will be delivered through ACRRM, with up to 100 RG training places each year.

The RGTS is a four-year, fully funded GP training program that leads to Fellowship of ACRRM. The RGTS is a component of the NRGP, acknowledging the extended requirements and skills of RGs. It focuses on meeting the diverse needs of regional, rural and remote Australians. The intended outcomes of the RGTS are:

- Increased access to primary healthcare services in rural and remote communities;
- Safe and high-quality primary healthcare services delivered by well-trained general practitioners with training in extended skills; and

- Increased interest in a career as a rural generalist general practitioner.
- Trainees are yet to commence on the RGTS, and recruitment activities are ongoing.

Murrumbidgee Innovative Employment Model

The Murrumbidgee Rural Generalist Training Pathway (MRGTP) trial, formerly known as the Murrumbidgee Single Employer trial, commenced on 1 November 2020. It tests the feasibility of flexible employment arrangements between the hospital system and community primary care settings in MM 4-7 locations.

Five trainees have commenced training in the locations of Wagga Wagga, Gundagai, Temora, Cootamundra and Young. A maximum of twenty rural generalist trainees will take part in the trial over four years.

Additional programs relevant to the NRGP

Rural Procedural Grants Program

The Rural Procedural Grants Program (RPGP) aims to improve rural and remote healthcare service delivery and workforce retention by supporting procedural VR GPs to undertake CPD to maintain or enhance existing procedural and emergency medicine skills (including emergency mental health).

The program recognises that in rural, remote and very remote locations, GPs make a critical contribution to their communities by providing services that would be referred to a specialist in a metropolitan location.

The program provides rural GPs and eligible locum GPs with a grant, to partially subsidise the costs of attending approved CPD activities to maintain and enhance their procedural and emergency medicine skills, relevant to their location and community need.

It is a demand driven program and was first implemented in 2004 with the policy objective of supporting rural health care service delivery and workforce retention. The RPGP has two components:

- Rural procedural GPs practising in surgery, anaesthetics and/or obstetrics.
- Rural GPs practising emergency medicine (including mental health services).

Eligible GPs can receive up to a maximum of $32,000 in grants per annum ($20,000 for procedural GPs and $12,000 for emergency medicine GPs, noting GPs can be eligible for both) to maintain procedural and emergency medicine skills.

In the 2020/2021 financial year, the grant agreements to administer the program totalled $19,165,000 (GST exclusive). In June 2021, Minister Hunt agreed to the program being extended to 31 December 2023 at a cost of up to $38.9 million.

From July 2020, this program transferred to using MMM geographical classification system with eligible doctors working in MM 3-7, previously it has used the ASGC-RA. This amendment aligns with the commitment to transition Commonwealth workforce programs to the MMM classification.

During 2020, amendments to the program guidelines were implemented to respond to the COVID-19 pandemic, allowing for participants to claim for online CPD activities that are normally out of scope for RPGP grant support. This temporary amendment allowed rural GPs to maintain their procedural skills through the period of border restrictions and social distancing. The current end date for these COVID-19 amendments is December 2021.

General Practitioner Procedural Training Support Program

Similar to the RPGP, the General Practitioner Procedural Training Support Program (GPPTSP) aims to improve access to maternity services for women in rural and remote communities by supporting VR GPs practising in rural and remote communities (MM3 – 7) to attain procedural skills in obstetrics and anaesthetics.

The GPPTSP is a competitive scholarship program providing $40,000 (GST exclusive) to cover the costs of training and time away from a practice to up to 10 GP Fellows to gain a statement of satisfactory completion of Advanced Rural Skills Training in Anaesthesia and up to 25 GP Fellows to achieve the Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology.

There have been ten rounds of the program from 2010 to 2020. The positions on offer have been increasingly difficult to fill despite widespread promotion of the program. This is partly due to the program only being open to VR GPs since 1 January 2019. Additionally, some successful candidates have struggled to find a training position, as they are competing with registrars undertaking advanced skills posts as part of their Fellowship requirements.

From 1 January 2019, the program's geographic eligibility criteria updated from ASGC-RA 2-5 (2006) to MM 3-7.

Terms of Reference C: Impact of COVID-19 on doctor shortages in outer metropolitan, rural and regional Australia

The COVID-19 crisis has challenged the Department to ensure Australia's health workforce has been able to continue to deliver high quality services to the community in the short and long term.

Immediate issues included protecting the workforce from viral transmission, overwork, and mental health impacts of the pandemic. Elective procedures were deferred and resources were channelled into intensive care, infectious diseases and public health expertise. Longer-term issues include managing the disruption to training programs, overseas recruitment, and the impacts to migration and population growth. There may also be changes to the way some services are provided in future, following the rapid expansion of telehealth in the delivery of primary care services. This may produce benefits to patients and some providers, but appears to have reduced demand for specialised after hours providers.

Understanding the long-term impact of the COVID-19 virus on those infected may also impact on models of care and demand for particular types of services in areas hardest hit by the pandemic.

The Department has worked closely with key stakeholder organisation on arrangements to provide continuity and flexibility in workforce supply and development.

Impacts on GP MBS billing

The number of GPs increased from 37,472 in 2019 to 37,785 in 2020. However, the number of trainees and non-VR GPs decreased from 3,916 to 3,774 and 4,003 to 3,866 respectively. Anecdotal reports are that some practices closed but their number or location is not published. As already mentioned, the reduction in non-VR GPs was planned. The unplanned reduction in GP registrars due to decreased applications to the specialty was compounded by a small number of GP registrars having to leave their practices because there was insufficient patient load or for other personal reasons.

Despite the overall increase in GP numbers, calculated GPFTE dropped 1.5% from 29,854 in 2019 to 29,419 in 2020, after years of successive growth. This has several potential causes. Some GPs switched to work some sessions in state government roles in public health or respiratory clinics, and some took leave because of their own health or the need to care for family members during lockdowns.

Cancellation of elective surgery led to a reduction in GPs' provision of anaesthetics and assistance at operations which is seen in reduced claims against these Broad Types of Service (BTOS) items. Attendances to GP surgeries for management of chronic disease reduced, whilst anecdotal reports are that GPs non-billable and non-clinical time increased due to the need to learn about and prepare practices and staff for changing local restrictions and guidelines.

Reduced intrastate and interstate travel due to COVID-19 may have caused the reduction in the number of GPs working in New South Wales, Western Australia, South Australia and the Australian Capital Territory, and in MM 3-6 and MM 7 between 2019 and 2020. In the Northern Territory, the number of GPs has been decreasing since 2017 so this is less likely to be just due to COVID-19.

Impact on workload and wellbeing

Reports on the impact of COVID-19 on GP workloads and wellbeing are still emerging. An early report by the ANZ-Melbourne Institute[101] reported that around one-quarter of GPs reported falls in working hours, while one-quarter reported increases in working hours. Female GPs were more likely to report an increase in working hours.

The same report[102] found that around 60 per cent of doctors reported feeling more stressed than usual, similar for both GPs and non-GP specialists. This was associated with a fall in income. Those who were financially stressed or had applied for JobKeeper payments for their practice staff were more likely to report probable serious mental illness.

Maintaining access to workforce and services

Telehealth reforms

In March 2020 telehealth item numbers were expanded to enable video and telephone consultations to reduce the risks of the COVID-19 spreading via face-to-face contact. Since that time, over 300 new temporary COVID-19 MBS telehealth items have been implemented as part of the Government's COVID-19 response.

Previously, telehealth item numbers were available for specific circumstances, such as improving access to care for patients in rural and remote areas. The COVID-19 MBS telehealth services can be provided by: GPs and non-specialist medical practitioners providing services to a known patient; consultant physicians and specialists including psychiatrists, anaesthetists and dental specialists; nurse practitioners; midwives; and allied health practitioners including for mental health services.

COVID telehealth arrangements have been refined over time since first being introduced. Changes made on 20 July 2020 mean GPs may only provide an MBS COVID-19 telehealth service if they or their practice has an existing clinical relationship with the patient. An existing relationship is established through a face to face consultation with the patient either delivered by the same GP, or another practitioner at the same practice, in the previous 12-months. There are some limited exemptions to this requirement including for patients living in a COVID-19 impacted area (a Commonwealth declared hot spot or other

101 Scott, A. (2020) *The impact of COVID-19 on GPs and non-GP specialists in private practice*, ANZ-Melbourne Institute Heath Sector Report, Melbourne Institute Applied Economic and Social Research.
102 Scott, A. (2020) *The impact of COVID-19 on GPs and non-GP specialists in private practice*, ANZ-Melbourne Institute Heath Sector Report, Melbourne Institute Applied Economic and Social Research.

area where a person's movement is restricted by a State or Territory public health requirement to isolate or quarantine).

Initially, GPs were required to bulk bill telehealth consultations. To support GPs, between 30 March 2020 and 30 September 2020 the bulk billing incentive payment was doubled (including the rBBI) and specific bulk billing MBS incentive items were introduced. This measure ceased on 1 October 2020. From 1 October 2020, GPs are no longer required to bulk bill their telehealth services and may make decisions about whether to bulk bill eligible patients, including for telehealth consultations, as per normal GP services. The Government continues to work with peak bodies and consumer groups to design ongoing telehealth services as part of broader primary care reforms to modernise Medicare and provide flexibility of access to primary and allied healthcare services.

Impact of telehealth reforms

In 2019 GPs claimed 0.05 million MBS telehealth items. In 2020 this increased very significantly to 36.96 million. There was a decrease in standard (face to face) consultations from 100.86 million in 2019 to 77.99 million in 2020[103].

Since 13 March 2020, over 73 million MBS COVID-19 telehealth services have been delivered to over 15 million patients by more than 87,000 providers. Almost 25 per cent of all COVID-19 MBS telehealth services have been provided to Australians in rural and remote locations.

As part of the 2021-22 Budget, the Government committed $204.6 million to extend COVID-19 MBS telehealth to 31 December 2021, building on previous investment of $3.6 billion since March 2020.

Appendix D: MBS data since introduction of COVID-19 telehealth services provides more information on MBS data since the introduction of COVID-19 telehealth services.

Residential Aged Care Facilities during COVID-19

Temporary MBS items are available until 30 June 2022 to support people living in Residential Aged Care Facilities (RACFs) with their mental and physical health, especially those who have been affected by the COVID-19 pandemic.

Residents can now access an additional five services per calendar year for selected physical therapy services (exercise physiology, occupational therapy, and physiotherapy). Residents can also access up to 20 Medicare subsidised individual psychological services each calendar year (psychiatrists, psychologists and general practitioners) through the Better Access initiative.

To access services, the resident must have a referral from a GP or other medical practitioner as part of a GP mental health treatment plan or psychiatrist assessment and management plan, or a psychiatrist.

[103] Department of Health (2021), General Practice Workforce providing Primary Care services in Australia, https://hwd.health.gov.au/resources/data/gp-primarycare.html.

Flag fall fees are also now available for GPs, other medical practitioners and allied health practitioners, making it easier for them to deliver face-to-face services in RACFs.

In addition, temporary face-to-face MBS items have been introduced for RACF residents to support longer initial individual allied health chronic disease management services and initial Indigenous follow up services.

The Government is funding in-reach group physical therapy sessions, via PHNs, for residents in RACFs affected by COVID-19 outbreaks to restore physical functioning impacted as a result of COVID-19 disease or lockdowns. There 119 RACFs eligible for this program are those that had experienced a COVID-19 outbreak as at October 2020.

The therapies included in this measure are physiotherapy, exercise physiology and occupational therapy. This is a time limited boost measure, with the group therapy to run twice-weekly for six months only. The program has been impacted by recent COVID-19 restrictions in NSW and Victoria. To accommodate these additional restrictions, it is anticipated that the program will continue to be rolled out until 31 March 2022.

Increasing the available workforce

The Department has worked to identify people in the health workforce who are not fully utilised, so that additional capacity can be released into the system. This may include doctors and nurses working part-time hours, those not working because elective procedures were cancelled and other registered health professionals currently not practising.

In collaboration with Ahpra and the relevant National Boards, a short-term pandemic response sub-register was established from 6 April 2020. This enabled qualified and experienced, but not currently practising, doctors, nurses, midwives, pharmacists and Aboriginal and Torres Strait Islander Health Practitioners to quickly and safely return to practice. The sub-register included 29,000 practitioners available to employers.

For primary care, the department established a web portal with the Recruitment, Consulting and Staffing Association Australia & New Zealand where those wishing to return to primary care from the Ahpra sub-register could register their interest.

The department has also been working to better utilise the nurse practitioner workforce during the pandemic through connecting nurse practitioners and Vaccine Administration System providers.

Maintaining services through flexibilities in workforce programs

The Government invests around $1.5 billion in health workforce programs that enhance access to health services across Australia and ensure the community benefits from a high quality workforce, trained to professional standards. These programs are an important platform to address emerging pressures for local health services delivering the COVID-19 response.

The following key initiatives were adjusted as part maintaining access to workforce and services during the COVID-19 pandemic:

- Enhancing locum support. Locums play a key workforce role, including replacing health workers who may have contracted COVID-19, are in isolation or experiencing burn out. The Government introduced a range of flexibilities, including extending the locum tenens from two to 12 weeks without needing a new Medicare provider number, and extending the eligibility of the RLAP to cover instances of illness or isolation, or for vacant positions.
- PIP. Temporary changes were made to the PIP Teaching Incentive to enable teaching of medical students via teleconferencing and other flexibilities to continue payment of the incentive.
- After hours. Extension to expiring deeds of agreement under the AMDS program were applied where accreditation site visits were unavailable. This ensured that participating doctors can continue to deliver after-hours home visits.
- Supporting the RFDS. The Department agreed to flexibilities in the existing RFDS funding to support the COVID-19 response, including enhancing the RFDS telehealth platform, increasing the workforce to operate this service, and supporting demand for aeromedical evacuations for people identified with or at risk of contracting COVID-19.

As part of the $2.4 billion National Health Response Plan for COVID-19, the Government also provided a one-off investment of $52.8 million to increase aeromedical capacity to evacuate COVID-19 cases and deliver equity in healthcare to vulnerable populations in rural, regional and remote Australia. Funding was provided to state aeromedical providers and the RFDS, including to support delivery of fly-in GP respiratory clinics and testing.

Additionally, funding of $10 million was made available for GP locum relief to specific areas of shortage arising from the COVID-19 pandemic. However, this did not proceed due to lack of demand from the primary care workforce. This was in part due to the introduction of telehealth items in March 2020 and the inability for GPs to take leave and undertake professional development, which reduced demand for locum support in 2020.

Maintaining distribution

The COVID-19 virus has placed significant workload pressures on doctors and medical practices across Australia over a long period of time. Many practices in regional, rural and remote areas were already facing challenges and doctor shortages prior to the COVID-19 pandemic.

Distribution mechanisms, such as the application of rural program classifications through the MMM and the application of DPA have been maintained for program and Medicare provider number eligibility assessment to ensure there was no encouragement for the workforce to move out of rural and remote Australia during the pandemic.

In recognition that border, quarantine and lockdown restrictions were impacting the movement of doctors, in the period to 31 October 2021, the Department allowed the automatic extension of section 19AB exemptions for up to 6 months for some doctors with expiring provider numbers.

We also introduced automatic extensions for section 3GA placements and extended program end dates by 6 months. Affected 3GA initiatives include the:

- Special Approved Placement Programs
- AMDS
- MDRAP.

Impacts on workforce supply

Impact on overseas recruitment

COVID-related border restrictions and decisions not to travel will see fewer than anticipated IMGs entering the primary health care system in the 2020-21 program year.

Under the Visas for GPs Program, there was a small increase in the reduction of IMGs entering the primary health care system from around 336 in 2019-20 to around 350 in 2020-21. Part of this increased reduction can be attributed to the impact of COVID-19.

Impacts on future workforce supply

The pandemic has impacted both training of health professionals and the clinical education arrangements for students that occur within health services. Key stakeholders, including governments, employers, universities and regulators have worked together to develop approaches to minimise disruptions and maintain future workforce supply. Students and health professionals in training and their teachers and supervisors, have adjusted to major changes to their expected study and work. Despite this disruption most health professionals have completed their course of study as expected.

The Government provided temporary waivers to ongoing rural workforce and training program participation requirements, due to postponed examinations and training courses, and to ensure health professionals remain available in rural and remote locations. These arrangements ceased on 31 October 2020.

Health students

Student clinical placements were significantly disrupted in 2020 by COVID-19, including travel restrictions and safety requirements. National principles for clinical education during the COVID-19 pandemic were agreed to guide the decisions of professions, accreditation authorities, education providers and health services about student clinical education during the COVID-19 pandemic response. These were published on the Department's website on 24 April 2020 and announced on 1 May 2020.

Due to the COVID-19 pandemic, in 2020 a reduction in the total number of placements was observed, but the average duration of short-term placements was slightly longer. This can be seen in the medical training data under the RHMT Program, with short-term medical placements increasing to an average of around 4.14 weeks in duration in 2020 compared to approximately 3.89 weeks in 2019. Additionally, there was a small increase of 12-month medical placements in 2020 compared to 2019 which may reflect some students staying in one location for a longer period to minimise the impact of COVID-19 travel restrictions.

A survey in 2020 of RHMT Program universities indicated most would not meet rural training targets - medical, nursing, dental and allied health rural placements were affected, requiring a change in placement duration, location, or a complete cancellation. Many placements were cancelled, particularly those in remote and highly vulnerable communities. Many interstate placements were cancelled due to border restrictions, uncertainty about changing border arrangements, and quarantine/biosecurity requirements.

Universities reported developing innovative methods using digital platforms to continue their curriculum and provide clinical skills training remotely. Initial analysis of RHMT program data supports Australian Rural Health Education Network research that identified multidisciplinary placements were adversely impacted more than medical and nursing placements. RHMT program data for 2020 indicates multidisciplinary placements were reduced by both number and duration and this was more evident in Victorian Universities and those with placements in the Northern Territory. The survey will be repeated in 2021 to investigate ongoing issues Universities are facing with COVID 19 restrictions.

Medical students

On 1 May 2020 the Commonwealth Government announced a new paid medical assistant role to employ some final-year medical students in health care as part of the response to COVID-19, with further exploration between Medical Deans Australia and New Zealand (MDANZ) and all states and territories to support the health care workforce during this health emergency. A recent evaluation found that the Assistant in Medicine position was effective and a useful addition to the medical workforce during 2020. The role has also had unplanned benefits in supporting medical student transition to internship[104].

On 28 May 2020, the Government announced funding of $690,000 to MDANZ to support online mental health first aid training for medical students to ensure they can recognise and respond to the extra stresses associated with the COVID-19 pandemic. Uptake has been positive and 2,734 medical students have now completed the online training. Student feedback has been predominantly positive.

[104] NSW Health, Assistant in Medicine Evaluation Report, https://www.health.nsw.gov.au/workforce/medical/Pages/aim-evaluation-report.aspx#:~:text=Assistant%20in%20Medicine%20Evaluation%20Report%20The%20Assistant%20in,and%20support%2C%20as%20part%20of%20the%20multi-disciplinary%20team.

Junior doctors

Australian Health Ministers' Advisory Council endorsed maintaining the current clinical year start date for 2021, following consideration of a national approach to Junior Medical Officer Recruitment.

The Commonwealth's JDTP (see section titled 'Early rural primary care experiences: Junior Doctor Training Program') has been affected by changes to some training rotations and the prioritisation of COVID-19 work within hospital settings. A flexible approach is being taken to placement targets in the short term while maintaining long term partnerships across training networks.

GP registrars

Early research by GP Synergy[105] comparing the impact of COVID-19 on GP registrar experiences found that consultation durations were shorter during COVID-19 (significantly shorter for telehealth) with fewer problems seen during the consultation, both of which have implications for registrars' education experience. The research also raised concern regarding the educational breadth and depth of registrar experiences during COVID-19, with early data suggesting considerable decreases in registrars performing some procedures such as cryotherapy and cervical screening, but large increases in administering intramuscular injections. As these finding are based on early data, more research is needed to clarify the impact of COVID-19 on registrar education and procedural experience.

Policy changes were introduced to the AGPT program providing additional flexibilities for registrars, including extensions to training times, leave and transfers between training locations and regions. These aimed to support registrars required to spend a longer time in training due to the postponement of RACGP fellowship exams.

Review of COVID-19 impacts on training

The Australian Medical Council (AMC) and the Council of Presidents of Medical Colleges (CPMC) received funding from the Department to investigate the impacts of the COVID-19 pandemic on specialist medical training and accreditation in Australia.

Early indications from an initial review of literature and stakeholder consultations undertaken by CPMC[106] confirmed the pandemic impacted training requirements, education delivery, wellbeing and clinical practice. Some of these impacts were new, particularly those related to travel restrictions and the rapid transfer of materials online.

Other initial CPMC findings were that the pandemic exacerbated long standing issues like geographic maldistribution of specialists, inflexibility of training requirements and delivery, and a lack of coordination in determining training places. Stakeholders rapidly responded to

105 This early research is based on 75.1% of GP Synergy registrars, with data collected from 2 March 2020 to 12 June 2020. Unpublished paper: GP Synergy (2020) 'Comparison of registrars; general practice experience before and during COVID-19: GP Synergy', Version 1.0, 29 June 2020.

106 CPMC (2021) "Literature Review: COVID-19 Impacts on Postgraduate Medical Education", available: https://cpmc.edu.au/wp-content/uploads/2021/09/LiteratureReview_COVID19MedTraining.pdf and CPMC (2021) "Report 1: Training impacts, responses and opportunities", available: https://cpmc.edu.au/wp-content/uploads/2021/09/Report1_ImpactsResponsesOpportunities.pdf.

the pandemic so that education, assessment and accreditation were generally able to continue and meet quality standards. Many of these responses were seen as improvements on the current system, such as moving education online, innovating in exam delivery, and communicating more responsively.

Early indications from the AMC's[107] work were that, to continue to provide training during the COVID-19 pandemic, specialist medical colleges adapted and accelerated some changes to training programs, such as creating new online educational resources. Some existing barriers to training, such as limited availability of learning sessions and resources, were reduced as a result. Early findings also noted additional flexibility in college training policies, for example recognition of other learning, and enhanced collaboration between colleges and jurisdictions on workforce and training requirements.

Work for this project is ongoing and will be released by the AMC and CPMC[108].

Possible longer-term impacts

From a workforce planning perspective, the pandemic poses challenges to the way in which future demand for a medical workforce is assessed. Border closures raise questions about the appropriate level of 'redundancy' that should be built into a demand model (including domestic and international workforce flow). Changes to regional populations and migration highlight the need for flexibility and responsiveness in Australia's workforce.

The Department continued working with stakeholders throughout 2020 to progress the NMWS. This critical piece of work will support future medical workforce planning, including growing the generalist workforce and addressing workforce maldistribution.

The activities and learnings from the early COVID-19 response have been incorporated into the NMWS consultation and analysis. It will provide a blueprint for collaborative efforts to address the uncertainty and pressures brought about by crises such as pandemics or natural disasters. See the next section 'Terms of Reference D: Other related matters impacting outer metropolitan, rural and regional access to quality health services – future reform directions' for more on future directions and the NMWS.

COVID-19 has further highlighted the need for a national data strategy supported by robust analytical tools with 'real time' scenarios testing and planning capabilities to respond to emerging situations that require a national level attention.

107 Unpublished project work (2021) "Effecting reforms to Australia's specialist medical training and accreditation system post COVID-19", Australian Medical Council and College of Presidents of Medical Colleges. See website: www.amc.org.au/amc-special-projects

108 Project websites: www.amc.org.au/amc-special-projects and https://cpmc.edu.au/special-projects/medical-training-system-review-project/

Terms of Reference D: Other related matters impacting outer metropolitan, rural and regional access to quality health services – future reform directions

Developing a NMWS

A NMWS is being developed to guide long-term collaborative medical workforce planning across Australia, and will identify achievable, practical actions to build a sustainable, highly trained medical workforce. The draft strategy will be considered for endorsement by Health Ministers in 2021.

There is a need to adjust the medical workforce, to grow the number of general practitioners and 'specialist generalists' whilst also getting them to areas of need, in regional, rural and remote Australia. This is reflected within several of the priorities to be addressed in the final strategy.

A series of actions will be recommended as part of the strategy under five priority areas:

- Collaborate on planning and design
- Rebalance supply and distribution
- Reform the training pathway
- Strengthen the generalist capability of the workforce
- Support for medical practitioners to train and work flexibly

The draft strategy acknowledges the need to rebalance the supply and distribution of the medical workforce. The focus of imbalance includes geographical location, the over and under supply of medical specialities and Australia's domestic and international workforce supply, and the need to grow the Aboriginal and Torres Strait Islander medical workforce.

The draft strategy also examines the current training pathway, both in terms of its structure and the overall experience for trainees. A key objective of the draft strategy is the need to further reduce the metro-centricity of medical training by enabling more training opportunities across regional and rural Australia.

The draft strategy emphasises the need to grow general practice and generalist practitioners across the medical workforce to achieve a greater balance between generalism and subspecialisation, by encouraging the medical workforce to be confident and competent to work across a broad scope of practice, able to meet the diverse needs of Australian communities, especially rural and remote communities. An effective and efficient medical workforce requires a balance of doctors with broad and narrow scopes of practice, and across primary, secondary and tertiary care.

Innovative and multidisciplinary models of care

The Innovative Models of Care program supports communities to trial practical, sustainable and locally supported proposals for new primary care models to attract and retain rural health professionals and encourage the use of multidisciplinary teams. Outcomes from these initial trials will inform options for wider primary care reforms in the future.

The Government recognises that traditional models of GP service delivery may not work in all communities, due to the inability of some markets to sustain viable private practice. Across the 2020–21 and 2021–22 Budgets the Government has invested more than $5.1 million to test new approaches through the delivery of innovative primary care models for trial.

Communities have shown strong interest in trialling innovative approaches, with a range of proposals developed for sub-regional models where a network of doctors, nurses and midwives and allied health professionals work together to deliver appropriate, targeted care across care sectors or across a subregion of small towns. These multidisciplinary models help to address issues of professional isolation and supervision that frequently impact on the attraction and retention of a rural workforce.

A requirement of the innovative models of care is that they have strong links with primary care service providers in their region, including the PHN and Local Health District (LHD). Siloed approaches to rural primary healthcare are failing patients and clinicians and undermine effective implementation of national policies in rural areas. A collaborative joint service planning approach across all stakeholders in a region will ensure models meet genuine community need.

The NSW Rural Doctors Network (NSW RDN) is funded until 30 June 2022 to implement trials in Western and Southern NSW. The NSW RDN works closely with key organisations in the relevant communities to deliver this work, including LHDs and PHNs. An additional grant round is underway to provide $2.2 million over five years to a successful grant recipient to implement a trial outside New South Wales.

Trial funding is novel in that it supports governance and program arrangements to bring together existing resources into an operational and coordinated network across communities. Models being funded are identified based on their readiness for implementation.

Several PHNs are playing a key role working in partnership with the Department of Health, state and territory governments and local stakeholders to develop new and innovative models of care. Common elements across the trials include: new approaches to resource and funding distribution (such as pooling with LHDs and other sources), better integration and collaboration through multi-disciplinary practitioner teams, better utilisation of digital and telehealth solutions, and improving how these regions can attract and retain their health workforce.

National Rural Health Commissioner – PRIMM

The National Rural Health Commissioner is also working with regions to support the development of 'trial ready' localised innovative models of care through the PRIMM grants.

PRIMM grants will provide funding of up to $400,000 each for six sub-regions to design primary health care models to address their localised needs. The grants will fund proposals that demonstrate community collaboration and engagement and focus on multidisciplinary care approaches to address challenges in a region. Further grant rounds will be held in 2021–22 and will be available for application at: www.grants.gov.au.

Innovative Employment Models Trials: Remote Vocational Training Scheme

The Government funds the RVTS, which is a three or four year GP training program that delivers structured distance education and supervision to medical practitioners while they continue to provide general medical services in Aboriginal and Torres Strait Islander communities and rural and remote locations throughout Australia, while studying towards fellowship of ACRRM or RACGP.

Funding of $20.9m (GST excl) over three years provide training for two streams:

- Doctors working in MM 4-7 locations; and
- Doctors working in ACCHS in MM 2-7 locations.

The RVTS provides 32 commencing places per year, of which up to 10 places are situated in ACCHS. The RVTS has provided training to more than 400 doctors in over 300 rural, remote and Aboriginal and Torres Strait Islander communities across Australia. Overall, 90 per cent of participants who have completed the program have attained GP Fellowship qualifications.

The Government is providing $5 million for the RVTS Extended Targeted Recruitment pilot, as part of the Department's innovative employment model trials. The pilot will test the success of wage equalisation by offering additional income support funding to recruit and retain doctors working in rural, remote and Aboriginal and Torres Strait Islander communities that have a medical workforce need.

This complements the MRGTP employment trial, outlined in section 'Murrumbidgee Innovative Employment Model'.

Expansion of Rural Generalism – Allied Health Rural Generalist Pathway

The Government is also investing in allied health rural generalists (RGs) as a means of increasing access to primary health care outside capital cities. An allied health RG is an allied health professional that has obtained advanced skills and experience allowing them to broaden their scope of practise within their own discipline, relevant to the needs of the community they service.

Allied health RGs are professionals capable of working with many different client populations, across all ages and states and in different health settings. They are capable and confident to work with a broad scope within their profession. Allied health RGs need the

training, time and support to enhance and apply their skills across a broad context. Allied health RGs practice under the regulatory instruments of their specific profession.

The Government funds Services for Australian Rural and Remote Allied Health to administer the Allied Health Rural Generalist Workforce and Education Scheme (AHRGWES). Initially funded for two years from September 2019, the pilot program provides scholarships to graduate and early career allied health professionals and implementation packages for employers and includes training, education and capacity building opportunities.

Early work within the AHRGWES will directly contribute to expanding the scope of practice of allied health professionals and provide rural and remote communities with increased access to a highly skilled specialist generalist allied health workforce. It improves allied health professionals' capability, competence and confidence by providing:

- Formal education,
- Structured supervision and support for the trainee from experienced clinicians, and
- Support to implement innovative and effective solutions to the challenges of delivering healthcare across geographically dispersed and culturally diverse populations.

To date there has been full uptake of the AHRGWES, with 35 practitioners currently working within allied health practices across six jurisdictions in MM 2 – MM 6 locations. Professions currently include dietetics, occupational therapy, pharmacy, physiotherapy, psychology, radiography, speech pathology, podiatry and social work. A full evaluation of the pilot is underway.

The Government has expanded the program and from September 2021, will provide a further 90 workplace training packages for early career allied health practitioners and 30 traineeships for Allied Health Assistants. This will help consumers in rural and remote areas, by giving them better access to a highly skilled allied health workforce, and greater opportunities to improve their health outcomes.

Ongoing review of classification systems

The Department continues to review and refine its distribution mechanisms to ensure they are contemporary, fit for purpose and effective.

Distribution Working Group and DPA review

Expert advice supports ongoing development of the DPA distribution mechanism and MMM.

The Distribution Working Group (DWG), which replaced the earlier Rural Classification Technical Working Group, was established in 2019 and includes representatives from a broad range of stakeholders including the RACGP, the AMA, the Rural Doctors Association of Australia, and the National Rural Health Commissioner to ensure a range of views are considered.

The DWG was established to provide independent expert advice on the use of geographic distribution systems in Australia for the purpose of ensuring appropriate distribution of the health workforce to areas of acute need. A key role of the DWG is to provide advice on the implications of changes to existing methodologies and provide advice regarding areas consistently raising concerns about their MMM or DPA classification.

There are sector concerns about the effects of the DPA system. A review is underway examining whether there are improvements that can be made in how to measure service access, identify areas where health services are needed compared with other areas, where restricted doctors should work and one that considers contemporaneous factors.

This review will include stakeholder consultation and consider changes to the existing automatic rules including moving to automatic DPA status for MM 3-7 areas. Further, an assessment of how other criteria might be applied to permit Government program access for areas with DPA status as part of designing a measure that is transparent, fair and creates trust and understanding with stakeholders and communities as to the outcome of any assessment.

Role of technology

National Digital Health Strategy

Opportunities for digital systems to play a central role in supporting tailored and responsive healthcare have never been greater, and expectations for digital based services, particularly from consumers, are high.

The Australian Digital Health Agency's National Digital Health Strategy (NDHS) sets out priorities to build the country's digital health capability. The NDHS seeks to marshal the expertise, innovation, capabilities and resources of all Australian governments, public and private health sectors, digital innovators, researchers and consumers to drive agreed digital health priorities, programs and investments that support broader health reform and needs across the country.

The current NDHS was developed in partnership and approved by all Australian governments in August 2017 and has a 5-year timeframe. It provides a focal point for health service design to address one of the greatest challenges to our health system – delivering high-quality and timely health services to people living in rural and remote areas.

Digital technology opens up new possibilities for people in Australia's regions to access health services currently available in our cities – without the need to travel out of their communities. More digital services are being designed for healthcare providers working in regional and remote areas to connect with a wider support team in both the community and public health sectors in other locations, bring greater health benefits and outcomes to patients.

Making better use of telehealth, integrating with services such as Hospital in the Home, and ensuring visiting specialists use a shared health record are helping to overcome the tyranny of distance when delivering health services across all parts of the country.

The NDHS has delivered three Communities of Excellence, designed to improve health and wellbeing through connected digital health communities in rural and remote areas across Australia[109]. The program will use learnings from participating communities to create a toolkit that can be used by other similar communities. Within each community, there were five key areas of focus:

1. Connecting the community's healthcare providers to My Health Record
2. Supporting the expansion and availability of telehealth across all areas of healthcare
3. Increasing awareness and use of secure messaging for the exchange of clinical information across different care settings
4. Enabling the use of electronic prescriptions in general practices and pharmacies
5. Building digital health literacy and participation among healthcare providers, patients and their families.

The Australian Digital Health Agency has commenced the development of a new NDHS that will leverage the achievements of the current Strategy and set new national digital health priorities over a minimum 5-year timeframe. The new NDHS is expected to be agreed by Australian governments and made public by June 2022.

Commonwealth Digital Health Blueprint (the Blueprint)

COVID-19 has accelerated the use of digital services, such as telehealth, in an unprecedented way. Working with sector partners, the Blueprint looks to leverage this momentum to support digital capabilities that contribute to the delivery of the Government's reform priorities – primary care, aged care, mental health and preventative care, and digital health literacy.

The Blueprint will support the Commonwealth in directing its substantial investment in digital health initiatives in support of national long-term health priorities and critical needs identified by healthcare providers and consumers, across primary care, aged care, mental health, preventive care, chronic disease, rural and remote care and Aboriginal and Torres Strait Islander communities.

It will position the Commonwealth to provide clear leadership and direction for digital health across the sector and support the development of national strategies like the Australian Digital Health Agency's new NDHS.

The department is currently consulting internal and external stakeholders on a draft of the Blueprint. It will be iterated towards finalisation based on stakeholder feedback. It is anticipated the Blueprint will be completed by the end of 2021.

109 The communities are Emerald (Queensland), Hedland (Western Australia), and East Arnhem (Northern Territory).

The Blueprint will deliver a two-year rolling plan that maps capabilities the Commonwealth has already funded, such as the next generation of the My Health Record System, and electronic prescribing technology that enables the prescribing and dispensing of medicines electronically as an alternative to a paper prescription. The Blueprint will also detail how continued investment will build on these to deliver on the Minister's agenda, across two, five and 10-year horizons.

Digital mental health services

Digital mental health services generally focus on high prevalence mental health conditions such as anxiety and depression, and can be delivered online via desktops, mobile devices and apps. The term also extends to telephone and online crisis and counselling services.

Digital mental health services are delivered in real time through multiple settings, including the home, the workplace, schools and through clinicians' workplaces. Some services offer fully automated self-help programs, while others involve guidance from clinicians, volunteer crisis supporters, teachers, administrators or peers. The broad range of digital mental health treatment options span health promotion, education, prevention, treatment and recovery and can be accessed anywhere in Australia.

The digital mental health services funded by the Australian Government are free or low cost, and cover a range of counselling, treatment and crisis support services, including suicide prevention and peer support. Funded services include, for instance, Lifeline Australia, Kids Helpline, ReachOut, Mindspot (online clinic), SANE Australia's online community forums and e-Mental Health in Practice (eMHprac). These services are available on the Government's digital mental health gateway, Head to Health at www.headtohealth.gov.au.

Recognising the participation of the primary health care sector is crucial to the success of digital mental health services. eMHprac was established to raise awareness amongst health professionals about digital mental health services. eMHPrac focuses on e-mental health promotion, free training and support for GP's, allied health professionals and service providers working with Aboriginal and Torres Strait Islander people (in Northern Territory, Far North Queensland and Northern New South Wales).

Work is underway on the Government's Budget commitment to transform the existing Head to Health gateway into a more comprehensive national mental health platform. This work will leverage the successful Head to Health gateway, transforming it overtime into a more comprehensive national mental health platform, helping more Australians experiencing mental health challenges be heard, find a path forward and access supports that are right for them.

Work will occur in stages, putting user needs at the centre and testing elements before we scale, to help establish strong fundamentals and ready the platform for future growth. The first stage of work, a beta version of the new platform is expected to become available in the first half of 2022. The Government also provided additional funding to support digital mental health service delivery, and for the implementation of an accreditation scheme for

the National Safety and Quality Digital Mental Health Standards. The Standards aim to improve the quality of digital mental health service provision, and protect service users and their support people.

System-wide reform and innovation: NHRA

The 2020-25 NHRA Addendum was agreed by the Australian Government with all state and territory governments on 29 May 2020 and commenced on 1 July 2020. The NHRA sets out the financial and governance arrangements for Australia's public hospital system for the next five years, and commits all Australian governments to work in partnership to improve health outcomes for Australians and ensure the sustainability of the Australian health system.

The 2020-25 NHRA also includes a shared commitment by all Australian governments to long-term system-wide health reforms to improve health outcomes for all Australians and create a more efficient and sustainable health system. The long-term reforms are:

- Nationally cohesive Health Technology Assessment
- Paying for value and outcomes
- Joint planning and funding at the local level
- Empowering people through health literacy
- Prevention and wellbeing
- Enhanced health data.
- Interfaces between health, disability and aged care systems.

These reforms will:

- enable new flexible ways for governments to pay for and commission health services;
- improve the way health services are planned and delivered at the local level so that health services are well-coordinated and suit the needs of the community; and
- trial new models of care in a range of circumstances to ensure they meet the needs of all Australians, including rural and remote areas, as well as vulnerable populations.

States and territories have the flexibility to identify priority reforms and determine the scope and timing of activities to best suit local needs and support local health system diversity, readiness and funder and provider capabilities. The Commonwealth continues to work collaboratively with states and territories to develop and progress implementation plans for the reforms.

The Addendum to the NHRA 2020–21 to 2024–25 maintains a commitment to significant public hospital funding reforms and ensuring equitable access to public hospitals for all Australians.

Under the 2020-25 Addendum to the NHRA, the Australian Government is investing an estimated $6.1 billion over five years from 2020-21 in block funding to all states and territories to support services provided by small, rural, and regional hospitals.

Specific points within the NHRA addendum specifically address the issues of equity of access for rural and remote health services. Clauses address rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes, and that all Australians should have equitable access to high quality health care, including those living in regional and remote areas.

The Health Innovation Fund

The Health Innovation Fund (HIF) provides funding to states and territories (States) on a population share basis to fund trials that are consistent with the NHRA. These aim to ensure equitable access of health services, including primary health services, to all Australian's regardless of their geographical location.

In 2018-2019 the HIF Stage 1 provided $50 million to New South Wales and Western Australia. In 2021-2022 another $50 million has been provided to all States to fund projects under HIF Stage 2. HIF Stage 2 includes two projects that relate to the provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians:

- *Torres and Cape Health Care (TORCH) Commissioning Fund:* This project will develop a detailed business case, governance arrangements, local service planning and reporting tools and data frameworks for a Torres and Cape Health Care (TORCH) Commissioning Fund. A commissioning fund may potentially improve health outcomes in the Torres and Cape by better coordinating care pathways, funding, governance and decision making between primary care, community controlled and hospital-based services. This project aims to support improved access to culturally appropriate healthcare services, integrate and coordinate care across multiple providers, and provide quality data and transparency of costs and funding.
- *Rapid Access Specialist In-reach Service trial:* The trial will provide staff specialist support from the Tasmanian Health Service (predominantly general physicians) to primary care sites in the western corridor of Tasmania for rapid advice and review of patients with chronic and complex healthcare needs. Primary care services may include GP practices, district hospitals and community health centres. The service will support patients to receive their care in the community before their condition deteriorates to the point they require lengthy or repeated periods in emergency departments or hospital inpatient beds.

Collaborating on reform

Lumos: a system-wide approach

The NRHA and HIF supports a whole-of-system approach to health reform, including partnerships between the Commonwealth, States, PHNs and primary care providers.

Lumos is a new program that sheds light on the patient journey through the New South Wales health system by securely linking encoded and de-identified data from general practices to other health data in New South Wales, including hospital, emergency department, mortality, and others.

The project is a partnership between the New South Wales Ministry of Health, New South Wales PHNs and participating general practices. PHNs are encouraged to work innovatively and collaboratively with their respective states and territories to drive regionally tailored, patient-oriented approaches to primary care.

A pilot project conducted from 2016 to 2019 across four New South Wales PHNs successfully extracted data from more than 40 general practices, covering approximately 400,000 patients. The Western Sydney PHN was an early participant, enabling a focus on outer metropolitan experiences of the health system.

Following the successful pilot, the HIF provided funding from January 2019 to July 2022 to expand Lumos. The expanded initiative aims to link data from 500 NSW general practices (~4 million patients), with the data spanning regional, remote and metropolitan areas of NSW. It also expands the initial pilot to all 10 NSW PHNs, spanning 17 Local Health Districts.

Reports issued every six months show general practices insights such as how often their patients go to hospital and potentially avoidable emergency department visits by their patients over an average 24-hour period. This can help identify opportunities for improving patient outcomes and experiences.

As of October 2020, more than 250 practices have joined the project, with recruitment an ongoing activity of the New South Wales PHNs. The HIF Stage Two funds a supplementary project from July 2021 to November 2023, which will deliver planning and funding tools, using data to explore and plan innovative models of care and measure their impact.

PHNs and collaborative commissioning

PHNs continue to have a key role increasing the efficiency and effectiveness of primary care services, supporting patient-centred care tailored to the needs of their regions. A key role of PHNs is to fund primary care services. They do this through commissioning a rigorous process of planning, procuring, monitoring and evaluating services.

In New South Wales, five PHNs are participating in collaborative commissioning initiatives, funded by the New South Wales Ministry of Health. Collaborative Commissioning partners local health districts and primary health networks in Patient Centred Co-commissioning

Groups (PCCGs). PCCGs focus on local health needs and specific models of care to improve patient and community outcomes.

Under the collaborative commissioning model, local health districts and PHNs work together to test, modify and refine a model of care for their region. Once implemented, models are assessed for sustainability, with data from the Lumos program used to assist in monitoring and evaluation. Models of care that demonstrate improved outcomes for patients and the community during the feasibility implementation phase, continue to full implementation.

The collaborative commissioning approach incentivises local partnerships for integration of care across the entire continuum and embeds local accountability

Five PHNs are currently participating in PCCGs, with work on models of care currently in development or implementation phases:

1. Western Sydney LHD and Western Sydney PHN (WentWest)
    - alternative care for people with low acuity conditions presenting to the Emergency Department
    - cardiology in the community
    - rapid expansion of care in the community
2. Western NSW and Far West LHDs, Western NSW PHN and NSW RDN
    - addressing poorly managed type 2 diabetes
3. Northern Sydney LHD and Sydney North PHN
    - urgent care for frail and older persons
4. Murrumbidgee LHD and Murrumbidgee PHN
    - improving outcomes for people with chronic obstructive pulmonary disease and congestive heart failure
5. Nepean Blue Mountains LHD and Nepean Blue Mountains PHN
    - addressing obesity and/or type 2 diabetes mellitus.

Integrating services through PHNs

PHNs also continue to have an important role integrating services to provide care in community and primary care settings, rather than in acute care or residential settings. The 2021-22 Budget provided $37.3 million over 4 years (2021-22 to 2024-25) for the Greater Choice for At Home Palliative Care (GCfAHPC) initiative.

Under the GCfAHPC pilot, PHNs engage staff to implement innovative and locally appropriate initiatives, which are aimed at improving awareness for patients and health providers, facilitating improved access to safe, quality palliative care services at home, and supporting end of life care systems and services in primary and community care settings.

The investment in the 2021-22 Budget followed a successful trial with 11 PHNs, including facilitating improved access to palliative care at home for those living in regional, rural and remote areas. Activities included building the capacity of the health workforce, including GPs, through education and training, to deliver quality palliative care.

National rural and remote mental health strategy

In December 2018, the Senate Community Affairs References Committee handed down its Inquiry Report into Accessibility and quality of Mental Health Services in Rural and Remote Australia (Senate Inquiry). The report's key findings included that people living in rural and remote Australia face a range of barriers and challenges in accessing quality mental health services, including availability of suitable services, attitudes to mental illness, and mental health literacy; workforce shortages; and the need for a more strategic approach was needed to coordinating and funding services in these areas.

The Government committed to responding to the recommendations outlined by the Senate Inquiry. This includes best approach for the Strategy and addressing low rates of access to services, workforce shortages, the high rate of suicide, cultural realities, language barriers and the social determinants of mental health in rural and remote communities.

In considering a Strategy, other national reforms will need to be taken into account, including: the National Mental Health Workforce Strategy; the National Mental Health Commission's Vision 2030 for Mental Health and Suicide Prevention; the Productivity Commission's Final Inquiry Report into Mental Health; and the National Suicide Prevention Adviser's Final Advice.

The National Mental Health and Suicide Prevention Plan

The Government is committed to mental health reform and is working to ensure all Australians have access to a world class health system supported by a highly trained and qualified workforce, including those in outer metro, regional and rural locations.

In the 2021-22 Budget, the Government announced an additional $2.3 billion investment in the National Mental Health and Suicide Prevention Plan (Plan) to lead landmark reform.

The Plan details five key pillars of reform to the mental health and suicide prevention system: prevention and early intervention, suicide prevention, treatment, supporting the vulnerable, and workforce and governance.

Mental health and suicide prevention workforce

The Plan includes a significant investment to support the mental health and suicide prevention workforce, including:

- $58.8 million to grow and upskill the mental health and suicide prevention workforce, with a focus on attracting and retaining a mental health workforce to rural and remote settings;

- $15.9 million to support GPs and other medical practitioners by providing specialised training and resources to enhance their capacity to address mental health concerns of patients; and
- $2.6 million for tailored mental health supports and to reduce the stigma associated with health practitioners seeking help.

The Department of Health and National Mental Health Commission are jointly developing a 10-year National Mental Health Workforce Strategy (the Strategy) which will be finalised in late 2021.

The work is being informed by an independent Taskforce which includes representatives from across the mental health sector. The Taskforce's draft Strategy is open for public consultation until 31 August 2021 and is available at acilallen.com.au/NMHWS.

GP's role in the mental health system

As part of the Plan, the Government invested $34.2 million to support GPs in their role as a key entry point into the mental health system by expanding and implementing the Initial Assessment and Referral (IAR) tool in primary care settings.

This investment includes targeted funding to provide training and support to GPs, staff in Head to Health centres, AMSs and services commissioned by PHNs, by embedding National IAR Training and Practice Support Officers within the 31 PHNs.

Funding to support integration of the Decision Support Tool with existing clinical software used in general practices, will also play a key role in supporting GPs through IAR implementation.

On 30 November 2020, the Government announced $2 million to undertake a comprehensive evaluation of Better Access initiative in line with the recommendation of the Productivity Commission through its Inquiry into Mental Health. The evaluation commenced in August 2021 and is expected to be completed by June 2022.

GPs play a central role in the delivery of the Better Access initiative through providing assessment and planning services, treatment services and/or referrals to appropriate treatment, as well as review and ongoing management of patients with a diagnosed mental disorder. The evaluation will consider the effectiveness of the Better Access initiative in achieving its overall aims of improving patient outcomes and increasing access to mental health care. The first stage of the evaluation will give specific consideration to factors that impact access to and uptake of services by population demographics including location.

The evaluation findings will guide any future reforms to the initiative, including any reforms to improve access to GP mental health services and outcomes for patients who live in outer metropolitan, rural and regional locations.

National Mental Health and Suicide Prevention Agreement

The National Cabinet has committed, through the National Federation Reform Council, to developing a new National Mental Health and Suicide Prevention Agreement. The National

Agreement will be the vehicle to deliver reform to realise a comprehensive, coordinated, compassionate and consumer focused mental health and suicide prevention system with joint accountability and clear funding arrangements across all governments.

The National Agreement will consider key mental health reports and inquiries including the key recommendations from the Productivity Commission Inquiry into Mental Health, the National Suicide Prevention Adviser's advice and the Royal Commission into Victoria's Mental Health System.

The National Agreement will consider the mental health and suicide prevention needs of different population groups, appropriate to age and development needs, including equitable access for Australia's rural, regional and remote communities. The National Agreement will honour commitments made by all Governments to the National Agreement on Closing the Gap, and to improving Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services.

Aboriginal and Torres Strait Islander mental health and suicide prevention

As a part of the $79.0 million Aboriginal and Torres Strait Islander mental health and suicide prevention package, announced in the 2021-22 Budget, the Department of Health will work with Aboriginal and Torres Strait Islander people to implement key initiatives under a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. This includes:

- $27.3 million for phased implementation, and evaluation of culturally-sensitive, co-designed aftercare services through regionally-based organisations, with Aboriginal and Torres Strait Islander organisations being preferred service providers;
- $23.8 million to support the establishment of regional suicide prevention networks and lead commissioning officers for each state and territory;
- $16.6 million to establish and evaluate a culturally-appropriate 24/7 crisis line to be governed and delivered by Aboriginal and Torres Strait Islander people, as developed and delivered in partnership between Gayaa Dhuwi (Proud Spirit) Australia and Lifeline Australia;
- $6.1 million to support national Aboriginal and Torres Strait Islander leadership for suicide prevention;
- $1.5 million to support a review to examine the Aboriginal and Torres Strait Islander health sector delivering mental health services for Aboriginal and Torres Strait Islander people; and
- $1.1 million to the Black Dog Institute to work with the Aboriginal and Torres Strait Islander Lived Experience Centre to support the inclusion of people with lived experience in the co-design, implementation and evaluation of suicide prevention activity.

The 2021-22 Budget also included funding of $9.2 million over four years (2021-22 to 2024-25) for a national survey to measure the prevalence of mental health in the Aboriginal and Torres Strait Islander population. The survey will be co-designed and implemented with Aboriginal and Torres Strait Islander peoples, and will be designed to be culturally appropriate and meet the needs of the community.

National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031

Although Aboriginal and Torres Strait Islander people are employed in the health care and social assistance sector more than any other industry (AIHW 2019b), they are still significantly underrepresented; in 2016, Aboriginal and Torres Strait Islander people only represented 1.8% (ABS 2016) of the health workforce, despite being 3.3% of the Australian population (3.1% of the working age population) (ABS 2016b).

The Commonwealth Department of Health is currently finalising the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 (National Workforce Plan), which has been co-designed in genuine partnership with Aboriginal and Torres Strait Islander people.

Rural and regional Australians are disproportionately impacted by health workforce shortages. Aboriginal and Torres Strait Islander people are estimated to make up 47% of very remote populations compared to 2.7% in non-remote areas.

The National Workforce Plan includes targeted implementation actions to attract, recruit and retain Aboriginal and Torres Strait Islander people across the entire health workforce in all roles and locations. These include additional supports for remote students, flexible workplace and education arrangements, and the development of partnerships to co-design workforce initiatives at local levels.

The National Workforce Plan is expected to be finalised in the fourth quarter of 2021.

Primary Health Care 10-Year Plan

The Australian Government is developing the Primary Health Care 10-Year Plan (the Plan), to modernise the primary health care system to be more integrated, efficient, patient-centred and equitable. The Plan will also set the reform agenda for primary healthcare for the next decade and is part of the first pillar of the Australia's Long Term National Health Plan as announced in August 2019. The Government established the Primary Health Reform Steering Group (Steering Group) in late 2019 to advise on the development of the Plan and implementation of Voluntary Patient Registration (VPR).

The development of the Plan has been informed through extensive consultation with people with lived experience, researchers, health professionals and peak organisations through over 20 targeted roundtable consultations during 2019-2020. In addition, the Steering Group released their draft recommendations for the consultation between 15 June 2021 and 27 July 2021 and received over 200 submissions from professional bodies, stakeholder and advocacy organisations, researchers, state and territory governments and individuals.

The key themes from the consultation process included:

- Access to appropriate care - Improve access to timely and convenient primary health care, particularly for rural and remote communities, Indigenous Australians, Older Australians (including in residential care), people with disability and other disadvantaged or marginalised groups.
- Workforce – Incentives to reduce barriers and attract more medical students into general practice, workforce maldistribution and shortages of GPs, allied health and nursing providers in rural and remote areas. More sustainable local community-led approaches are needed.
- Funding models - Funding for primary health care is complex with variable funding mechanisms. There was broad agreement that pure fee-for-service models do not encourage fully integrated care, provide limited incentives for flexible team based care and reward throughput instead of value of care. There was support for more flexible funding approaches.
- Integrated person-centred care – Australia's health system is fragmented and difficult to navigate. Strong support exists for actions which improve integration, particularly the interfaces between primary health care and the hospital sector, palliative care, aged care, disability, mental health and other social support services.
- Future focus - Strong support for quality adoption of genomics and precision medicine, point of care testing and embracing new technologies and methods.

The Plan is expected to be finalised in late 2021.

Voluntary Patient Registration

In the 2019-20 Budget, the Government announced $448.5 million for a voluntary patient enrolment model for patients aged 70 years and over. In the 2019-20 MYEFO, the Government provided an additional $7.2 million to include Aboriginal and Torres Strait Islander people aged 50 years and over.

The COVID-19 pandemic has transformed the delivery of healthcare and introduced the potential of telehealth consultations. Primary health care peak bodies have proposed a model of voluntary patient enrolment, involving a patient's enrolment with a general practice being a requirement to access Medicare funded telehealth services, to Government and this model is currently under consideration.

Voluntary Patient Registration (VPR) is intended to provide a continuity of care framework and will be a platform for future funding reform enrolling patients at the practice level, rather than with an individual GP. It will allow for flexibility in rural and remote areas and within ACCHS, where continuity with a single GP is often not possible due to workforce issues.

The aim of patient enrolment is to foster and support an ongoing relationship between the patient and their preferred GP or general practice that will ensure high quality patient-

centred care. It will protect the patients and practices who provide high quality longitudinal care from predatory business models and behaviours.

VPR will form part of the Plan.

National roadmap for improving the health of Australians with intellectual disability

The Government is developing a national roadmap for improving the health of Australians with intellectual disability. The roadmap will be implemented from 2020 as part of the Primary Health Care 10-Year Plan.

On 2 August 2019, the Government convened a roundtable of people with intellectual disability and their family members, academic experts and health care providers across a range of disciplines to discuss the challenges facing people with intellectual disability in accessing appropriate health care, and the opportunities to improve the system.

The roundtable identified key elements of a national roadmap for improving the health of Australians with intellectual disability. The national roadmap will identify:

- better models of care for people with intellectual disability and their families;
- better support for health professionals to provide better care for people with intellectual disability; and
- research, data and measurement to support continuing improvement.

As well as identifying practical ways to improve health care for this group, the national roadmap will increase recognition that people living with intellectual disability have the right to the same quality and access to health services as every other Australian.

A key priority of the roadmap will be a Primary Care Enhancement Program, to be developed through four lead PHNs over the next four years, with a view to national rollout across all PHNs.

A generational plan for aged care

The Government is investing $17.7 billion into an aged care reform package of measures to provide respect, care and dignity to senior Australians.

The Royal Commission into Aged Care Quality and Safety recommended reforms to create an aged care sector that is more transparent, accountable and empowers senior Australians to make informed choices. Key reforms will include:

- Up to 120,000 more GP in-reach services for aged care residents in 2021.
- Surge workforce increase in regional and rural locations.
- A new workforce of trusted First Nations people to assist older First Nations people to navigate and access aged and disability care.

The 2020-21 Budget included a number of key measures that support rural and regional primary and aged care, including:

- Delivery of a new residential aged care funding model, which will improve funding for rural and remote aged care providers.
- $25.1 million to expand the RLAP, so aged care providers in rural and regional areas will have increased access to a surge workforce (a temporary workforce who are already training and qualified in the positions needed). See the section titled 'Workforce relief: Rural Locum Assistance Program' for more information on this program).
- $135.6 million in financial support for registered nurses, including those working in rural and remote areas providing aged care.
- Expansion of the Multi-Purpose Service (MPS) program – see below.

The MPS program

The MPS program is a long-standing joint initiative of the Australian and state and territory governments. The MPS program provides integrated health and aged care services for small regional and remote communities. The program allows services to exist in locations that could not viably support a standalone hospital or aged care home.

The services delivered can include: aged care (residential, respite and home care); acute care; emergency care 24/7; sub-acute care; primary care; allied health care; community care; and other health services.

The MPS program was intended to offer a solution by enabling a more innovative, flexible and integrated approach to the delivery of health and aged care services and the flexible use of funding and resources in a way that addresses the specific needs of each community. MPS facilities were often established in communities which had an existing community hospital providing sub-acute care for their elderly and, in many cases, some form of de facto residential aged care through long stay or nursing home type categories of frail older patients.

The Commonwealth funds the aged care component of the service under the *Aged Care Act 1997*, while state and territory governments provide health services funding. The majority of services are co-located with a hospital or health service.

As at 30 June 2021 there were 3,696 operational MPS places (3,203 residential, 493 home care) across 179 multi-purpose services. The MPS Program focuses on providing services to older people in rural and remote areas.

As at 30 June 2020 more than half of MPS clients using residential care were in outer regional areas and 29.6% of clients are in remote or very remote areas.

A total of $1.1 billion in funding over four years from 2021-22 has been allocated to the MPS program as at Budget 2021-22. This includes new funding for additional supports. The program has been expanded, including new initiatives such as infrastructure projects and funding uplifts for residential aged care in response to the Royal Commission

Appendix A: Incentives and support for GP practices by MM

The Government funds a number of programs to provide incentives to encourage doctors to move to, and remain working in, regional, rural and remote Australia. Eligibility is generally based on the MMM classification system.

Incentives and support for GPs and general practices in MM 1 locations

MM1 encompasses metropolitan areas: Major cities accounting for 70% of Australia's population and all areas categorised ASGS-RA1.

Name	Description	Incentives (financial and other)
Bulk Billing Incentive	Bulk billing incentives are payable to medical practitioners in areas classified as metropolitan (MM1) who provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age.	MBS item: 10990 = $6.55 64990 = $6.15 74990 = $6.15
Approved Medical Deputising Services Program (AMDS)	The AMDS program enables a restricted non-vocationally registered workforce to provide after-hours services to the community when working for an Approved Medical Deputising Service. AMDS participants are granted access to specific after hour's items in the MBS. This program does not provide financial incentive. The AMDS satisfies section 19AA of the *Health Insurance Act 1973.*	AMDS participants are granted access to specific after-hours items in the MBS.
Health Workforce Scholarship Program	Provides postgraduate/ continuous professional development (CPD) scholarships targeted to GPs, Nursing and Allied Health Professionals. Eligible locations include: • Qualified health professionals providing primary health care in MM 1-2 locations only if employed by an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation; or • Qualified health professionals providing primary health care in rural and remote locations in MM 37 locations.	Scholarship - Students receive $10,000 per year for 2 years Bursary - Covers the cost of training, accommodation, travel or course fees and/or to cover or partially cover training related expenses.
Medical Outreach Indigenous Chronic Disease Program	Incentives are payable to health professionals providing chronic disease outreach services for Aboriginal and Torres Strait Islander people in MM1 - MM7 locations where the relevant State/Territory fund holder has identified a gap in services.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).

Name	Description	Incentives (financial and other)
Workforce Incentive Program (WIP) – Practice Stream	The WIP Practice Stream provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals in MM 1-7. Practices in MM 3-7 locations are eligible to receive an additional rural loading on top of their incentive payment.	Up to $125,000 per annum for a single practice.

Incentives and support for GPs and general practices in MM 2 locations

MM2 encompasses regional centres: Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are in, or within a 20km drive of a town with over 50,000 residents.

Name	Description	Incentives (financial and other)
Rural Bulk Billing Incentive	Bulk billing incentives are payable to medical practitioners in areas classified as regional centres (MM 2) who provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age.	MBS item: 10991 = $9.90 64991 = $9.30 74991 = $9.30
Approved Medical Deputising Services Program (AMDS)	The AMDS program enables a restricted non-vocationally registered workforce to provide after-hours services to the community when working for an AMDS. Participants are granted access to specific after hour's items in the MBS. This program does not provide financial incentives. The AMDS satisfies section 19AA of the *Health Insurance Act 1973*.	AMDS participants are granted access to specific after-hours items in the MBS.
Health Workforce Scholarship Program	Provides postgraduate/continuous professional development (CPD) scholarships targeted to GPs, Nursing and Allied Health Professionals. Eligible locations include: • Qualified health professionals providing primary health care in MM 1-2 locations only if employed by an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation; or • Qualified health professionals providing primary health care in rural and remote locations in MM 37 locations.	Scholarship - Students receive $10,000 per year for 2 years Bursary - Covers the cost of training, accommodation, travel or course fees and/or cover or partially cover training related expenses.
Medical Outreach	Incentives are payable to health professionals providing chronic disease outreach services for	Costs associated with delivering outreach

Name	Description	Incentives (financial and other)
Indigenous Chronic Disease Program	Aboriginal and Torres Strait Islander people in MM 1-7 locations where the relevant State/Territory fundholder has identified a gap in services.	services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Rural Locum Assistance Program (RLAP)	The RLAP provides targeted locum support in MM 2-7 locations. It enhances the ability of nurses, allied health professionals, general practitioners (GP obstetricians and GP anaesthetists), and specialists (obstetricians and anaesthetists) to take leave for recreation or to undertake continuing professional development (CPD). Support includes the costs of travel, accommodation, travel allowance and incentives for locums.	Support includes the costs of travel, accommodation, travel allowance and incentives for locums. GPs can take planned leave and undertake CPD.
Healthy Ears - Better Hearing, Better Listening	Incentives are payable to health professionals, including medical specialists, allied health professionals, aboriginal health workers and GPs, providing outreach ear and hearing health services to Aboriginal and Torres Strait Islander children aged 0-21 years in MM 2-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
More Doctors for Rural Australia Program (MDRAP)	MDRAP supports non-vocationally recognised (non-VR) doctors to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway. The MDRAP also supports junior doctors and locums providing services in rural and remote communities. Note: MM 2 practices must also be located within a DPA to be eligible for the MDRAP. The MDRAP is not available at non-DPA locations.	The MDRAP Support Package provides funding to support supervision and education for eligible MDRAP participants: - Up to $500 reimbursed to doctors who complete foundation general practice training modules - Up to $13,600 per participant for approved learning and development activities - Up to $30,000 per fulltime participant annually in quarterly supervision payments.
Rural Health Workforce Support Activity	Rural Workforce Agencies in each State and the Northern Territory are funded to deliver a range of activities aimed at addressing the	Specific grants to health professionals not exceeding $25,000.00 per

Name	Description	Incentives (financial and other)
	misdistribution of the health workforce through the following program elements: Access; Quality; and Sustainability. Grants to health professionals can include: • Recruitment costs or as incentives • Orientation expenses • Relocation expenses to move to a rural area • Locum support • Assist with access to continuing professional development opportunities.	annum, and capped at $50,000.00, in totality.
Remote Vocational Training Scheme (RVTS)	The RVTS delivers structured distance education and supervision to doctors to support them in gaining fellowship of the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine while they provide general medical services. Supervision is facilitated remotely, and delivery caters to the unique needs of doctors working in remote communities by supporting them to achieve Fellowship through a distance education model. It allows training to be completed in an accredited post, without leaving your community. It has two trainee streams: • The AMS Stream, providing training for doctors working in Aboriginal Community Controlled Health Services (MM 2-7) • The Remote Stream for doctors working in rural & remote Australia (MM 4-7) Note: For MM2-4 locations, doctors must be working in an Aboriginal Community Controlled Health Service.	Fully Government funded. The provision of distance education and supervision to doctors to support them in gaining fellowship without travelling long distances or relocating. Being on a College-approved training program will be mandatory before sitting Fellowship exams from 2022.
Practice Incentives Program (PIP)	The PIP incentives are available to support general practice activities that encourage continuing improvement and quality of care, enhance capacity and improve access and health outcomes for patients. It is administered by Services Australia on behalf of the Department of Health. There are currently eight incentives under the PIP: • eHealth (e-PIP), • Teaching, • Indigenous Health (IHI), • GP Aged Care Access (ACAI), • GP Procedural • After Hours	PIP loading for each Rural, Remote and Metropolitan Area (RRMA) category RRMA 1 - 0% RRMA 2 - 0% RRMA 3 - 15% RRMA 4 - 20% RRMA 5 - 40% RRMA 6 - 25% RRMA 7 - 50%

Name	Description	Incentives (financial and other)
	• Quality Improvement (PIPQI) and • Rural Loading; the PIP rural loading is added as a total to PIP incentive payments (except for ACAI, as this is a GP payment not a practice payment) for practices located in Rural Remote and Metropolitan Areas (RRMA) 3-7. Under PIP, the COVID-19 Vaccine GP incentive is an additional/temporary incentive which does not attract a rural loading. This temporary incentive supports PIP eligible general practices participating in Australia's COVID-19 Vaccine National Rollout to provide continuity of care and two doses of a COVID-19 vaccine to their patients.	
Workforce Incentive Program (WIP) – Practice Stream	The WIP Practice Stream provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals in MM 1-7. Practices in MM 3-7 locations are eligible to receive an additional rural loading on top of their incentive payment.	Up to $125,000 per annum for a single practice.

Incentives and support for GPs and general practices in MM 3 locations

MM 3 encompasses large rural towns: Inner Regional (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents.

Name	Description	Incentives (financial and other)
Rural Bulk Billing Incentive (until 1 Dec 2021)	Higher incentives are payable to medical practitioners in areas classified as regional, rural or remote (MM 2-7) who provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age.	MBS item: 10991 = $9.90 64991 = $9.30 74991 = $9.30
Rural Bulk Billing Incentive (from 1 Jan 2022)	From 1 January 2022, the Rural Bulk Billing Incentives (RBBI) will increase for doctors and patients in rural and remote communities. This incentive will be scaled according to the MM classification of each location in Australia. The rural bulk billing incentive available in MM 3 locations will be approximately 160% of the standard bulk billing rate available in metropolitan areas.	MBS item: 10991 = $10.50 64991 = $9.85 74991 = $9.85

Name	Description	Incentives (financial and other)
Approved Medical Deputising Services Program (AMDS)	The AMDS program allows a restricted non-vocationally registered workforce to provide after-hours services to the community when working for an AMDS. Participants are granted access to specific after hour's items in the MBS. This program does not provide financial incentive. The AMDS satisfies section 19AA of the *Health Insurance Act 1973.*	AMDS participants are granted access to specific after-hours items in the MBS.
Health Workforce Scholarship Program	Provides postgraduate/ continuous professional development scholarships targeted to GPs, Nursing and Allied Health Professionals. Eligible locations include: • Qualified health professionals providing primary health care in MM 1-2 locations only if employed by an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation; or • Qualified health professionals providing primary health care in rural and remote locations in MM 3-7 locations.	Scholarship - Students receive $10,000 per year for 2 years Bursary - Covers the cost of training, accommodation, travel or course fees and/or cover or partially cover training related expenses.
Medical Outreach Indigenous Chronic Disease Program	Incentives are payable to health professionals providing chronic disease outreach services for Aboriginal and Torres Strait Islander people in MM 1-7 locations where the relevant State/Territory fund holder has identified a gap in services.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Rural Locum Assistance Program (RLAP)	The RLAP provides targeted locum support in MM 2-7 locations. It enhances the ability of nurses, allied health professionals, general practitioners (GP obstetricians and GP anaesthetists), and specialists (obstetricians and anaesthetists) to take leave for recreation or to undertake continuing professional development (CPD). Support includes the costs of travel, accommodation, travel allowance and incentives for locums.	Support includes the costs of travel, accommodation, travel allowance and incentives for locums. GPs can take planned leave and undertake CPD.
Healthy Ears - Better Hearing, Better Listening	Incentives are payable to health professionals, including medical specialists, allied health professionals, aboriginal health workers and GPs, providing outreach ear and hearing health services to Aboriginal and Torres Strait Islander children aged 0-21 years in MM 2-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel,

Name	Description	Incentives (financial and other)
		meals and accommodation).
More Doctors for Rural Australia Program (MDRAP)	MDRAP supports non-vocationally recognised (non-VR) doctors to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway. The MDRAP also supports junior doctors and locums providing services in rural and remote communities. Note: MM 3 practices must also be located within a DPA to be eligible for the MDRAP. The MDRAP is not available at non-DPA practices.	The MDRAP Support Package provides funding to support supervision and education for eligible MDRAP participants: - Up to $500 reimbursed to doctors who complete foundation general practice training modules - Up to $13,600 per participant for approved learning and development activities - Up to $30,000 per fulltime participant annually in quarterly supervision payments.
Rural Health Workforce Support Activity	Rural Workforce Agencies in each State and the Northern Territory are funded to deliver a range of activities aimed at addressing the misdistribution of the health workforce through the following program elements: Access; Quality; and Sustainability. Grants to health professionals can include: • Recruitment costs or as incentives • Orientation expenses • Relocation expenses to move to a rural area) • Locum support • Assist with access to Continuing Professional Development opportunities.	Specific grants to health professionals not exceeding $25,000.00 per annum, and capped at $50,000.00, in totality.
Remote Vocational Training Scheme (RVTS)	The RVTS delivers structured distance education and supervision to doctors to support them in gaining fellowship of the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine while they provide general medical services. Supervision is facilitated remotely, and delivery caters to the unique needs of doctors working in remote communities by supporting them to achieve Fellowship through a distance education model. It allows training to be completed in an accredited post, without leaving your community.	Fully Government funded. The provision of distance education and supervision to doctors to support them in gaining fellowship without travelling long distances or relocating. Being on a College-approved training program will be mandatory before sitting

Name	Description	Incentives (financial and other)
	It has two trainee streams: • The Aboriginal Medical Service Stream, providing training for doctors working in Aboriginal Community Controlled Health Services (MM 2-7) • The Remote Stream for doctors working in rural & remote Australia (MM 4-7) For MM 2-4 locations, doctors must be working in an Aboriginal Community Controlled Health Service.	Fellowship exams from 2022.
Rural Health Outreach Fund (RHOF)	The RHOF aims to improve access to medical specialists, GPs, allied and other health providers in regional, rural and remote areas of Australia by supporting outreach health activities. There are four health priorities under the RHOF: maternity and paediatric health, eye health, mental health and support for chronic disease management.	The RHOF works by removing barriers such as the cost of travel, facility hire and equipment leasing, to enable a range of health professionals to provide outreach services.
Eye and Ear Surgical Support	Incentives are payable to health professionals providing expedited access to eye and/or ear surgical support services to Aboriginal and Torres Strait Islander people who reside in MM 3-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Practice Incentives Program (PIP)	The PIP incentives are available to support general practice activities that encourage continuing improvement and quality of care, enhance capacity and improve access and health outcomes for patients. It is administered by Services Australia on behalf of the Department of Health. There are currently eight incentives under the PIP: • eHealth (e-PIP), • Teaching, • Indigenous Health (IHI), • GP Aged Care Access (ACAI), • GP Procedural • After Hours • Quality Improvement (PIPQI) and • Rural Loading; the PIP rural loading is added as a total to PIP incentive payments (except for ACAI, as this is a GP payment not a	PIP loading for each Rural, Remote and Metropolitan Area (RRMA) category RRMA 1 - 0% RRMA 2 - 0% RRMA 3 - 15% RRMA 4 - 20% RRMA 5 - 40% RRMA 6 - 25% RRMA 7 - 50%

Name	Description	Incentives (financial and other)
	practice payment) for practices located in Rural Remote and Metropolitan Areas (RRMA) 3-7. Under PIP, the COVID-19 Vaccine GP incentive is an additional/temporary incentive which does not attract a rural loading. This temporary incentive supports PIP eligible general practices participating in Australia's COVID-19 Vaccine National Rollout to provide continuity of care and two doses of a COVID-19 vaccine to their patients.	
Workforce Incentive Program (WIP) – Practice Stream	The WIP Practice Stream provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals. Practices in MM 3-7 locations are eligible to receive a rural loading on top of their incentive payment. The rural loading is applied in recognition of the difficulties rural and remote communities face attracting and retaining health professionals.	Up to $125,000 per annum for a single practice. Eligible for an additional 30% rural loading.
Workforce Incentive Program (WIP) - Doctor Stream	The WIP - Doctor Stream aims to encourage medical practitioners to practise in regional, rural and remote communities (MM 3-7) and to promote careers in rural medicine through the provision of financial incentives. Incentive amounts are dependent on the MM classification and the amount of time spent working in the location. To be eligible for the WIP - Doctor Stream, medical practitioners must: • Provide a minimum amount of eligible primary care services in eligible locations and/or undertake eligible GP training under an approved training pathway • Meet the required number of active quarters for payment • Have an eligible current Medicare provider number • Have provided current bank details to Services Australia specifically for the WIP - Doctor Stream in the required timeframe.	Year 1 - $0 Year 2 - $4,500 Year 3 - $7,500 Year 4 - $7,500 Year 5 plus - $12,000
Rural Procedural Grants Program (RPGP)	The RPGP supports procedural GPs in rural and remote areas to attend relevant continuing professional development (CPD) activities,	Procedural skills - up to $20,000 per year

Name	Description	Incentives (financial and other)
	focused on both skills maintenance and upskilling for procedural skills and emergency medicine. Support is provided in the form of grant payments which are designed to assist with the cost of attending CPD activities, including course costs, locum relief and travel expenses. Grants are calculated on the number of training days. Current COVID-19 amendments are in place to reduce the daily payment for all categories to $1000 per day for online CPD (normally $2000 and restricted to face to face CPD activities).	Emergency medicine - up to $6,000 per year Emergency mental health - up to $6,000 per year.
General Practitioner Procedural Training Support Program (GPPTSP)	The GPPTSP is an optional, competitive scholarship program that provides $40,000 (GST exclusive) to up to 10 GP Fellows to gain a statement of satisfactory completion of Advanced Rural Skills Training in Anaesthesia, and up to 25 GP Fellows to achieve the Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology. Payments are in instalments with completion required within two years of commencing training.	$40,000 per applicant who completes training.
Premium Support Scheme (PSS)	The PSS is an Australian Government scheme that helps eligible medical practitioners with the costs of their medical indemnity insurance. Eligible medical practitioners continue to see the benefit of the PSS through reductions in the level of premiums charged to them by their medical indemnity insurers. The Australian Government makes payments to medical indemnity insurers for the PSS. Eligibility for the PSS: • A medical practitioner whose gross medical indemnity costs exceed 7.5% of estimated gross income from private billings; or • A procedural general practitioner in a rural area (MM 3-7); or • A medical practitioner who has applied for and has been deemed to be eligible for a subsidy under the Medical Indemnity Support Scheme (MISS) for a premium period ending 1 July 2021, i.e. former MISS participants.	The PSS is designed to ensure that if a medical practitioner's gross medical indemnity costs exceed 7.5% of his or her gross private medical income, he or she will receive a Government subsidy of 60% towards the cost of the premium beyond that threshold limit. Procedural GPs working in rural areas are eligible for the PSS regardless of whether they meet other PSS eligibility criteria. The PSS will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances (i.e. same location, same

Name	Description	Incentives (financial and other)
		income, and same insurer).
Regional Pharmacy Maintenance Allowance (RPMA)	The RPMA Program is aimed at supporting access to PBS medicines and pharmacy services for people living in regional, rural and remote areas by providing financial support to eligible pharmacy owners in regional, rural and remote areas. RPMA is part of the suite of Rural Support Programs funded under the Seventh Community Pharmacy Agreement (7CPA). RPMA aims to maintain equitable and sustainable access to PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicines, and pharmacy services for patients in regional, rural and remote areas of Australia, through supporting the pharmacy network.	The RPMA is calculated annually, based on the remoteness of the pharmacy according to the MMM and PBS prescription volumes. Pharmacies located within MMM categories 3 – 7 are eligible for an allowance, depending on their PBS prescription volume. Pharmacies with low prescription volumes in more remote areas receive the highest level of the Allowance.
Rural Continuing Professional Education Allowance	The Rural Continuing Professional Education Allowance assists pharmacists from regional, rural and remote areas to access CPD activities by providing financial support for travel and accommodation. The Program also provides funding for professional educators to travel to a rural location to deliver CPD activities to a group of practising pharmacists.	The Allowance supports the regional, rural and remote pharmacy workforce, to maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Intern Incentive Allowance for Rural Pharmacies (IIARP)	The IIARP for rural Pharmacies is aimed at improving the regional, rural and remote workforce by providing incentive payments to pharmacy owners or eligible hospital authorities offering a placement for a pharmacy graduate during their intern year in a regional, rural or remote Pharmacy. Applicants must be residing and working in an MM 3-6 location or be a professional educator who delivered CPD in an MM 3-7 location.	The IIARP is designed to strengthen and support the regional, rural and remote pharmacy workforce, and in turn maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Rural Intern Training Allowance (RITA)	The RITA provides financial support for pharmacy Interns practicing in regional, rural and remote areas to access compulsory training activities required as part of their Intern Training Program. Applicants must be residing in and completing their intern training year in an MM 3-7 location.	The RITA is intended to defray travel and accommodation costs associated with undertaking compulsory intern training workshops, training days

Name	Description	Incentives (financial and other)
		and examinations in regional, rural and remote areas.
Rural Pharmacy Student Placement Allowance Program (RPSPA)	The RPSPA provides financial support to Australian universities to facilitate Pharmacy Student placements in regional, rural and remote communities. The Allowance assists with students' travel and accommodation costs for participating in placements in regional, rural and remote areas. The Program aims to facilitate positive regional, rural and remote placement experiences for pharmacy students in order to encourage students to return to regional, rural and remote communities upon graduation.	The RPSPA provides financial support to encourage and enable Australian universities offering pharmacy courses leading to registration as a pharmacist to deliver student placements in regional, rural and remote communities.
Rural Pharmacy Scholarship Mentor Scheme (RPSMS)	The RPSMS aims to encourage and support Aboriginal and Torres Strait Islander scholars and scholars from regional, rural and remote locations to undertake undergraduate and graduate studies in pharmacy at an Australian university, by providing guidance and support from a practising regional, rural, or remote pharmacist mentor during each year of their pharmacy studies. Mentors can choose to be paid for participating in the Scheme and if so can receive a payment per mentored scholar per year.	The RPSMS provides pharmacy students with guidance and support from a practising regional, rural or remote Pharmacist. Involvement in the Mentor Scheme is compulsory for all holders of the Rural Pharmacy Scholarship and holders of the Aboriginal and Torres Strait Islander Pharmacy Scholarship.
Rural Pharmacy Scholarship Scheme (RPSS)	The RPSS provides financial support to students from regional, rural and remote communities to undertake undergraduate or postgraduate studies in pharmacy at university. Scholarship holders are encouraged to seek employment in regional, rural and remote areas following graduation.	The RPSS supports the regional, rural and remote pharmacy workforce. Applicants with a historic home address in an MM 3-7 location will be deemed eligible.

Incentives and support for GPs and general practices in MM 4 locations

MM 4 encompasses medium rural towns: Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 or MM 3, and are in, or within a 10km drive of a town with between 5,000 to 15,000 residents.

Name	Description	Incentives (financial and other)
Rural Bulk Billing Incentive (until 31 Dec 2021)	Higher incentives are payable to medical practitioners in areas classified as regional, rural or remote (MM 2-7) who provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age.	MBS item: 10991 = $9.90 64991 = $9.30 74991 = $9.30
Rural Bulk Billing Incentive (from 1 Jan 2022)	From 1 January 2022, the Rural Bulk Billing Incentives (RBBI) will increase for doctors and patients in rural and remote communities. This incentive will be scaled according to the MM classification of each location in Australia. The rural bulk billing incentive available in MM 4 locations will be approximately 160% of the standard bulk billing rate available in metropolitan areas.	MBS item: 10991 = $10.50 64991 = $9.85 74991 = $9.85
Approved Medical Deputising Services Program (AMDS)	The AMDS program allows a restricted non-vocationally registered workforce to provide after-hours services to the community when working for an AMDS. Participants are granted access to specific after hour's items in the MBS. This program does not provide financial incentive. The AMDS satisfies section 19AA of the *Health Insurance Act 1973*.	AMDS participants are granted access to specific after-hours items in the MBS.
Health Workforce Scholarship Program	Provides postgraduate/continuous professional development (CPD) scholarships targeted to GPs, Nursing and Allied Health Professionals. Eligible locations include: • Qualified health professionals providing primary health care in MM 1-2 locations only if employed by an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation; • Qualified health professionals providing primary health care in rural and remote locations in MM 3-7 locations.	Scholarship - Students receive $10,000 per year for 2 years Bursary - Covers the cost of training, accommodation, travel or course fees and/or cover or partially cover training related expenses.
Medical Outreach Indigenous Chronic Disease Program (MOICDP)	Incentives are payable to health professionals providing chronic disease outreach services for Aboriginal and Torres Strait Islander people in MM 1-7 locations where the relevant	Costs associated with delivering outreach services are payable to eligible health professionals to remove

Name	Description	Incentives (financial and other)
	State/Territory fund holder has identified a gap in services.	a range of financial disincentives (e.g. travel, meals and accommodation).
Rural Locum Assistance Program (RLAP)	The RLAP provides targeted locum support in MM 2-7 locations. It enhances the ability of nurses, allied health professionals, general practitioners (GP obstetricians and GP anaesthetists), and specialists (obstetricians and anaesthetists) to take leave for recreation or to undertake continuing professional development (CPD). Support includes the costs of travel, accommodation, travel allowance and incentives for locums.	Support includes the costs of travel, accommodation, travel allowance and incentives for locums. GPs can take planned leave and undertake CPD.
Healthy Ears - Better Hearing, Better Listening	Incentives are payable to health professionals, including medical specialists, allied health professionals, aboriginal health workers and GPs, providing outreach ear and hearing health services to Aboriginal and Torres Strait Islander children aged 0-21 years in MM 2-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
More Doctors for Rural Australia Program (MDRAP)	Supports non-vocationally recognised (non-VR) doctors to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway. The MDRAP also supports junior doctors and locums providing services in rural and remote communities. Note: MM 4 practices must also be located within a DPA to be eligible for the MDRAP. The MDRAP is not available at non-DPA practices.	The MDRAP Support Package provides funding to support supervision and education for eligible MDRAP participants: • Up to $500 reimbursed to doctors who complete foundation general practice training modules • Up to $13,600 per participant for approved learning and development activities • Up to $30,000 per fulltime participant annually in quarterly supervision payments.
Eye and Ear Surgical Support	Incentives are payable to health professionals providing expedited access to eye and/or ear	Costs associated with delivering outreach

Name	Description	Incentives (financial and other)
	surgical support services to Aboriginal and Torres Strait Islander people who reside in MM 3-7 locations.	services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation)
Rural Health Workforce Support Activity	Rural Workforce Agencies in each State and the Northern Territory are funded to deliver a range of activities aimed at addressing the misdistribution of the health workforce through the following program elements: Access; Quality; and Sustainability. Grants to health professionals can include: • Recruitment costs or as incentives • Orientation expenses • Relocation expenses to move to a rural area • Locum support • Assist with access to continuing professional development opportunities.	Specific grants to health professionals not exceeding $25,000.00 per annum, and capped at $50,000.00, in totality.
Remote Vocational Training Scheme (RVTS)	The RVTS delivers structured distance education and supervision to doctors to support them in gaining fellowship of the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine while they provide general medical services. Supervision is facilitated remotely and delivery caters to the unique needs of doctors working in remote communities by supporting them to achieve Fellowship through a distance education model. It allows training to be completed in an accredited post, without leaving your community. It has two trainee streams: • The AMS Stream, providing training for doctors working in Aboriginal Community Controlled Health Services (MM 2-7) • The Remote Stream for doctors working in rural & remote Australia (MM 4-7) For MM 2-4 locations, doctors must be working in an Aboriginal Community Controlled Health Service.	Fully Government funded. The provision of distance education and supervision to doctors to support them in gaining fellowship without travelling long distances or relocating. Being on a College-approved training program will be mandatory before sitting Fellowship exams from 2022.
Rural Health Outreach Fund (RHOF)	The RHOF aims to improve access to medical specialists, GPs, allied and other health providers in regional, rural and remote areas of Australia by supporting outreach health	The RHOF works by removing barriers such as the cost of travel, facility hire and

Name	Description	Incentives (financial and other)
	activities. There are four health priorities under the RHOF: maternity and paediatric health, eye health, mental health and support for chronic disease management.	equipment leasing, to enable a range of health professionals to provide outreach services.
Practice Incentives Program (PIP)	The PIP incentives are available to support general practice activities that encourage continuing improvement and quality of care, enhance capacity and improve access and health outcomes for patients. It is administered by Services Australia on behalf of the Department of Health. There are currently eight incentives under the PIP: • eHealth (e-PIP), • Teaching, • Indigenous Health (IHI), • GP Aged Care Access (ACAI), • GP Procedural • After Hours • Quality Improvement (PIPQI) and • Rural Loading; the PIP rural loading is added as a total to PIP incentive payments (except for ACAI, as this is a GP payment not a practice payment) for practices located in Rural Remote and Metropolitan Areas (RRMA) 3-7. Under PIP, the COVID-19 Vaccine GP incentive is an additional/temporary incentive which does not attract a rural loading. This temporary incentive supports PIP eligible general practices participating in Australia's COVID-19 Vaccine National Rollout to provide continuity of care and two doses of a COVID-19 vaccine to their patients.	PIP loading for each Rural, Remote and Metropolitan Area (RRMA) category RRMA 1 - 0% RRMA 2 - 0% RRMA 3 - 15% RRMA 4 - 20% RRMA 5 - 40% RRMA 6 - 25% RRMA 7 - 50%
Workforce Incentive Program (WIP) – Practice Stream	The WIP Practice Stream provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals. Practices in MM 3-7 locations are eligible to receive a rural loading on top of their incentive payment. The rural loading is applied in recognition of the difficulties rural and remote communities face attracting and retaining health professionals.	Up to $125,000 per annum for a single practice. Eligible for an additional 30% rural loading.

Name	Description	Incentives (financial and other)
Workforce Incentive Program (WIP) - Doctor Stream	The WIP - Doctor Stream aims to encourage medical practitioners to practise in regional, rural and remote communities (MM 3-7) and to promote careers in rural medicine through the provision of financial incentives. Incentive amounts are dependent on the MM classification and the amount of time spent working in the location. To be eligible for the WIP - Doctor Stream, medical practitioners must: • Provide a minimum amount of eligible primary care services in eligible locations and/or undertake eligible general practice (GP) training under an approved training pathway • Meet the required number of active quarters for payment • Have an eligible current Medicare provider number • Have provided current bank details to Services Australia specifically for the WIP - Doctor Stream in the required timeframe.	Year 1 – $0 Year 2 – $8,000 Year 3 – $13,000 Year 4 – $13,000 Year 5 plus – $18,000
Rural Procedural Grants Program (RPGP)	The RPGP supports procedural GPs in rural and remote areas to attend relevant continuing professional development (CPD) activities, focused on both skills maintenance and upskilling for procedural skills and emergency medicine. Support is provided in the form of grant payments which are designed to assist with the cost of attending CPD activities, including course costs, locum relief and travel expenses. Grants are calculated on the number of training days. Current COVID-19 amendments are in place to reduce the daily payment for all categories to $1000 per day for online CPD (normally $2000 and restricted to face to face CPD activities).	Procedural skills - up to $20,000 per year Emergency medicine - up to $6,000 per year Emergency mental health - up to $6,000 per year.
Premium Support Scheme (PSS)	The PSS is an Australian Government scheme that helps eligible medical practitioners with the costs of their medical indemnity insurance. Eligible medical practitioners continue to see the benefit of the PSS through reductions in the level of premiums charged to them by their medical indemnity insurers. The Australian Government makes payments to medical indemnity insurers for the PSS.	The PSS is designed to ensure that if a medical practitioner's gross medical indemnity costs exceed 7.5% of his or her gross private medical income, he or she will receive a Government subsidy of 60% towards the cost of the premium

Name	Description	Incentives (financial and other)
	Eligibility for the PSS: • A medical practitioner whose gross medical indemnity costs exceed 7.5% of estimated gross income from private billings; or • A procedural general practitioner in a rural area (MM 3-7); or • A medical practitioner who has applied for and has been deemed to be eligible for a subsidy under the Medical Indemnity Support Scheme (MISS) for a premium period ending 1 July 2021, i.e. former MISS participants.	beyond that threshold limit. Procedural GPs working in rural areas are eligible for the PSS regardless of whether they meet other PSS eligibility criteria. The PSS will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances (i.e. same location, same income, and same insurer).
Regional Pharmacy Maintenance Allowance (RPMA)	The RPMA is aimed at supporting access to PBS medicines and pharmacy services for people living in regional, rural and remote areas by providing financial support to eligible pharmacy owners in regional, rural and remote areas. RPMA is part of the suite of Rural Support Programs funded under the Seventh Community Pharmacy Agreement (7CPA). RPMA aims to maintain equitable and sustainable access to PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicines, and pharmacy services for patients in regional, rural and remote areas of Australia, through supporting the pharmacy network.	The RPMA is calculated annually, based on the remoteness of the pharmacy according to the MMM and PBS prescription volumes. Pharmacies located within MMM categories 3 – 7 are eligible for an allowance, depending on their PBS prescription volume. Pharmacies with low prescription volumes in more remote areas receive the highest level of the Allowance.
Rural Continuing Professional Education Allowance	The Rural Continuing Professional Education Allowance assists pharmacists from regional, rural and remote areas to access CPD activities by providing financial support for travel and accommodation. The Program also provides funding for professional educators to travel to a rural location to deliver CPD activities to a group of practising pharmacists.	The Allowance supports the regional, rural and remote pharmacy workforce, to maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Intern Incentive Allowance for Rural Pharmacies (IIARP)	The IIARP for rural Pharmacies is aimed at improving the regional, rural and remote workforce by providing incentive payments to pharmacy owners or eligible hospital authorities	The IIARP is designed to strengthen and support the regional, rural and remote pharmacy

Name	Description	Incentives (financial and other)
	offering a placement for a pharmacy graduate during their intern year in a regional, rural or remote Pharmacy. Applicants must be residing and working in an MM 3-6 location or be a professional educator who delivered CPD in an MM 3-7 location.	workforce, and in turn maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Rural Intern Training Allowance (RITA)	The RITA provides financial support for pharmacy Interns practicing in regional, rural and remote areas to access compulsory training activities required as part of their Intern Training Program. Applicants must be residing in and completing their intern training year in an MM 3-7 location.	The RITA is intended to defray travel and accommodation costs associated with undertaking compulsory intern training workshops, training days and examinations in regional, rural and remote areas.
Rural Pharmacy Student Placement Allowance Program (RPSPA)	The RPSPA provides financial support to Australian universities to facilitate Pharmacy Student placements in regional, rural and remote communities. The Allowance assists with students' travel and accommodation costs for participating in placements in regional, rural and remote areas. The Program aims to facilitate positive regional, rural and remote placement experiences for pharmacy students in order to encourage students to return to regional, rural and remote communities upon graduation.	The RPSPA provides financial support to encourage and enable Australian universities offering pharmacy courses leading to registration as a pharmacist to deliver student placements in regional, rural and remote communities.
Rural Pharmacy Scholarship Mentor Scheme (RPSMS)	The RPSMS aims to encourage and support Aboriginal and Torres Strait Islander scholars and scholars from regional, rural and remote locations to undertake undergraduate and graduate studies in pharmacy at an Australian university, by providing guidance and support from a practising regional, rural, or remote pharmacist mentor during each year of their pharmacy studies. Mentors can choose to be paid for participating in the Scheme and if so can receive a payment per mentored scholar per year.	The RPSMS provides pharmacy students with guidance and support from a practising regional, rural or remote Pharmacist. Involvement in the Mentor Scheme is compulsory for all holders of the Rural Pharmacy Scholarship and holders of the Aboriginal and Torres Strait Islander Pharmacy Scholarship.
Rural Pharmacy Scholarship Scheme (RPSS)	The RPSS provides financial support to students from regional, rural and remote communities to undertake undergraduate or postgraduate studies in pharmacy at university. Scholarship holders are encouraged to seek employment in	The RPSS supports the regional, rural and remote pharmacy workforce.

Name	Description	Incentives (financial and other)
	regional, rural and remote areas following graduation.	Applicants with a historic home address in an MM 3-7 location will be deemed eligible.

Incentives and support for GPs and general practices in MM 5 locations

MM 5 encompasses small rural towns: All remaining Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas.

Name	Description	Incentives (financial and other)
Rural Bulk Billing Incentive (until 31 Dec 2021)	Higher incentives are payable to medical practitioners in areas classified as regional, rural or remote (MM 2-7) who provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age.	MBS item: 10991 = $9.90 64991 = $9.30 74991 = $9.30
Rural Bulk Billing Incentive (from 1 Jan 2022)	From 1 January 2022, the Rural Bulk Billing Incentives (RBBI) will increase for doctors and patients in rural and remote communities. This incentive will be scaled according to the MM classification of each location in Australia. The rural bulk billing incentive available in MM 5 locations will be approximately 170% of the standard bulk billing rate available in metropolitan areas.	MBS item: 10991 = $11.15 64991 = $10.45 74991 = $10.45
Approved Medical Deputising Services Program (AMDS)	The AMDS program allows a restricted non-vocationally registered workforce to provide after-hours services to the community when working for an AMDS. Participants are granted access to specific after hour's items in the MBS. This program does not provide financial incentive. The AMDS satisfies section 19AA of the *Health Insurance Act 1973*.	AMDS participants are granted access to specific after-hours items in the MBS.
Health Workforce Scholarship Program	Provides postgraduate/ continuous professional development scholarships targeted to GPs, Nursing and Allied Health Professionals. Eligible locations include: • Qualified health professionals providing primary health care in MM 1-2 locations only if employed by an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation; or	Scholarship - Students receive $10,000 per year for 2 years Bursary - Covers the cost of training, accommodation, travel or course fees and/or cover or partially cover training related expenses.

Name	Description	Incentives (financial and other)
	• Qualified health professionals providing primary health care in rural and remote locations in MM 3-7 locations.	
Medical Outreach Indigenous Chronic Disease Program	Incentives are payable to health professionals providing chronic disease outreach services for Aboriginal and Torres Strait Islander people in MM 1-7 locations where the relevant State/Territory fund holder has identified a gap in services.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Rural Locum Assistance Program (RLAP)	The RLAP provides targeted locum support in MM 2-7 locations. It enhances the ability of nurses, allied health professionals, general practitioners (GP obstetricians and GP anaesthetists), and specialists (obstetricians and anaesthetists) to take leave for recreation or to undertake continuing professional development (CPD). Support includes the costs of travel, accommodation, travel allowance and incentives for locums.	Support includes the costs of travel, accommodation, travel allowance and incentives for locums. GPs can take planned leave and undertake CPD.
Healthy Ears - Better Hearing, Better Listening	Incentives are payable to health professionals, including medical specialists, allied health professionals, aboriginal health workers and GPs, providing outreach ear and hearing health services to Aboriginal and Torres Strait Islander children aged 0-21 years in MM2-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
More Doctors for Rural Australia Program (MDRAP)	Supports non-vocationally recognised (non-VR) doctors to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway. The MDRAP also supports junior doctors and locums providing services in rural and remote communities.	The MDRAP Support Package provides funding to support supervision and education for eligible MDRAP participants: • Up to $500 reimbursed to doctors who complete foundation general practice training modules • Up to $13,600 per participant for approved learning

Name	Description	Incentives (financial and other)
		and development activities • Up to $30,000 per fulltime participant annually in quarterly supervision payments.
Rural Health Outreach Fund (RHOF)	The RHOF aims to improve access to medical specialists, GPs, allied and other health providers in regional, rural and remote areas of Australia by supporting outreach health activities. There are four health priorities under the RHOF: maternity and paediatric health, eye health, mental health and support for chronic disease management.	The RHOF works by removing barriers such as the cost of travel, facility hire and equipment leasing, to enable a range of health professionals to provide outreach services.
Eye and Ear Surgical Support	Incentives are payable to health professionals providing expedited access to eye and/or ear surgical support services to Aboriginal and Torres Strait Islander people who reside in MM 3-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Rural Health Workforce Support Activity	Rural Workforce Agencies in each State and the Northern Territory are funded to deliver a range of activities aimed at addressing the misdistribution of the health workforce through the following program elements: Access; Quality; and Sustainability. Grants to health professionals can include: • Recruitment costs or as incentives • Orientation expenses • Relocation expenses to move to a rural area) • Locum support • Assist with access to continuing professional development opportunities.	Specific grants to health professionals not exceeding $25,000.00 per annum, and capped at $50,000.00, in totality.
Remote Vocational Training Scheme (RVTS)	The RVTS delivers structured distance education and supervision to doctors to support them in gaining fellowship of the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine while they provide general medical services. Supervision is facilitated remotely and delivery caters to the unique	Fully Government funded. The provision of distance education and supervision to doctors to support them in gaining fellowship

Name	Description	Incentives (financial and other)
	needs of doctors working in remote communities by supporting them to achieve Fellowship through a distance education model. It allows training to be completed in an accredited post, without leaving your community. It has two trainee streams: • The Aboriginal Medical Service Stream, providing training for doctors working in Aboriginal Community Controlled Health Services (MM 2-7). • The Remote Stream for doctors working in rural & remote Australia (MM 4-7).	without travelling long distances or relocating. Being on a College-approved training program will be mandatory before sitting Fellowship exams from 2022.
Remote Vocational Training Scheme (RVTS) Extended Targeted Recruitment Pilot	The RVTS Extended Targeted Recruitment pilot commenced early 2021 and aims to improve the attraction of GP trainees in rural and remote areas by providing salary incentives to doctors as they train towards GP fellowship. The pilot will recruit up to 10 doctors, focusing on Aboriginal and Torres Strait Islander communities and rural and remote locations with high medical workforce need (MM 5-7).	Salary support per placement by training year: Year 1 - $200,000 Year 2 - $200,000 Year 3 - $100,000
Practice Incentives Program (PIP)	The PIP incentives are available to support general practice activities that encourage continuing improvement and quality of care, enhance capacity and improve access and health outcomes for patients. It is administered by Services Australia on behalf of the Department of Health. There are currently eight incentives under the PIP: • eHealth (e-PIP), • Teaching, • Indigenous Health (IHI), • GP Aged Care Access (ACAI), • GP Procedural • After Hours • Quality Improvement (PIPQI) and • Rural Loading; the PIP rural loading is added as a total to PIP incentive payments (except for ACAI, as this is a GP payment not a practice payment) for practices located in Rural Remote and Metropolitan Areas (RRMA) 3-7.	PIP loading for each Rural, Remote and Metropolitan Area (RRMA) category RRMA 1 - 0% RRMA 2 - 0% RRMA 3 - 15% RRMA 4 - 20% RRMA 5 - 40% RRMA 6 - 25% RRMA 7 - 50%

Name	Description	Incentives (financial and other)
	Under PIP, the COVID-19 Vaccine GP incentive is an additional/temporary incentive which does not attract a rural loading. This temporary incentive supports PIP eligible general practices participating in Australia's COVID-19 Vaccine National Rollout to provide continuity of care and two doses of a COVID-19 vaccine to their patients.	
Workforce Incentive Program (WIP) – Practice Stream	The WIP Practice Stream provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals. Practices in MM 3-7 locations are eligible to receive a rural loading on top of their incentive payment. The rural loading is applied in recognition of the difficulties rural and remote communities face attracting and retaining health professionals.	Up to $125,000 per annum for a single practice. Eligible for an additional 30% rural loading.
Workforce Incentive Program (WIP) - Doctor Stream	The WIP - Doctor Stream aims to encourage medical practitioners to practise in regional, rural and remote communities (MM 3-7) and to promote careers in rural medicine through the provision of financial incentives. Incentive amounts are dependent on the MM classification and the amount of time spent working in the location. To be eligible for the WIP - Doctor Stream, medical practitioners must: Provide a minimum amount of eligible primary care services in eligible locations and/or undertake eligible general practice (GP) training under an approved training pathway Meet the required number of active quarters for payment Have an eligible current Medicare provider number Have provided current bank details to Services Australia specifically for the WIP - Doctor Stream in the required timeframe.	Year 1 – $0 Year 2 – $12,000 Year 3 – $17,000 Year 4 – $17,000 Year 5 plus – $23,000
Rural Procedural Grants Program (RPGP)	The Rural Procedural Grants Program (RPGP) supports procedural GPs in rural and remote areas to attend relevant continuing professional development (CPD) activities, focused on both skills maintenance and	Procedural skills - up to $20,000 per year Emergency medicine - up to $6,000 per year

Name	Description	Incentives (financial and other)
	upskilling for procedural skills and emergency medicine. Support is provided in the form of grant payments which are designed to assist with the cost of attending CPD activities, including course costs, locum relief and travel expenses. Grants are calculated on the number of training days. Current COVID-19 amendments are in place to reduce the daily payment for all categories to $1000 per day for online CPD (normally $2000 and restricted to face to face CPD activities).	Emergency mental health - up to $6,000 per year.
General Practitioner Procedural Training Support Program (GPPTSP)	The GPPTSP is an optional, competitive scholarship program that provides $40,000 (GST exclusive) to up to 10 GP Fellows to gain a statement of satisfactory completion of Advanced Rural Skills Training in Anaesthesia, and up to 25 GP Fellows to achieve the Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology. Payments are in instalments with completion required within two years of commencing training.	$40,000 per applicant who completes training.
Premium Support Scheme (PSS)	The PSS is an Australian Government scheme that helps eligible medical practitioners with the costs of their medical indemnity insurance. Eligible medical practitioners continue to see the benefit of the PSS through reductions in the level of premiums charged to them by their medical indemnity insurers. The Australian Government makes payments to medical indemnity insurers for the PSS. Eligibility for the PSS: • A medical practitioner whose gross medical indemnity costs exceed 7.5% of estimated gross income from private billings; or • A procedural general practitioner in a rural area (MM 3-7); or • A medical practitioner who has applied for and has been deemed to be eligible for a subsidy under the Medical Indemnity Support Scheme (MISS) for a premium period ending 1 July 2021, i.e. former MISS participants.	The PSS is designed to ensure that if a medical practitioner's gross medical indemnity costs exceed 7.5% of his or her gross private medical income, he or she will receive a Government subsidy of 60% towards the cost of the premium beyond that threshold limit. Procedural GPs working in rural areas are eligible for the PSS regardless of whether they meet other PSS eligibility criteria. The PSS will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances

Name	Description	Incentives (financial and other)
		(i.e. same location, same income, and same insurer).
5 Year Overseas Trained Doctor Scheme	The Five Year Scheme encourages overseas trained doctors (OTDs) and FGAMS to work in regional, rural and remote locations by allowing a reduction of moratorium time (i.e. the time they must work in a DPA or DWS location). The time reduction increases the more rural or regional the doctor practices in. Doctors on the Scheme are required to complete a "return of service" of between 3-5 years in an eligible rural or remote community, in agreed locations. To qualify for a non-location specific exemption (i.e. time "off" their moratorium), each Five Year Scheme participant must: • Complete a return of service of between three and five years in an eligible regional or remote DWS community • Obtain Fellowship of either the Royal Australian College of General Practitioners or Australian College of Rural and Remote Medicine during the return of service; and • Become an Australian permanent resident (make a permanent commitment to Australia).	Non-location specific exemption for the agreed period of their remaining moratorium time.
Intern Incentive Allowance for Rural Pharmacies – Extension Program	The Intern Incentive Allowance for Rural Pharmacies – Extension Program provides funding to pharmacy owners located in rural and remote communities to assist employing newly-Registered Pharmacists beyond their internship training year.	Continues to support employment of newly-Registered Pharmacists for a minimum of 12 continuous months. The newly-Registered Pharmacist must have been employed as an intern in the same Pharmacy in the preceding year and must meet the Pharmacist Eligibility Criteria as set out in the Program Rules

Name	Description	Incentives (financial and other)
Regional Pharmacy Maintenance Allowance (RPMA)	The RPMA Program is aimed at supporting access to PBS medicines and pharmacy services for people living in regional, rural and remote areas by providing financial support to eligible pharmacy owners in regional, rural and remote areas. RPMA is part of the suite of Rural Support Programs funded under the Seventh Community Pharmacy Agreement (7CPA). RPMA aims to maintain equitable and sustainable access to PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicines, and pharmacy services for patients in regional, rural and remote areas of Australia, through supporting the pharmacy network.	The RPMA is calculated annually, based on the remoteness of the pharmacy according to the MMM and PBS prescription volumes. Pharmacies located within MMM categories 3 – 7 are eligible for an allowance, depending on their PBS prescription volume. Pharmacies with low prescription volumes in more remote areas receive the highest level of the Allowance.
Rural Continuing Professional Education Allowance	The Rural Continuing Professional Education Allowance assists pharmacists from regional, rural and remote areas to access CPD activities by providing financial support for travel and accommodation. The Program also provides funding for professional educators to travel to a rural location to deliver CPD activities to a group of practising pharmacists.	The Allowance supports the regional, rural and remote pharmacy workforce, to maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Intern Incentive Allowance for Rural Pharmacies (IIARP)	The IIARP for rural Pharmacies is aimed at improving the regional, rural and remote workforce by providing incentive payments to pharmacy owners or eligible hospital authorities offering a placement for a pharmacy graduate during their intern year in a regional, rural or remote Pharmacy. Applicants must be residing and working in an MM 3-6 location or be a professional educator who delivered CPD in an MM 3-7 location.	The IIARP is designed to strengthen and support the regional, rural and remote pharmacy workforce, and in turn maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Rural Intern Training Allowance (RITA)	The RITA provides financial support for pharmacy Interns practicing in regional, rural and remote areas to access compulsory training activities required as part of their Intern Training Program. Applicants must be residing in and completing their intern training year in an MM 3-7 location.	The RITA is intended to defray travel and accommodation costs associated with undertaking compulsory intern training workshops, training days and examinations

Name	Description	Incentives (financial and other)
		in regional, rural and remote areas.
Rural Pharmacy Student Placement Allowance Program (RPSPA)	The RPSPA Program provides financial support to Australian universities to facilitate Pharmacy Student placements in regional, rural and remote communities. The Allowance assists with students' travel and accommodation costs for participating in placements in regional, rural and remote areas. The Program aims to facilitate positive regional, rural and remote placement experiences for pharmacy students in order to encourage students to return to regional, rural and remote communities upon graduation.	The RPSPA provides financial support to encourage and enable Australian universities offering pharmacy courses leading to registration as a pharmacist to deliver student placements in regional, rural and remote communities.
Rural Pharmacy Scholarship Mentor Scheme (RPSMS)	The RPSMS aims to encourage and support Aboriginal and Torres Strait Islander scholars and scholars from regional, rural and remote locations to undertake undergraduate and graduate studies in pharmacy at an Australian university, by providing guidance and support from a practising regional, rural, or remote pharmacist mentor during each year of their pharmacy studies. Mentors can choose to be paid for participating in the Scheme and if so can receive a payment per mentored scholar per year.	The RPSMS provides pharmacy students with guidance and support from a practising regional, rural or remote Pharmacist. Involvement in the Mentor Scheme is compulsory for all holders of the Rural Pharmacy Scholarship and holders of the Aboriginal and Torres Strait Islander Pharmacy Scholarship.
Rural Pharmacy Scholarship Scheme (RPSS)	The RPSS provides financial support to students from regional, rural and remote communities to undertake undergraduate or postgraduate studies in pharmacy at university. Scholarship holders are encouraged to seek employment in regional, rural and remote areas following graduation.	The RPSS supports the regional, rural and remote pharmacy workforce. Applicants with a historic home address in an MM 3-7 location will be deemed eligible.

Incentives and support for GPs and general practices in MM 6 locations

MM 6 encompasses Remote communities: Remote mainland areas (ASGS-RA 4) and remote islands less than 5kms offshore. Additionally, islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland are classified as MM 6.

Name	Description	Incentives (financial and other)
Rural Bulk Billing Incentive (until 31 Dec 2021)	Higher incentives are payable to medical practitioners in areas classified as regional, rural or remote (MM 2-7) who provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age.	MBS item: 10991 = $9.90 64991 = $9.30 74991 = $9.30
Rural Bulk Billing Incentive (from 1 Jan 2022)	From 1 January 2022, the Rural Bulk Billing Incentives (RBBI) will increase for doctors and patients in rural and remote communities. This incentive will be scaled according to the MM classification of each location in Australia. The rural bulk billing incentive available in MM 6 locations will be approximately 180% of the standard bulk billing rate available in metropolitan areas.	MBS item: 10991 = $11.80 64991 = $11.05 74991 = $11.05
Approved Medical Deputising Services Program (AMDS)	The AMDS program allows a restricted non-vocationally registered workforce to provide after-hours services to the community when working for an AMDS. Participants are granted access to specific after hour's items in the MBS. This program does not provide financial incentive. The AMDS satisfies section 19AA of the *Health Insurance Act 1973*.	AMDS participants are granted access to specific after-hours items in the MBS.
Health Workforce Scholarship Program	Provides postgraduate/ continuous professional development scholarships targeted to GPs, Nursing and Allied Health Professionals. Eligible locations include: • Qualified health professionals providing primary health care in MM 1-2 locations only if employed by an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation; or • Qualified health professionals providing primary health care in rural and remote locations in MM 3-7 locations.	Scholarship - Students receive $10,000 per year for 2 years Bursary - Covers the cost of training, accommodation, travel or course fees and/or cover or partially cover training related expenses.
Medical Outreach Indigenous Chronic Disease Program	Incentives are payable to health professionals providing chronic disease outreach services for Aboriginal and Torres Strait Islander people in MM 1-7 locations where the relevant State/Territory fund holder has identified a gap in services.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).

Name	Description	Incentives (financial and other)
Rural Locum Assistance Program (RLAP)	The RLAP provides targeted locum support in MM 2-7 locations. It enhances the ability of nurses, allied health professionals, general practitioners (GP obstetricians and GP anaesthetists), and specialists (obstetricians and anaesthetists) to take leave for recreation or to undertake continuing professional development (CPD). Support includes the costs of travel, accommodation, travel allowance and incentives for locums.	Support includes the costs of travel, accommodation, travel allowance and incentives for locums. GPs can take planned leave and undertake CPD.
Healthy Ears - Better Hearing, Better Listening	Incentives are payable to health professionals, including medical specialists, allied health professionals, aboriginal health workers and GPs, providing outreach ear and hearing health services to Aboriginal and Torres Strait Islander children aged 0-21 years in MM2-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
More Doctors for Rural Australia Program (MDRAP)	Supports non-vocationally recognised (non-VR) doctors to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway. The MDRAP also supports junior doctors and locums providing services in rural and remote communities.	The MDRAP Support Package provides funding to support supervision and education for eligible MDRAP participants: • Up to $500 reimbursed to doctors who complete foundation general practice training modules • Up to $13,600 per participant for approved learning and development activities • Up to $30,000 per fulltime participant annually in quarterly supervision payments.
Rural Health Outreach Fund (RHOF)	The RHOF aims to improve access to medical specialists, GPs, allied and other health providers in regional, rural and remote areas of Australia by supporting outreach health activities. There are four health priorities under the RHOF: maternity and paediatric health, eye	The RHOF works by removing barriers such as the cost of travel, facility hire and equipment leasing, to enable a range of health

Name	Description	Incentives (financial and other)
	health, mental health and support for chronic disease management.	professionals to provide outreach services.
Eye and Ear Surgical Support	Incentives are payable to health professionals providing expedited access to eye and/or ear surgical support services to Aboriginal and Torres Strait Islander people who reside in MM 3-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Remote Vocational Training Scheme (RVTS) Extended Targeted Recruitment Pilot	The RVTS Extended Targeted Recruitment pilot commenced early 2021 and aims to improve the attraction of GP trainees in rural and remote areas by providing salary incentives to doctors as they train towards GP fellowship. The pilot will recruit up to 10 doctors, focusing on Aboriginal and Torres Strait Islander communities and rural and remote locations with high medical workforce need (MM 5-7).	Salary support per placement by training year: Year 1 - $200,000 Year 2 - $200,000 Year 3 - $100,000
Rural Health Workforce Support Activity	Rural Workforce Agencies in each State and the Northern Territory are funded to deliver a range of activities aimed at addressing the misdistribution of the health workforce through the following program elements: Access; Quality; and Sustainability. Grants to health professionals can include: • Recruitment costs or as incentives • Orientation expenses • Relocation expenses to move to a rural area) • Locum support • Assist with access to continuing professional development opportunities.	Specific grants to health professionals not exceeding $25,000.00 per annum, and capped at $50,000.00, in totality.
Workforce Incentive Program (WIP) – Practice Stream	The WIP Practice Stream provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals. Practices in MM 3-7 locations are eligible to receive a rural loading on top of their incentive payment. The rural loading is applied in recognition of the difficulties rural and remote	Up to $125,000 per annum for a single practice. Eligible for an additional 50% rural loading.

Name	Description	Incentives (financial and other)
	communities face attracting and retaining health professionals.	
Workforce Incentive Program (WIP) - Doctor Stream	The WIP - Doctor Stream aims to encourage medical practitioners to practise in regional, rural and remote communities (MM 3-7) and to promote careers in rural medicine through the provision of financial incentives. Incentive amounts are dependent on the MM classification and the amount of time spent working in the location. To be eligible for the WIP - Doctor Stream, medical practitioners must: • Provide a minimum amount of eligible primary care services in eligible locations and/or undertake eligible general practice (GP) training under an approved training pathway • Meet the required number of active quarters for payment • Have an eligible current Medicare provider number • Have provided current bank details to Services Australia specifically for the WIP - Doctor Stream in the required timeframe.	Year 1 – $16,000 Year 2 – $16,000 Year 3 – $25,000 Year 4 – $25,000 Year 5 plus – $35,000
Remote Vocational Training Scheme (RVTS)	The RVTS delivers structured distance education and supervision to doctors to support them in gaining fellowship of the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine while they provide general medical services. Supervision is facilitated remotely and delivery caters to the unique needs of doctors working in remote communities by supporting them to achieve Fellowship through a distance education model. It allows training to be completed in an accredited post, without leaving your community. It has two trainee streams: • The Aboriginal Medical Service Stream, providing training for doctors working in Aboriginal Community Controlled Health Services (MM 2-7). • The Remote Stream for doctors working in rural & remote Australia (MM 4-7).	Fully Government funded. The provision of distance education and supervision to doctors to support them in gaining fellowship without travelling long distances or relocating. Being on a College-approved training program will be mandatory before sitting Fellowship exams from 2022.

Name	Description	Incentives (financial and other)
Practice Incentives Program (PIP)	The PIP incentives are available to support general practice activities that encourage continuing improvement and quality of care, enhance capacity and improve access and health outcomes for patients. It is administered by Services Australia on behalf of the Department of Health. There are currently eight incentives under the PIP: • eHealth (e-PIP), • Teaching, • Indigenous Health (IHI), • GP Aged Care Access (ACAI), • GP Procedural • After Hours • Quality Improvement (PIPQI) and • Rural Loading; the PIP rural loading is added as a total to PIP incentive payments (except for ACAI, as this is a GP payment not a practice payment) for practices located in Rural Remote and Metropolitan Areas (RRMA) 3-7. Under PIP, the COVID-19 Vaccine GP incentive is an additional/temporary incentive which does not attract a rural loading. This temporary incentive supports PIP eligible general practices participating in Australia's COVID-19 Vaccine National Rollout to provide continuity of care and two doses of a COVID-19 vaccine to their patients.	PIP loading for each Rural, Remote and Metropolitan Area (RRMA) category RRMA 1 - 0% RRMA 2 - 0% RRMA 3 - 15% RRMA 4 - 20% RRMA 5 - 40% RRMA 6 - 25% RRMA 7 - 50%
Rural Procedural Grants Program (RPGP)	The Rural Procedural Grants Program (RPGP) supports procedural GPs in rural and remote areas to attend relevant continuing professional development (CPD) activities, focused on both skills maintenance and upskilling for procedural skills and emergency medicine. Support is provided in the form of grant payments which are designed to assist with the cost of attending CPD activities, including course costs, locum relief and travel expenses. Grants are calculated on the number of training days. Current COVID-19 amendments are in place to reduce the daily payment for all categories to	Procedural skills - up to $20,000 per year Emergency medicine - up to $6,000 per year Emergency mental health - up to $6,000 per year.

Name	Description	Incentives (financial and other)
	$1000 per day for online CPD (normally $2000 and restricted to face to face CPD activities).	
Premium Support Scheme (PSS)	The PSS is an Australian Government scheme that helps eligible medical practitioners with the costs of their medical indemnity insurance. Eligible medical practitioners continue to see the benefit of the PSS through reductions in the level of premiums charged to them by their medical indemnity insurers. The Australian Government makes payments to medical indemnity insurers for the PSS. Eligibility for the PSS: • A medical practitioner whose gross medical indemnity costs exceed 7.5% of estimated gross income from private billings; or • A procedural general practitioner in a rural area (MM 3-7); or • A medical practitioner who has applied for and has been deemed to be eligible for a subsidy under the Medical Indemnity Support Scheme (MISS) for a premium period ending 1 July 2021, i.e. former MISS participants.	The PSS is designed to ensure that if a medical practitioner's gross medical indemnity costs exceed 7.5% of his or her gross private medical income, he or she will receive a Government subsidy of 60% towards the cost of the premium beyond that threshold limit. Procedural GPs working in rural areas are eligible for the PSS regardless of whether they meet other PSS eligibility criteria. The PSS will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances (i.e. same location, same income, and same insurer).
General Practitioner Procedural Training Support Program (GPPTSP)	The GPPTSP is an optional, competitive scholarship program that provides $40,000 (GST exclusive) to up to 10 GP Fellows to gain a statement of satisfactory completion of Advanced Rural Skills Training in Anaesthesia, and up to 25 GP Fellows to achieve the Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology. Payments are in instalments with completion required within two years of commencing training.	$40,000 per applicant who completes training.
5 Year Overseas Trained Doctor Scheme	The Five Year Scheme encourages overseas trained doctors (OTDs) and FGAMS to work in regional, rural and remote locations by allowing a reduction of moratorium time (i.e. the time they must work in a DPA or DWS	Non-location specific exemption for the agreed period of their remaining moratorium time.

Name	Description	Incentives (financial and other)
	location). The time reduction increases the more rural or regional the doctor practices in. Doctors on the Scheme are required to complete a "return of service" of between 3-5 years in an eligible rural or remote community, in agreed locations. To qualify for a non-location specific exemption (i.e. time "off" their moratorium), each Five Year Scheme participant must: • Complete a return of service of between three and five years in an eligible regional or remote DWS community • Obtain Fellowship of either the Royal Australian College of General Practitioners or Australian College of Rural and Remote Medicine during the return of service; and • Become an Australian permanent resident (make a permanent commitment to Australia).	
Intern Incentive Allowance for Rural Pharmacies – Extension Program	The Intern Incentive Allowance for Rural Pharmacies – Extension Program provides funding to pharmacy owners located in rural and remote communities to assist employing newly-Registered Pharmacists beyond their internship training year.	Continues to support employment of newly-Registered Pharmacists for a minimum of 12 continuous months. The newly-Registered Pharmacist must have been employed as an intern in the same Pharmacy in the preceding year and must meet the Pharmacist Eligibility Criteria as set out in the Program Rules
Regional Pharmacy Maintenance Allowance (RPMA)	The RPMA Program is aimed at supporting access to PBS medicines and pharmacy services for people living in regional, rural and remote areas by providing financial support to eligible pharmacy owners in regional, rural and remote areas. RPMA is part of the suite of Rural Support Programs funded under the Seventh Community Pharmacy Agreement (7CPA). RPMA aims to maintain equitable and sustainable access to PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicines, and pharmacy services for patients	The Allowance is calculated annually, based on the remoteness of the pharmacy according to the MMM and PBS prescription volumes. Pharmacies located within MMM categories 3 – 7 are eligible for an allowance, depending on their PBS prescription volume.

Name	Description	Incentives (financial and other)
	in regional, rural and remote areas of Australia, through supporting the pharmacy network.	Pharmacies with low prescription volumes in more remote areas receive the highest level of the Allowance.
Rural Continuing Professional Education Allowance	The Rural Continuing Professional Education Allowance assists pharmacists from regional, rural and remote areas to access CPD activities by providing financial support for travel and accommodation. The Program also provides funding for professional educators to travel to a rural location to deliver CPD activities to a group of practising pharmacists.	The Allowance supports the regional, rural and remote pharmacy workforce, to maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Intern Incentive Allowance for Rural Pharmacies (IIARP)	The IIARP for rural Pharmacies is aimed at improving the regional, rural and remote workforce by providing incentive payments to pharmacy owners or eligible hospital authorities offering a placement for a pharmacy graduate during their intern year in a regional, rural or remote Pharmacy. Applicants must be residing and working in an MM 3-6 location or be a professional educator who delivered CPD in an MM 3-7 location.	The IIARP is designed to strengthen and support the regional, rural and remote pharmacy workforce, and in turn maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Rural Intern Training Allowance (RITA)	The RITA provides financial support for pharmacy Interns practicing in regional, rural and remote areas to access compulsory training activities required as part of their Intern Training Program. Applicants must be residing in and completing their intern training year in an MM 3-7 location.	The RITA is intended to defray travel and accommodation costs associated with undertaking compulsory intern training workshops, training days and examinations in regional, rural and remote areas.
Rural Pharmacy Student Placement Allowance Program (RPSPA)	The RPSPA provides financial support to Australian universities to facilitate Pharmacy Student placements in regional, rural and remote communities. The Allowance assists with students' travel and accommodation costs for participating in placements in regional, rural and remote areas. The Program aims to facilitate positive regional, rural and remote placement experiences for pharmacy students in order to encourage students to return to	The RPSPA provides financial support to encourage and enable Australian universities offering pharmacy courses leading to registration as a pharmacist to deliver student placements in

Name	Description	Incentives (financial and other)
	regional, rural and remote communities upon graduation.	regional, rural and remote communities.
Rural Pharmacy Scholarship Mentor Scheme (RPSMS)	The RPSMS aims to encourage and support Aboriginal and Torres Strait Islander scholars and scholars from regional, rural and remote locations to undertake undergraduate and graduate studies in pharmacy at an Australian university, by providing guidance and support from a practising regional, rural, or remote pharmacist mentor during each year of their pharmacy studies. Mentors can choose to be paid for participating in the Scheme and if so can receive a payment per mentored scholar per year.	The RPSMS provides pharmacy students with guidance and support from a practising regional, rural or remote Pharmacist. Involvement in the Mentor Scheme is compulsory for all holders of the Rural Pharmacy Scholarship and holders of the Aboriginal and Torres Strait Islander Pharmacy Scholarship.
Rural Pharmacy Scholarship Scheme (RPSS)	The RPSS provides financial support to students from regional, rural and remote communities to undertake undergraduate or postgraduate studies in pharmacy at university. Scholarship holders are encouraged to seek employment in regional, rural and remote areas following graduation.	The RPSS supports the regional, rural and remote pharmacy workforce. Applicants with a historic home address in an MM 3-7 location will be deemed eligible.

Incentives and support for GPs and general practices in MM 7 locations

MM 7 encompasses very remote communities: Very remote areas (ASGS-RA 5) and all other remote island areas more than 5kms offshore.

Name	Description	Incentives (financial and other)
Rural Bulk Billing Incentive (until 31 Dec 2021)	Higher incentives are payable to medical practitioners in areas classified as regional, rural or remote (MM 2-7) who provide bulk billed services to vulnerable patient groups, such as people with concession cards and children under 16 years of age.	MBS item: 10991 = $9.90 64991 = $9.30 74991 = $9.30
Rural Bulk Billing Incentive (from 1 Jan 2022)	From 1 January 2022, the Rural Bulk Billing Incentives (RBBI) will increase for doctors and patients in rural and remote communities. This incentive will be scaled according to the MM classification of each location in Australia.	MBS item: 10991 = $12.50 64991 = $12.15 74991 = $12.15

Name	Description	Incentives (financial and other)
	The rural bulk billing incentive available in MM 7 locations will be approximately 190% of the standard bulk billing rate available in metropolitan areas.	
Approved Medical Deputising Services Program (AMDS)	The AMDS program allows a restricted non-vocationally registered workforce to provide after-hours services to the community when working for an AMDS. Participants are granted access to specific after hour's items in the MBS. This program does not provide financial incentive. The AMDS satisfies section 19AA of the *Health Insurance Act 1973.*	AMDS participants are granted access to specific after-hours items in the MBS.
Health Workforce Scholarship Program	Provides postgraduate/ continuous professional development scholarships targeted to GPs, Nursing and Allied Health Professionals. Eligible locations include: • Qualified health professionals providing primary health care in MM 1-2 locations only if employed by an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation; or • Qualified health professionals providing primary health care in rural and remote locations in MM 3-7 locations.	Scholarship - Students receive $10,000 per year for 2 years Bursary - Covers the cost of training, accommodation, travel or course fees and/or cover or partially cover training related expenses.
Medical Outreach Indigenous Chronic Disease Program	Incentives are payable to health professionals providing chronic disease outreach services for Aboriginal and Torres Strait Islander people in MM 1-7 locations where the relevant State/Territory fund holder has identified a gap in services.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Rural Locum Assistance Program (RLAP)	The RLAP provides targeted locum support in MM 2-7 locations. It enhances the ability of nurses, allied health professionals, general practitioners (GP obstetricians and GP anaesthetists), and specialists (obstetricians and anaesthetists) to take leave for recreation or to undertake continuing professional development (CPD). Support includes the costs of travel, accommodation, travel allowance and incentives for locums.	Support includes the costs of travel, accommodation, travel allowance and incentives for locums. GPs can take planned leave and undertake CPD.

Name	Description	Incentives (financial and other)
Healthy Ears - Better Hearing, Better Listening	Incentives are payable to health professionals, including medical specialists, allied health professionals, aboriginal health workers and GPs, providing outreach ear and hearing health services to Aboriginal and Torres Strait Islander children aged 0-21 years in MM 2-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
More Doctors for Rural Australia Program (MDRAP)	Supports non-vocationally recognised (non-VR) doctors to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway. The MDRAP also supports junior doctors and locums providing services in rural and remote communities.	The MDRAP Support Package provides funding to support supervision and education for eligible MDRAP participants: • Up to $500 reimbursed to doctors who complete foundation general practice training modules • Up to $13,600 per participant for approved learning and development activities • Up to $30,000 per fulltime participant annually in quarterly supervision payments.
Rural Health Workforce Support Activity	Rural Workforce Agencies in each State and the Northern Territory are funded to deliver a range of activities aimed at addressing the misdistribution of the health workforce through the following program elements: Access; Quality; and Sustainability. Grants to health professionals can include: • Recruitment costs or as incentives • Orientation expenses • Relocation expenses to move to a rural area) • Locum support • Assist with access to continuing professional development opportunities.	Specific grants to health professionals not exceeding $25,000.00 per annum, and capped at $50,000.00, in totality.

Name	Description	Incentives (financial and other)
Remote Vocational Training Scheme (RVTS)	The RVTS delivers structured distance education and supervision to doctors to support them in gaining fellowship of the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine while they provide general medical services. Supervision is facilitated remotely and delivery caters to the unique needs of doctors working in remote communities by supporting them to achieve Fellowship through a distance education model. It allows training to be completed in an accredited post, without leaving your community. It has two trainee streams: • The Aboriginal Medical Service Stream, providing training for doctors working in Aboriginal Community Controlled Health Services (MM 2-7). • The Remote Stream for doctors working in rural & remote Australia (MM 4-7).	Fully Government funded. The provision of distance education and supervision to doctors to support them in gaining fellowship without travelling long distances or relocating. Being on a College-approved training program will be mandatory before sitting Fellowship exams from 2022.
Remote Vocational Training Scheme (RVTS) Extended Targeted Recruitment Pilot	The RVTS Extended Targeted Recruitment pilot commenced early 2021 and aims to improve the attraction of GP trainees in rural and remote areas by providing salary incentives to doctors as they train towards GP fellowship. The pilot will recruit up to 10 doctors, focusing on Aboriginal and Torres Strait Islander communities and rural and remote locations with high medical workforce need (MM 5-7).	Salary support per placement by training year: Year 1 - $200,000 Year 2 - $200,000 Year 3 - $100,000
Practice Incentives Program (PIP)	The PIP incentives are available to support general practice activities that encourage continuing improvement and quality of care, enhance capacity and improve access and health outcomes for patients. It is administered by Services Australia on behalf of the Department of Health. There are currently eight incentives under the PIP: • eHealth (e-PIP), • Teaching, • Indigenous Health (IHI), • GP Aged Care Access (ACAI), • GP Procedural	PIP loading for each Rural, Remote and Metropolitan Area (RRMA) category RRMA 1 - 0% RRMA 2 - 0% RRMA 3 - 15% RRMA 4 - 20% RRMA 5 - 40% RRMA 6 - 25% RRMA 7 - 50%

Name	Description	Incentives (financial and other)
	• After Hours • Quality Improvement (PIPQI) and • Rural Loading; the PIP rural loading is added as a total to PIP incentive payments (except for ACAI, as this is a GP payment not a practice payment) for practices located in Rural Remote and Metropolitan Areas (RRMA) 3-7. Under PIP, the COVID-19 Vaccine GP incentive is an additional/temporary incentive which does not attract a rural loading. This temporary incentive supports PIP eligible general practices participating in Australia's COVID-19 Vaccine National Rollout to provide continuity of care and two doses of a COVID-19 vaccine to their patients.	
Workforce Incentive Program (WIP) – Practice Stream	The WIP Practice Stream provides financial incentives to support general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals. Practices in MM 3-7 locations are eligible to receive a rural loading on top of their incentive payment. The rural loading is applied in recognition of the difficulties rural and remote communities face attracting and retaining health professionals.	Up to $125,000 per annum for a single practice. Eligible for an additional 50% rural loading.
Workforce Incentive Program (WIP) - Doctor Stream	The WIP - Doctor Stream aims to encourage medical practitioners to practise in regional, rural and remote communities (MM 3-7) and to promote careers in rural medicine through the provision of financial incentives. Incentive amounts are dependent on the MM classification and the amount of time spent working in the location. To be eligible for the WIP - Doctor Stream, medical practitioners must: • Provide a minimum amount of eligible primary care services in eligible locations and/or undertake eligible general practice (GP) training under an approved training pathway • Meet the required number of active quarters for payment	Year 1 – $25,000 Year 2 – $25,000 Year 3 – $35,000 Year 4 – $35,000 Year 5 plus – $60,000

Name	Description	Incentives (financial and other)
	• Have an eligible current Medicare provider number • Have provided current bank details to Services Australia specifically for the WIP - Doctor Stream in the required timeframe.	
Rural Health Outreach Fund (RHOF)	The RHOF aims to improve access to medical specialists, GPs, allied and other health providers in regional, rural and remote areas of Australia by supporting outreach health activities. There are four health priorities under the RHOF: maternity and paediatric health, eye health, mental health and support for chronic disease management.	The RHOF works by removing barriers such as the cost of travel, facility hire and equipment leasing, to enable a range of health professionals to provide outreach services.
Eye and Ear Surgical Support	Incentives are payable to health professionals providing expedited access to eye and/or ear surgical support services to Aboriginal and Torres Strait Islander people who reside in MM 3-7 locations.	Costs associated with delivering outreach services are payable to eligible health professionals to remove a range of financial disincentives (e.g. travel, meals and accommodation).
Rural Procedural Grants Program (RPGP)	The Rural Procedural Grants Program (RPGP) supports procedural GPs in rural and remote areas to attend relevant continuing professional development (CPD) activities, focused on both skills maintenance and upskilling for procedural skills and emergency medicine. Support is provided in the form of grant payments which are designed to assist with the cost of attending CPD activities, including course costs, locum relief and travel expenses. Grants are calculated on the number of training days. Current COVID-19 amendments are in place to reduce the daily payment for all categories to $1000 per day for online CPD (normally $2000 and restricted to face to face CPD activities).	Procedural skills - up to $20,000 per year Emergency medicine - up to $6,000 per year Emergency mental health - up to $6,000 per year.

Name	Description	Incentives (financial and other)
Premium Support Scheme (PSS)	The PSS is an Australian Government scheme that helps eligible medical practitioners with the costs of their medical indemnity insurance. Eligible medical practitioners continue to see the benefit of the PSS through reductions in the level of premiums charged to them by their medical indemnity insurers. The Australian Government makes payments to medical indemnity insurers for the PSS. Eligibility for the PSS: • A medical practitioner whose gross medical indemnity costs exceed 7.5% of estimated gross income from private billings; or • A procedural general practitioner in a rural area (MM 3-7); or • A medical practitioner who has applied for and has been deemed to be eligible for a subsidy under the Medical Indemnity Support Scheme (MISS) for a premium period ending 1 July 2021, i.e. former MISS participants.	The PSS is designed to ensure that if a medical practitioner's gross medical indemnity costs exceed 7.5% of his or her gross private medical income, he or she will receive a Government subsidy of 60% towards the cost of the premium beyond that threshold limit. Procedural GPs working in rural areas are eligible for the PSS regardless of whether they meet other PSS eligibility criteria. The PSS will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances (i.e. same location, same income, and same insurer).
General Practitioner Procedural Training Support Program (GPPTSP)	The GPPTSP is an optional, competitive scholarship program that provides $40,000 (GST exclusive) to up to 10 GP Fellows to gain a statement of satisfactory completion of Advanced Rural Skills Training in Anaesthesia, and up to 25 GP Fellows to achieve the Diploma of the Royal Australian and New Zealand College of Obstetrics and Gynaecology. Payments are in instalments with completion required within two years of commencing training.	$40,000 per applicant who completes training.
5 Year Overseas Trained Doctor Scheme	The Five Year Scheme encourages overseas trained doctors (OTDs) and FGAMS to work in regional, rural and remote locations by allowing a reduction of moratorium time (i.e. the time they must work in a DPA or DWS location). The time reduction increases the more rural or regional the doctor practices in.	Non-location specific exemption for the agreed period of their remaining moratorium time.

Name	Description	Incentives (financial and other)
	Doctors on the Scheme are required to complete a "return of service" of between 3-5 years in an eligible rural or remote community, in agreed locations. To qualify for a non-location specific exemption (i.e. time "off" their moratorium), each Five Year Scheme participant must: • Complete a return of service of between three and five years in an eligible regional or remote DWS community • Obtain Fellowship of either the Royal Australian College of General Practitioners or Australian College of Rural and Remote Medicine during the return of service; and • Become an Australian permanent resident (make a permanent commitment to Australia).	
Intern Incentive Allowance for Rural Pharmacies – Extension Program	The Intern Incentive Allowance for Rural Pharmacies – Extension Program provides funding to pharmacy owners located in rural and remote communities to assist employing newly-Registered Pharmacists beyond their internship training year.	Continues to support employment of newly-Registered Pharmacists for a minimum of 12 continuous months. The newly-Registered Pharmacist must have been employed as an intern in the same Pharmacy in the preceding year and must meet the Pharmacist Eligibility Criteria as set out in the Program Rules
Regional Pharmacy Maintenance Allowance (RPMA)	The RPMA is aimed at supporting access to PBS medicines and pharmacy services for people living in regional, rural and remote areas by providing financial support to eligible pharmacy owners in regional, rural and remote areas. RPMA is part of the suite of Rural Support Programs funded under the Seventh Community Pharmacy Agreement (7CPA). RPMA aims to maintain equitable and sustainable access to PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicines, and pharmacy services for patients in regional, rural and remote areas of Australia, through supporting the pharmacy network.	The RPMA is calculated annually, based on the remoteness of the pharmacy according to the MMM and PBS prescription volumes. Pharmacies located within MMM categories 3 – 7 are eligible for an allowance, depending on their PBS prescription volume. Pharmacies with low prescription volumes in more remote areas

Name	Description	Incentives (financial and other)
		receive the highest level of the Allowance.
Rural Continuing Professional Education Allowance	The Rural Continuing Professional Education Allowance assists pharmacists from regional, rural and remote areas to access CPD activities by providing financial support for travel and accommodation. The Program also provides funding for professional educators to travel to a rural location to deliver CPD activities to a group of practising pharmacists.	The Allowance supports the regional, rural and remote pharmacy workforce, to maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Intern Incentive Allowance for Rural Pharmacies (IIARP)	The IIARP for rural Pharmacies is aimed at improving the regional, rural and remote workforce by providing incentive payments to pharmacy owners or eligible hospital authorities offering a placement for a pharmacy graduate during their intern year in a regional, rural or remote Pharmacy. Applicants must be residing and working in an MM 3-6 location or be a professional educator who delivered CPD in an MM 3-7 location.	The IIARP is designed to strengthen and support the regional, rural and remote pharmacy workforce, and in turn maintain access to quality pharmacy services for patients residing in regional, rural and remote regions of Australia.
Rural Intern Training Allowance (RITA)	The RITA provides financial support for pharmacy Interns practicing in regional, rural and remote areas to access compulsory training activities required as part of their Intern Training Program. Applicants must be residing in and completing their intern training year in an MM 3-7 location.	The RITA is intended to defray travel and accommodation costs associated with undertaking compulsory intern training workshops, training days and examinations in regional, rural and remote areas.
Rural Pharmacy Student Placement Allowance Program (RPSPA)	The RPSPA provides financial support to Australian universities to facilitate Pharmacy Student placements in regional, rural and remote communities. The Allowance assists with students' travel and accommodation costs for participating in placements in regional, rural and remote areas. The Program aims to facilitate positive regional, rural and remote placement experiences for pharmacy students in order to encourage students to return to regional, rural and remote communities upon graduation.	The RPSPA provides financial support to encourage and enable Australian universities offering pharmacy courses leading to registration as a pharmacist to deliver student placements in regional, rural and remote communities.

Name	Description	Incentives (financial and other)
Rural Pharmacy Scholarship Mentor Scheme (RPSMS)	The RPSMS aims to encourage and support Aboriginal and Torres Strait Islander scholars and scholars from regional, rural and remote locations to undertake undergraduate and graduate studies in pharmacy at an Australian university, by providing guidance and support from a practising regional, rural, or remote pharmacist mentor during each year of their pharmacy studies. Mentors can choose to be paid for participating in the Scheme and if so can receive a payment per mentored scholar per year.	The RPSMS provides pharmacy students with guidance and support from a practising regional, rural or remote Pharmacist. Involvement in the Mentor Scheme is compulsory for all holders of the Rural Pharmacy Scholarship and holders of the Aboriginal and Torres Strait Islander Pharmacy Scholarship.
Rural Pharmacy Scholarship Scheme (RPSS)	The RPSS provides financial support to students from regional, rural and remote communities to undertake undergraduate or postgraduate studies in pharmacy at university. Scholarship holders are encouraged to seek employment in regional, rural and remote areas following graduation.	The RPSS supports the regional, rural and remote pharmacy workforce. Applicants with a historic home address in an MM 3-7 location will be deemed eligible.

Appendix B: List of Primary Care Programs

This appendix provides further information about a number of programs that have not been outlined, or have been referenced very briefly, in the main body of the document. These programs invest in specific elements of the workforce, or in technological solutions to improve access to services for people in outer regional, regional, rural and remote locations.

Pharmacy programs

Program	Description	Role	Impact on outer metro, regional/rural/remote
Rural Pharmacy Liaison Officer Program (RPLO)	The RPLOP program aims to support Pharmacists and Pharmacy Students practising in regional, rural and remote areas and to deliver local programs that support clinical placements and promote intra-professional collaboration and support. These local programs facilitate professional development and networking opportunities between Pharmacies, Pharmacy Departments, Pharmacists, Pharmacy Students, and university Pharmacy Schools. Payments are made to participating universities.	The RPLO supports the regional, rural and remote pharmacy workforce.	The RPLO Program seeks to raise the profile of pharmacy within the UDRH and Pharmacy Schools, and to enable rural pharmacists and pharmacy graduates to acquire the necessary skills to practise effectively in rural areas. Universities with UDRHs and Pharmacy Schools are eligible for participation in the RPLO Program.

Program	Description	Role	Impact on outer metro, regional/rural/remote
Administrative Support to Pharmacy Schools Scheme (ASPSS)	Pharmacy Schools receive support for administration of regional, rural and remote placement programs via the Administrative Support to Pharmacy Schools Scheme.	The ASPSS supports the regional, rural and remote pharmacy workforce through financial support to universities participating in the program.	The ASPSS provides financial support to universities to facilitate placements for students in regional, rural and remote areas, and to promote the RPSPA, RPSS and ATSIPSS.

Workforce, general practice and indigenous programs

Program	Description	Role	Impact on outer metro, regional/rural/remote
Training and Professional Support for the Remote Health Workforce (TPSR) Program	The Government funds CRANAplus $14.37 million (GST excl) over three years (from 2021-22 to 2023-24) to deliver its TPSR Program to support health professionals working in remote areas, with education, mental health and well-being support and professional services relevant to their context of practice.	This initiative aims to: • Enhance knowledge and skills of health care professionals working in remote and isolated areas of Australia. • Increase support for the mental health and wellbeing of health care professionals, and their families, working in remote and isolated areas of Australia. • Increase recruitment and retention of health care professionals working in remote and isolated areas of Australia.	

Program	Description	Role	Impact on outer metro, regional/rural/remote
Visiting Optometrists Scheme (VOS)	The VOS supports optometrists to deliver outreach optometric services to remote and very remote locations.	The VOS reimburses outreach-related expenses like: • travel, accommodation and meals • facility fees and administrative support at the outreach location • locum support at the home practice • lease and transport of equipment.	Overall, services provided through this scheme more than tripled between 2010–11 and 2018–19[105].
Support for the Fly-In Fly-Out (FIFO) and Drive-In Drive-Out (DIDO) industries	Through the 2021-22 Budget, the Government also committed funding of $6.3 million to increase specialised early intervention mental health support and suicide prevention services available to the male-dominated Fly In Fly Out (FIFO)/Drive-In Drive-Out (DIDO) industries.	FIFO and DIDO workers in the mining and construction industries have higher than average rates of anxiety and depression, experience higher rates of suicidal intent, and are more likely to have poor mental health. To ensure FIFO and DIDO workers are receiving tailored support, specialised services are required that recognise the impact long-distance commuting can have on mental health.	
Practice Incentives Program (PIP)	The PIP exists to support continuous improvement in General Practice; increase quality of care delivered; enhance capacity in General Practice; and improve access and health outcomes for patients.	The PIP provides targeted financial incentive payments through ten different incentive payments, with some having a focus on supporting General Practice in a rural and remote settings.	As at May 2021, there were 6,418 accredited General Practices participating in the PIP. These practices are distributed across varied RRMA classifications: • 69% are located in RRMA 1

Program	Description	Role	Impact on outer metro, regional/rural/remote
		The PIP uses the Rural, Remote and Metropolitan Areas (RRMA) geographical classification system to determine the rurality and remoteness of practices, and their eligibility to participate in several incentives.	• 8% are located in RRMA 2 • 7% are located in RRMA 3 • 5% are located in RRMA 4 • 8% are located in RRMA 5 • 2% are located in RRMA 6 • 1% are located in RRMA 7.
PIP - Procedural GP Payment	This PIP payment encourages General Practices in rural and remote areas to maintain local access to surgical, anesthetic and obstetric services	This payment is available to eligible to practices based in RRMA 3 to 7 areas.	
PIP - After Hours Incentive	This PIP payment supports General Practices to provide patients with appropriate access to after hours care.	Practices in a rural and remote areas (RRMA 5 to 7) can claim the highest tier (Level 5) if the practice provides after hours care to practice patients in the complete after hours period.	
PIP - Rural Loading Incentive	This PIP payment provides additional financial support to practices in rural and remote areas, in recognition of the added difficulties of providing medical care in a rural and remote setting.	The rural loading component ranges from 15% to 50% depending on the remoteness of the practice location, and is applied on top of the total incentive payments to be paid to the practice for the payment quarter.	

Program	Description	Role	Impact on outer metro, regional/rural/remote
Practice Incentive Program eHealth Incentive (ePIP)	The intent of the ePIP is to encourage clinical practices to keep up to date with the latest developments in digital health and adopt new digital health technology as it becomes available. It aims to help practices improve administration processes and patient care. A (desktop) review of ePIP is currently underway. The Review will consider the existing ePIP eligibility requirements and whether they need to be improved and/or modernised, as well as any emerging requirements that may be added to, or replace existing eligibility requirements. Consideration will also be given to how ePIP can maintain relevance and continue to best support general practices given the rapid expansion and evolution of digital health services.	To be eligible for ePIP, practices must be registered in the PIP, meet five eligibility requirements as well as their practice's Shared Health Summary minimum upload target. ePIP incentive payments are currently capped at $12,500 per general practice per quarter with a maximum payment of $50,000 per year. The requirements for this incentive support the direction of the Australian Government's My Health Record Strategy. ePIP is administered by Services Australia.	As at 30 June 2021, 5,770 general practices were registered for ePIP out of 6,376 general practices registered for the PIP. $77.9 million has been expended on the Practice Incentives Program eHealth Incentive (ePIP) as at 31 January 2021. As at 25 April 2021, 6.2 million shared health summaries (SHS) have been uploaded into the My Health Record (MHR) system. Approximately 79 per cent of SHS had been uploaded by ePIP participating practices.

Program	Description	Role	Impact on outer metro, regional/rural/remote
Indigenous Health Workforce Traineeships (IHWT) program	The IHWT provides $13.6 million over three years (2020-21 to 2022-23) to approved National Aboriginal Community Controlled Health Organisation affiliates, or equivalent organisations. Organisations funded under the IHWT program will administer the program on the Department's behalf, and work with ACCHSs to identify, recruit and support Aboriginal and Torres Strait Islander trainees.	The program aims to: • Increase the number of skilled Aboriginal and Torres Strait Islander people working in the Aboriginal and Torres Strait Islander primary health care sector. • Create viable career pathways in health for Aboriginal and Torres Strait Islander people. • Build the capacity of ACCHSs to provide culturally appropriate health care to its Aboriginal and Torres Strait Islander clients.	
Leaders in Indigenous Medical Education (LIME) Network	The Medical Deans Australia and New Zealand received funding of over $680,000 in 2020-21 for its LIME Network.	The key objectives of the LIME Network are to support quality and effective teaching of Aboriginal and Torres Strait Islander health in medical education, as well as best practice in the recruitment and retention of Aboriginal and Torres Strait Islander medical students.	The LIME Network provides a community of practice for members to share ideas and experiences and get support from colleagues, noting some members (given the low representation of Aboriginal and Torres Strait Islander people in the medical workforce) may feel isolated within their own institutions.

Program	Description	Role	Impact on outer metro, regional/rural/remote

Indigenous Australians' Health Program (IAHP)	The program's objective is to provide Aboriginal and Torres Strait Islander people with access to effective high-quality, culturally appropriate primary health care services in urban, regional, rural and remote locations across Australia.	The Australian Government funds the Primary Health Care (PHC) program under the IAHP. The PHC program aims to improve health outcomes for Aboriginal and Torres Strait Islander people through the following:
		• the delivery of primary health care services tailored to the needs of the Aboriginal and Torres Strait Islander community, including:
		  ○ culturally-appropriate clinical services,
		  ○ a range of population health services, and
		  ○ activities that support the delivery of essential clinical services;
		• improving access to antenatal care and child, maternal and family health services by Aboriginal and Torres Strait Islander children, their mothers and families;
		• the prevention, detection and management of chronic diseases;
		• investment in priority health areas in regions of high health need; and
			The IAHP PHC Funding Model commenced 1 July 2020, and was co-designed with the sector.
			This helps to deliver better health outcomes for Aboriginal and Torres Strait Islander people. An additional $90m over three years was provided under the new funding model, with a significant proportion provided to organisations outside of metropolitan areas.

Program	Description	Role	Impact on outer metro, regional/rural/remote
		• improving the clinical effectiveness of the health system and supporting sustainable, long term service reform delivery and improvement through Continuous Quality Improvement.	

Technology-focused initiatives

Program	Description	Role	Impact on outer metro, regional/rural/remote
2021-22 Supporting Medication Management in Residential Aged Care Initiative	The *2021-22 Supporting Medication Management in Residential Aged Care Initiative* will encourage uptake of digital health products in the residential aged care sector to improve health outcomes	This initiative will deliver: • A grant to incentivise the adoption of electronic National Residential Medication Charts, and will be weighted to provide higher levels of payment to rural and remote RACFs • Enhancements to the My Health Record system to digitise patient transfer information and increase the uptake and use of My Health Records in RACFs, including in rural and remote areas	The initiative is still in preliminary phases. Data from the current trial of electronic National Residential Medication Charts demonstrates that this product reduces both medication safety risks and administrative burden for all users and consumers, particularly those in rural and remote regions, through the provision of electronic medication ordering and digital collaboration tools.

Program	Description	Role	Impact on outer metro, regional/rural/remote
Improving Access to Medicines – ePrescribing for Safer Medicines	The 2018-19 Budget measure *Improving Access to Medicines – ePrescribing for Safer Medicines* provided for the development and implementation of Electronic Prescribing. Electronic prescribing is also an important component of digital health, identified as a priority in the National Digital Health Strategy (2018-2020).	• Electronic Prescriptions are an alternate legal form of prescription and have been successfully rolled out nationally. • The Active Script List (ASL), an integral part of electronic prescribing, is a token management system that provides a list of a patient's active prescriptions and removes the need for them to manage multiple tokens. ASL has now rolled out nationally in Fred software enabled pharmacies.	• E-Prescribing has an important role in assisting regional, rural and remote communities to overcome the challenges of distance when accessing medication. • Currently 67% of individual prescribers have generated an electronic prescription and more than 98% of community pharmacies have dispensed at least one electronic prescription. • As of 17 August 2021, 15.12m electronic prescriptions have been generated (including originals and repeats), 10.15m dispensed and over 30 thousand patients have registered for an ASL. • Individuals can only sign up for an ASL via their healthcare professional at the moment. The Department is looking at legislative changes that will enable patients to use a mobile application or an online pharmacy website to fill out an ASL registration form to complete 'self-registration'.

Program	Description	Role	Impact on outer metro, regional/rural/remote
Guaranteeing Medicare – Diagnostic Imaging	The 2021-22 Budget measure *Guaranteeing Medicare – Diagnostic Imaging* provided for the modernisation of Diagnostic Imaging to develop a streamlined electronic referral solution, which will assist in the determination of the need for diagnostic imaging.	• The digitalisation of diagnostic imaging referrals will ensure patient choice of service provider is maintained, and will ensure a stable, competitive diagnostic imaging industry within Australia. • This measure will establish a national interoperable solution across the diagnostic imaging sector. This will benefit patients and providers who will be able to access historical reports thus reducing duplicate imaging, ensuring patient safety. • Digitalising referrals, requests and results for diagnostic imaging services will ensure the timely transfer of accurate, clinically relevant and standardised information, including appropriate use criteria, between the requesting practitioners and the service providers.	• This initiative is currently in the planning phase. • The Department is working with the Australian Digital Health Agency to develop a Proof of Concept and to set up a technical working group to co-design the digitalisation of diagnostic imaging referrals. • Work is also being planned to develop an agreed Radiology Referral Set that standardises terminology

Appendix C: MBS data relating to changes to annual indexation of MBS items

All MBS - Benefits per service

Data shown are: total MBS benefits per service for all BTOS, based on date of processing (DOP), financial year (2011-12 to 2020-21) and per patient MMM region (1-7, and National Average)

Figure 18: Average MBS benefit per service by MMM

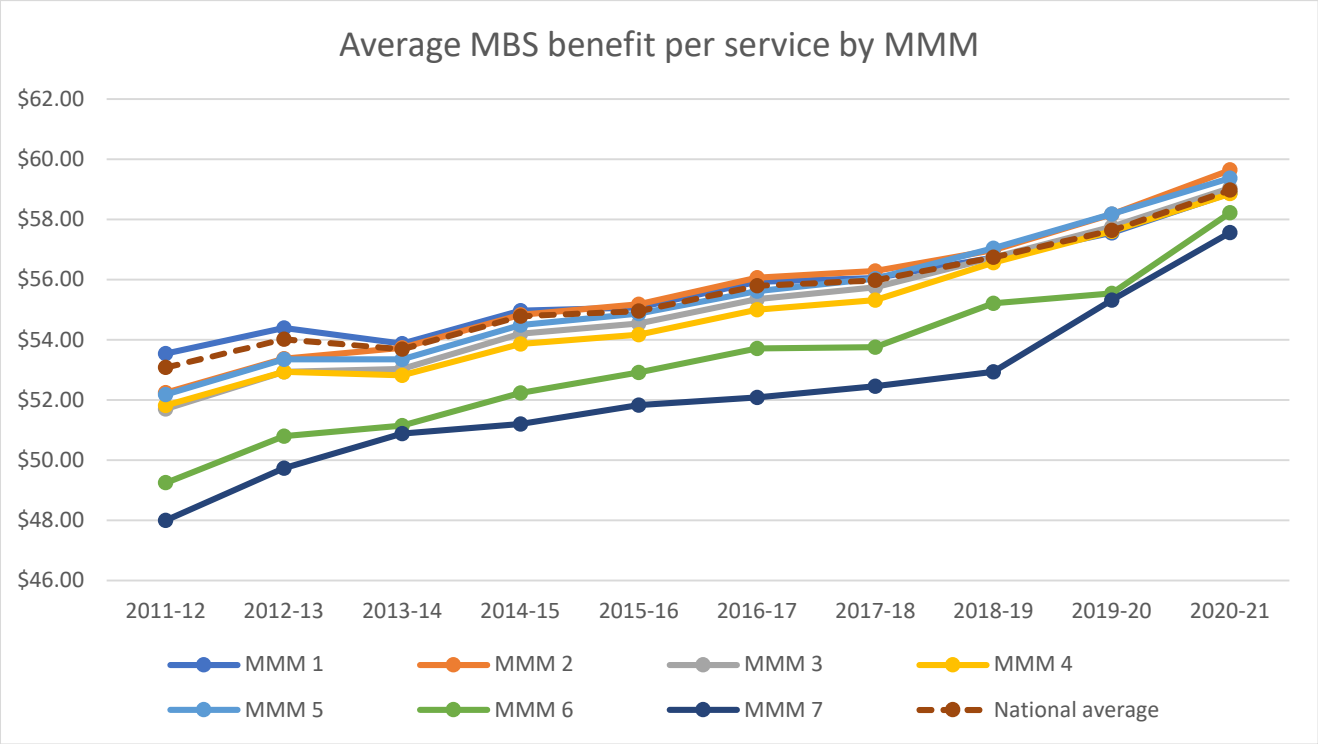


Table 5: Average MBS benefit per service by MMM

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	$53.54	$52.25	$51.70	$51.82	$52.18	$49.25	$48.00	$53.08
2012-13	$54.39	$53.37	$52.94	$52.93	$53.35	$50.79	$49.74	$54.02
2013-14	$53.87	$53.73	$53.03	$52.81	$53.35	$51.15	$50.88	$53.69
2014-15	$54.97	$54.82	$54.20	$53.85	$54.49	$52.23	$51.20	$54.78
2015-16	$55.07	$55.18	$54.54	$54.17	$54.87	$52.91	$51.83	$54.96
2016-17	$55.92	$56.07	$55.35	$54.99	$55.61	$53.71	$52.09	$55.80
2017-18	$56.05	$56.29	$55.74	$55.32	$56.03	$53.75	$52.46	$55.98
2018-19	$56.74	$56.97	$56.73	$56.56	$57.04	$55.21	$52.93	$56.74
2019-20	$57.55	$58.17	$57.76	$57.60	$58.18	$55.54	$55.31	$57.64
2020-21	$58.88	$59.64	$59.04	$58.86	$59.37	$58.22	$57.57	$58.98

GP non-referred attendances - Benefits per service

Data shown are: total MBS benefits per service for GP non-referred attendances, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average)

Figure 19: Average MBS benefits per service for GP non-referred attendances

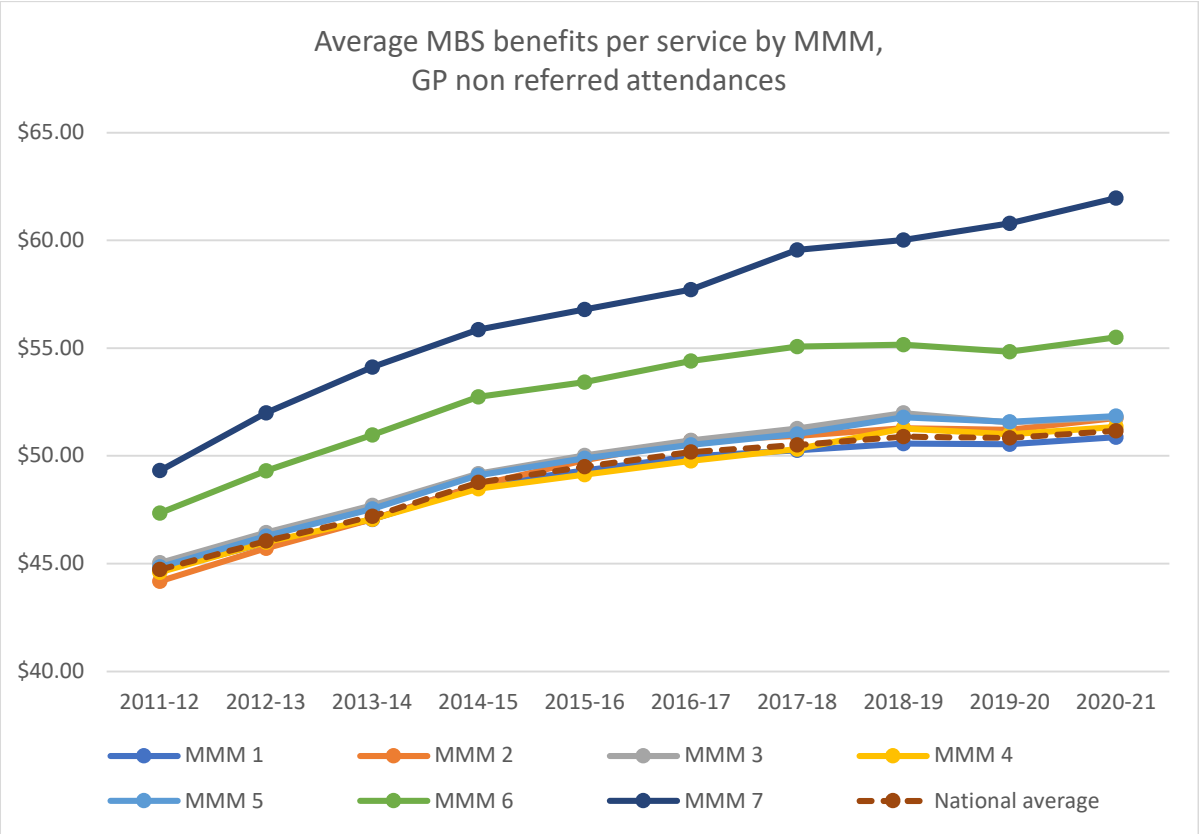


Table 6: Average MBS benefits per service for GP non-referred attendances

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	$44.70	$44.19	$45.04	$44.60	$44.85	$47.35	$49.32	$44.73
2012-13	$45.97	$45.71	$46.44	$46.00	$46.28	$49.31	$52.00	$46.06
2013-14	$47.05	$47.06	$47.71	$47.06	$47.54	$50.98	$54.12	$47.20
2014-15	$48.64	$48.64	$49.17	$48.47	$49.10	$52.74	$55.86	$48.77
2015-16	$49.32	$49.79	$50.03	$49.13	$49.88	$53.42	$56.80	$49.51
2016-17	$49.97	$50.70	$50.72	$49.77	$50.51	$54.41	$57.71	$50.19
2017-18	$50.25	$50.93	$51.27	$50.32	$51.01	$55.07	$59.55	$50.51
2018-19	$50.56	$51.28	$51.99	$51.27	$51.79	$55.16	$60.01	$50.90
2019-20	$50.55	$51.21	$51.55	$51.00	$51.59	$54.83	$60.79	$50.83
2020-21	$50.87	$51.76	$51.79	$51.35	$51.85	$55.51	$61.96	$51.17

GP non-referred attendances - Bulk billing rate

Data shown are: total bulk billing rates for GP non-referred attendances, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average). It is noted that telehealth services introduced in March 2020 as part of the response to the COVID-19 pandemic initially included a bulk billing requirement for valid claims. This requirement ceased on 1 October 2020.

Figure 20*:* Bulk billing rates for GP non-referred attendances

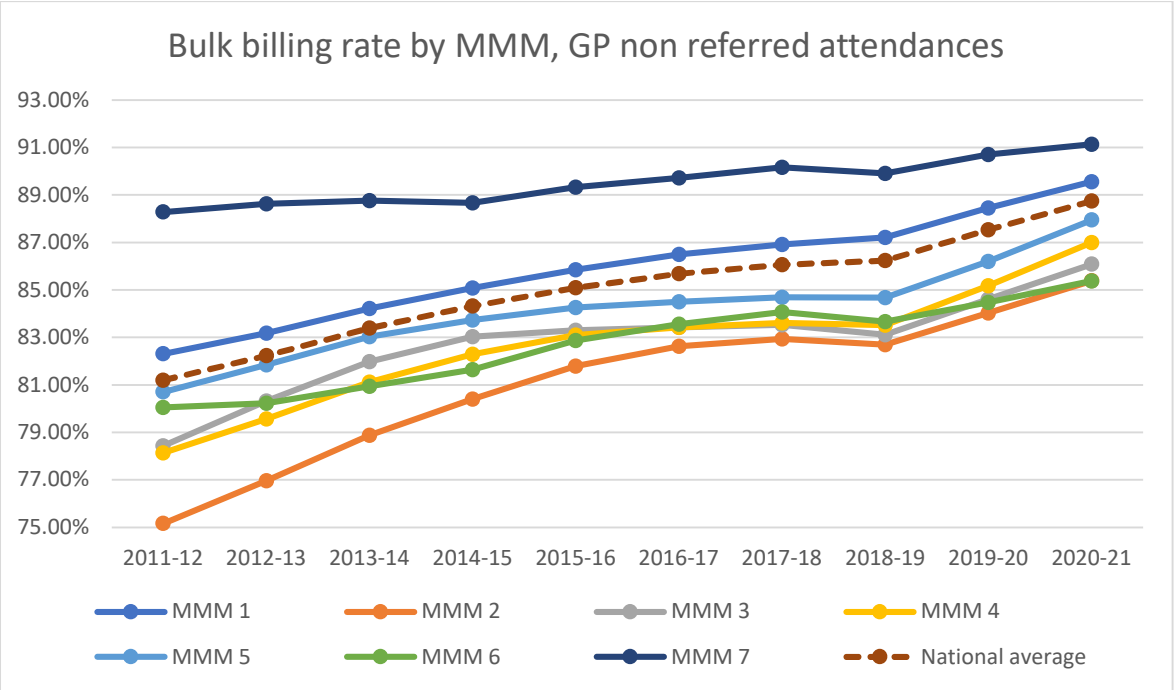


Table 7*:* GP non-referred attendances bulk billing rates

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	82.31%	75.17%	78.44%	78.14%	80.71%	80.06%	88.29%	81.20%
2012-13	83.18%	76.96%	80.32%	79.56%	81.85%	80.22%	88.62%	82.23%
2013-14	84.21%	78.87%	81.98%	81.12%	83.03%	80.94%	88.76%	83.40%
2014-15	85.08%	80.40%	83.03%	82.29%	83.74%	81.64%	88.67%	84.32%
2015-16	85.85%	81.79%	83.30%	83.10%	84.25%	82.87%	89.32%	85.10%
2016-17	86.50%	82.62%	83.43%	83.42%	84.50%	83.56%	89.72%	85.69%
2017-18	86.92%	82.94%	83.53%	83.61%	84.69%	84.07%	90.17%	86.07%
2018-19	87.22%	82.70%	83.11%	83.52%	84.67%	83.66%	89.90%	86.24%
2019-20	88.46%	84.03%	84.60%	85.17%	86.20%	84.47%	90.71%	87.54%
2020-21	89.56%	85.39%	86.09%	87.00%	87.95%	85.38%	91.14%	88.75%

GP non-referred attendances - Average out of pocket for services that are not bulk billed

Data shown are: average out of pocket rates for out-of-hospital patients who are charged a co-payment for GP non-referred attendances, per DOP financial year (2011-12 to 2020-21) and per patient MMM (1-7, and National Average)

Figure 21: Average out of pocket for GP non-referred attendances where a copayment is charged

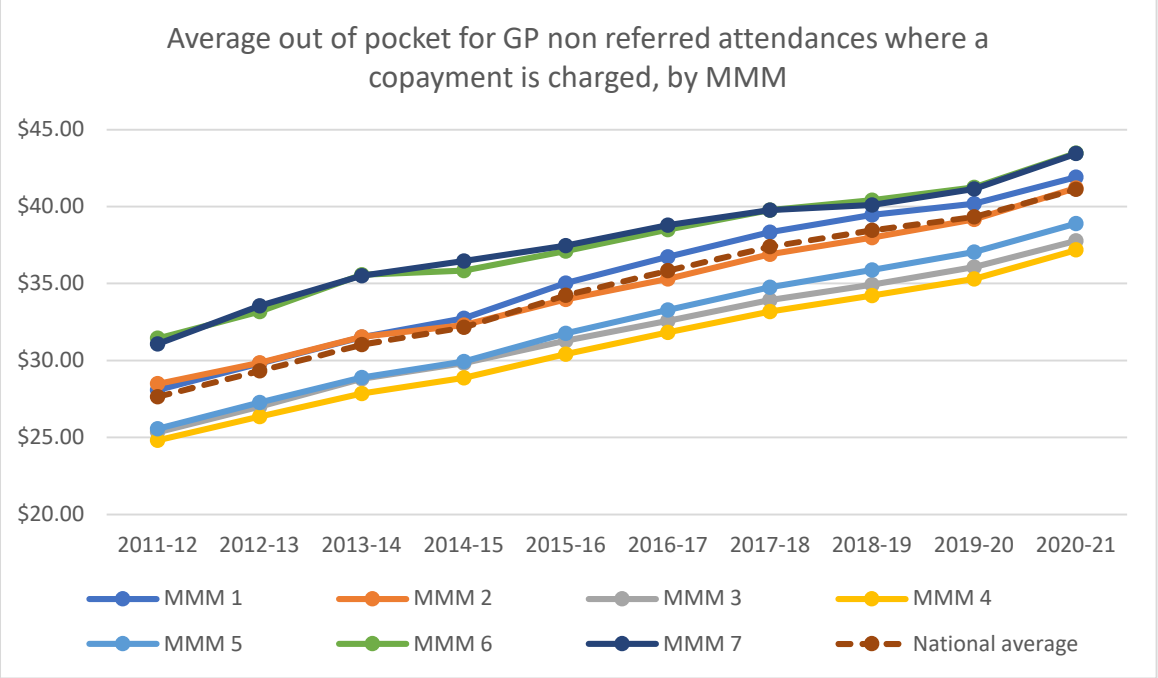


Table 8: Average out of pocket for GP non-referred attendances where a copayment is charged

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	$28.09	$28.48	$25.35	$24.82	$25.57	$31.45	$31.08	$27.65
2012-13	$29.80	$29.84	$27.00	$26.35	$27.26	$33.16	$33.56	$29.32
2013-14	$31.50	$31.53	$28.81	$27.84	$28.88	$35.57	$35.50	$31.03
2014-15	$32.73	$32.30	$29.83	$28.87	$29.93	$35.83	$36.46	$32.16
2015-16	$35.03	$33.97	$31.28	$30.40	$31.76	$37.11	$37.45	$34.24
2016-17	$36.74	$35.29	$32.58	$31.82	$33.28	$38.50	$38.80	$35.83
2017-18	$38.33	$36.89	$33.93	$33.17	$34.76	$39.77	$39.77	$37.39
2018-19	$39.45	$37.99	$34.92	$34.22	$35.87	$40.41	$40.10	$38.46
2019-20	$40.19	$39.16	$36.07	$35.29	$37.04	$41.24	$41.14	$39.33
2020-21	$41.91	$41.20	$37.77	$37.18	$38.90	$43.48	$43.44	$41.12

MBS services per patient by MMM region

Data shown are: average MBS service per patient for all MBS services and patients by MMM region and national average, per DOP financial year (2011-12 to 2020-21). The following figures and tables are based on total counts of MBS claims, noting that patients may appear in multiple MMM regions per year.

Figure 22: Average number of MBS services per patient

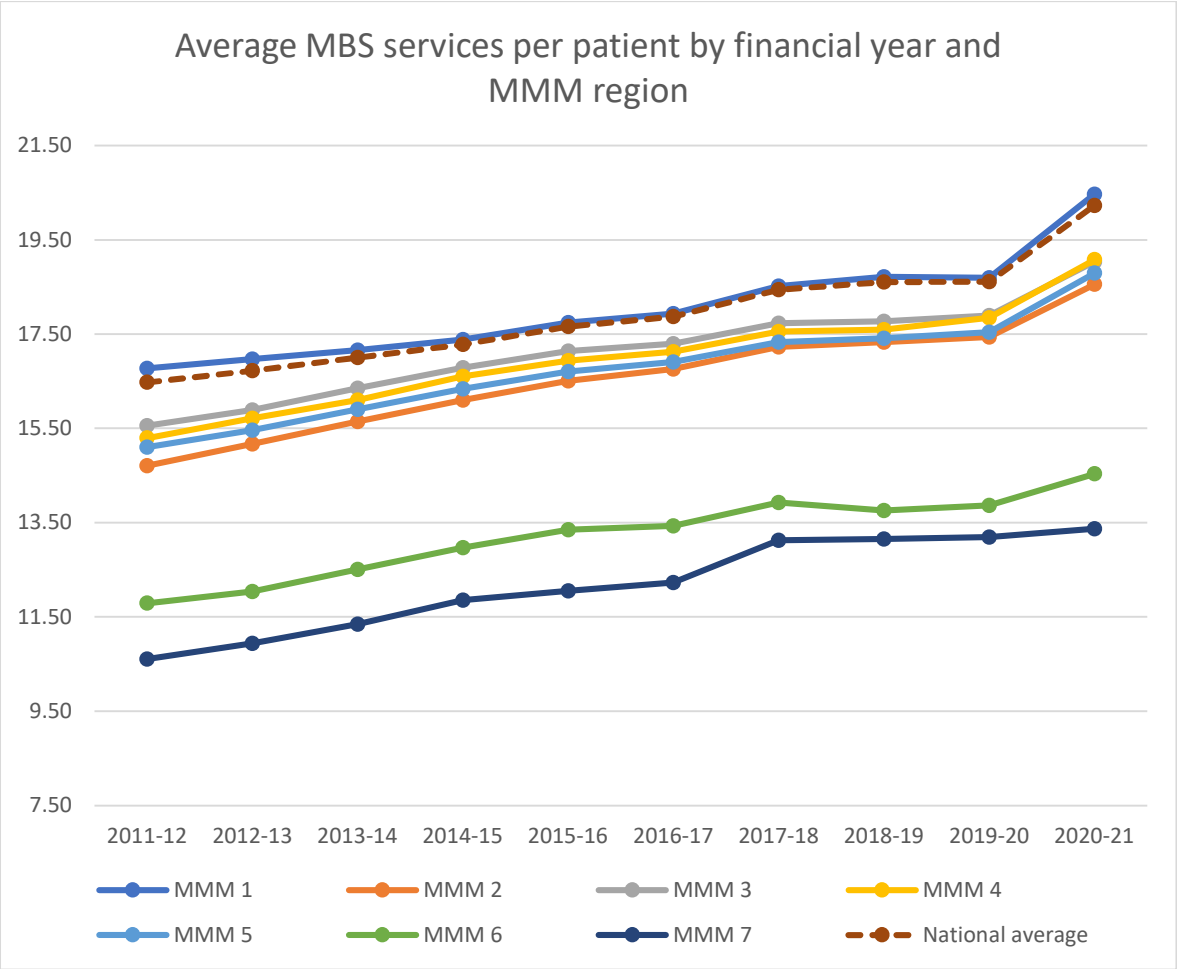


Table 9: Average MBS services per patient

FY	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2011-12	16.77	14.71	15.56	15.30	15.10	11.79	10.61	16.48
2012-13	16.97	15.17	15.89	15.71	15.46	12.04	10.94	16.73
2013-14	17.16	15.64	16.35	16.10	15.91	12.51	11.35	17.01
2014-15	17.39	16.10	16.79	16.60	16.34	12.97	11.85	17.28
2015-16	17.75	16.51	17.14	16.94	16.71	13.35	12.06	17.67
2016-17	17.93	16.76	17.30	17.13	16.91	13.43	12.23	17.87
2017-18	18.52	17.23	17.73	17.56	17.33	13.93	13.13	18.44
2018-19	18.71	17.33	17.77	17.60	17.41	13.76	13.16	18.61
2019-20	18.70	17.44	17.89	17.85	17.54	13.86	13.20	18.61
2020-21	20.47	18.56	19.04	19.08	18.80	14.54	13.37	20.23

Appendix D: MBS data since introduction of COVID-19 telehealth services

The following figures and tables present MBS data since the introduction of COVID-19 telehealth services, describing telehealth as a proportion of MBS activity overall, by BTOS as a proxy for provider-type, and by MMM region.

Percentage of all MBS services provided as telehealth (excluding COVID-19 pathology)
Data shown in Table 10/Figure 23 are: proportion of all MBS services provided as telehealth (defined as COVID phone, COVID video and pre-COVID telehealth items) for all BTOS except COVID pathology, per quarter (2020 Q1 to 2021 Q2) and per patient MMM (1-7, and National Average)

Figure 23: Proportion of total MBS services provided as telehealth (video or phone), excluding COVID pathology items

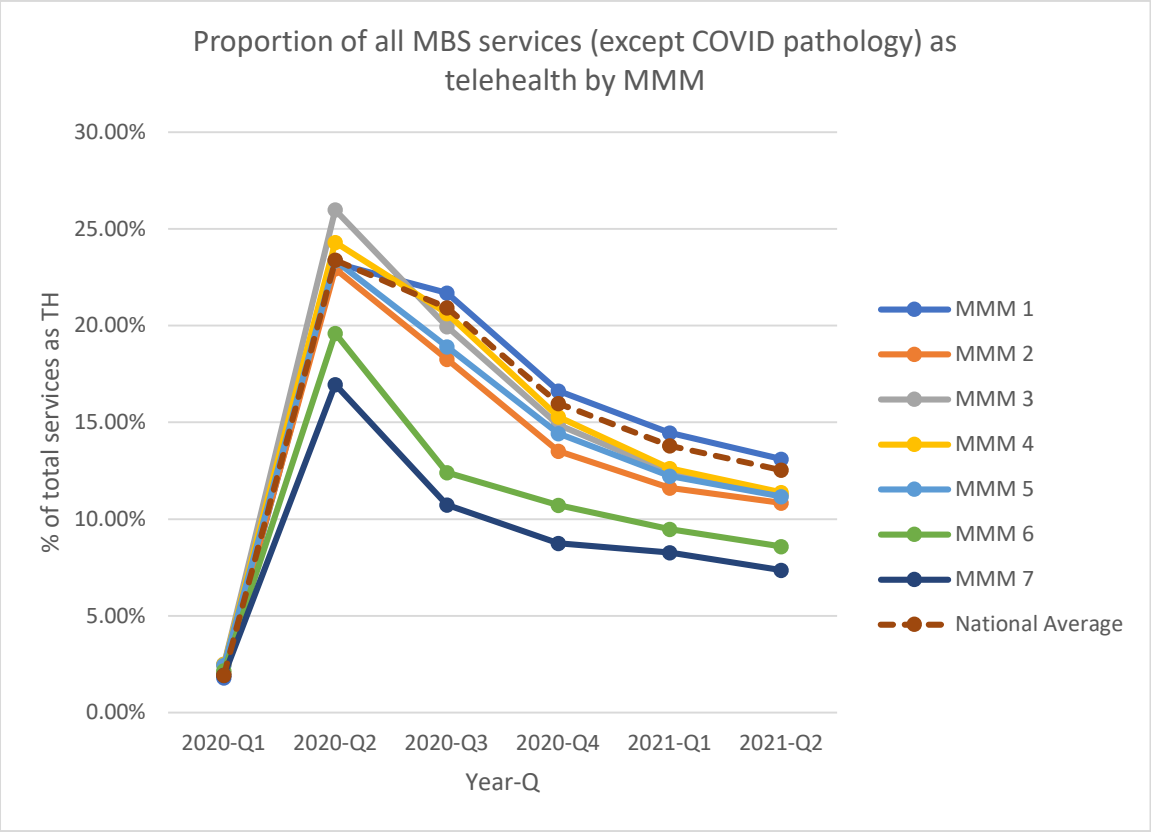


Table 10: Proportion of total services provided as telehealth (video or phone)

Year-Qtr	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2020-Q1	1.80%	2.06%	2.51%	2.50%	2.45%	2.16%	1.94%	1.94%
2020-Q2	23.25%	22.94%	25.99%	24.31%	23.37%	19.61%	16.97%	23.40%
2020-Q3	21.69%	18.26%	19.95%	20.63%	18.91%	12.41%	10.74%	20.93%
2020-Q4	16.63%	13.51%	14.88%	15.29%	14.43%	10.73%	8.75%	15.98%
2021-Q1	14.46%	11.62%	12.44%	12.62%	12.22%	9.48%	8.27%	13.81%
2021-Q2	13.11%	10.84%	11.27%	11.38%	11.17%	8.59%	7.37%	12.54%

Percentage of non-referred attendances provided as telehealth

Data shown in Table 10: Proportion of total services provided as telehealth (video or phone)Table 11/Figure 24 are: proportion of all GP non-referred attendances services provided as telehealth (defined as COVID phone, COVID video and pre-COVID telehealth items), per quarter (2020 Q1 to 2021 Q2) and per patient MMM (1-7, and National Average). Excludes COVID vaccine services.

Figure 24: Proportion of GP non-referred attendances provided as telehealth (video or phone)

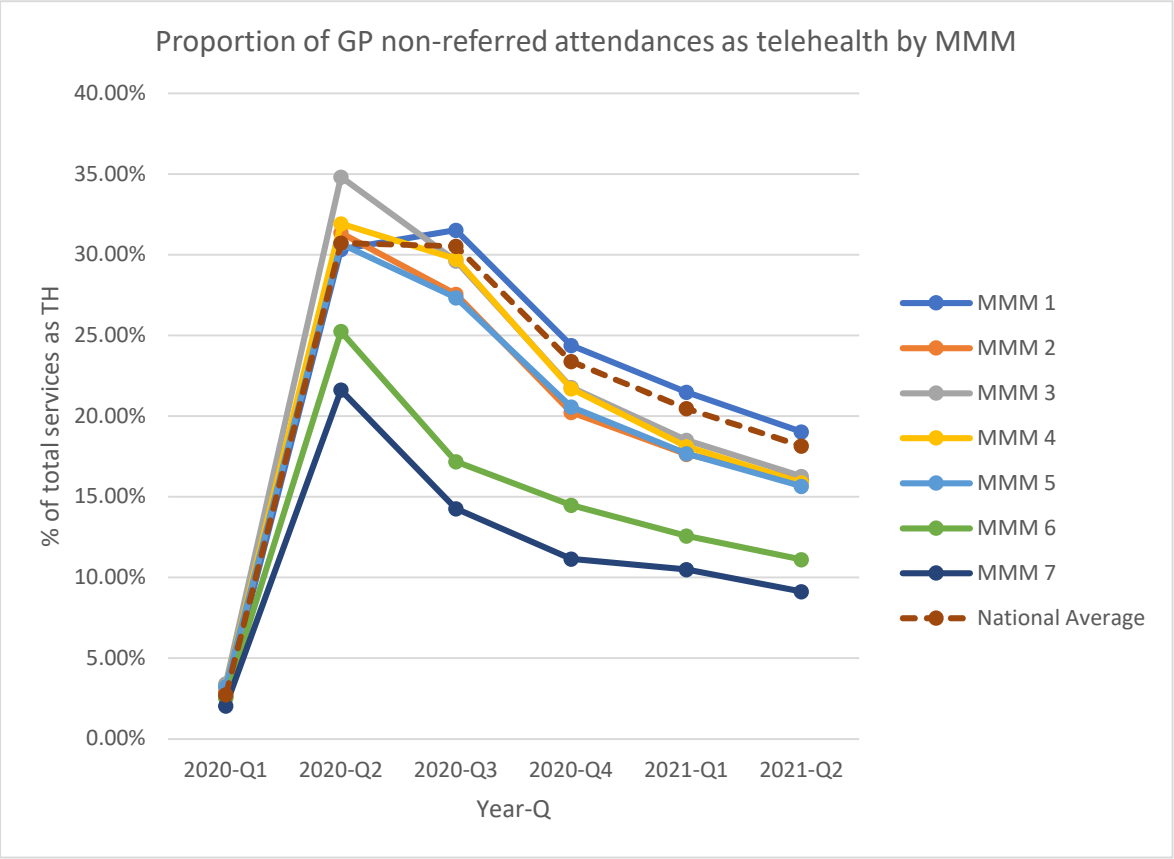


Table 11: Proportion of GP non-referred attendances provided as telehealth (video or phone)

Year-Qtr	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2020-Q1	2.59%	2.94%	3.41%	3.24%	3.24%	2.54%	2.04%	2.73%
2020-Q2	30.34%	31.36%	34.82%	31.93%	30.68%	25.25%	21.62%	30.73%
2020-Q3	31.53%	27.55%	29.62%	29.74%	27.34%	17.17%	14.26%	30.53%
2020-Q4	24.39%	20.23%	21.78%	21.71%	20.58%	14.48%	11.14%	23.39%
2021-Q1	21.48%	17.64%	18.51%	18.11%	17.68%	12.58%	10.50%	20.47%

2021-Q2	19.03%	16.04%	16.27%	15.88%	15.66%	11.12%	9.13%	18.16%

Percentage of allied health services provided as telehealth

Data shown in Table 12/Figure 25 are: proportion of all other allied health services provided as telehealth (defined as COVID phone, COVID video and pre-COVID telehealth items), per quarter (2020 Q1 to 2021 Q2) and per patient MMM (1-7, and National Average).

Figure 25: Proportion of allied health provided as telehealth (video or phone)

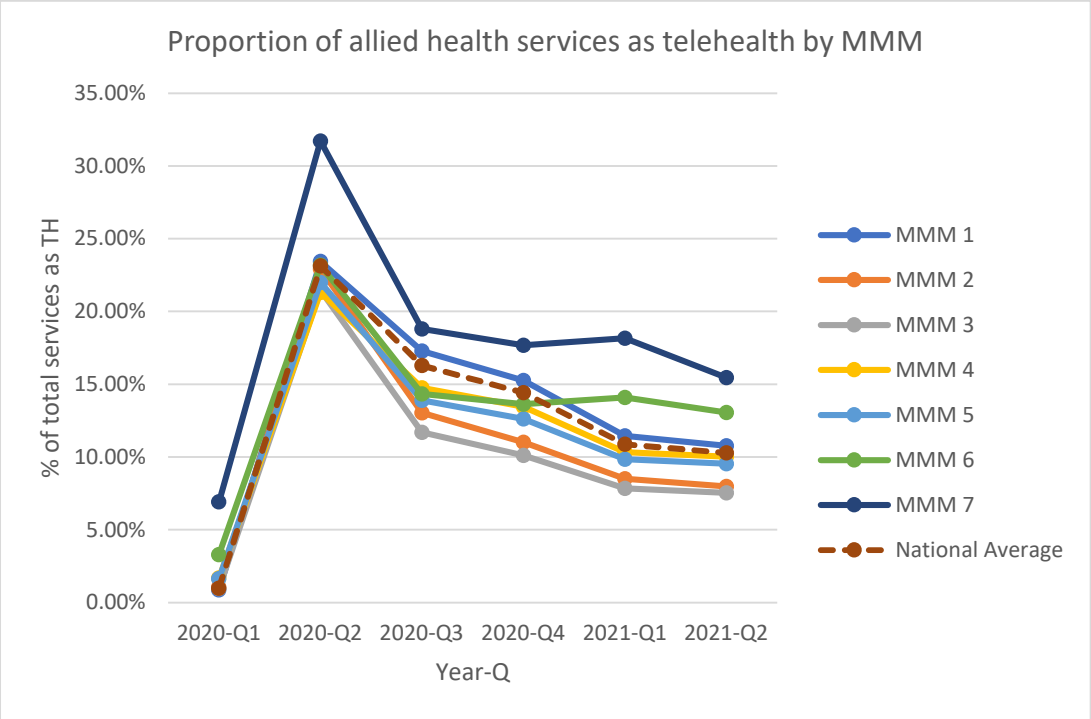


Table 12: Proportion of BTOS other allied health provided as telehealth (video or phone)

Year-Qtr	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2020-Q1	0.88%	1.08%	0.97%	1.69%	1.64%	3.30%	6.92%	0.99%
2020-Q2	23.44%	22.92%	21.46%	21.31%	22.00%	23.18%	31.72%	23.12%
2020-Q3	17.28%	13.04%	11.70%	14.76%	13.90%	14.34%	18.81%	16.29%
2020-Q4	15.26%	11.02%	10.10%	13.45%	12.62%	13.64%	17.68%	14.43%
2021-Q1	11.45%	8.51%	7.86%	10.32%	9.84%	14.09%	18.16%	10.89%
2021-Q2	10.77%	7.98%	7.54%	10.02%	9.53%	13.06%	15.45%	10.28%

Percentage of specialist services provided as telehealth

Data shown in Table 13/Figure 26 are: proportion of specialist services provided as telehealth (defined as COVID phone, COVID video and pre-COVID telehealth items), per quarter (2020 Q1 to 2021 Q2) and per patient MMM (1-7, and National Average).

Figure 26: Proportion of specialist services provided as telehealth (video or phone)

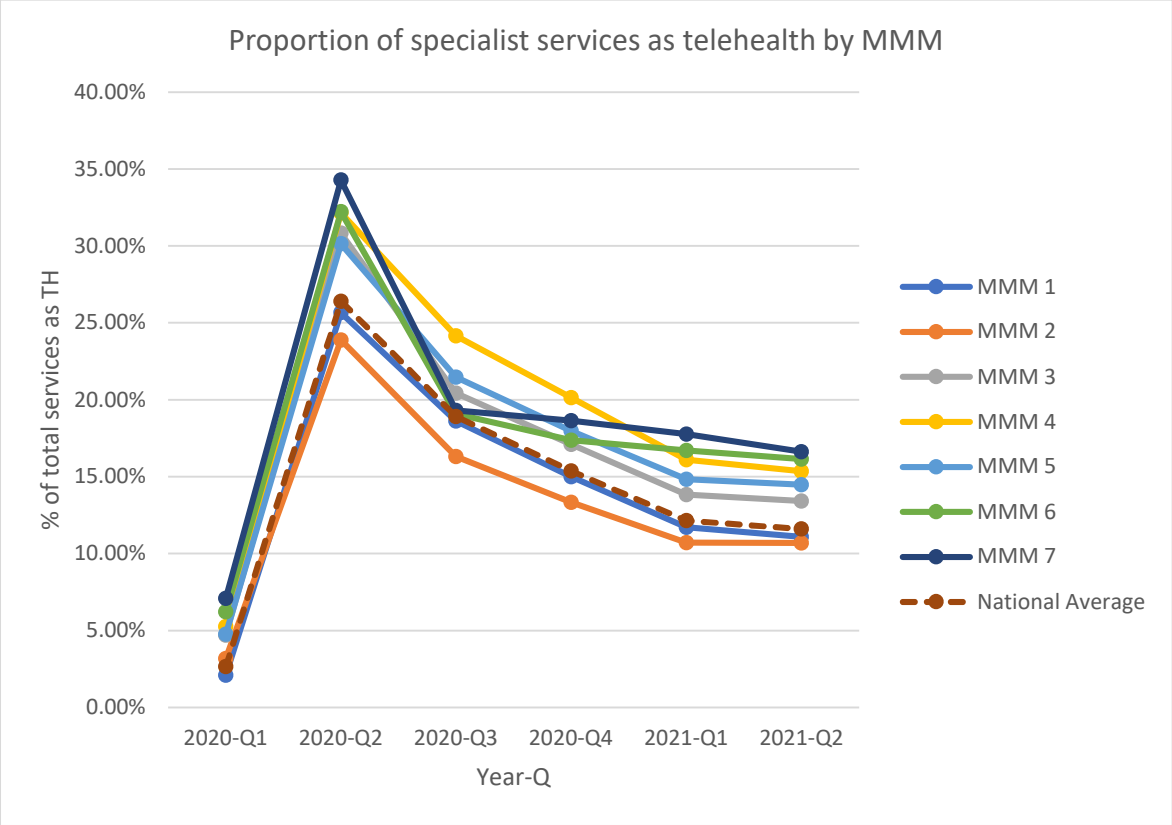
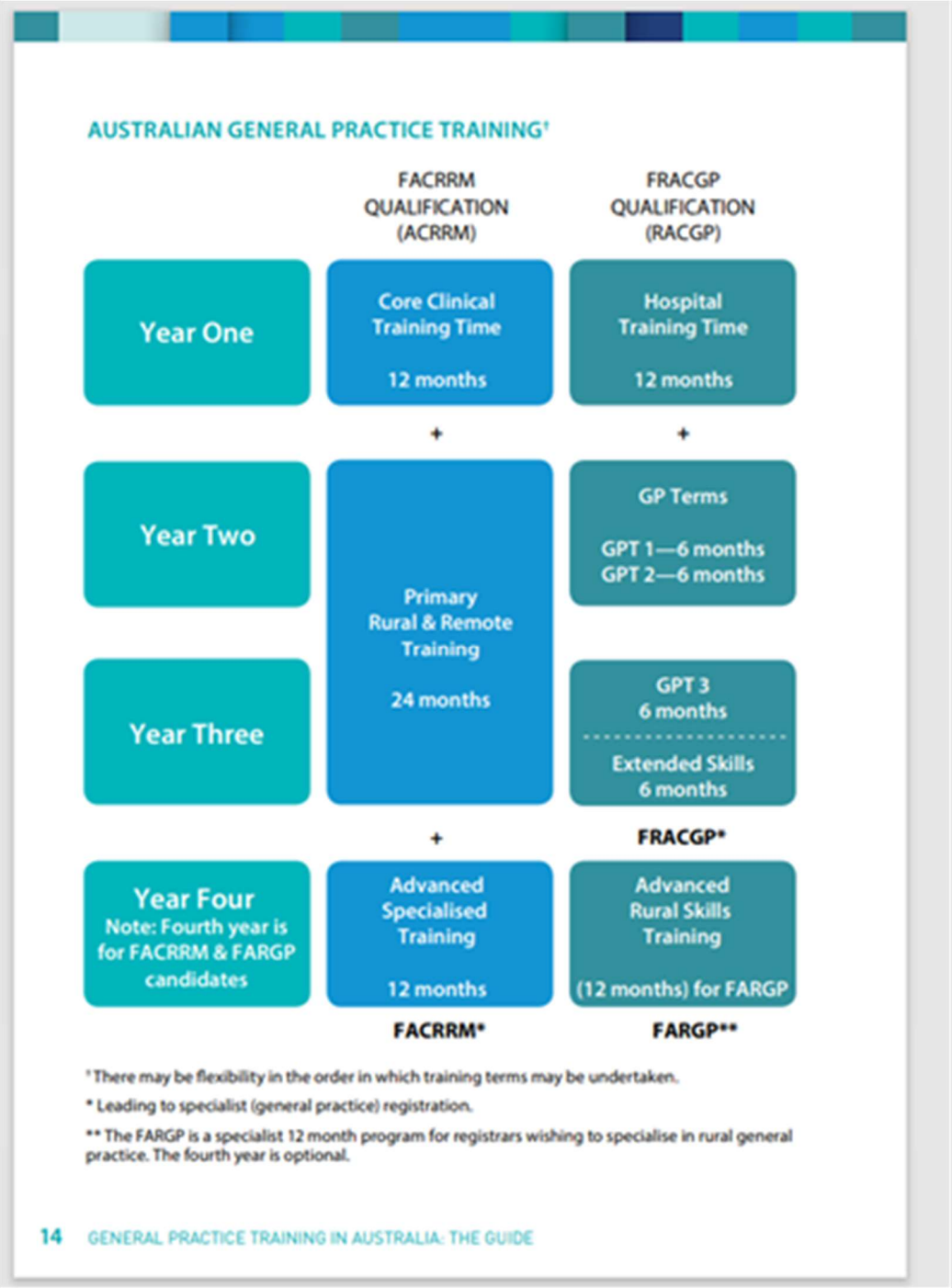


Table 13: Proportion of specialist services provided as telehealth (video or phone)

Year-Qtr	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7	National Average
2020-Q1	2.09%	3.18%	4.70%	5.27%	4.76%	6.21%	7.08%	2.66%
2020-Q2	25.67%	23.89%	30.83%	32.14%	30.14%	32.22%	34.28%	26.41%
2020-Q3	18.61%	16.32%	20.44%	24.16%	21.47%	19.08%	19.31%	18.91%
2020-Q4	14.99%	13.32%	17.10%	20.14%	17.98%	17.36%	18.65%	15.37%
2021-Q1	11.71%	10.71%	13.84%	16.10%	14.84%	16.71%	17.77%	12.14%
2021-Q2	11.09%	10.69%	13.42%	15.36%	14.48%	16.15%	16.63%	11.60%

Appendix E: Australian General Practice Training

Figure 27: Diagram of Australian General Practice Training (Source: General Practice Training in Australia – The Guide)



Appendix F: Australian GP Training Timeline

Australian GP Training Timeline - 1958 to 2000

1958
- Royal Australian College of General Practitioners (RACGP) formed

1973
- General practice training available for the first time in Australia. Federal funded goes to the RACPG to run the Family Medicine Program (FMP)

1987
- Fellowship introduced as the end point of GP training

1989
- The introduction of vocational registration for GPs, and plans for compulsory training

1992
- Commencement of the RACGP Rural Training Scheme

1993
- FMP has 833 doctors enrolled

1994
- Federal government concerned at the number of graduating GPs and reduces available GP training places to 400

1996
- RACGP offers Graduate Diploma in Rural General Practice
- Australian government mandated vocational training and registration and tied this to A1 Medicare payments
- Exemptions introduced to allow non-VR doctors to work in general practice and claim A1 rebates. Exemptions focused on fixing undersupply and included
  - Rural locum relief program
  - After hours deputising services
  - Rural country relieving program (Queensland)
  - Outer metropolitan placement program
  - Temporary resident other medical practitioner program
- The Special Access Placement Program gave non-VR doctors access to A2 rebates (50% of MBS rate). Doctors on exemptions were expected to work towards Fellowship

1997
- The Australian College of Rural and Remote Medicine (ACRRM) constituted

Late 1990s
- Commonwealth funds a joint venture board between ACRRM and RACGP, which establishes the Pilot Remote Vocational Training Scheme (PRVTS). PRVTS starts training in 1999 with 11 registrars

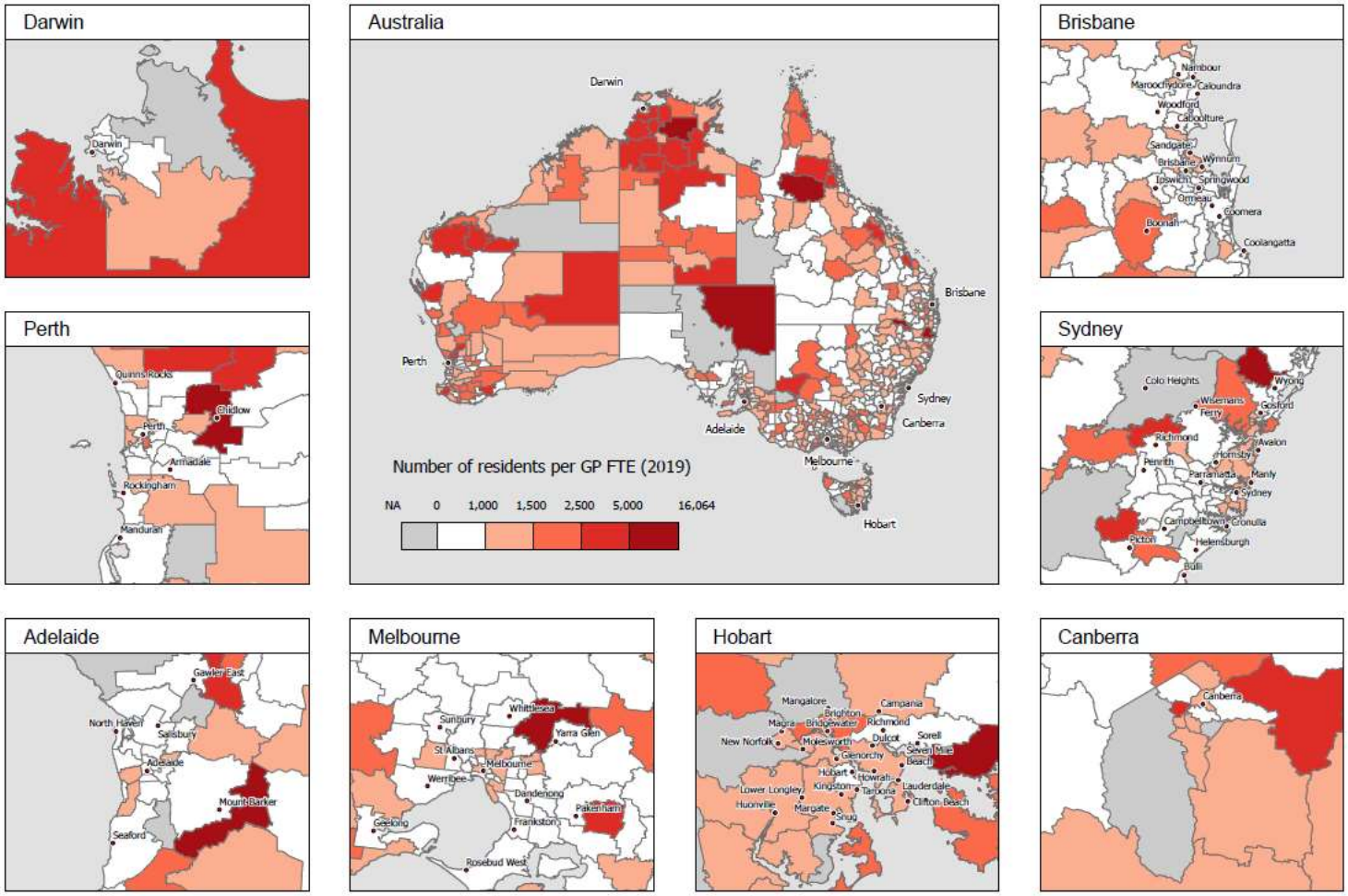
1997
- Ministerial review of General Practice Training commenced
- Funding for an extra 50 places allocated, and 150 required to be in small rural areas

2000
- Minister of Health announces a commonwealth owned company General Practice Education and Training (GPET) will be formed

Australian GP Training Timeline - 2001 to Present

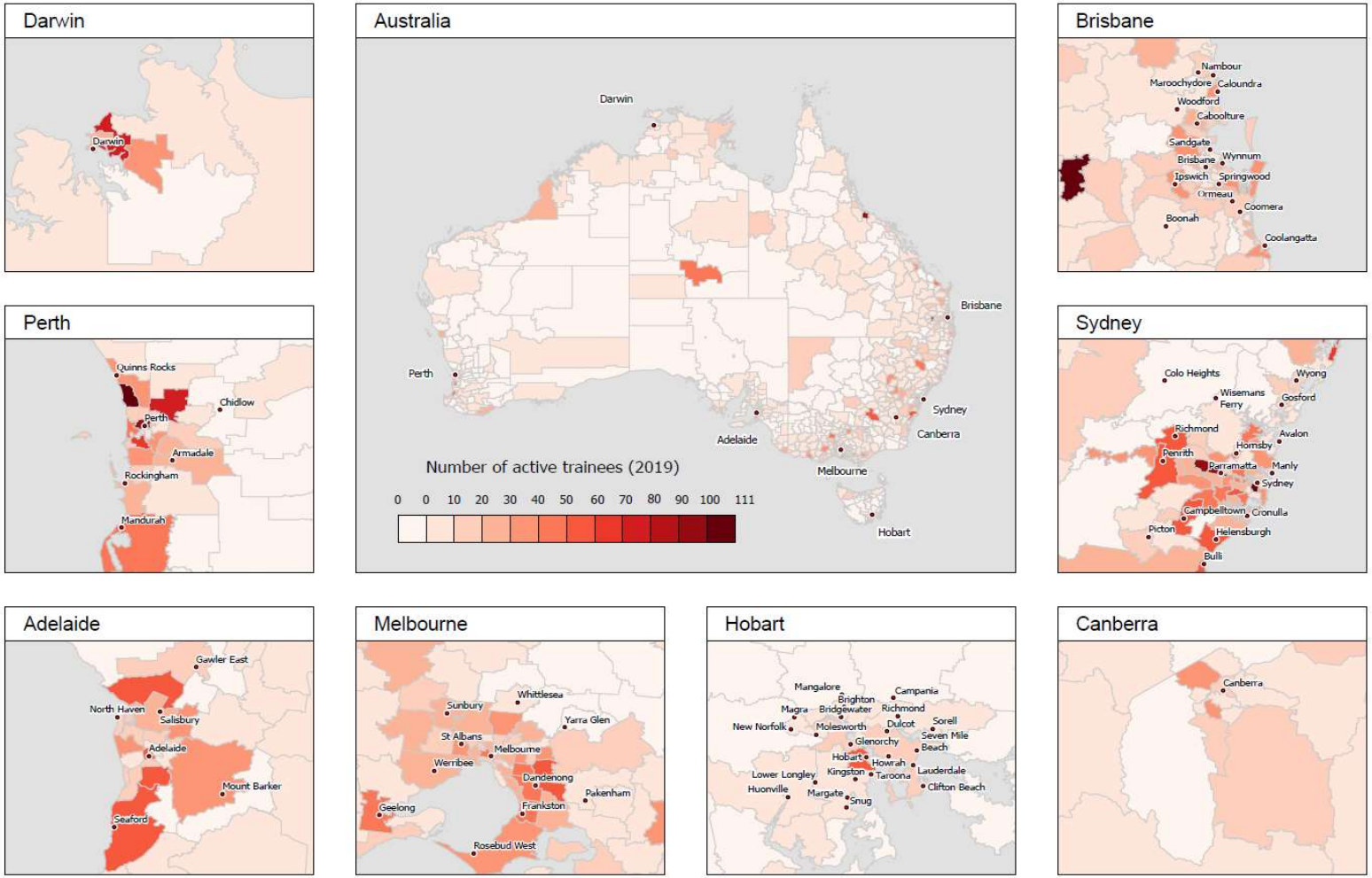
Appendix G: Number of residents per GP FTE (2019)

Figure 28: GP Full-time Equivalent (GPFTE) for the 2019 calendar year and the ABS Estimated Residential Population (ERP) for June 2019 (preliminary figures), similarly aggregated by GP Catchment (Source: HeaDSUPP)



Appendix H: Active Trainees 2019

Figure 29: AGPT Trainee numbers for the 2019 calendar year aggregated for each GP Catchment (Source: HeaDSUPP)



Appendix I: RHMT Program sites (RCS, UDRH and RTH)

Figure 30: Map of Rural Clinical School locations, 2019 (Source: Department of Health, RHMT Program data)

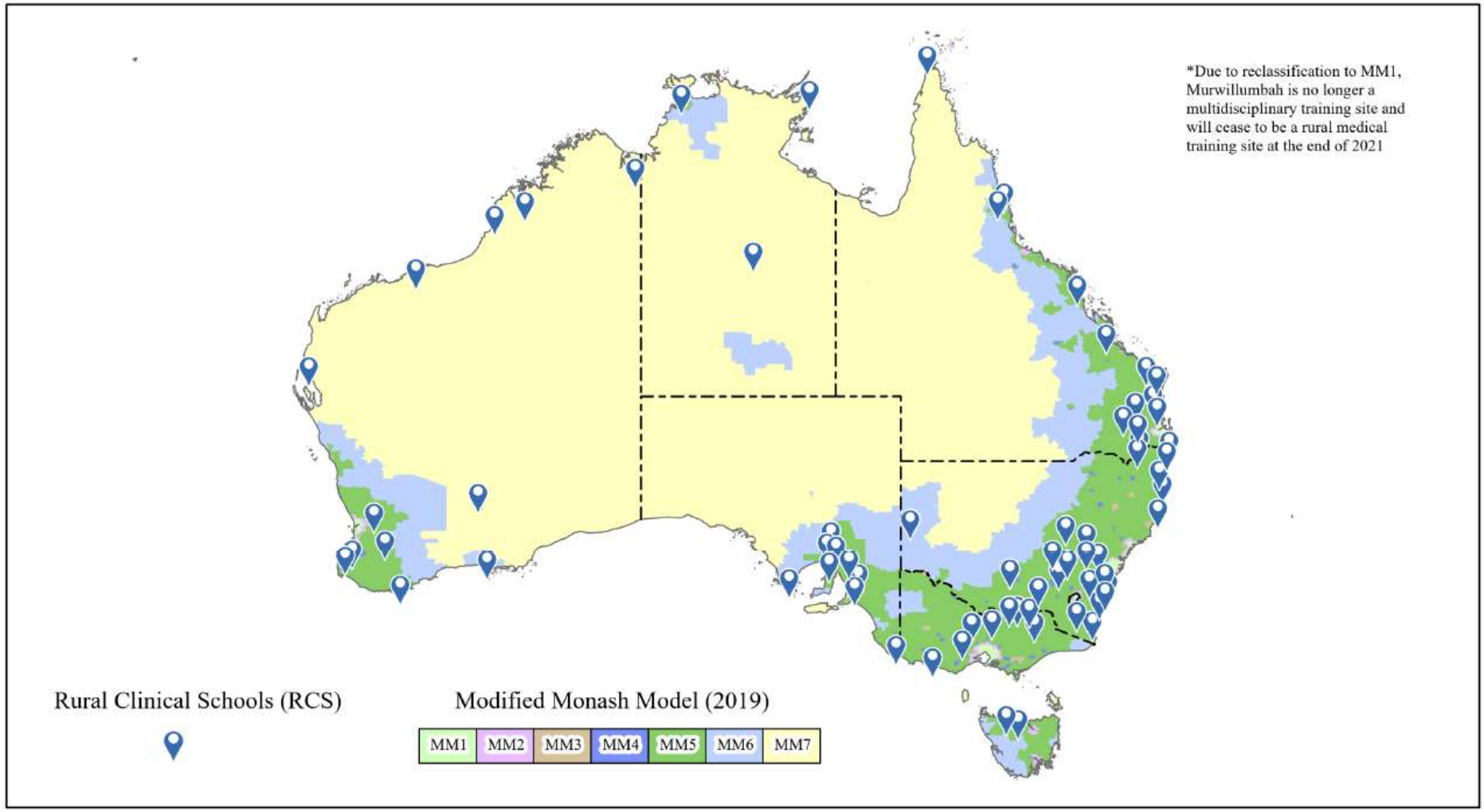


Figure 31: Map of University Department of Rural Health locations (2019) (Source: Department of Health, RHMT Program data)

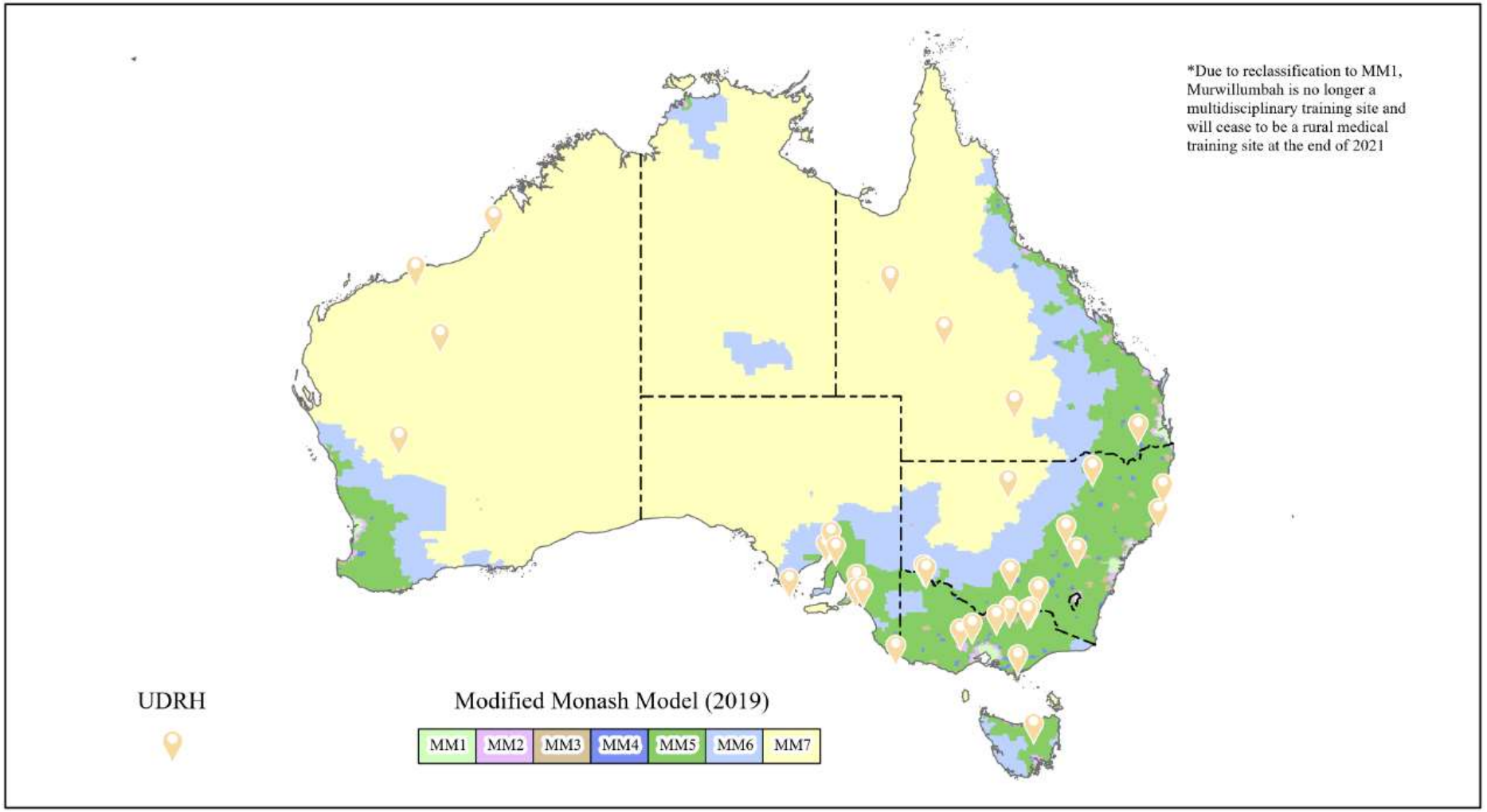
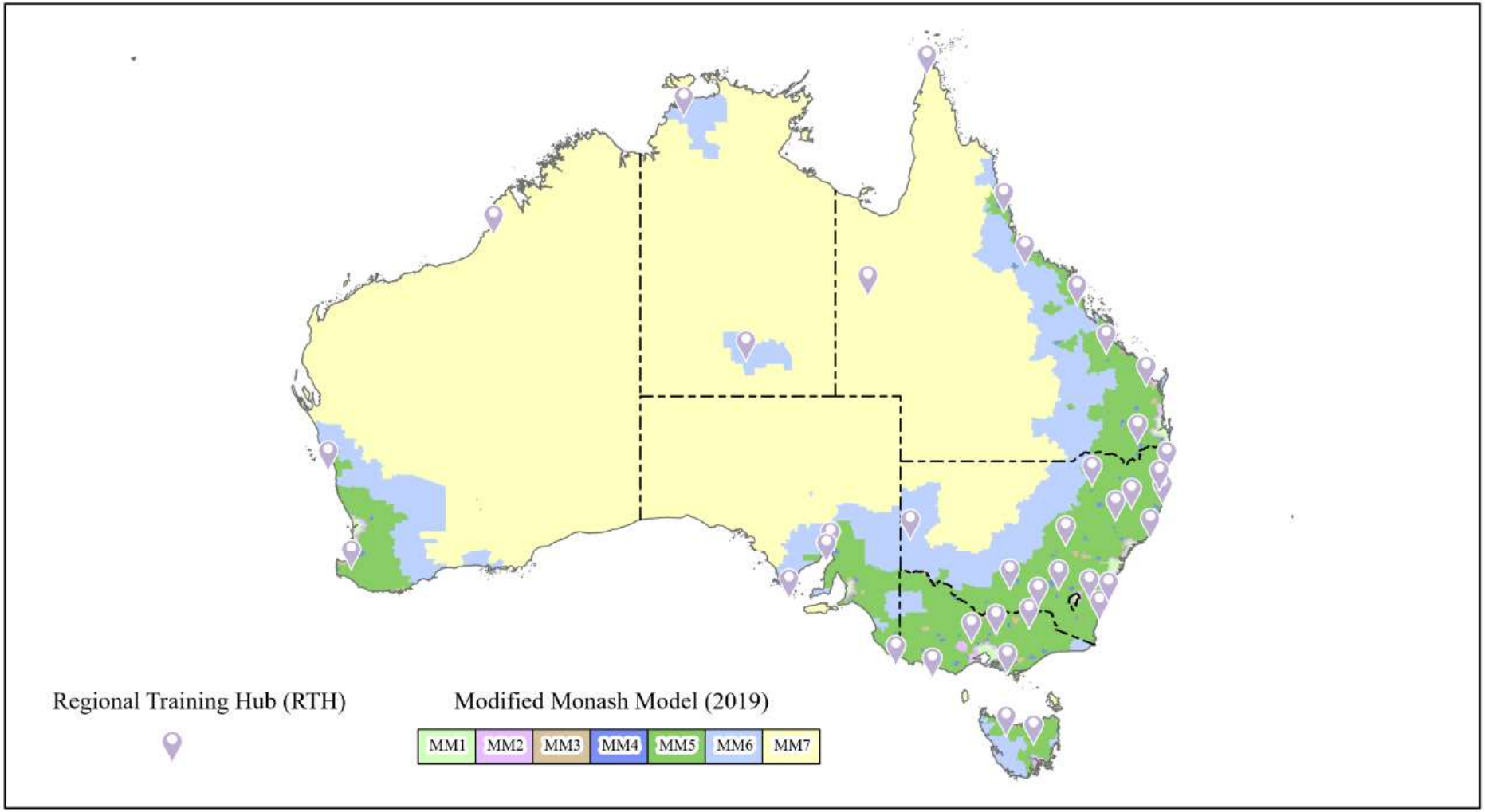


Figure 32: Map of Regional Training Hub locations (2019) (Source: Department of Health, RHMT Program data)



Appendix J: Examples of reform work led by PHNs

Health Pathways

PHNs commission the digital health tool HealthPathways which supports General Practitioners to better manage patients in the community while promoting health care integration. HealthPathways is a free online manual which provides best practice guidance on the assessment and management of more than 550 conditions. HealthPathways information is tailored to each local region and reflects agreement between primary care clinicians and specialists on how patients with particular conditions will be managed in the local context.

Evaluations have found that HealthPathways is a useful tool for health professionals including General Practitioners and it has improved collaboration between acute and primary care sector clinicians.

Central Queensland Wide Bay PHN - StepCare

Central Queensland Wide Bay PHN have established a mental health program in conjunction with the Black Dog institute and have been working over the last two years with General Practices across the region to offer the StepCare service – an innovative mental health service that uses digital health technology. In 2018-2020 over 1400 patients participated in the initiative, and data shows it has been very valuable in the early detection of anxiety, depression, suicidality and risky drinking.

North Coast PHN - Aboriginal and Torres Strait Islander Health Team

North Coast PHN has provided support for its Aboriginal and Torres Strait Islander identified workforce, employing a team of high skilled Aboriginal and Torres Strait Islander professionals in 2019-2020 to lead Aboriginal health priorities.

The team was recruited to improve trust and relationships with Aboriginal communities and Aboriginal organisations and improve effectiveness in progressing Aboriginal health initiatives with GPs, including activities to support the Aboriginal workforce.

Led by a Deputy Director level position that sits on the Healthy North Coast Executive and supported by five Aboriginal Health Coordinators (one with a specific portfolio in social and emotional wellbeing), Healthy North Coast's new Aboriginal Health Team began to drive cultural safety internally and in the primary health care workforce, and specifically in supporting the Aboriginal health workforce in the last financial year.

This program has resulted in General Practitioners and other primary health care providers becoming more aware of the health needs of the Aboriginal community in their areas. In 2019-20, North Coast PHN recorded 94.9% of services delivered to the regional Indigenous population where the services were culturally appropriate (a 6% increase from 89.2% in 2018-19).

North Coast PHN - Primary Care Impact site

North Coast PHN has also developed the Primary Care Impact site as central library of quality improvement topics and projects housing information on all our current projects, as well as pre-populated quality improvement activities or the resources for practices to create their own Quality Improvement. The Quality Improvement tips for success page has ideas on how to make Quality Improvement and project work more successful, enjoyable and sustainable. To date 58 practices have actively engaged with the platform. All initiatives are followed up Primary Health Care Coordinators directly with General Practices. The site is available here https://hnc.org.au/primary-care-impact.

North Coast PHN - General Practitioner Framework for a COVID19 Outbreak in residential aged care

North Coast PHN developed a framework to support continuous General Practitioner coverage in a RACFs during a COVID-19 outbreak. Preparation materials, outbreak systems and processes, and an evaluation method were developed in collaboration with GPs working in RACFs, LHDs, Public Health Units and RACF managers.

The framework is available here https://hnc.org.au/primary-care-impact-topics/increase-gp-preparedness-for-covid-19-outbreak-in-racf.

The framework has been introduced to 80 RACFs and 400 GPs across the region.

Western NSW PHN - Dubbo General Practice Engagement Officer

The General Practice Engagement Officer is responsible for supporting, coordinating, development of and delivery of General Practice engagement initiatives across the Western NSW PHN area. The General Practice Engagement Officer works collaboratively with General Practitioners and General Practices within the WNSW PHN area to:

- increase engagement with the PHN programs and services;
- increase knowledge of the PHN programs and support the delivery of appropriate initiatives;
- facilitate opportunities of engagement for all health providers;
- support General Practices and Primary Health Care service providers to make systems improvements within the WNSW PHN region; and
- create opportunities for General Practice engagement in the joint development of new models of care and identification of General Practice champions to provide input to those projects.

This role also works closely with other teams in the PHN to support GPs, General Practice teams and broader primary health care services to improve and better coordinate care through:

- supported access to regional/local information systems and various other enablers such as clinical referral pathways, and emerging shared care and clinical information tools and processes;
- facilitation of networking groups between health professionals; and
- development of resources to support new health professionals.

This role has delivered the SHARE project and Regional Electronic Health Record Project, which has delivered an innovative new software iRAD (integrated real-time active data) for clinicians to share critical patient data between hospitals, General Practice and other connected healthcare professionals. iRAD delivers an interoperability system that enables informed decision making and high-quality patient outcomes by providing secure, timely and accurate sharing of patient information between health providers.

After Hours – the Bribie Island Pilot

In December 2020, the Government provided $550,000 (GST incl) to Brisbane North PHN to establish a three-year trial to increase access to after hours primary health care services on Bribie Island.

No General Practices or medical deputising services provide after hours primary care services on Bribie Island. The nearest hospital, Caboolture, is 23km from Bribie.

The design of the after hours service and approach to tender is being informed by a co-design process involving key local stakeholders, including local General Practices.

After hours services are expected to commence in late 2021, with the trial concluding in June 2024.