Diagnosing a rural doctor deficiency:

Symptoms of labour shortages in Shepparton general practice

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Commissioned by Suzanna Sheed MP for Shepparton

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Executive Summary

The Australian rural health system has endured two decades of policy reform. Targeted Commonwealth funding to university Departments of Rural Health, streamlined domestic pathways to general practice, and regulatory strategies for International Medical Graduates and Bonded Medical Placements have achieved relative success in prioritising rural health pathways across Australia. However, compulsory workforce allocation to Distribution Priority Areas (DPA) have reduced comprehensive community needs to statistical factors. Moreover, Cobram, Echuca and Shepparton are the only regional towns outside of metropolitan Melbourne not designated as DPA in Victoria.

Presenting the Greater Shepparton local government area as a comprehensive case study of non-DPA in regional Victoria, this report investigates the cause and effect of labour shortages in Shepparton general practice. With direct access to University of Melbourne's Rural Clinical School and government funded health infrastructure development, Shepparton general practice should demonstrate ongoing self-sufficiency. However, the past year has revealed high turnover rates and low retention capacity across major medical clinics in Shepparton; directly impacting patient health outcomes and doctor's mental health. Through an investigation of labour deficiency in Shepparton general practice, this report outlines key policy recommendations to reprioritise community in the delivery of primary care in regional Victoria.

Key Recommendations

1. Reallocate Shepparton as a **Distribution Priority Area.**
2. Reinstate the **Bilateral Agreement between the Commonwealth and Victoria on Coordinated Care**.
3. Introduce a **Victorian Rural Health Workforce Committee** to ensure cohesion of rural health policy and initiatives in Victoria.
4. Determine **regional recruitment benchmarks** for university Departments of Rural Health and Rural Clinical Schools.
5. Formalise **collegial support frameworks and rural mentorship models** across Victorian Primary Health Networks, Primary Care Partnerships, and Local Hospital Networks
6. Strengthen **domestic recruitment strategies** to reduce unsustainable dependence on International Medical Graduates in rural health.

Abbreviations

ABS – Australian Bureau of Statistics

ASGS-RA – Australian Statistical Geography Standard Remoteness Area

AGPTP – Australian General Practice Training Program

BMP – Bonded Medical Placements

DPA – Distribution Priority Area

DOH – Department of Health

EVGPT – Eastern Victoria GP Training

GPs – General Practitioners

GVH – Goulbourn Valley Health Shepparton hospital

ICM – Integrated Care Model

IMG – International Medical Graduates

LGA – Local Government Area

LHN – Local Hospital Networks

MCCC - Murray City Country Coast GP Training

MDMS - Murray-Darling Medical School Network

MMM – Modified Monash Model of Remoteness

PCP – Primary Care Partnerships

PHN – Primary Health Networks

RACGP – Royal Australian College for General Practitioners

RTOs – Regional Training Organizations

SRHS - Stronger Rural Health Strategy

VICM – Victorian Integrated Care Model

VRHWC – Victorian Rural Health Workforce Committee

WHO – World Health Organization

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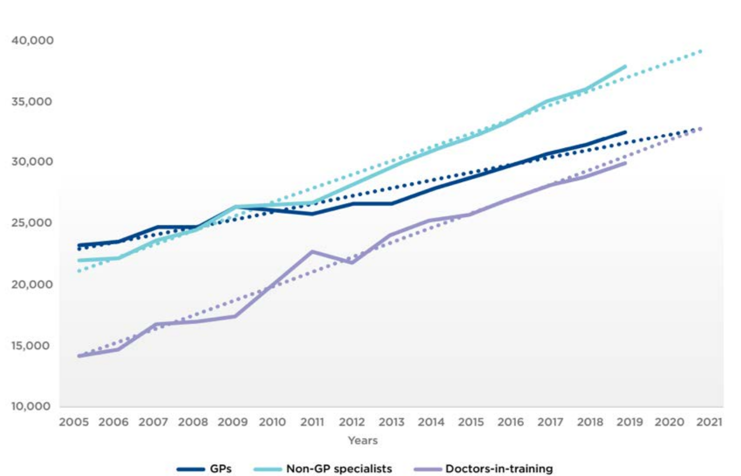
Chapter 1: Introduction

1.1 Background

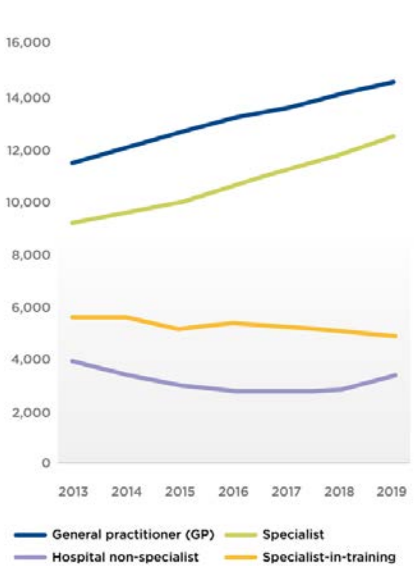
Recent developments in primary care policy have generated exponential growth across the Australian medical workforce (Figure 1). However, the growing number of non-GP specialists surpasses the total number of GPs, with 5,283 more non-GP specialists than GPs in 2019. International Medical Graduates (IMGs) account for 35.1% of all healthcare practitioners in Australia (Figure 1). Since 2013, IMGs have incurred a steady increase in Australia; GPs by 4.5% and non-GP specialists by 6%. (Figure 2; Scott 2021, pp. 4-5).

Figure 1: Total Australian doctors 2005 to 2019 (projections to 2021)



Source: Scott, A, 2021 *The Evolution of the Medical Workforce,* ANZ Melbourne Isntitute*,* pp. 6-8.

Figure 2: Total International Medical Graduates, by doctor type (2013 to 2019)



Australian primary health legislation is intersectional in State and Federal policy. In general practice, clinics are privately owned businesses supported by the commonwealth Medicare Benefit Scheme (MBS) and Commonwealth funded training programs. First-year medical internships are conducted in State-funded, public hospital settings. Local Hospital Networks (LHN), Primary Care Partnerships (PCP), and Primary Health Networks (PHN) are also restricted by Federal and State dichotomy. The consequences of a fragmented primary care system are most evident in general practice across regional, rural, and remote contexts of Australia.

Rural and remote general practice in Australia has sustained significant policy reform over the past 20 years. Based on World Health Organization (WHO) guidelines that promote a "more equitable health workforce distribution" (WHO 2010, pp. 7-8), Australian rural health policy endorses rural health education pathways (postgraduate to generalism), workforce regulatory strategies and incentives to improve health outcomes of rural communities. (Walters et al. 2017, pp. 56-58).

To promote equitable delivery of Rural health services across Australia, the Federal Department of Health (DOH) implemented the 'Modified Monash Model of Remoteness' (MMM) based on the Australian Bureau of Statistics (ABS) 'Australian Statistical Geography Standard Remoteness Area' (Figure 6 and 7). Generalised remoteness frameworks support area specific infrastructure, funding, and workforce allocation to 'Distribution Priority Areas' (DPA) across rural and remote Australia. Australia's ongoing analysis of rural health workforce retention and allocation data has been endorsed by WHO (2020, pp. 15). Figure 3 outlines MMM terms of reference, defined by total population and distance from centralised populations (metropolitan and regional centres). The terms 'regional' and 'rural' are used interchangeably in both structures and will be addressed accordingly throughout this report.

Figure 3: Modified Monash Model of Remoteness (MMM)

Modified Monash Category (MMM 2019)	Description (including the Australian Statistical Geography Standard – Remoteness Area (2016)
MM 1	**Metropolitan areas:** Major cities accounting for 70% of Australia's population All areas categorised ASGS-RA1.
MM 2	**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.
MM 3	**Large rural towns:** Inner (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. For example: Dubbo, Lismore, Yeppoon, Busselton.
MM 4	**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. For example: Port Augusta, Charters Towers, Moree.
MM 5	**Small rural towns:** All remaining Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas. For example: Mount Buller, Moruya, Renmark, Condamine.
MM 6	**Remote communities:** Remote mainland areas (ASGS-RA 4) AND remote islands less than 5kms offshore. For example: Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland. Additionally, islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM 6 for example: Bruny Island.
MM 7	**Very remote communities:** Very remote areas (ASGS-RA 5). For example: Longreach, Coober Pedy, Thursday Island and all other remote island areas more than 5kms offshore.

Source: DOH, 2019 *Modified Monash Model – Fact Sheet*, p. 1

Regional Context: Shepparton

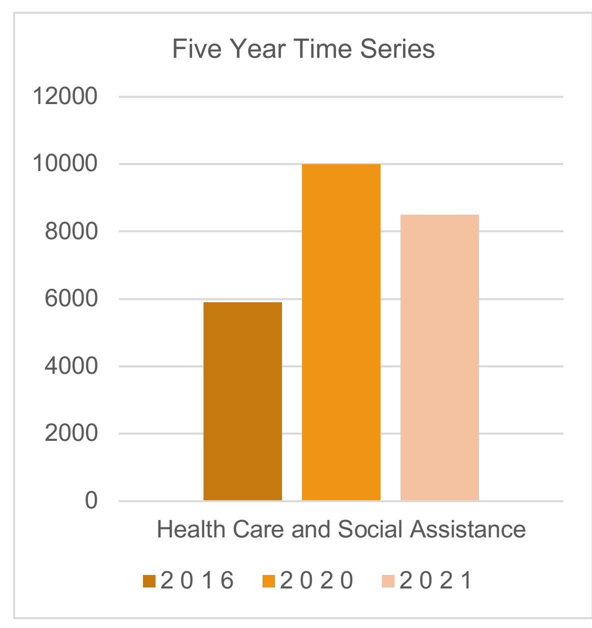
The regional City of Shepparton is central north of Victoria, in the Greater Shepparton local government area (LGA) and Shepparton State electorate. With a current LGA population of 67,100, Shepparton population is expected to grow at a rate of 0.9% per annum from 2016

to 2036 (RDV 2021, par 1). Situated within the Goulburn Valley region of Victoria, Shepparton offers a rich agricultural-based economy and significant multicultural diversity, with 14.9% of the population born overseas and 3.4% identifying as Aboriginal and/or Torres Strait Islander (ABS 2020).

The Health Care and Social Assistance sector is the primary employment and largest revenue industry for Greater Shepparton, generating $434 million and 10,000 jobs in 2020 (Figure 4; RDV 2021, par. 8). There are 22 general practice clinics in Greater Shepparton, with an average of 87.9 GPs available per 100,000 people (Murray PHN 2020a). In 2014, Greater Shepparton council ranked 14th in Victoria for overall GP attendances, with a rate of 6,607.6 per 1000 people. The percentage of males who attended a GP was among the highest in the state at with 91.4% (DHHS 2014, p. 12).

Shepparton (MM 3) reaches allocated benchmarks for community GP accessibility, relative to national averages and accessibility in MM 2 areas. Therefore, Shepparton is not designated a DPA and is ineligible for targeted rural recruitment initiatives; IMGs and Bonded Medical Placements (BMPs) will not receive a Medicare Provider number if they chose to practice in non-DPA clinics (DOH, 2021a, par. 4). Most Victorian designated non-DPAs border metropolitan Melbourne, except Echuca, Cobram and Shepparton in the Murray PHN (Figure 7).

Figure 4: Shepparton Employment by Industry



Source: Australian Government (2021) *Labour Market Information Portal*

With a diverse community for medical training, recent infrastructure developments at Goulburn Valley Health (GVH) hospital, and direct access to University of Melbourne's well-funded Department of Rural Health, Shepparton general practice should demonstrate self-sufficiency. However, Shepparton health care and social assistance employment suffered a 15% decline in 2021 (Figure 4). This modelling suggests there is a disconnect between current research, governmental funding, and lived experience of Shepparton GPs.

Figure 5: Map of Modified Monash Model of remoteness (Victoria)

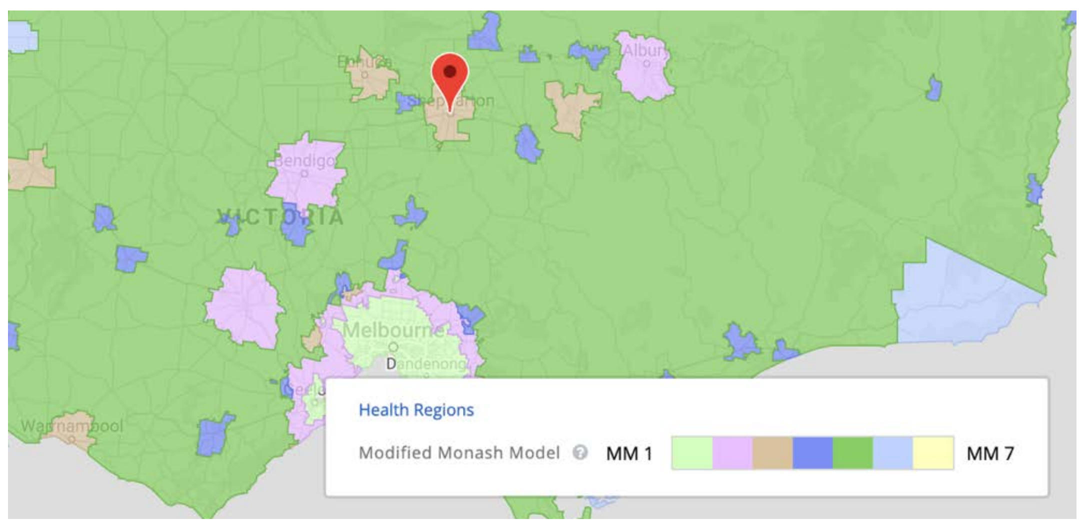


Figure 6: Map of Australian Statistical Geography Standard Remoteness Area (Victoria)

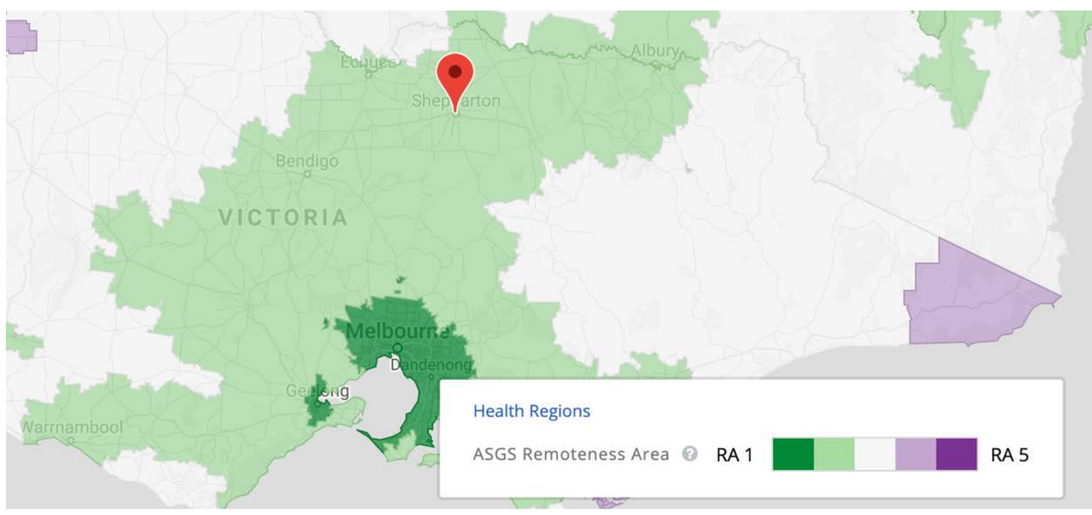
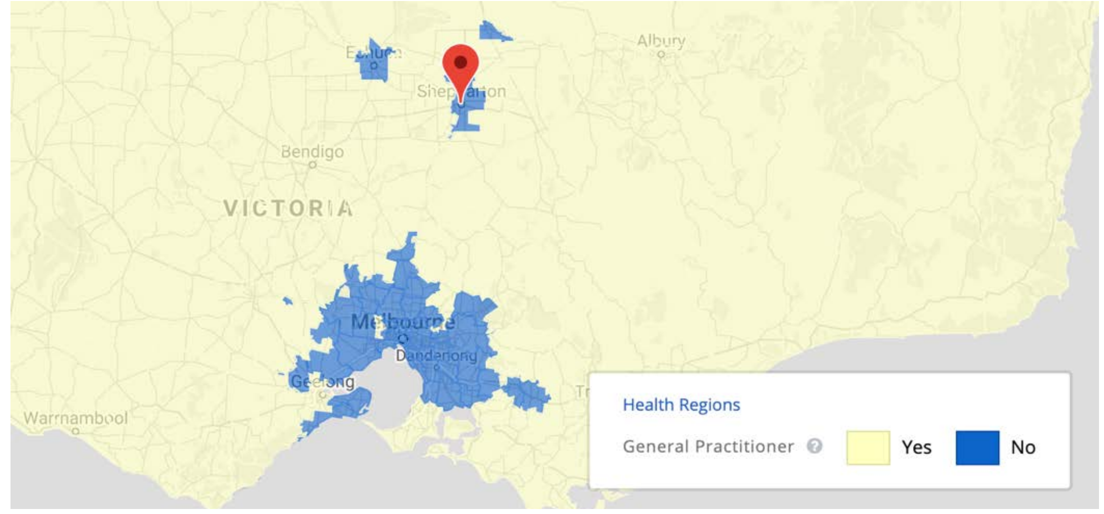


Figure 7: Map of Distribution Priority Area (Victoria)



Source: DOH, 2021b *Health Workforce Locator*, Australian Government

1.2 Research Aim

The primary purpose of this report is to investigate the cause and effect of labour shortages in Shepparton general practice, defining reasons for high turnover and low retention of GPs in Shepparton, and the direct impacts on GPs and patient health outcomes. Based on these conclusions, this report outlines policy recommendations to develop the delivery of primary care in regional Victoria. This secondary aim proposes Shepparton as an indicative case study of non-DPA allocation in regional Victoria; redefining Federal rural health policy to prioritise community-led delivery of primary care in Victoria.

1.3 Methods

This report collates a range of existing global, national, and state-wide research on the causation and outcomes of regional skilled health labour shortages. Developing the thematic literature review conducted by Cosgrave et al. (2019, p. 15), this research approaches retention strategies of regional general practice through relevant social determinants of health; capacity of rural health universities (recruitment factors), advocation for general practice (pathways to integration), and experience of regional contexts (markers of adaption).

Labour shortages within the Victorian regional health framework are not a prominent case study in academic literature. To ensure relevant community-based outcomes, this report includes primary qualitative data through semi structured, in-depth interviews with Shepparton GPs (Appendix 1). Participants were selected from four major commercial clinics in Shepparton, prioritized by longevity in Shepparton general practice. Consequently, all participants own, partially own, or manage registrar training at their clinic.

Embedded qualitative data contextualises the complexities of healthcare retention in Shepparton, analysing patient health outcomes and physician efficiency to support responsive Federal and State policy initiatives (Cosgrave et al. 2019, p. 15). Integrating key concepts from current academic literature, thematic coding was established prior to the interview process. Raw qualitative data was analysed accordingly, within the themes:

- Regional context
- Turnover and retention of staff
- Workplace efficiency
- Regional patient health outcomes

- Personal impact
- Resolutions

Interviews were conducted in accordance with the ethical guidelines of Australian Catholic University (Appendix 2). Participation was voluntary and permission was granted for the identification of all participants (Table 1).

Table 1: Profile of Interview Participants

Dr. Elizabeth Kennedy Shepparton Medical Clinic 10th September 2021	**Dr. Rachel Adams** Princess Park Clinic 15th September 2021
Women's health University educator: University of Melbourne, Department of Rural Health University of Glasgow: IMG Practicing in Shepparton since 2013	Paediatrics and mental health Studied in Melbourne, internship with Goulbourn Valley Health, registrar training in Benella and Shepparton Practicing in Shepparton since 2001 Owner
Dr. John Guymer Wyndham House Clinic 17th September 2021	**Dr. Ursula Russell** Shepparton Lister House Clinic 20th September 2021
Geriatrics and aged care Shepparton born, regional locum placements Practicing in Shepparton since 1989 Partial owner	Mixed demographics of long-term patients University of Melbourne, internship with Goulbourn Valley Health and registrar training at Lister House University educator: Rural Clinical School (Shepparton) Practicing in Shepparton since 1988

1.4 Scope and Limitations

Remoteness Area Classification

In line with MMM data, ‘rural’ and ‘regional’ were considered preferential research terms. ‘Remote’ focused literature was excluded from this research, as remote health research is more conducive to interstate contexts and a small area of Victoria within ABS area classification (Figure 5).

Specific Healthcare Settings

This research features the experience of Shepparton GPs in the Victorian rural health system. The complexities of specific healthcare settings (mental, allied, Indigenous, and women’s health) cannot adequately be detailed within the time frame and word limit. There remains capacity for further research in these areas.

COVID-19 Restrictions

The sudden COVID-19 outbreak in Shepparton limited the availability for community-based research. In addition to state-wide lockdown restrictions, emergency relief and the provision of primary care were prioritized over participation in this research. However, this limitation provided a timely reminder for participants about compounding effects of labour shortages during a global pandemic.

1.5 Report Structure

The report is structured in four sections. Chapter two contextualises the complexities of primary care in Shepparton, comparing qualitative data with academic literature on regional health. Chapter three presents common health concerns in Shepparton, detailing the impact of health labour shortages on patient health outcomes. Chapter four analyses existing infrastructure and rural health policy. In the final chapter, conclusive recommendations are outlined for the development of regional primary care delivery in Shepparton and regional Victoria.

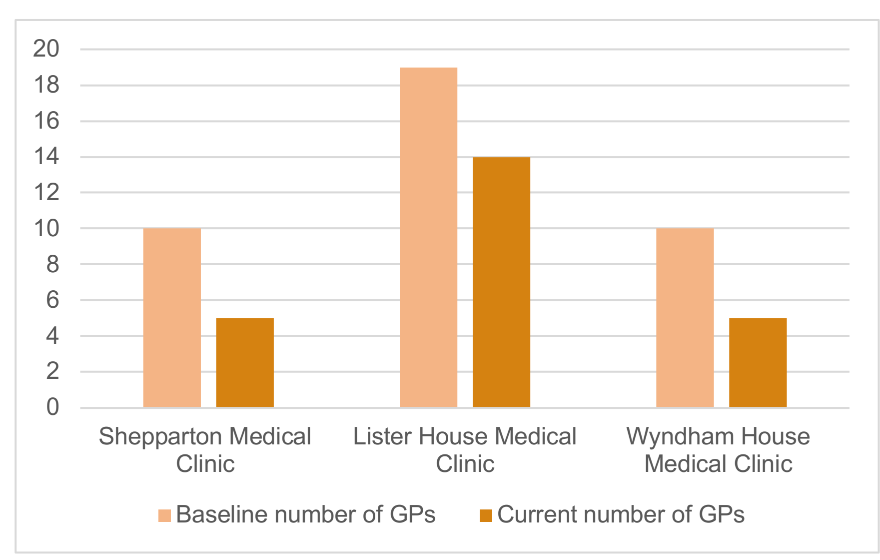
Chapter 2: Provision of Primary Care in Shepparton

2.1. High workforce turnover and low retention capacity

Federal rural health policy, funding and strategic planning implementation have historically benefitted the Shepparton region, incurring a 4100 increase in health workforce recruitment between 2016 and 2020. However, the retention capacity of Shepparton primary care remains inefficient, suffering a 15% workforce decline between 2020 and 2021. (Figure 3)

Low GP retention is common issue among Shepparton GPs. 3 out of 4 participant GPs acknowledged a turnover rate between 25% (Adams) and 50% (Kennedy & Guymer) in the past year (Figure 8). Reasons for GP departure included pandemic and workload fatigue, relocation to metropolitan areas, and ‘Diversity of Training’ programs (MCCC, 2020). All participants expressed concern for the imminent retirement of long-term GPs in the region; a personal matter for Dr. Guymer, Dr. Kennedy and Dr. Russell who have been in general practice since late 1980’s. Without DPA classification, the Shepparton community will lose trusted GPs and recruit limited registrars to replace them.

Figure 8: Staff turnover rate of Shepparton general practice



Registrars and International Medical Graduates

Shepparton offers a unique rural context, with direct access to medical students from the University of Melbourne’s Rural Clinical School in Shepparton. Lister House, Wyndham House, and Shepparton Medical Centre remain a critical part of the ‘Extended Rural Cohort’

training program for the University of Melbourne's Department of Rural Health (DRH 2020, p. 25). Research by McGrail et al. (2016, pp. 219-202) concurs with Dr. Adams, who noted "because [registrars have] trained here [at Shepparton's Rural Clinical School], we get to keep some." However, Shepparton GPs have become "very dependent on registrars" (Guymer) and "when you've got a student, you are slower. It takes longer to do the consultation" (Kennedy). The multidisciplinary, multi-doctor GP facilities in Shepparton are "quite attractive to train in", but "as soon as [registrars are] fully trained, they tend to leave" (Kennedy).

To obtain Australian medical recognition, IMGs are required to undertake a moratorium, up to ten years' experience in DPAs. Federal requirements have sustained a significant portion of IMGs in Shepparton, as IMGs account for half of total GPs in the participating clinics. However, Dr. Adams notes there are "lots of loopholes and a lot of doctors we lose, even though they're still on their 10-year moratorium and they are required to work in country areas, go back to Melbourne". Moreover, replacement IMGs and BMPs will not enter Shepparton general practice without the MBS support provided by DPA classification.

The current level of IMG recruitment to rural areas is unsustainable, compounded by the COVID-19 pandemic. According to O'Sullivan et al. (2019), an equitable transition from rural dependence on IMGs "requires a degree of societal determination to transition away from continued heavy [IMG] use and development of local training pathways as the alternative" (2019, p. 7). Sudden pandemic-related restrictions and Shepparton classification as a non-DPA causes "potentially detrimental effects on immediate access to medical care in communities that are more [IMG] dependent" (O'Sullivan et al. 2019, p. 7).

2.2. Goulburn Valley Health

GVH is the "main referral health service for the Hume region" (VHBA 2016, par. 1). GVH Shepparton offers a diverse range of services to the region, including patient from paediatric to aged care, oncology, dental, community and mental health (GVH 2021). In 2016, the Victorian Government invested $229.3 million into GVH Shepparton. The investment proposed more inpatient and intensive care beds, improved service capacity for maternity and paediatric care, refurbished rooms for medical imaging, and newly developed inpatient buildings, operating theatres, and 24-hour emergency department by 2022. (VHBA 2016, par. 1).

Despite recent investments, most participant GPs are a reluctant to send patients to GVH, identifying ongoing resourcing issues (excessive wait times and staff miscommunication) and inadequate delivery of care (Adams, Guymer, & Russell). Referral hesitancy within the local public system compounds perceived workload of Shepparton GPs, while decreasing non-urgent presentations to GVH emergency department. Glenister et al. (2021, p. 10) suggest patient attendance at a single, long-term GP decreases utilization of the emergency department and provides optimal continuity of care. In Shepparton, there is a correlation between decreased attendance (Figure 10), GP hesitancy, and a 35-minute increase for non-subsequently admitted patients in GVH emergency department (Figure 9).

Figure 10: Non-urgent presentations to GVH emergency department

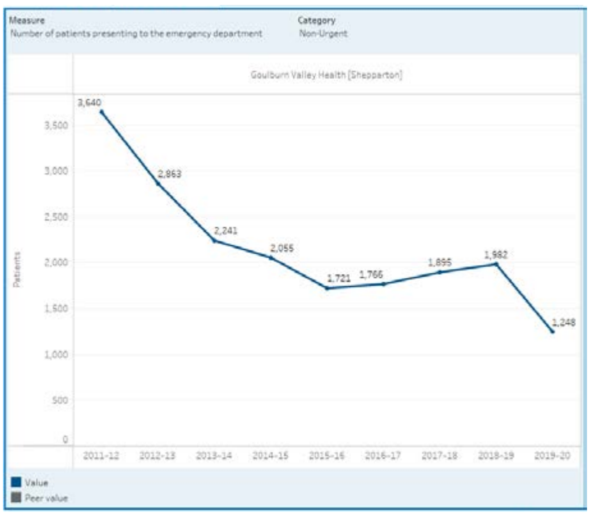
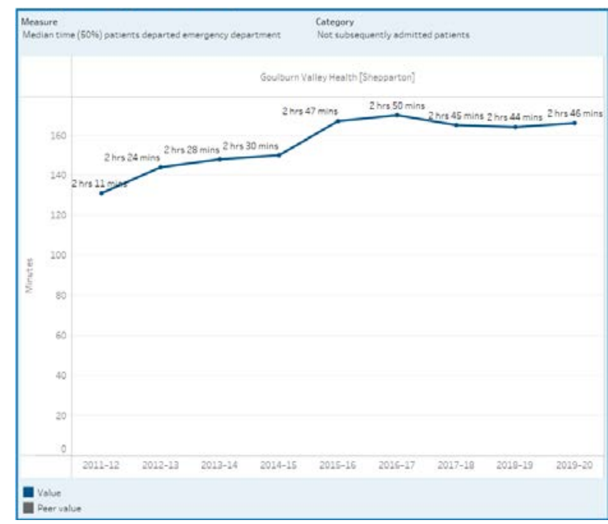


Figure 9: GVH emergency department wait times



Source: AIHW, 2021 **'G**oulburn Valley Health [Shepparton]**'**, MyHospitals data collection

According to Dr. Russell, inadequate staff resourcing at GVH directly impacts medical internship uptake in Shepparton.

> *If a young doctor wanted to come to work as an intern at the hospital,* ***they feel like they're going to get a substandard experience*** *because they're not getting quality registrars who are basically the main stay of the training…* ***If the hospital loses their accreditation for registrars, interns don't want to go there, they don't want to stay on to their second year.*** *That's the way that we've often recruited our registrars, once they've worked at the hospital for a period of time, we get to know them, we get to interview them for positions in the town. Sometimes they have established relationships in the town, they've studied here and now live here and they've come to do general practice in the town.* ***That is absolutely the pathway you want to see them come through.*** *But now, all of those really high-quality medical students,*

they're going to Ballarat, they're going to Bendigo…. You build a beautiful new hospital; it should be that attractive to go and work in… but ***you can't build culture in a building.*** (Russell)

Although higher intern satisfaction is reported in metropolitan contexts due to the large support network of doctors, qualitative explanations for low medical internship uptake in rural settings remain weak (McGrail et al. 2020, p. 6-7). For more conclusive explanations, internship experience surveys should be conducted across rural Victorian LHNs, including GVH.

2.3. Maintaining workplace efficiency with labour deficiency

The disadvantageous position of labour shortages has a direct impact on workplace efficiency, extending hours, increasing workload and burnout in Shepparton general practice.

Extended and after-hours care

When asked about an average day at their practice, all participating GPs detailed an extended working day between 8:00am and 6:30pm. The "universal" (Russell) experience of extended hours in Shepparton general practice included attending 'emergency' patients during GPs lunch break, aged-care and home visitations. Fielding patient phone calls, emails and paperwork after hours were additional contributors to extended hours of care. Additionally, the ability for metropolitan GPs to work strict 8-hour shifts (9am-5pm) was a common belief among Shepparton GPs. Without increased recruitment to the region, Dr. Guymer fears "those mornings which I was planning on having off or doing nursing home visits will be seeing patients, because we won't be able to meet the demand otherwise".

2.4. Labour shortages: a burden on doctor's mental health

As consequence of poor work-life balance, sleep disruption and increased on-call hours, Fitzpatrick et al. (2020, pp. 612-615) found medical interns in Australian rural hospital settings are most likely to experience emotional exhaustion. In circumstances where factors of emotional exhaustion are persistent, burnout occurs; a common issue for primary care physicians across both metropolitan and rural settings (Clough et al. 2020, p. 1386).

Burnout is categorised as "a syndrome resulting from chronic occupational stress, involving dimensions of decreased sense of personal accomplishment, increased emotional exhaustion, and increased symptoms of depersonalization" (Clough et al. 2020, p. 1363). Clough et al. (2020, pp. 1372-1385) classified symptoms of burnout in regional GPs into three

themes: clinical environment, system level and personal factors. Clinical environment includes stressors of volume of work required, limited capacity to control working hours, patient load, or periods of rest and patient expectations regarding treatments, availability, or the role of the doctor. System-level concerns communication levels and limited resources (collegial support, access to specialists, and allied health services). GPs personal emotional response to complex patient care needs, community connection and work-life boundary are key personal factors.

In accordance with data collected by Clough et al. (2020), common symptoms of labour shortages in Shepparton medical clinic were pressure, loneliness and fatigue (Table 2).

Table 2: Symptoms of emotional exhaustion and burnout in Shepparton GPs

	Dr. Kennedy	Dr. Adams
Pressure *Clinical environment*	***You've got this constant pressure of patients****…You can't just say to patients 'okay, I can only deal with one thing, and you have to go away now' because they've been waiting to see you for 4-6 weeks. So, you need to [see them].*	***There's a lot of demand and I feel a lot of pressure to fit people in...*** *I just fit them in... I don't have my lunch; I don't have my day off. I put them in late at night.* ***That's what has to happen***
Loneliness *System-level*	*The problem in general practice is that it is* ***quite a siloed profession****; you go out, get your patient, you come back in your room again.*	***It's miserable, to be quite honest with you****... We see a patient, we open the door, we call the next patient in, we see a patient, we open the door, call the next patient in.* ***We don't walk out of our rooms****. We're here for 12 hours a day.*
Fatigue *Personal factors*	***It's very disheartening****... you work, work, work and you haven't got anybody to pass on the work too.* ***You're always thinking there's more and more to do here.***	*Most of us just soldier on, but we're tired and our families suffer****. There's no real respite…*** *The only way I can manage this, I have to be a robot.*

Protective factors also reduced the incidence of burnout in regional GPs; specifically clinical interest, supportive team, high levels of autonomy and clear work-life boundaries (clinical environment), adequate resourcing (system-level), emotional reward and perceived social support (personal factors) (Clough et al. 2020, pp. 1372-1385). In line with Clough et al.'s (2020) preventative factors, Dr. Russell's sustainability in general practice is dependent on work-life balance and collegial support (Table 3). To reduce incidence of burnout in Shepparton general practice, increased staffing should be supported by flexible working arrangements, GP autonomy, and collegial support systems (Chapter 4.2).

Table 3: Evidence of work-life balance in a Shepparton GP

	Dr. Russell
Adequate breaks *Clinical environment*	***My sustainability in general practice probably has got a lot to do with the lifestyle I've been allowed to have in general practice in Shepparton****, I have a lot of balance in my life… I'm a contractor, so* ***I can pretty much choose when, the hours I want to work and whatever balance I want to achieve****.*
Shared responsibility *System-level*	*[The receptionists] will wander around until they can eyeball somebody and say 'we've got this [patient]' and generally one of us is going to say 'sure, squeeze them in'.* ***If I can't, it will be somebody else. If they can't, it will be me.***
Collegial support *Personal factors*	*We've got a lot [of doctors] that I came through with that are in the process of retiring, so, we've got younger doctors who stepped up into the partnership* ***and still maintain that real close family bond****.* ***We've got an incredible structure for supporting those junior doctors****. So, basically there's a heck of a lot of checking in on them, assisting them, and having an open door…* ***We're here to support [registrars], but also making sure I'm looking after myself to role model that.***

Chapter 3: Shepparton Health Profile

According to Dr. Guymer, there is an inherent “health risk living in rural areas”. Generalisations are regularly made about health disparities between rural and metropolitan Australians, criticizing the fragmented delivery of primary care in rural and remote Australia. The Australian Institute for Health and Wellbeing (AHIW) indicated increased prevalence of chronic diseases, higher mortality rates, lower life expectancy, smaller healthcare facilities and higher reliance on GPs as key determinants of health in rural Australia. (AIHW 2019, sect 1-3). Labour shortages in regional general practice exacerbate already poor health outcomes of rural communities.

3.1. Chronic health conditions in Shepparton

A quantitative population health study by Bourke et. al. (2019, pp. 33-41) collated data from localised community health surveys over a two-year period; 2016 to 2018. Results were analysed against data from the initial *Crossroads* (2000) study, collating a longitudinal population health study of Shepparton and Mooroopna.

Chronic health conditions were identified as the most common health concerns for the community (Table 4). Broadly, chronic physical and mental health conditions are most evident in an ageing and Indigenous populations (AIHW 2019, sect. 1). Chronic illness management was identified as the main reason for patient reattendance to Shepparton GPs. Murray PHN (2020b, p. 37) identified cancer, alcohol and other drugs disorders, and domestic violence as additional health concerns for the Greater Shepparton LGA.

Table 4: Community Health Profile of Shepparton and Mooroopna Population

22% (295) of total respondents reported experiencing **chronic pain**	• Arthritis: 30% • Musculoskeletal: 16% • Injury: 13% • Inflammatory: 8% • Nerve: 7% • Other: 26%
18% (243) have a **disability**	• Physical disability (legs and feet): 9.7% • Physical disability (other): 6.9% • Physical disability (arms and hands): 4.8% • Chronic pain: 8.6%

	• Mental health or emotional condition: 4.6% • Respiratory: 2.6% • Deafness: 1.6% and Blindness: 1.2%
15% (206) have a **heart condition** or have previously had a **stroke**	• Irregular heartbeat • Chest pain • Heart valve disease
8.5% (114) have been diagnosed with **diabetes**	• Type 2: 75% • Gestational: 12.3% • Type 1: 7% • Other (unsure or borderline): 5.7%
	Of the 343 people randomly selected to attend a health screening clinic, **19% had high or very high levels of psychological distress** Of 161 respondents that used mental health services, **7% had seen a psychologist** and **3% had seen a psychiatrist**

Source: Bourke, et al. 2019, *Crossroads II: a repeated population health study in Shepparton and Mooroopna 2016-2018*, pp. 33-41

3.2. Imbalanced interdependence: Rural GPs and specialists

For Dr. Adams, long-term management of chronic health conditions in general practice impacts appointment availability and is the most "draining" part of regional general practice, "because you know you've got 6 months of this. This person who really needs help now, …you've got nowhere to send them". Dr. Guymer acknowledges Shepparton GPs have "adapt[ed]" their co-ordination of diabetes care, to "manage [patients with diabetes] ourselves at least for 3 months before they can get an appointment with an endocrinologist".

A GP-led, integrated care model for advanced diabetes is considered "service delivery innovation" (Foster et. al 2016, p. 2) for healthcare efficiency and patient accessibility. A similar cross-professional, integrated care model for severe and persistent mental health conditions simplifies patient access to mental health care and encourages shared case management between rural psychiatrists and GPs. However, community-led service delivery frameworks presuppose adequate resourcing in both primary and secondary care and require legislative redefinition of professional roles and responsibilities (Chapter 4.3; Foster et. al, 2016, pp. 5-9; Fitzpatrick et al., 2018 pp.6-7).

3.3. Patient accessibility and satisfaction

Bourke et al. (2019, pp. 23-24) identified higher rates of patient satisfaction in Shepparton and Mooropna general practice than in *Crossroads* (2000); 64% indicated they were ‘very satisfied’, 30% were ‘satisfied’ and 2% were ‘dissatisfied’ or ‘very dissatisfied’. However, patient accessibility has declined since 2016-2018. 78% of respondents to Bourke et al.’s study saw a GP within three days of making an appointment, whereas interviewed GPs specified appointment waitlists of 4-6 weeks in 2021.

Despite increased waitlists, 3 of 4 GPs rejected the concept of adverse health outcomes due to labour shortages. “Because people like me keep making space to see them and put out the little fires, we can usually keep them at a point where they can kind of cope” (Adams). For these GPs, there was a mutual understanding that patients will never be refused care in general practice; “patients can get into the junior doctors, or they can see someone on the day. Maybe not their preferred doctor” (Guymer) and “if I can’t, it will be somebody else. If they can’t, it will be me” (Russell). However, ‘emergency’ appointments were generally only accepted for patients known to Shepparton GPs. Within practice distribution of patients is a determinant of high satisfaction and positive health outcomes for patients (Glenister et al. 2021, pp. 8-10).

Chapter 4: Developing Regional Primary Health

4.1. Rural Health University and Postgraduate Medical Training

University of Melbourne: Department of Rural Health and Rural Clinical School

For over two decades, rural health universities have performed a critical role in Commonwealth rural health workforce policy and initiatives (Walters et al. 2017, pp. 56-57; Lyle & Greenhill 2018, p. 316). Domestic recruitment strategies are based on evidence that suggests medical students from rural backgrounds, with onset rural intention, are most likely to practice in rural contexts; often in rural areas with similar characteristics of their hometown (McGrail et al. 2011, pp. 5-6; Poole et al. 2016, pp. 63-65; Poole et al. 2021 p. 370). Moreover, regional based universities attract medical students with rural intention and undertaking medical training in regional contexts increases probability of rural retention (Wooley & Ray 2019, pp. 128-130). Sustainable rural workforce outcomes from University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS) may have lag times of 10-15 years, the co-located University of Melbourne UDRH and RCS have achieved tangible results in Shepparton general practice over a 20-year period (O'Sullivan 2019, p. 6; Guymer, Adams, Russell, & Kennedy).

In 2018, the Federal DOH enacted the 'Stronger Rural Health Strategy' (SRHS), expanding MBS to include non-vocationally recognised doctors practicing in rural areas (MM 2-7), and streamlining GP training and qualification pathways across rural Australia (DOH 2018a). SRHS comprised 'The Murray-Darling Medical School Network' (MDMS) initiative, investing $95.4 million over four years to strengthen rural health university partnerships across Victoria and New South Wales. In Victoria, collaboration between University of Melbourne UDRH (Shepparton) and La Trobe University (Bendigo and Wodonga) was initiated through MDMS (DOH 2018b). Funding allocated under MDMS assisted key infrastructure development and the annual allocation of 30 students to University of Melbourne UDRH, including 15 preselected from La Trobe University's Bachelor of Biomedical Science undergraduate degree. The first cohort under MDMS funding will commence study in 2022 (DRH 2021, par. 2-3).

To accurately evaluate retention success in rural Victoria under MDMS, transparent data collection must be established. In UDRH *Annual Reports*, University of Melbourne publishes data on number of students attending local RCS' (Table 5). It remains unclear what proportion of students attending Shepparton RCS go on to practice in Shepparton and surrounds, as

deidentified medical graduate distribution data is only available in a cross-sectional study of national RCS by McGirr et al. (2019).

Table 5: Number of medical students at University of Melbourne's Rural Clinical School (Shepparton)

	Year 2	Year 3	Year 3	Total
2016	21	7	9	**37**
2017	18	3	10	**31**
2018	18	-	10	**28**
2019	24	-	8	**32**
2020	24	-	2	**26**

Source: DRH, 2016-2020 Annual *Reports*, University of Melbourne

Rural health university funding and infrastructure developments are ineffectual without confirmed efficacy, continued advocacy for Generalism, and promotion of regional health contexts, as "any attempts to recruit will need to tackle the misconceptions about rural life" (Guymer). Malatzky et al. (2014, pp. 438-439) suggest targeted recruitment policy and incentives position rural health as systemically deficient or inferior. Therefore, medical educators have a greater responsibility to highlight the considerable complexity and diversity of rural generalism to establish sustainable recruitment practices.

GP Training and Rural Generalist Programs

To obtain fellowship as an Australian GP, postgraduate vocational training must be undertaken in accordance with the Australian General Practice Training Program (AGPTP). As a secondary partner to AGPTP, the Royal Australian College for General Practitioners (RACGP) is the leading national GP training program, followed by the Australian College of Rural and Remote Medicine (ACRRM). Currently, RACGP determines key frameworks for Regional Training Organizations (RTOs) to complete both rural and metropolitan pathways of GP training. Murray City Country Coast GP Training (MCCC) and Eastern Victoria GP Training (EVGPT) are the only RTOs in Victoria.

In 2018, the National Rural Health Commissioner announced a national 'Rural Generalist Program' framed around the collaborative 'Collingrove Agreement' with RACGP and ACCRM. The program ratified the college's proposal for a streamlined rural pathway for prospective GPs, targeting the multifaceted delivery of care within rural general practice. The agreement integrated a supervisory 'National Taskforce', with a secondary 'Distribution Working Group', 'Rural Jurisdictional Workforce Forum', and 'Rural Health Stakeholder Roundtable' (Worley 2018, pp. 9-18). Following this proposal, the Federal DOH approved the "transition of the AGPTP to a College-led model" (DOH 2021c, par. 2) by February 2023. According to MCCC, DOH has not detailed a plan to transition from RTOs to an RACGP or ACCRM-led model (Appendix 4). Without a secure plan, MCCC faces compounded recruitment difficulties and further disengagement among GP training supervisors. MCCC's concerns are shared by the WA GP Training Advisory Council (Jupp et al. 2021, par 5).

4.2. Collegial support: rural mentorship models

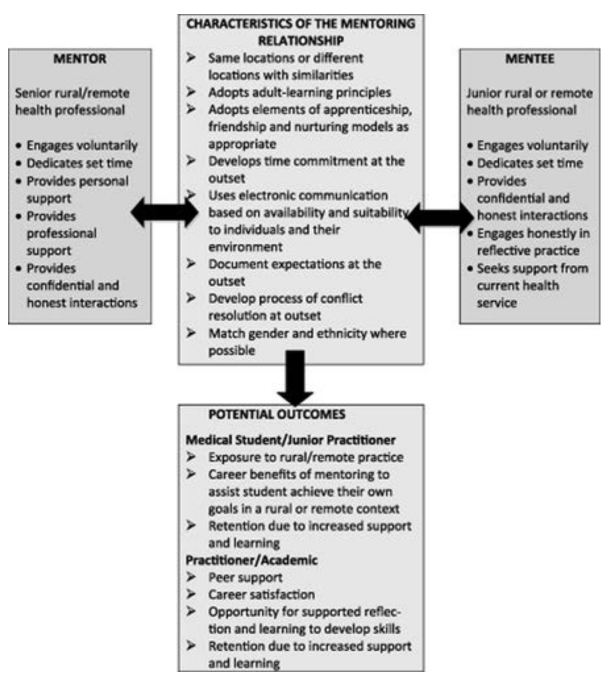
Effective internal and regional support systems have the capacity to encourage retention of GPs in Shepparton. Bourke et. al. (2014) and Cosgrave (2020) formulate rural mentorship models that emphasize relationship building between community settings, established local GPs and doctors in training. Models of professional clinical supervision are well-established throughout national GP training programs and RTOs. However, collective loneliness in Shepparton GPs suggests permanent mentorship and collegial support structures are inefficient in areas of workforce shortage.

Bourke et. al. (2014)'s 'Rural Mentoring Model' promotes interprofessional connection between mentor (senior doctor) and mentee (junior doctor) (Figure 11). According to Bourke et al., a "supported, satisfied, [workforce] working towards aspirations" (2014, p. 5) are the key proponents of rural GP retention. This mentorship framework provides psychological and career support, reduces hierarchy, and enables a support network with GPs from different locations. A similar successful 'Practice to Practice' pilot program is currently available through RACGP (RACGP 2021). Successful logistical planning requires time and is dependent on workload of senior doctors, a retention paradox in contexts where labour shortages are present (Bourke et al. 2014, pp. 4-5).

Cosgrave's 'Whole-of-Person Retention Improvement Framework' progresses from Bourke et al.'s model to include an equally weighted connection to community and place (Figure 12). Cosgrave identifies that doctor in young adulthood (often unpartnered and without children)

are more likely to experience social alienation, or disparity between ‘newcomer’ and ‘local’, and relocate as consequence. Belonging-in-place is established within this framework through place-based planning, community engagement and innovation (Cosgrave 2020, pp. 8-11). Moreover, whole-of-person support frameworks and subsequent increased retention reduces established GPs workload, community pressure, burnout, and preventable long-term GP turnover. To facilitate higher levels of retention in rural Victorian primary care, permanent mentorship frameworks should be endorsed within PHNs, PCPs, and LHNs.

Figure 11: Rural Mentoring Model



Source: Bourke et al., 2014 ‘Mentoring as a retention strategy to sustain the rural and remote health workforce: A rural mentoring model’, p. 6

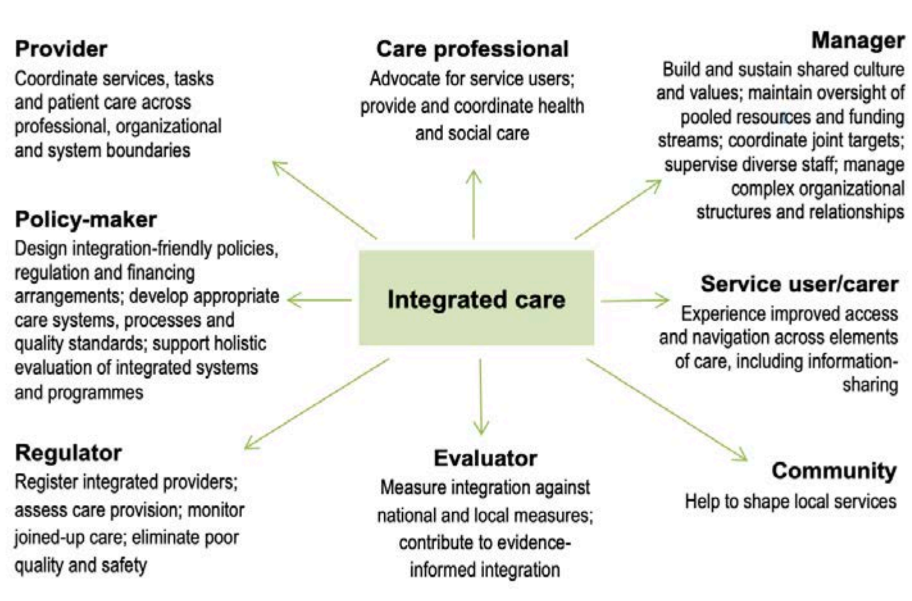
Figure 12: Whole-of-Person Retention Improvement Framework

Source: Cosgrave, C, 2020 ‘The Whole-of-Person Retention Improvement Framework: A Guide for Addressing Health Workforce Challenges in the Rural Context’, p. 3

4.3. Integrated Care Models in Victoria

'Integrated Care Models' (ICM) have achieved great success in primary care co-ordination in various rural contexts around the world (Nicholson et al. 2013, pp. 4-10). ICM's promote a multifaceted delivery of primary care, strengthening partnership between policy makers, health care providers and community-health professionals (Figure 13). WHO endorses system-level, multidisciplinary ICM's that prioritise common cause, vision and strategy, joint funding, planning and delivery, ongoing evaluation and developed quality improvement processes (WHO Europe 2016, pp. 18-19).

Figure 13: Stakeholders of an Integrated Care Model



Source: WHO Europe, 2016 *Integrated care models: an overview*, p. 3

In 2017-2018, the Victorian Department of Health and Human Services commenced a three-year trial of the 'Victorian Integrated Care Model' (VICM) in South Eastern Melbourne PHN. Developed by the Australian Disease Management Association, VICM enacted key system integration and primary care co-ordination reforms from the *Bilateral Agreement Between the Commonwealth and Victoria* (Australian Government 2018, Reform 25-27). The community-led VICM aimed to "improve the experiences of care and outcomes for patients with complex and chronic conditions" (ADMA 2021), strengthening collaboration between State and Commonwealth policymakers, LHNs, PHNs, PCPs, and community-health. The bilateral agreement expired on the 31 December 2019, shortly after the South Eastern Melbourne PHN trial concluded in April 2019. VICM trial outcomes are not publicly available and there are no further VICM implementation plans.

In 2020-2021, Murray PHN commenced the trial of an ‘Integrated Health Network’ in Buloke, Loddon and Gannawarra shires (Murray PHN 2021, pp. 3-6). Regional COVID-19 lockdowns postponed the trial commencement in Murray PHN. In cohesion with VICM findings, outcomes of the Murray PHN trial will directly benefit Shepparton, other regions of Murray PHN and broader regional Victoria.

4.4. Victorian Rural Health Workforce Committee

Despite increased funding allocation and infrastructure development across regional Victoria, the delivery of rural primary care remains fragmented and convoluted. There is capacity for state-wide stakeholder collaboration under a Victorian Rural Health Workforce Committee (VRHWC) that mirrors the National Taskforce of the Collingrove Agreement.

Table 6: Proposed stakeholder collaboration within Victorian Rural Health Workforce Committee

Department of Health	Rural health universities	GP training programs	Research agencies	Workforce representatives
Federal State	University of Melbourne La Trobe University	RACGP ACCRM MCCC* EVGPT* **RTOs are redundant from 2023*	Rural Workforce Agency Victoria University funded researchers	Medical clinics Hospitals Other medical professionals

The proposal of VRHWC reintegrates the bilateral agreement between Commonwealth and Victoria for rural primary care and facilitates workforce co-ordination between key stakeholders (Table 6). Preserving transparency of rural health policy reform and initiative outcomes (VICM and MDMS), VRHWC prioritises integral regional contribution to the discussion of national rural health policy.

Chapter 5: Conclusion and recommendations

Following 20-years of reform, Australian rural health policy has neglected community health outcomes for domestic recruitment targets, broad regulatory strategies, and equitable distribution strategies. Historically, the Victorian regional town of Shepparton has benefited from Federal rural health initiatives. However, the past year has incurred a significant decline across Shepparton health care and social assistance employment, with 50 to 25% turnover rate in general practice. Evidence of GP burnout, increased presentation of chronic health conditions in general practice, and referral hesitancy to local specialists are compounding factors of GP shortages in Shepparton. Adequate infrastructure, current streamlined rural heath university pathways, and lenient regulatory strategies remain insufficient to facilitate long-term labour retention in Shepparton primary care. To ensure community needs are met across regional Victoria, a jurisdictional transition of broad national rural health strategies to state-based primary care should be considered.

Key Recommendations

1. Reallocate Shepparton as a **Distribution Priority Area.** Consider median age of general practitioners, relative access to secondary care (specialists and hospitals), and history of retention as contributory factors of Distribution Priority Area allocation.

2. Reinstate the **Bilateral Agreement between the Commonwealth and Victoria on Coordinated Care**. Recommence trials of Integrated Care Networks across regional Victoria.

3. Introduce a **Victorian Rural Health Workforce Committee** to ensure cohesion of rural health policy and initiatives in Victoria.

4. To encourage data transparency, **determine regional recruitment benchmarks** for university Departments of Rural Health and Rural Clinical Schools.

5. Formalise **collegial support frameworks and rural mentorship models** across Victorian Primary Health Networks, Primary Care Partnerships, and Local Hospital Networks.

6. Strengthen **domestic recruitment strategies** to reduce unsustainable dependence on International Medical Graduates in rural health. Continue advocacy for Rural Generalist Program as equivalent to Specialist pathways and outline a clear transitional plan from RTOs to College-led general practitioner training programs.

There remains capacity for qualitative data comparison with departing registrars and fellowed GPs from Shepparton medical clinics. Likewise, internship experience surveys should be across Goulburn Valley Health and other Victorian LHNs. Further investigation should be conducted regarding the trial outcomes of Victorian Integrated Care Model and justifications for lack of available data, as well as graduate data transparency from University of Melbourne's Department of Rural Health in Shepparton.

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Appendices

Appendix 1 - Outline of interview questions with thematic coding

Section	Question
Personal	**Tell me about yourself:** • Name • Specialization (if applicable) • Name and location of current practice • Did you grow up regional/in Shepparton? o How would you describe your experience working and living in the Shepparton region to someone (like me) who has never lived regionally?
Personal	**Do you consider yourself a recent graduate (within the past 5 years), migrant, or long-term GP?** • Which best represents the workforce at your practice? • Where did you study? ▪ Rural or Metropolitan? • Did this impact your decision working in Shepparton?
Working in Regional	**How long have you been a practicing GP in Shepparton?** • Have you worked in other regional or urban areas? • What do you enjoy most about working in Shepparton or other regional areas? • What do you like least about it? • What is the longest period you have practiced at a single location? • Is it your current workplace?
Working in Regional	**What is the quality of your practice facilities?** • Poor/Average/Good/Excellent • How do they compare to others in the Shepparton region? • Did this impact your decision to work at the practice? *Elaborate.*
Patient Outcomes	**Tell me about an average day at your practice.** • How many patients do you attend to per day? • What are your hours? • How many days do you work per week? • Are your patients long-term? i.e., are you the only GP your patients visit? • Majority in person or Telehealth? • Do you have a waitlist of patients?

Workplace Efficiency	**To what extent does your workplace suffer from skilled labour shortages?**
	• What do you think has contributed to this?
	   ▪ High turnover of staff?
	   ▪ Pandemic Related?
	   ▪ Inexperienced Staff?
	   ▪ Staff relocating?
	   ▪ Ageing workforce?

Workplace Efficiency	**In reference to the recent COVID-19 outbreak in Shepparton, how did labour shortages impact your practice's response?** • Were staff furloughed due to quarantine requirements? • How were you able to maintain workplace efficiency? • Was this different to last year's outbreak?
Patient Outcomes	**Without impacting patient confidentiality, tell me how patient outcomes are affected by the healthcare labour shortage at your clinic.** • For example, patients putting off attending doctor due to lack of available appointments and worsening
(GV) Regional Context	**Tell me about your experience referring patients to Goulburn Valley Health.** ▪ For example, emergency department, further testing ▪ How did the wait times effect your ability to provide adequate primary care?
Personal Impact	**How are you personally affected by the healthcare labour shortage at your clinic?** • And your workplace?
Personal Impact	**Have you ever thought about leaving the regional area due to workplace conditions?** • Due to stress from labour shortage? • Low quality facilities? • Quality of healthcare provided?
Working in Regional	**Why do you think healthcare labour shortages are affecting the entire Shepparton district?** • What's common among general practices in the area? • Do illnesses spread more quickly in the region?
Resolutions	**How can we develop the delivery of primary healthcare in Shepparton to benefit doctors (like yourself) and improve health outcomes for patients?** • Telehealth and Online Services – how do you think the system can be improved? • Facilities and cityscape – improve the liveability of the community, centralise/modernise facilities. • Education – For current and future GP's and Patients • Regional opportunities

Appendix 2 – Ethics: consent form and information sheet

Information Sheet

PROJECT TITLE: Impacts of skilled labour shortages on healthcare efficacy in the Shepparton district.

SUPERVISOR: Dr Niro Kandasamy and Dr Mark Chou (Lecturers-in-Charge) and Suzanna Sheed (MP for Shepparton)

STUDENT RESEARCHER: Madeline Pentland

STUDENT'S DEGREE: Bachelor of Arts/ Bachelor of Global Studies

Dear Participant

You have been asked to participate in this project as part of the coursework and assessment requirements for POLS311 Parliamentary Internship Research Report.

The purpose of this project is to investigate the impacts of skilled labour shortages on healthcare efficacy in the Shepparton district. In 2018, the Australian Federal Department of Health recognised Shepparton as a regional community in need of a more sustainable, high-quality health workforce. Despite established education initiatives in the region, healthcare and social assistance employment is down by 15% in the last year. Members of the Shepparton community and medical workforce have appealed to Suzanna Sheed's electoral office for labour shortage relief. This research project intends to gain an extensive understanding into the diverse effects of skilled General Practitioner (GP) labour shortages in the Shepparton district.

Should you agree to participate, you will be asked to answer questions regarding the number of patients attending your practice, the proportion of recent graduate, migrant and/or long-term General Practitioners working at your practice, and your observations of the impact of labour shortages on workplace efficiency, patient accessibility and general health outcomes in the Shepparton district. Patient's personal information will remain classified throughout the interview. In accordance with current COVID-19 restrictions, this interview will be conducted in person or online. Your involvement should take no longer than 30 minutes. You are under no obligation to participate in this project and may withdraw at any time.

The information you provide will form the basis of an assessment task for the student. The student's report may be used by Suzanna Sheed's electoral office. If you wish to remain anonymous, please let the student intern know on the consent form.

If you have any queries relating to your participation that cannot be answered by the student, or if you would like any further information or have any concerns about your participation, Suzanna Sheed's electoral office at suzanna.sheed@parliament.vic.gov.au. If you would like any further information regarding the Victorian Parliamentary Internship Program, please contact the Dr Niro Kandasamy by email at niro.kandasamy@acu.edu.au.

The research activity has been designed to meet the ethical standards outlined in the *National Statement on Ethical Conduct in Human Research* and the *Australian Code for the Responsible Conduct of Research*, and in accordance with the University's ethical guidelines. Please keep this letter as record and for information.

Thank-you for your time.

CONSENT FORM
Copy for Researcher / Copy for Participant to Keep

TITLE OF PROJECT: Impacts of skilled labour shortages on healthcare efficacy in the Shepparton district.

(NAME OF) SUPERVISOR: Dr Niro Kandasamy and Dr Mark Chou (Lecturers-in-Charge) and Suzanna Sheed (MP for Shepparton)

(NAME OF) STUDENT RESEARCHER: Madeline Pentland

I .... *(the participant)* have read *(or, where appropriate have had read to me)* and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this research project which takes no more than 30 minutes and will be digitally recorded, realising that I can withdraw my consent at any time (without adverse consequences). I agree that research data collected for the study will be exclusively used for the purpose of assignment preparation and will not be used for any other purpose, including publication or be available publicly.

I want my information to be identified: Yes / No (circle one)

I consent to the audio of the interview being recorded: Yes / No (circle one)

NAME OF PARTICIPANT: ....

SIGNATURE: .... DATE: ....

SIGNATURE OF SUPERVISOR): ....DATE: ....

SIGNATURE OF STUDENT RESEARCHER: ....DATE: ……………..

Appendix 3 – Victorian pathways to become a Rural Generalist

- ➢ Following completion of a relevant undergraduate degree and postgraduate medical training (preferential: UDRH and RCS), prospective GPs commence pathways to fellowship through RTOs and national training programs.
- ➢ Historically, GPs (also known as Generalists) have the choice of metropolitan or rural placements. A range of government incentives are available for rural placements. Regardless of remoteness, all medical interns (first year) undertake placement in hospital settings.
- ➢ A new Rural Generalist pathway was announced in 2018. Federal rural Generalist pathways connect prospective GP to national GP training services, whereas Victorian rural Generalist pathways prioritise RTOs. This division will change following the impending dissolution of RTOs.

	Australian General Practice Training (AGPT) - Rural Pathway	Remote Vocational Training Scheme (RVTS)	Independant Pathway (IP)	Lateral entry for Fellowed GPs
Suited to	Recent medical graduates and experienced non-vocationally recognised doctors who prefer educator directed learning	Recent graduates and experienced non-vocationally recognised doctors, who have enough experience to work with remote clinical supervision in rural/ remote areas and/or Aboriginal Medical Services	Experienced non-vocationally recognised doctors who are seeking flexibility in training location and education	GP's who already hold a FRACGP who are looking to upskill as a Rural Generalist by completing the Fellowship of Advanced Rural General Practice (FARGP)
Training timeframes*	4 years FTE* (FACRRM) 4 years FTE* (FRACGP + FARGP)	4 years FTE* (FACRRM) 4 years FTE* (FRACGP + FARGP)	4 years FTE*	12+ months FTE*
Training Organisation	RTOs† in Victoria: • EVGPT • MCCC	RVTS accredited by ACRRM and RACGP	ACRRM	RACGP
Location	Regional, rural and remote facilities depending on college training requirements.	Live and work in rural or remote community, or work in an Aboriginal Medical Service	Regional, rural and remote facilities with some skills training in metropolitan locations	Regional, rural and remote facilities. Minimum 12 months in a MM 3-7 location.
Practice Placement	RTOs will facilitate placements based on preferred location/s	Be eligible to be employed as a trainee GP in a rural or remote location or in an Aboriginal Community Controlled Health Service (ACCHOs).	Must arrange own employment in an accredited post, have the post accredited, or be prepared to move to an accredited post	Already employed as a GP. Participate in the VRGP Rural Generalist Advanced match for advanced skills training.
Application process	Apply to ACRRM and/or RACGP for a specific region • Complete the ACRRM and/or the RACGP selection process • Be accepted by an RTO • Commence training	Apply to RVTS • Selection by RVTS • Enrol with either ACRRM and/or RACGP • Commence training	Apply to ACRRM • Complete the ACRRM Selection process • See College website for further information	Apply to RACGP • Obtain a RGA position through VRGP RGA match process.
Fees	Training is fully Commonwealth funded	Training is Commonwealth funded, some self-funding may be required	Training is partially Commonwealth funded if eligible under the FSP** otherwise self-funded.	Training is self-funded.
	Assessment fees are self-funded College application fees may apply			

*FTE = Full-Time Equivalent
**FSP = Non-VR Fellowship Support Program (page 24)
†RTOs = Regional Training Organisations (page 8)

Source: Victorian Rural Generalist Program, (2021) 'GP College Training options for becoming a Rural Generalist', Victorian Government, viewed 13 October 2021 <https://www.vicruralgeneralist.com.au/rg1-2>.

Appendix 4 – Letter of concern from Suzanne Harrison (MCCC)

- Consent for the inclusion of this letter was attained from Suzanna Sheed MP and Suzanne Harrison from MCCC on 13 October 2021.

MURRAY CITY COUNTRY COAST **GP TRAINING**

Level 1/10-16 Forest Street Bendigo 3550
91A McKillop Street Geelong 3220
Level 2/369 Royal Parade Parkville 3052
Level 1/49 Kepler Street Warrnambool 3280
Level 4/111-113 Hume Street Wodonga 3690

26 August 2021

Dear representative of the people of Victoria

On behalf of the Board of Murray City Country Coast GP Training (MCCC), I am writing to alert you to some significant concerns for the future of General Practice training.

MCCC is the Regional Training Organisation (RTO) responsible for training approximately 650 GP registrars, under the guidance of approximately 900 GP supervisors, throughout Victoria each year. We are the most significant GP workforce contributor for our community with 75% of training undertaken in rural areas.

The proposed transition to college-led training from the previous model of Australian General Practice Training (AGPT) is proposed to be completed by February 2023 (originally December 2022) and currently we have no clear plan of how this is to occur. Despite RTOs regularly meeting with the Department of Health and GP colleges little progress towards transition has occurred, with fear and anxiety about the fate of the AGPT program continuing to grow.

The uncertainty around the future of this program is having a negative effect, not only on MCCC, but the broader community. Experienced MCCC staff are facing an unknown future, impacting staff retention and leaving the program weakened to deliver its workforce outcomes. We are at risk of losing the GP supervisors who provide the training, as well as facing increasing difficulty in recruiting applicants to the program. Insufficient GP registrars training in the community will severely affect the rural workforce. Junior doctors are currently reluctant to join the program until there is more certainty, especially in relation to how and where they will train.

I do not believe this issue is unique to MCCC - it is a problem facing all RTOs around the country. In short, the Australian General Practice Training program is suffering extensively. The transition to college-led training needs prompt attention to ensure that GPs continue to be trained and that rural populations are not further deprived of GPs.

We need decisions to be made to create some certainty around the Australian General Practice Training program. At present there is little that MCCC can do to prevent a major catastrophe, especially for our rural communities.

We have raised these concerns with Minister Gillespie and received no reply. We acknowledge that the COVID-19 pandemic makes this a challenging time for all stakeholders involved in the provision of health care, however as the health and wellbeing of your constituents is likely to bear the brunt of declining numbers of General Practitioners, especially in rural and outer metropolitan Victoria, the Board of MCCC felt it important to raise this matter for your information.

I would be pleased to meet with you to discuss these concerns at your convenience. In this regard, please contact Greg McMeel, Chief Executive Officer via email (Greg.McMeel@mccc.com.au) to co-ordinate a meeting.

Yours faithfully

Dr Suzanne Harrison
Board of Directors Chair
Murray City Country Coast GP Training

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