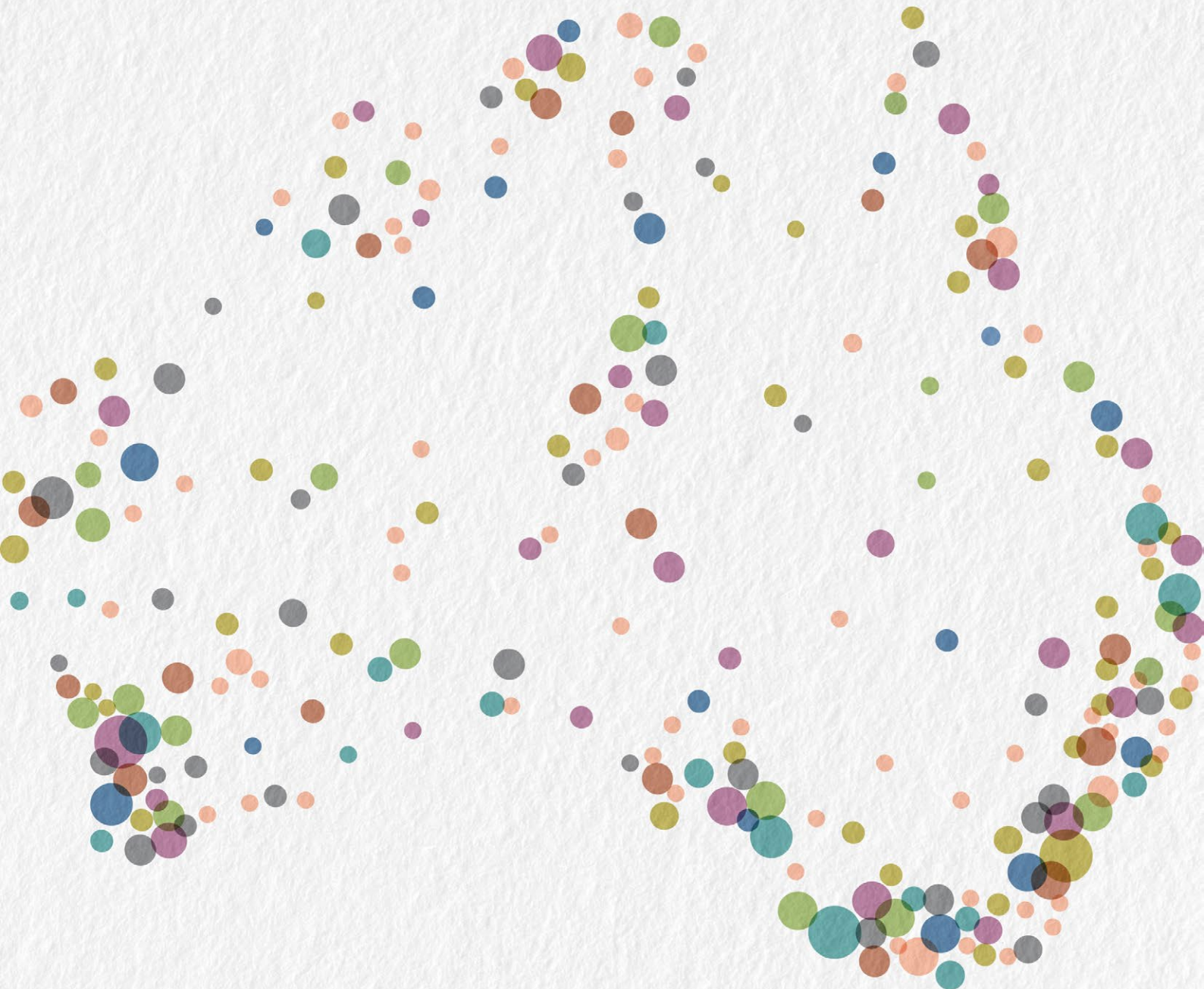


October 2024



Working Better for
Medicare Review
Final Report

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Supported by:



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Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal and Community Controlled Health Services
ACPA	Australian Community Pharmacy Authority
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practitioner Training
AHPRA	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
AMDS	Approved Medical Deputising Services
AMGs	Australian Medical Graduates
AMSANT	Aboriginal Medical Services Alliance Northern Territory
APED	Approved Private Emergency Department
ASGS-RA	Australian Statistical Geographic Standard - Remoteness Area
AST	Advanced Skills Training
BMP	Bonded Medical Program
CAAC	Central Australian Aboriginal Congress
CAGR	Compound Annual Growth Rate
CALD	Culturally and Linguistically Diverse
CARA	Centre for Australian Research into Access
CSP	Commonwealth-Supported Place
DoHA	Department of Home Affairs
DoHAC	Department of Health and Aged Care
DPA	Distribution Priority Area
DWG	Distribution Working Group
DWS	District of Workforce Shortage
ERP	Estimated Resident Population
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FARGP	Fellowship in Advanced Rural General Practice
FGAMS	Foreign Graduates of an Accredited Medical School ¹
FRACGP	Fellow of the Royal Australian College of General Practitioners

1 Refers to Doctors who received their primary medical qualification from an accredited Medical School in Australia or New Zealand, but were not a permanent resident or citizen of Australia or New Zealand when enrolled in the Medical School.

FSE	Full Service Equivalent ²
FSP	Fellowship Support Program
FTE	Full-time Equivalent
GP	General Practitioner
GPT	General Practitioner Training
HMA	Healthcare Management Advisors
IMGs	International Medical Graduates ³
IP	Independent Pathway
IRSD	Index of Relative Socio-Economic Disadvantage
IT	Information Technology
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer+
LHN	Local Health Network
MABEL	Medicine in Australia - Balancing Employment and Life
MBS	Medicare Benefits Scheme
MDRAP	More Doctors for Rural Australia Program
MJA	Medical Journal of Australia
MMM	Modified Monash Model
MSOD	Medical Schools Outcomes Database
NACCHO	National Aboriginal Community Controlled Health Organisations
NAT	National Assessment Tool
NHMRC	National Health and Medical Research Council
NHRA	National Health Reform Agreement
NMWS	National Medical Workforce Strategy
NT	Northern Territory
NZMG	New Zealand Medical Graduate
OECD	Organisation for Economic Co-operation and Development
OTDs	Overseas Trained Doctors ⁴
PEP	Practice Experience Program
PFP	Pre-Fellowship Program
PGY	Post Graduate Year
PHiDU	Public Health Information Development Unit

2 The FSE method uses a statistical model to estimate a workload for medical practitioners according to their services billed. While the MBS claims data does not include information on duration, the schedule includes time-based regulations for some items that can be used to estimate a proxy for duration.

3 Includes OTDs and FGAMS

4 Refers to Doctors with a primary medical qualification from a Medical School outside of Australia or New Zealand

PHN	Primary Health Network
PIP	Practice Incentives Program
RA 3-5	Remoteness Area 3-5
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RFDS	Royal Flying Doctors Service
ROSO	Return of Service Obligation
RPL	Recognition of Prior Learning
RRMA	Rural, Remote and Metropolitan Areas
RVTS	Remote Vocational Training Scheme
SA #	Statistical Area #
SD	Standard Deviations
SEIFA	Socio-Economic Indexes for Areas
SRHS	Stronger Rural Health Strategy
STP	Specialist Training Program
VPE	Voluntary Patient Enrolment
VR	Vocationally Recognised
WA	Western Australia
WACHS	Western Australia Country Health Service
WBFMR	Working Better for Medicare Review
WIP	Workforce Incentives Program
WPPPOs	Workforce Planning and Prioritisation Program Organisations

Executive Summary

As part of the *Strengthening Medicare* reforms, on 21 November 2023 Minister Butler announced the "*Working Better for Medicare Review*." The intent of the Review was to examine and recommend changes to:

- Sections 19AA and 19AB of the *Health Insurance Act 1973*
- Distribution Priority Area (DPA) classification
- District of Workforce Shortage (DWS) classification, and
- The Modified Monash Model (MMM) classification.

Government uses this legislation and distribution mechanisms to better support health professionals in areas of greatest need across Australia and to better target health workforce programs.

The specific Terms of Reference for the Review were to consider several aspects of the distribution levers and their interplay with each other including:

- Confirming the original objectives of the distribution levers.
- Evaluating the appropriateness and robustness of the assumptions underpinning the distribution levers.
- Considering and reporting on the value of retaining the distribution levers.
- Assessing the alignment of distribution levers with current health workforce policies and priorities.
- Identifying key factors and barriers impacting appropriateness and effectiveness.
- If appropriate, identifying opportunities to improve the operation of the distribution levers in achieving current health workforce policy objectives.
- Considering and where appropriate make recommendations on alternative approaches to the Department for achieving the intent of the distribution levers.
- Identifying the future role for distribution levers.

Consistent with other Strengthening Medicare reform measures, the *Working Better for Medicare Review* falls under the auspices of the Strengthening Medicare Implementation Oversight Committees.

Professor Sabina Knight, Director, James Cook University Central Queensland, Centre for Rural and Remote Health and Adjunct Professor Mick Reid, Principal, Michael Reid and Associates, were appointed as Independent Lead Reviewers (Reviewers) to lead and coordinate the Review work streams and deliver this Report.

Two consulting firms were engaged to address aspects of the Review.

Healthcare Management Advisors (HMA): Engaged to undertake the Review of Section 19AA of the *Health Insurance Act 1973*, the Distribution Priority Area (DPA) mechanism and the Review of the Modified Monash Model (MMM).

HealthConsult: Engaged to undertake the Review of Section 19AB of the *Health Insurance Act 1973*, and the District of Workforce Shortage (DWS) mechanism.

In addition, HMA engaged the Centre for Australian Research into Access (CARA) at Deakin University to assist in the analytics regarding MMM.

The reports of both HMA and HealthConsult have been incorporated into this Report.

300 submissions were provided to the Department of Health and Aged Care (DoHAC/Department) relating to the Review, and both the Reviewers and Consultants held extensive consultations with key stakeholders. These consultations included those undertaking the related reform initiatives under the Strengthening Medicare agenda.

The contribution of the DoHAC personnel supporting the *Working Better for Medicare Review* is acknowledged by the Reviewers. The completion of this complex Report would not have been possible without this extensive Departmental assistance.

For the purposes of this report, International Medical Graduates (IMGs) include both Overseas Trained Doctors (OTDs) and Foreign Graduates of an Accredited Medical School (FGAMS).

A brief description of the current relevant legislation and distribution levers is shown on the following page.

Section 19AA - Health Insurance Act 1973

The original purpose of 19AA was to ensure high standards of General Practitioner (GP) and non-GP specialist medical service provision in Australia. Doctors who are permanent residents or citizens of Australia must hold vocational recognition or be actively working towards it before they can access Medicare benefits.

Over time, 19AA has become associated with a secondary policy goal related to distribution of doctors outside metropolitan areas, which is achieved by requirements in the College training programs for practice in the MM 2-7 or MM 3-7 locations, depending on the program. Section 3GA of the Act allows practitioners who do not have a Specialist Registration to access Medicare benefits through undertaking an approved training program, at an eligible location, for a defined period.

Section 19AB - Health Insurance Act 1973

19AB sets out the rules for IMGs regarding where they may work in Australia. It allows payment of Medicare benefits to IMGs only if they work in a DPA (for GPs) or DWS (for non-GP specialists) location for up to 10-years from the date of their first registration as a medical practitioner in Australia ("the 10-year moratorium").

Section 19AB also works in conjunction with Section 3GA, which allows medical practitioners working towards vocational recognition to access Medicare benefits if they are enrolled in approved workforce or training programs.

Distribution Priority Area (DPA)

The DPA classification identifies locations in Australia with a shortage of General Practitioner (GP) services. IMGs who wish to work as GPs must work in a DPA to be eligible to access Medicare.

Australian Graduates of Australian Medical Schools on a bonded program must also work in a DPA.

District of Workforce Shortage (DWS)

A DWS is an area where people have poor access to non-GP specialist medical practitioners assessed against a national benchmark. This is measured by assessing the full-time specialist equivalent level for an area against the national average.

Population and Medicare billing data is used to get a ratio in each Australian Statistical Geography Standard SA3 area for eight selected specialist groups.

Modified Monash Model (MMM)

MMM is used to define whether a location is metropolitan, regional, rural, remote or very remote. The measure of remoteness and population size is described on a scale from MM1 to MM7.

MMM is based on the Australian Statistical Geography Standard – Remoteness Areas (ASGS-RA) framework and features derived from the Medicine in Australia - Balancing Employment and Life (MABEL) longitudinal survey undertaken in 2011. The MMM classifications are reviewed and updated after each census (every 5 years).

A number of fundamental changes are proposed for Sections 19AA, 19AB, DPA and DWS. To assist in overseeing their implementation, the establishment of a small *Health Workforce Independent Review Panel*, with DoHAC as secretariat, is proposed.

With respect to **Section 19AA**, the original intent, which required medical practitioners to hold specialist registration or to be enrolled in a training program towards specialist registration in order to access Medicare, remains current today. As such, Section 19AA should be retained to ensure training standards, currency of knowledge and skills across all medical specialities are maintained.

Whilst retaining Section 19AA, a number of initiatives are proposed to:

- better target training supervision to areas of greater need
- better measure the effectiveness of 3GA training programs on rural health workforce outcomes, and
- enable the GP Colleges to move towards competency-based training which recognises prior learning and experience.

Section 19AB sets out the rules for IMGs regarding where they work in Australia, by providing payment of Medicare benefits only if the IMGs work in a DPA or DWS location for up to ten years from the date of their first registration as a medical practitioner in Australia.

Without 19AB, there is a strong view that many IMGs would choose to practice in metropolitan areas. While there was support for the retention of 19AB, the extent of exemptions to the 10-year moratorium is undermining the efforts to address workforce maldistribution. For example, in 2023, DoHAC approved 1,790 submissions for exemptions while Services Australia approved a further 2,545.

As with 19AA, it is proposed that Section 19AB be retained, including the 10-year moratorium, at least in the medium term, until Australia is closer to self-sufficiency in meeting medical workforce needs and there are improved employment options and/ or distribution incentives in place to ensure sufficient doctors practice in areas of greatest need.

The current method of determining DPA status via automatic application of MMM2-7 blankets means that of the 827 GP catchments across Australia, 700 (85%) now have DPA status. The almost universal view of submissions and consultations suggest DPA *in its current format* is no longer an effective distribution lever.

As a distribution lever DPA should be retained. However, fundamental reform of its calculation and application is proposed whereby the focus is on distributing GPs to areas of comparatively higher need, rather than only identifying areas of GP workforce shortage. GP catchment areas should be retained as the prime building block to establish DPA status. However, MMM should no longer be used to establish blanket rule exemptions.

Therefore, DPA status would not automatically apply to any location. In future, each GP catchment area would individually be accorded DPA/non DPA status.

An enhanced methodology is also proposed to calculate DPA status with an expanded range of input factors from the National Assessment Tool (NAT). This approach will provide a workforce need score for each GP catchment. The identification of an appropriate threshold (ie. those GP catchments not designated DPA compared to those designated DPA) requires more detailed analysis by the Department, together with the process to implementation.

This approach will enable a more transparent mechanism to assess DPA status and will also enable greater agility in recognising and adjusting changes to DPA status for any GP catchment.

As with DPA, the Review found significant issues with the construct of the **DWS** that are impacting its effectiveness and ability to direct IMGs to work in areas of need. There are too many areas within cities, and heavily populated centres outside these cities, that are classified as DWS. Like the issues that were noted in exemptions for Section 19AB, the construct of the DWS is resulting in a 'watering down' of its ability to adequately address workforce maldistribution.

Consultations with the Department highlighted a need to balance a more 'discipline-specific' approach to benchmarking areas of workforce shortage while minimising the administrative and data burden required to implement and update a future workforce shortage classification. In response, several changes are proposed as to how DWS locations are identified. Key changes include:

- a more nuanced approach to selecting specialties that are eligible for consideration as DWS. Rather than being based on a threshold with limited evidence, a broader range of considerations is proposed to identify which specialties should and should not be considered for DWS.
- defining DWS at Statistical Area (SA) 4 level rather than SA3. This will result in larger DWS catchments which is expected to provide a more robust measure of specialist access (consistent with the greater catchment areas typically required for non-GP specialists) and fewer boundary issues.
- updating the benchmark used to identify areas of workforce shortage to be based on the median Full-Service-Equivalent (FSE) per-capita, rather than comparing FSE to the national average. Further changes are recommended to use this benchmark to establish a system for 'grading' areas of workforce shortage to support the targeting of more positive distribution levers.

The **MMM** measures remoteness and population size using a scale of MMM categories MM1 to MM7 – whereby MM1 describes metropolitan areas and MM7 describes very remote communities.

MMM is used across at least 58 programs within DoHAC to guide program discussions. It is also used in several other government agencies such as NDIS. Generally, for these programs, stakeholders reported that a remoteness measure for ongoing policy planning is still needed and MMM is better than previous measures.

The findings of this Review do not support the continued blanket application of MMM to identify DPAs, favouring a more nuanced approach based on individual GP catchment areas.

As such, the use of MMM is not proposed for the ongoing application and usage of Sections 19AA, 19AB, DPA and DWS. It was beyond the brief of this Review to recommend any changes to the broader continued usage of MMM across other DoHAC programs.

The seventh term of reference of this Review states:

Consider and, where appropriate, make recommendations on alternative approaches to the Department for achieving the intent of the distribution levers.

A range of **complementary strategies** to the ongoing construct and application of Sections 19AA, 19AB, DPA and DWS are proposed. Some of these are longer term initiatives, but equally critical to sustaining an adequate health workforce which is distributed across Australia in an equitable way.

The first of these relates to developing a more appropriate balance between the domestically trained medical workforce and Australia's high dependency on IMGs. The maldistribution of doctors (by geography and specialty) is the main reason why the country imports around the same number of doctors from overseas as it graduates from Australian medical schools each year. International medical labour recruitment is, in effect, the country's longstanding 'temporary fix' for regional medical workforce shortage.

While IMGs are a critically important component of Australia's medical workforce both in primary care and hospital settings, as proposed in the *National Medical Workforce Strategy 2021-2031*, there should be identification of a national self-sufficiency target for the Australian Medical workforce which:

- guides a reduced dependency on IMGs, and
- identifies new training places which are specifically targeted to best address workforce shortages.

It is important that additional investment in domestic workforce training, together with any other workforce program investments are aligned and recognise existing institutional track records.

The development of national self-sufficiency targets should not focus solely on the medical workforce. Such targets are equally relevant to other primary care health professionals.

The recently released *Australian Government Migration Strategy* identified eight key actions, two of which are directly relevant to this Review:

- planning migration to get the right skills to the right places, and
- the prioritisation of visas for regional Australia.

There should be an enhanced mechanism established between the Department of Home Affairs (DoHA) and DoHAC to facilitate discussions between the two Departments on how these two actions can be implemented as they relate to the health workforce.

The synergy between this Review and the concurrent *Scope of Practice Review Issues Paper No.2*, which advocates an extension of blended funding mechanisms, will enable multi-disciplinary care teams to leverage and extend the existing workforce where members are able to work to full scope of practice collaboratively. Facilitating and incentivising the evolution of these multi-disciplinary teams is particularly important for those parts of Australia with persistent difficulties in attracting and retaining medical practitioners.

There is a need to building the capacity of the medical workforce to support teaching, training and research. Increased training dollars/support is proposed to be directed at both supervisors in training and the workforce receiving the training. The geographic allocations should be graduated by classification of relative need/remoteness. In addition to overall funding enhancements, facilitating entry of IMGs to existing programs is proposed.

Building the capacity of the primary care sector to support teaching, training and research is not limited to the medical workforce. A post-graduate program of training support is equally important for other primary care providers such as nurse practitioners, midwives and rural and remote area nurses.

Many of the recommendations in this Review will assist the ongoing viability of the 145 Aboriginal and Community Controlled Health Services (ACCHS) across Australia. As identified in the four priority reform areas of Closing the Gap, the Reviewers advocate the continual growth of the ACCHS sector across metropolitan, regional, rural and remote Australia.

Specific recommendations are as follows:

Governance:

Recommendation 1

The establishment of a small Health Workforce Independent Review Panel, with DoHAC as secretariat, is proposed to initially oversight the implementation regarding future arrangements for DPA/DWS/GP catchment methodologies and, in the longer term, to review appeals for a change to DPA status in the light of exceptional circumstances.

19AA:

Recommendation 2

Section 19AA should be retained to ensure training and practice standards, currency of knowledge and skills are maintained across all medical professions. The intent of Section 19AA should focus on the specialist registration of all medical practitioners who are Australian citizens or permanent residents, and who are seeking to access Medicare. This should include specialist registration and /or enrolment in a training program under Section 3GA.

Recommendation 3

The potential expansion of 3GA training programs to specific non-GP specialties with significant community-based practice should be assessed. Such an expansion will build upon the intent of Specialist Training Programs (STPs) to support specialist training rotations in settings outside of hospitals to broaden registrar experiences, particularly in areas of higher need.

Recommendation 4

Key performance indicators for GP training programs that demonstrate rural workforce outcomes during training and at 1,3 and 5-years post fellowship (or specialist registration) should be developed. These will provide insight into the effectiveness of rural training pathways and enable Commonwealth investment to be targeted and monitored.

Recommendation 5

Financial, professional and peer supports should be made available to all GP registrars- both Australian Medical Graduates (AMGs), and IMGs to match what is currently available under the Australian General Practitioner Training (AGPT) pathway, regardless of training pathway. This will provide the best opportunity for GP registrars to attain timely speciality registration.

Recommendation 6

Supervision of all GP training should be remunerated in line with the National Consistent Payment Framework and remote or blended (i.e. mix of remote and on-site) supervision models should be used to increase and sustain supervision capacity and capability in rural and remote areas.

19AB:

Recommendation 7

Section 19AB should be retained as it is widely considered to have mitigated the impacts of both domestically trained doctors and IMGs preferring to work in major cities. The objectives of Section 19AB should be clearly stated as only addressing medical workforce maldistribution.

Recommendation 8

Exemptions should be retained with some modification (see Section 3) that continue to be appropriate in meeting the objectives of Section 19AB should be retained. This includes retention of:

- Placement on a workforce training program
- 5 Years Overseas-Trained Doctor Scheme
- Commonwealth-funded Aboriginal and Torres Strait Islander primary health care services
- Competent Authority Pathway
- Movement Within Catchment.

Eligibility for several of the other exemptions to Section 19AB should be clarified and tightened, with robust definitions made publicly available and applied evenly for the following exemptions:

- Spousal
- Academic
- Locum
- After-Hours
- Assist at Operations
- Discretionary
- Replacement

The exemption categories, 'Specialty in acute shortage' and 'Prior Employment Negotiations' should be abolished as they will be redundant under the proposed changes to DWS.

Recommendation 9

The monitoring of exemption compliance should be enhanced. This will require shared responsibilities with Services Australia for systematic oversight. The proposed Health Workforce Independent Review Panel should be responsible for overseeing the assessment and approval of exemption applications to ensure independent and consistent decision-making.

Recommendation 10

The duration of moratorium requirements for IMGs under Section 19AB should continue to be 10-years, at least for the short-to-medium-term. To better incentivise IMGs to practise in areas of greatest need, there should be capacity for those IMGs who initially practise for a defined period in those areas to have a pathway and priority status to complete their 10-year moratorium in a DPA/DWS area of choice.

Recommendation 11

Training, supervision and support arrangements for IMGs subject to Section 19AB should be enhanced to improve the quality of care IMGs can provide in areas of need. Geographic allocation for training should be graduated to reflect differential areas of need.

Two specific initiatives are proposed.

- A Bridging Program should be developed for IMGs wanting to enter GP training and identified as requiring assistance.
- GP training places should be opened up to IMGs on temporary and or non-residency category visas once they have met College clinical requirements for entering training. Supervision of these IMGs be scaled appropriately for maximum support utilising on site and remote supervision models and developing a community of practice for the IMG.

DPA:

Recommendation 12

A distribution mechanism to aid in distributing the GP workforce (under Section 19AB) should be retained. A distribution lever is still required as maldistribution of the medical workforce – specifically GPs – remains an important issue. However, the DPA should focus on distributing GPs to areas of comparatively higher need (rather than only identifying areas of GP workforce shortage). This will prioritise the distribution of the finite pool of IMG GPs to the areas of most need across Australia.

Recommendation 13

The Department should move to progressively use the GP catchment area as the prime building block to establish DPA status. (as defined in Recommendation 14). MMM should no longer be used as a primary criterion for DPA status (i.e. remove all MMM blanket rules) and DPA status should not automatically apply to any location.

Recommendation 14

A new DPA classification methodology should be considered based on the existing National Assessment Tool (NAT), with consideration of additional indicators such as average distance and time from residential addresses to the nearest general practice. The new DPA threshold that determines whether a GP catchment has DPA status should be based on the NAT Workforce Need Score for GP catchments (calculated at a national level, not for each State/Territory). This approach will enable a simple and transparent mechanism to set the threshold for DPA status.

The Health Workforce Independent Review Panel should be used to assess any GP catchment anomalies that are not captured by the new DPA threshold.

Recommendation 15

Mechanisms should be incorporated to review DPA status annually. In addition, mechanisms to review applications for access to IMG workforce in areas without DPA status should be developed. This should be overseen by the proposed Health Workforce Independent Review Panel in collaboration with State and Territory Health Authorities, Primary Health Networks (PHNs) and local stakeholders.

Recommendation 16

Bonded Medical Program (BMP) Return of Service Obligation (ROSO) objectives will no longer align with DPA objectives and therefore, in future, should not be determined using DPA status. Instead, ROSO should align with the BMP intent which currently is regional, rural and remote areas.

DWS:

Recommendation 17

A modified form of the DWS should be retained as the approach to classifying workforce shortage for non-GP specialists. The objectives of the DWS should continue to focus on identifying areas where there are low levels of access to non-GP specialist medical care, to support Section 19AB. Current DWS objectives related to targeting incentives to improve access should also be retained and emphasised more strongly, to align with the widespread support for more positive levers to address workforce maldistribution. As with DPA (see Recommendation 16), DWS should no longer be used for determining locations for ROSO under the Bonded Medical Program.

Recommendation 18

A principles-based approach should be adopted to establish a revised and expanded list of specialties for inclusion in DWS and implement a process of regular (at least every two years) review of the list.

Recommendation 19

SA4 should be adopted as the geographic catchment to define the DWS classification.

- Blanket inclusion rules for Remoteness Area (RA) 3-5 locations should be retained in the DWS classification.
- FSE per-capita should continue to be used as the measure for defining DWS locations as it provides the most reliable and robust measure of access to non-GP specialist services across Australia.
- A more nuanced methodology based on the median FSE per capita is recommended as the basis for identifying areas of workforce shortage. Different benchmarks should be applied to metropolitan and non-metropolitan areas to establish severity 'gradings' for workforce shortage that would be used to inform incentives and moratorium scaling credits.

Complementary Strategies

Recommendation 20

As first proposed in the *National Medical Workforce Strategy 2021 – 2031* there should be a national self-sufficiency target for the Australian medical workforce. Such a target will guide the progressive reduced dependency on IMGs, coupled with growth in domestic medical school places targeted to best address current shortages. DoHAC should progress this as a priority.

Recommendation 21

Any alteration to the cap for medical student places to better align medical training numbers to regional shortages should also consider the workforce needs of other health professionals.

Recommendation 22

A program of post-graduate training and support for other primary care providers including remote and rural nurses, midwives and nurse practitioners, in areas of need, should be developed.

Recommendation 23

Discussions should occur between DoHAC and the Department of Home Affairs to enable best implementation of those recommendations arising from the *Australian Government Migration Strategy* which pertain to migration of health professionals.

Recommendation 24

The revised, more nuanced application of the DPA distribution levers to better identify and incentivise medical practice in areas of workforce shortages should be used to prioritise locales for implementation of the recommendations arising from the *Scope of Practice Review*.

Recommendation 25

The strategies to achieve more equitable distribution of doctors and other health professionals across Australia should align with the *National Agreement on Closing the Gap* and its four Priority Reform Areas. These strategies should thus concur with the Priority Reform Area for continued growth and support for ACCHS.

Recommendation 26

IMGs who have met the training requirements for AGPT Level 2 supervision should be eligible to take up unfilled funded training positions in the Aboriginal Health sector.

1. Introduction

Context to the Review

The “*Strengthening Medicare Taskforce Report*”, released in December 2022, outlined a vision for Australia’s primary care sector. The report recommended significant reforms to how primary care is funded and delivered in Australia.

As one part of the Strengthening Medicare reforms, on 21 November 2023 Minister Butler announced the “*Working Better for Medicare Review*.”

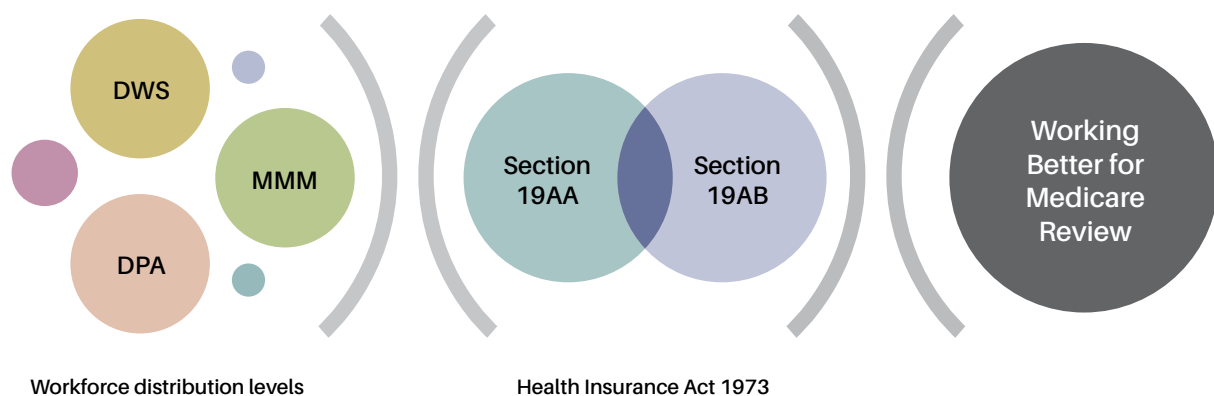
The “*Working Better for Medicare Review*” should be read in conjunction with other Strengthening Medicare reform measures and ongoing reviews that fall under the auspices of the *Strengthening Medicare Implementation Oversight Committee*. The Committee is Co-Chaired by the Department’s Deputy Secretary, Primary and Community Care Group and Deputy Secretary, Health Resourcing Group, with membership including a range of primary care stakeholders across nursing, medical, allied health, First Nations, States and Territories, consumers, and academics.

The intent of this Review was to examine and recommend changes to:

- Sections 19AA and 19AB of the *Health Insurance Act 1973*
- Distribution Priority Area (DPA) classification
- District of Workforce Shortage (DWS) classification, and
- The Modified Monash Model (MMM) classification.

Government uses this legislation and distribution mechanisms to direct health professionals to areas of greatest need across Australia and to better target health workforce programs.

Figure 1.1: Workforce legislation and distribution mechanisms



Sections 19AA and 19AB were part of a single amendment bill to the Health Insurance Act 1973, introduced by the Australian Government in 1996. DPA and DWS are the levers that articulate where IMGs can work, while MMM is a remoteness classification system, which is also used as a lever through application of blanket rules for DPA status. These could all be described as negative distribution levers that achieve their impact by restricting practice in contrast with other 'positive levers' which aim to incentivise practice in certain locations.

For the purposes of this report, International Medical Graduates (IMGs) include both Overseas Trained Doctors (OTDs) and Foreign Graduates of an Accredited Medical School (FGAMS).

This Review is designed to consider several aspects of the distribution levers (see page 3) and their interplay with each other, including:

- Confirming the original objectives of the distribution levers.
- Evaluating the appropriateness and robustness of the assumptions underpinning the distribution levers.
- Considering and reporting on the value of retaining the distribution levers.
- Assessing the alignment of distribution levers with current health workforce policies and priorities.
- Identifying key factors and barriers impacting appropriateness and effectiveness.
- If appropriate, identifying opportunities to improve the operation of the distribution levers in achieving current health workforce policy objectives.
- Consider and where appropriate make recommendations on alternative approaches to the Department for achieving the intent of the distribution levers.
- Identifying the future role for distribution levers.

Review Process

Professor Sabina Knight, Director, James Cook University Central Queensland, Centre for Rural and Remote Health and Adjunct Professor Mick Reid, Principal, Michael Reid and Associates, were appointed as Independent Lead Reviewers (Reviewers) to lead and coordinate the Review work streams and deliver this Report.

The Reviewers initially worked with the Department of Health and Aged Care (DoHAC) staff to engage two consulting firms to address aspects of the Review. These firms are:

- **Healthcare Management Advisors (HMA):** Engaged to undertake the Review of Section 19AA of the *Health Insurance Act 1973*, and the Distribution Priority Area (DPA) mechanism and
- **HealthConsult:** Engaged to undertake the Review of Section 19AB of the *Health Insurance Act 1973*, and the District of Workforce Shortage (DWS) mechanism.

In addition, HMA engaged the Centre for Australian Research into Access (CARA) at Deakin University to assist in the analytics regarding MMM.

The consulting firms, the Department of Health and Aged Care (DoHAC) and the Reviewers have worked together collaboratively in collectively undertaking consultations, data identification and endeavouring to ensure there are no internal inconsistencies in approaches.

The consulting firms submitted their final reports to DoHAC on 15 May, 2024. The reports of both HMA and HealthConsult have been incorporated into this Report.

With the assistance of DoHAC, the Reviewers and Consultants organised initial consultations with 30 key external stakeholder groups from 4-6 March to gain inputs on the Review. They have since consulted with more than 150 key stakeholders.

Internal stakeholder engagement was undertaken within DoHAC, with the Consultants meeting with many internal stakeholders to capture insights and perspectives on how the distribution levers are utilised across several departmental programs. Similar meetings were held at State /Territory jurisdictional level, both individually and collectively. The Reviewers interviewed numerous peak bodies including Primary Health Networks (PHNs), Aboriginal Community Controlled Health Services (ACCHS), consumer groups, Health Colleges and other professional groups and jurisdictional officials. Visits were made by the Reviewers to Western Australia, Northern Territory and Queensland.

Meetings have also been held with the Lead Reviewers of the concurrent *Scope of Practice Review*, *Reviews of General Practice Incentives and Primary Care After Hours Programs*.

A full list of stakeholder consultations held may be found at *Attachment 1* of this Report.

As part of the Review, a stakeholder survey was undertaken by Heartward Strategic via the DoHAC website online between 22 January and 18 March to gain inputs on the Review. A total of 296 submissions were completed and received, of which:

- 84 came from health professionals
- 86 came from organisations, and
- 93 came from the general public.

An additional 41 written submissions have also been received.

Two workshops, facilitated by the Reviewers, were held with the Consultants, Reviewers and an Expert Advisory Panel on 22 April and 16 May, 2024. This group discussed the preliminary findings arising from the Interim Reports submitted by the consultancy firms and it proved extremely valuable in challenging and reforming some ideas and suggesting a change of direction for others.

The contribution of the DoHAC personnel supporting the *Working Better for Medicare Review* is acknowledged by the Reviewers. The completion of this complex report would not have been possible without the extensive Departmental assistance.

The following Sections review and make recommendations on 19AA, 19AB, DPA, DWS and MMM. Section 7 examines a range of strategies which would complement those specific to the distribution levers and legislation.

Current Status

The *intent* of the existing DPA/DWS/MMM levers to better distribute general practice and other medical specialties to areas of need, remains relevant today.

However, as highlighted in the following Sections, the current mechanisms by which DPA/DWS/MMM are applied have not, and will not, best achieve the intent of the distribution levers.

For example, the ease of exemptions to DPA coupled with blanket application of DPA across MMM2-7 whereby 700 of the 827 GP catchment areas across Australia are currently DPA, renders DPA in its current form a weak distribution lever.

This weakness is demonstrated in *Table 1.1* (below) which shows limited changes from 2018 to 2023 in rectifying maldistribution of GP workforce per 100,000 population across MMM locations.

Table 1.1: GP FTE per 100,000 population across MMM locations 2018 & 2023

Location	2018	2023	Growth
MM1	117.6	115.2	-0.4%
MM2	110.5	109.9	-0.1%
MM3	126.3	125.7	-0.1%
MM4	130.1	127.0	-0.5%
MM5	77.2	78.2	0.3%
MM6	79.8	68.1	-3.1%
MM7	70.6	70.7	0.0%

Source: DoHAC Health Workforce Primary Care GP statistics by calendar year

With regard to DWS, as elaborated in Section 5, data analysis suggests that while some of the intent of DWS has been achieved, the formula by which DWS is calculated results in many areas of major cities, and large areas outside of major cities who can readily access specialists, being classified as DWS.

DWS relates to eight medical specialties, although the rationale by which these particular specialties were identified, lacks evidence.

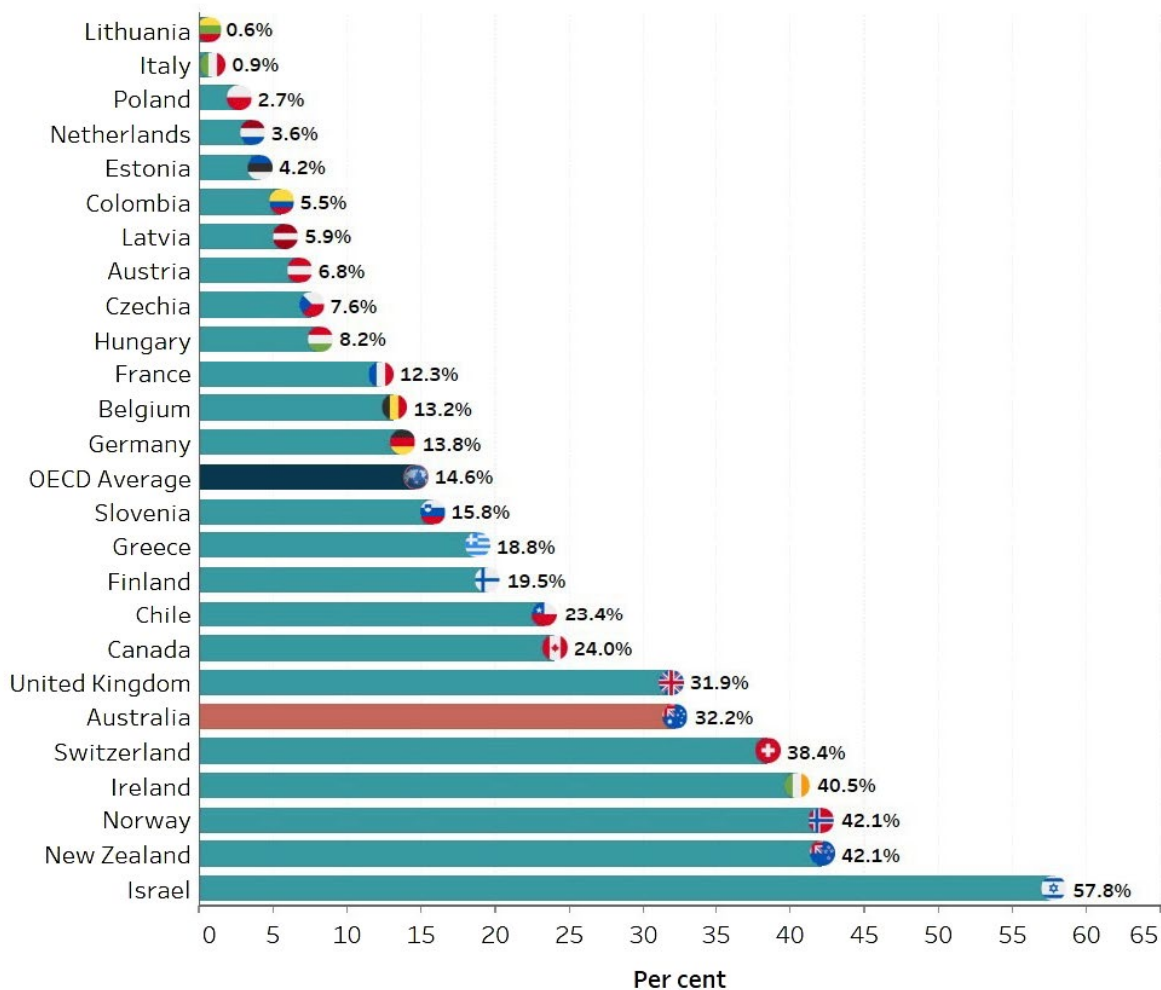
While there is a rationale for retaining 19AA and a modified 19AB, fundamental reform is proposed for DPA and DWS, coupled with a reappraisal of the usefulness of MMM for DPA purposes.

The Health Insurance legislation and distribution levers guide how IMGs can work in Australia. As shown in *Figure 1.2*, Australia has a high dependency on IMGs.

It is currently ranked sixth highest of 38 countries in the Organisation for Economic Co-operation and Development (OECD) for the percentage of IMGs.

As demonstrated by COVID, this high dependency on IMGs presents a significant risk to workforce domestic availability.

Figure 1.2: Proportion of IMGs by OECD Country, 2021



Source: OECD 2023

Notes: 25 of the 38 OECD countries reported on overseas trained doctors in 2021. The percentage of overseas trained doctors for Greece was calculated by AIHW.

Governance

Under the present arrangements, there is a Distribution Working Group (DWG) whose terms of reference are to provide independent advice to DoHAC and the Minister for Health and Aged Care on:

- Policy and program directions aimed at rebalancing the equitable distribution of the Australian medical workforce geographically.
- Requirements for tools and programs to promote equitable distribution of the medical workforce nationally, which may include health-related geographical classification (e.g. the Modified Monash Model, Distribution Priority Area indicator, District of Workforce Shortage indicator and GP Catchment methodologies), guidelines that contribute to distribution (e.g. section 19AB legislative guidelines)
- Other relevant issues identified by the Minister or Department related to medical workforce distribution.

The DWG comprises between 9 and 12 members, with composition determined by the Department and drawn from workforce experts, peak bodies representing the health workforce, the National Rural Health Commissioner, the Department, and independent medical advisers.

The Assistant Secretary of DoHAC Chairs the DWG and current membership consists of representatives from:

- Australian College of Rural and Remote Medicine
- Australian Medical Association
- Council of Presidents of Medical Colleges
- Lowitija Institute
- National Rural Health Alliance
- National Rural Health Commissioner
- Royal Australasian College of Medical Administrators
- Royal Australian College of General Practitioners
- Rural Doctors Association of Australia
- Consumers Health Forum of Australia.

The DWG has made a significant contribution to health workforce policy and program directions and the capacity for this broad policy advice by DWG should be sustained and enhanced.

As part of their current role, the DWG examines and recommends on appeals to DPA status which are submitted by individual practices within non-DPA GP catchment areas. The Reviewers believe that this should not be a function of the DWG.

A more agile structure comprising a small panel of independent experts, a Health Workforce Independent Review Panel, is proposed. As with the DWG, this Panel would be serviced by DoHAC and make determinations based on DoHAC advice. The terms of reference for this Panel would include:

- Assess data inputs for determination of GP catchment methodologies.
- Based on these GP catchment methodologies, assess the criteria for determination of DPA/non DPA status.
- Assess data inputs to DWS calculations.
- Review exceptional circumstances (normally submitted by an individual GP practice) within a defined variation from the agreed threshold to determine DPA/non DPA status. Capacity for review should be set at a small variation from this agreed threshold.
- Assess whether this exceptional circumstance warrants adjustment of the total GP catchment area.

The Reviewers believe the Health Workforce Independent Review Panel should not replace the broad policy advice the DWG is structured to provide. Rather, it will be more operationally involved. If this proposal is accepted, a review of the existing terms of reference of the DWG would be appropriate.

Recommendation 1

The establishment of a small Health Workforce Independent Review Panel, with DoHAC as secretariat, is proposed to initially oversee the implementation regarding future arrangements for DPA/DWS/GP catchment methodologies and, in the longer term, to review appeals for a change to DPA status in the light of exceptional circumstances.

2. Section 19AA

Background

Section 19AA requires doctors who are permanent residents or citizens of Australia to have completed (achieved specialist registration) or be undertaking vocational training with a recognised speciality College, registered under Division 6 of the Health Insurance Regulations 2018 (Regulations), to access Medicare benefits. Medical practitioners must hold specialist registration with:

- Royal Australian College of General Practitioners (RACGP)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Specialist Colleges (accredited with the Australian Medical Council).

Section 19AA applies to every medical practitioner who registered to practise medicine in Australia on or after 1 November 1996. There are no exemptions to Section 19AA. Under Section 3GA of the Act, several training programs allow non-vocationally recognised doctors to access the higher-level A1 Medicare benefits while they work towards their qualification. These programs are:

- ACRRM Independent Pathway
- Australian General Practice Training Program
- Remote Vocational Training Scheme
- RACGP Practice Experience Program:
 - Practice Experience Program Standard Stream (closed to new applicants)
 - Practice Experience Program Specialist Stream (remains open)
 - RACGP Fellowship Support Program
- ACRRM Rural Generalist Training Scheme.

Section 3GA also allows non-vocationally recognised doctors who do not have specialist registration to access Medicare benefits (non-VR items only) through an approved program, at an eligible location for a defined period. These Section 3GA workforce programs include:

Current programs:

- Approved Medical Deputising Services Program
- More Doctors for Rural Australia Program. (Note that this program will be replaced with the Pre-Fellowship Program in early 2024).

Available to current participants but closed to new applicants:

- Temporary Residents Other Medical Practitioners Program.

These programs aim/ed to assist workforce distribution and support the provision of care in areas classified as MM2-7 and DPA-eligible locations.

Currency of original objectives

The original intent of Section 19AA stemmed from a potential oversupply of GPs accessing Medicare with no regulatory oversight or recognition of vocational competency.

The original intent of Section 19AA was to:

- recognise General Practice as a discrete medical discipline requiring specialist postgraduate qualifications
- place private general practice and other specialities within a professional framework to ensure currency of knowledge and skills
- contain supply-driven cost pressures on the Medicare Benefits Schedule (MBS) by reducing the number of doctors working in general practice⁵.

Specialist registration requirement

Stakeholders strongly agreed that the underlying requirements for vocational training, resulting in a specialist postgraduate qualification, remain important quality and safety requirements for general practitioners and non-GP specialists. While specialist registration alone does not guarantee the quality and safety of a practitioner's services, holding and maintaining vocational recognition assumes a base skill level. It requires medical practitioners to access continuing professional development.

For medical practitioners, completing specialist registration is a recognised qualification among peers, other practitioners, and patients. The specialist registration is a nationally recognised and portable qualification. It also offers a variety of employment options, including salaried, contract, and business ownership.

Australia relies heavily on IMGs to meet workforce shortages, particularly in rural and remote areas; consultations and written submissions for the *Working Better for Medicare Review* focused heavily on this workforce. At the same time, there was a strong call for ongoing, strengthened, and targeted efforts to grow the Australian medical workforce through integrated and coordinated regional training networks. This is discussed more fully in Section 7.

5 DoHAC. Quality and Distribution of the General Practice Workforce - Impact of ss19AA and 19AB

A view proposed by a small minority of stakeholders suggests that removing the requirement for vocational recognition could allow suitably experienced doctors who do not wish to follow a vocational path to work within general practice and access Medicare within appropriate supervision arrangements. However, there was strong opposition to this approach for various reasons, including creating a 'second class' of GPs, questions around the scope of practice for those doctors, and the potential for additional supervision burden on Vocationally Recognised (VR) GPs.

Finding

The original intent of Section 19AA, to require medical practitioners to hold specialist registration or be enrolled in a training program towards specialist registration, remains current.

Supply-driven cost pressures on MBS

At the time 19AA was introduced, there had been a rise in medical expenditure by 81.5% per capita over the preceding two decades (compared with an increase of 40.4% in real annual GDP per capita). The medical workforce (GP and non-GP specialties) had more than doubled (from 21,150 practising clinicians in 1976 to 44,000 in 1996) compared with a population growth of 30% in the same timeframe.^{6,7} This represented an increase of nearly 60% in the number of medical practitioners per 100,000 population.

The introduction of 19AA was one of many measures designed to curb the oversupply of the medical workforce and restrict rising MBS costs. Other measures included limits to Commonwealth Supported Places for medical students, a reduction in the number of GP training places (both of which have since been reversed) and, in 2013, an introduction of a freeze on MBS indexation. This was in place until 2017, with a phased lifting until 2020.

GP headcount⁸ per 100,000 population has increased from 105.4 to 114.8 from 1996 to 2022. GPs represent 28.7% of the medical workforce overall, down from 40.5% in 1996 (*Table 2.1*). While this suggests Section 19AA effectively helped reduce the then perceived oversupply of GPs, current challenges in population health needs, GP supply, and maldistribution remain to be addressed.

6 Australian Medical Workforce Advisory Committee, AIHW, *Medical Workforce Supply and Demand in Australia: a discussion paper*, 1998.

7 Australian Medical Workforce Advisory Committee, AIHW, *Australian Medical Workforce Benchmarks*, 1996.

8 Headcount was analysed to ascertain the actual number of GPs as a measure of interest in general practice as a speciality.

Table 2.1: Changes in the medical workforce between 1996 and 2022

Profession	1996			2022		
	Headcount	Per 100,000	% medical workforce	Headcount	Per 100,000	% medical workforce
GPs	19,293	105.4	40.5%	30,759	114.8	28.7%
GP Trainees	1,223	6.7	2.6%	6,967	26.0	6.5%
Non-GP specialists	15,744	86.0	33.0%	39,582	147.7	37.0%
Non-GP specialist trainees	4,451	24.3	9.3%	18,736	69.9	17.5%
Other medical workforce	7,624	41.7	16.0%	21,664	80.8	20.2%
Total medical practitioner (practising clinicians)	47,682	260.6	100.0%	107,057	399.5	100.0%

Sources: Medical Labour Force data from the Australian Institute of Health and Welfare and Health Workforce Statistics provided by the Department.

Finding

Section 19AA's other original intent to contain supply-driven cost pressures on the MBS is irrelevant now, given the current challenges in population health needs, GP supply and maldistribution.

Effectiveness

The sections below explore the effectiveness of Section 19AA in promoting the uptake and successful completion of vocational training programs to achieve specialist registration.

Uptake of vocational training

The requirement for specialist registration sets a standard against which to practice and is a precursor to driving quality care. Data suggest that Section 19AA has promoted the uptake of vocational training for medical practitioners seeking to access the MBS.

Non-GP specialists

The number of non-GP specialists on vocational training pathways increased by 15% from 2013 to 2022 (*Figure 2.1*). The number of Australian Medical Graduates (AMGs) on non-GP specialist training pathways has continued to increase over the last several years.

The number of both AMGs and IMGs declined on non-GP specialist training pathways in 2019. The reduction in AMGs on non-GP specialist training pathways may be attributed to several factors, including control of Commonwealth-supported training positions in universities and the rise in hospital non-specialists.

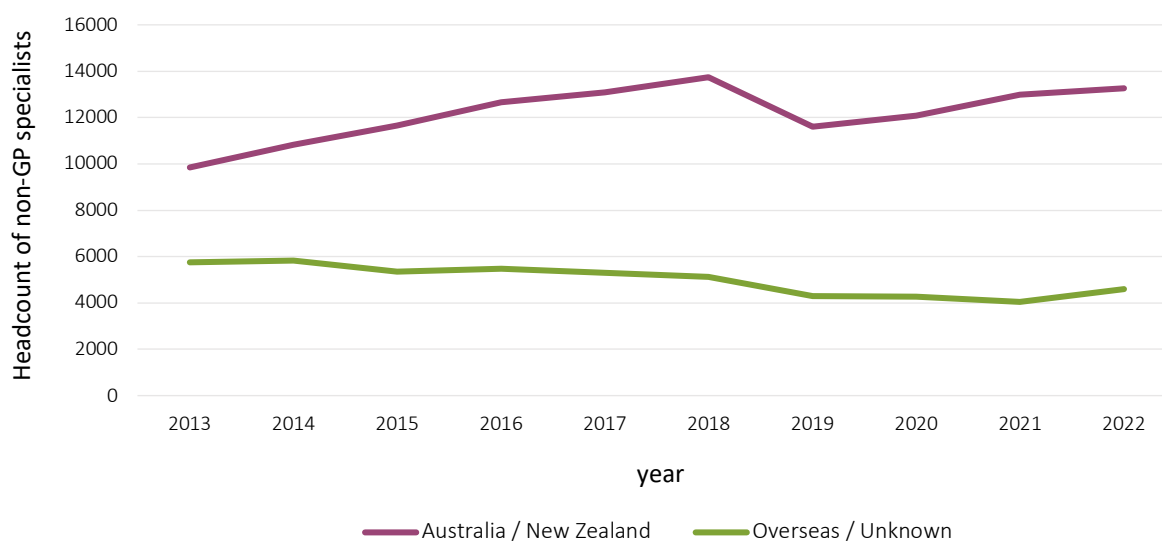
Anecdotally, there is a cohort of medical practitioners who have been in non-accredited specialist hospital positions for extended periods and are attempting to gain entry to specialist streams such as surgery or anaesthetics.

The decline of IMGs on vocational training pathways in 2019 may be attributable to the 2018 temporary skilled visa program changes, which made it more difficult for visa holders to stay permanently in Australia. However, a new Priority Migration Skilled Occupation List introduced in 2020 during COVID-19 has reversed this decline as it includes GPs, Resident Medical Officers, Psychiatrists, and Other Medical Practitioners. COVID-19 and temporarily reduced the intake of IMGs.

The 'Stronger Rural Health Strategy' policy initiative introduced the Visas for GPs program in 2019 and aimed to regulate the number of IMGs entering Australia. This program ended in September 2023.

Finding

The number of medical practitioners on non-GP specialist training pathways has increased overall over the last decade. The influence of Section 19AA is likely to be low given that non-GP specialist registrations were established prior. However, the number of IMGs on non-GP specialist pathways has decreased overall, likely attributable to visa program changes and COVID-19.

Figure 2.1: Non-GP specialists in vocational training from 2013 to 2022

Source: Non-GP specialist workforce statistics, Department of Health and Aged Care 2024

GPs

Section 19AA has promoted the uptake of vocational training for general practice, with 89% of doctors working in general practice in 2023 being vocationally recognised (VR) or in training in 2023, compared with 75% in 2000. In 2023, of the 48,768 doctors working in general practice, 36,967 were VR (76%), 5,285 were non-VR (11%), and 6,516 were in training (13%). This is a notable change since 2000, when of the 26,900 doctors working in general practice, 18,701 were VR (70%), 6,894 were non-VR (26%), and 1,305 were in training (5%). *Figure 2.2* shows the change in proportions of VR GPs, non-VR GPs, and GP trainees in Australia from 2000 to 2023 (based on headcount).

Table 2.2: Health workforce by profession (headcount)

Principal job area	2018		2022		CAGR*
	n	%	n	%	%
GP	30,066	30.6%	31,926	28.5%	1.5%
Hospital non-specialist	10,759	10.9%	14,260	12.7%	7.3%
Specialist	33,303	33.8%	39,582	35.4%	4.4%
Specialist-in-training	16,916	17.2%	18,736	16.7%	2.6%
Other clinicians	2,560	2.6%	2,553	2.3%	-0.1%
Non-clinician	4,791	4.9%	4,851	4.3%	0.3%
Total	98,395	100.0%	111,908	100.0%	3.3%

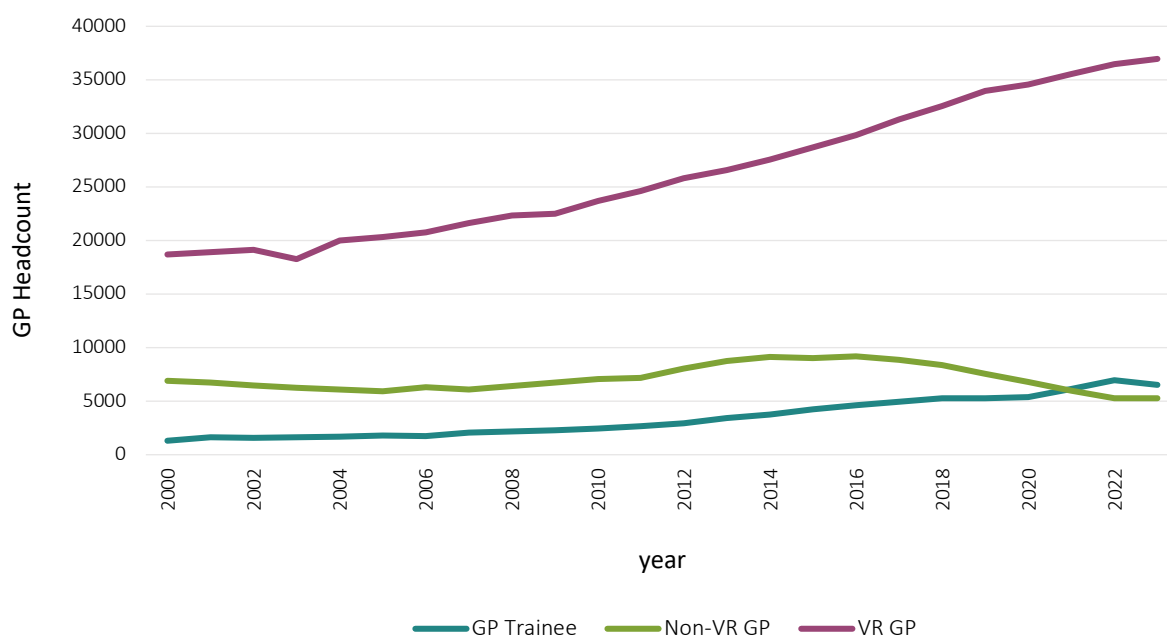
Source: Health Workforce Data: Summary by Medical Profession. *CAGR = Compound Annual Growth Rate

Selection of General Practice as a career path

As shown in *Table 2.1*, the structure of the medical workforce has changed since the introduction of Section 19AA in 1996, with GPs now representing a smaller proportion of the medical workforce than non-GP specialists. While non-GP specialists have remained stable (ranging from 33% to 37% of the medical workforce), the non-GP specialist trainee workforce has nearly doubled as a proportion of the workforce (9.3% to 17.5%) between 1996 and 2022.

Although the number and proportion of GP trainees as a percentage of the workforce has also increased over this period, it is only a third of non-GP specialist trainees (*Table 2.1*).

Figure 2.2: Proportion of GPs by VR status over time



Source: GP workforce statistics, Department of Health and Aged Care. Headcount based on at least one MBS service.

Finding

Section 19AA has promoted the uptake of vocational training for general practice. In 2023, 89% of doctors were either vocationally recognised or in training, compared with 75% in 2000.

The Medical Schools Outcomes Database (MSOD) surveys final year students enrolled in Australian medical schools, asking about their background, medical school experience, and any early preferences for their future careers.

Although General Practice is consistently in the top three specialisations' preference, the percentage of students wanting to pursue this path has steadily decreased from 17% in 2013 to 13.1% in 2021.

However, an additional 5.8% (ranked 8th) nominated Rural Generalist as their highest preference in 2021 (this option has only been available since 2020)⁹.

MSOD data also identify that over time, the top five factors influencing students' choice of career pathway have been:

- atmosphere/work culture
- alignment with personal values
- experience of specialty as a medical student
- intellectual content
- general medical school experiences.

The least influential factors are consistently reported as:

- partners' occupation
- parents/relatives
- financial costs of medical school education and/or debt.

The *2022 Australian Health Practitioner Regulation Agency (AHPRA) Medical Training Survey*¹⁰ showed that 16% of interns and 15% of prevocational and unaccredited trainees intended to pursue general practice training. It also showed that 10% of interns and 9% of prevocational unaccredited trainees were undecided about their career choices.

The findings of these two surveys suggest a potential scope to influence this cohort's decisions about a career in general practice through their undergraduate education and early career experiences.

Finding

There is a potential opportunity to influence career path decisions early on in undergraduate medical education and prevocational experiences

9 Medical Dean Australia and New Zealand, "Medical Schools Outcomes Database Report," 2023.

10 <https://www.medicaltrainingsurvey.gov.au/>

Non-vocational pathways

As shown in *Table 2.2* a growing number of Australian-trained doctors are not currently on or choosing vocational training pathways: 10,759 doctors in 2018 (10.9% of the total employed medical workforce), increasing to 14,260 (12.7% of the total medical workforce) in 2022. This represents a compound annual growth rate (CAGR) of 7.3% compared with 1.5% for general practitioners, 4.4% for specialists and 2.6% for specialists in training. The hospital non-specialist group is quite heterogeneous, including doctors:

- not completing or re-appraising training options
- waiting to get into the specialty of choice
- electing to work in mid-level positions in hospitals
- undertaking locum and temporary hospital roles
- leveraging the growing reliance on locums – where the demand for well-paid and discontinuous job options offering autonomy and flexibility
- potentially dissatisfied with training pathways
- prioritising a balance of work life and family life.

The growth in the hospital non-specialist workforce presents opportunities for general practice and other non-GP specialities currently experiencing workforce challenges to explore flexibility to enter training and recognition of prior learning for entry into training.

Finding

The observed rise in the hospital non-specialist workforce may be influenced by 19AA restrictions on MBS access without specialist registration. Further research into why this cohort is not selecting a vocational training pathway is warranted to understand why they are not and what would encourage them to consider a career in general practice or other non-GP specialist areas in a workforce shortage.

Section 3GA training programs

Section 3GA training programs allow non-vocationally recognised doctors to access the higher-level A1 Medicare benefits while they work towards their GP qualification.

It should be noted that general practice is the main specialty where registrars can access Medicare during training, and the only speciality with training programs currently registered under Section 3GA of the Act. Specialties including psychiatry, dermatology and rheumatology undertake a large proportion of work in private practice. Specialist College stakeholders indicated that expanded access to Medicare for these registrars would enhance training opportunities, particularly in rural and regional areas where Consultants usually work across public and private sectors.

However, the Commonwealth-funded Specialist Training Program (STP) may be best suited to enable training opportunities in rural and regional areas and private settings (i.e. specialist consulting rooms). The STP provides a Private Infrastructure and Clinical Supervision allowance of \$30,000 for training positions in a private sector setting. It also funds an additional \$25,000 Rural Support Loading allowance for training positions in regional, rural and remote areas.

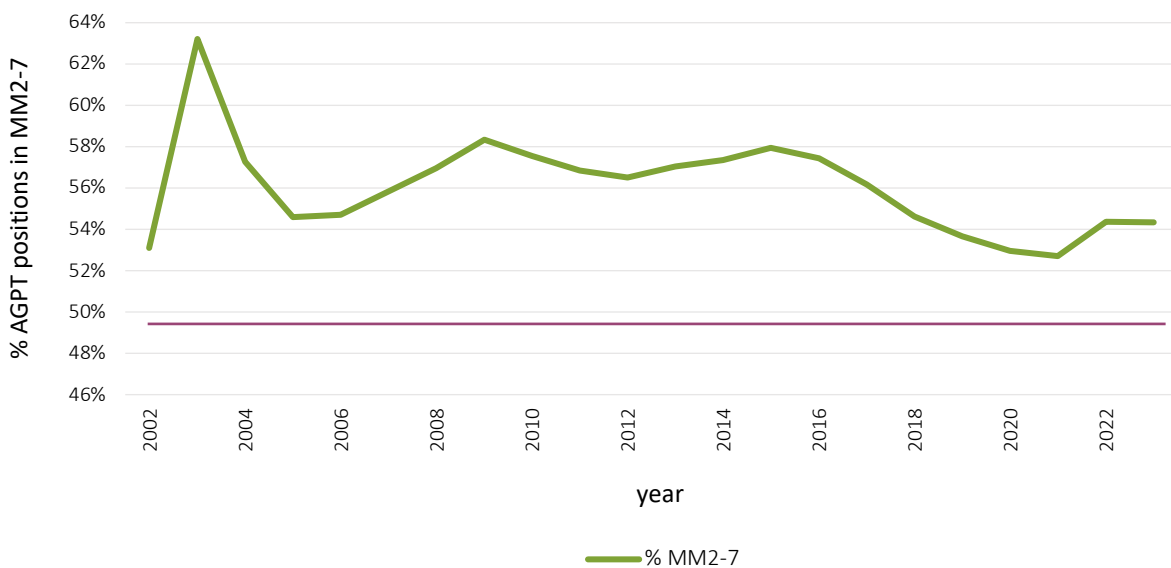
Effectiveness as a distribution lever

The Section 3GA training programs are intended to influence workforce distribution through specific training program guidelines and intersection with Section 19AB for IMGs.

Under the Commonwealth-funded Australian General Practice Training (AGPT) Program, there is an annual allocation of 1,500 trainees, and 50% are required to undertake their vocational training in regional, rural, or remote areas under the rural pathway (MM2-7). Of the 1,350 places managed by the RACGP, 600 were allocated to the rural pathway (MM2-7) and the remaining 750 to the general pathway. ACRRM manages 150 AGPT places annually, all of which are rural pathways. The RACGP general pathway requires 12 months (as two six-month rotations) of the three-year program to be completed in an outer metropolitan, rural or non-capital city location, determined by regional training and workforce location requirements and/or Aboriginal Community Controlled Health Services (ACCHS, which may be in a metropolitan area).

Between 2002 and 2023, over 50% of registrars completing an AGPT training position were in an MM2-7 location (Figure 2.3). AGPT registrars have decreased in all MMM areas except MM2 over the last five years (Appendix A).

Figure 2.3: Proportion of AGPT registrars in MM2-7



Source: GP workforce statistics, Department of Health and Aged Care 2024. Headcount based on at least one MBS service.

Several GP workforce training programs registered under Section 3GA have been rolled out over the last 20 years with varying intent and eligibility. All programs stipulate training locations within MM2-7, including more remote streams (MM4-7).

The Commonwealth-funded ACRRM Rural Generalist Training Scheme has an annual allocation of 100 places for AMGs and IMGs. Training occurs in ACRRM-accredited training posts (predominantly MM2-7) with some advanced skills training in metropolitan areas when required.

The Commonwealth-funded Remote Vocational Training Scheme (RVTS) intersects Section 19AA and Section 19AB, and registrars training with the RVTS can pursue specialist registration with RACGP or ACRRM. RVTS offers two training streams: the Remote stream (22 places per year) and the Aboriginal Medical Service stream (10 places per year). The remote stream requires registrars to be working in MM4–7.

The RACGP Practice Experience Program-Standard Stream commenced in 2019 as a pilot program offering 400 non-VR doctors a partially funded, self-directed education program to support their progress to specialist registration of the RACGP. This program has ceased taking applications. This program was available to applicants holding Australian citizenship, permanent or temporary residency. Under this program, applicants required general, provisional, or limited registration with the Australian Medical Council (AMC). The applicant needed a practice position accepted by the RACGP, located in MM2–7, and had to meet practice location requirements where the applicant was subject to Section 19AB. Approximately one-third of Practice Experience Program (PEP) positions were in an MM1 area. This is likely attributable to exemptions under Section 19AB.

Table 2.3: PEP training positions by MMM between 2019 and 2023

PEP	2019	2020	2021	2022	2023	5 Year Average	%
MM1	82	147	130	99	69	105.4	33%
MM2	36	113	112	71	27	71.8	22%
MM3	31	97	97	72	34	66.2	20%
MM4	16	73	68	NP	NP	31.4	10%
MM5	NP	93	85	51	18	49.4	15%
MM6	NP	NP	NP	NP	NP		
MM7		NP	NP				
Total	165	523	492	293	148	1,621	100%

Source: Non-GP specialist workforce statistics, Department of Health and Aged Care 2024. data is based on the number of providers who provided services while on a 3GA program, with a monthly derived major speciality as a GP while providing the service. NP = Not published.

The RACGP Fellowship Support Program (FSP) commenced in 2023 and replaced the Practice Experience Program—Standard Stream. It is a self-funded program. Applicants must have Australian citizenship or permanent or temporary residency and general, provisional, or limited registration. Training must occur in MM2–7. Training location data was not available at the time of this report.

Conversely, 95% of current training locations for registrars on the ACRRM Independent Pathway are located in MM2–7 (80% are located in MM3–7). In addition, the average time to specialist registration from the IP is 3.6 years, on par with doctors in the AGPT pathways.

Findings

- The AGPT program is distributing training positions as per the Commonwealth funding guidelines (50% in MM2–7 areas). However, the majority of AGPT registrars in non-metropolitan areas are located in MM2–3 (53% of non-metropolitan registrars, or 29% of all registrars). Continued maldistribution of the GP workforce suggests there is potential for stronger direction from the Commonwealth with initiatives to support training and supervision.
- Exemptions under Section 19AB has undermined the intent of Section 3GA workforce programs to distribute registrars outside of MM1 areas.

Rural retention post-specialist registration

The effectiveness of 3GA training programs as a distribution lever can be considered in terms of workforce retention in both the short term (as discussed above) and the medium term.

Consultations indicated that while the AGPT rural stream provides rural training places, it may not necessarily create a training pathway within a rural region to create the necessary environment for retention. Rural retention has not been measured for training programs targeted to IMGs (PEP and FSP), and stakeholder advice is that IMGs are more likely to move to metropolitan locations when they complete their moratorium requirements.

We know that 19AB is limited, and it loses workforce after it finishes. [There is a] constant throughput of IMGs through the bush.

Stakeholder consultation

Currently, the Colleges or the Workforce Planning and Prioritisation Program Organisations (WPPPOs) are not required to report on rural workforce retention. That said, ACRRM has analysed rural retention rates of all rural AGPT trainees, demonstrating that over 80% of ACRRM trainees worked rurally after five years compared with 42% of all rural trainees (*Table 2.4*).

Table 2.4: Rural AGPT trainee retention rates post-specialist registration

Years after specialist registration	all rural AGPT trainees	ACRRM AGPT trainees
1 year	57%	91%
3 years	45%	89%
5 years	42%	82%

Source: ACRRM Factsheet: Grow the Rural Generalist workforce as a rural healthcare solution

On average, RVTS doctors are estimated to have worked in their location for 1.6 years before joining the training program. With an average time to specialist registration of 3.6 years, retention in a community can total 5.2 years in the same practice when program time is considered. Findings from the recent evaluation of the RVTS report:

- 49% of the cohort remains at the same practice one year after completing the program
- 58% stay in the same region
- 61% stay within an MM4-7 location
- longer term it was found that the proportion working in MM4-7 after this time was around 30%.

Finding

Assessment of the effectiveness of 3GA training programs to promote workforce distribution and retention is not routinely measured or reported.

Time to specialist registration

Time to specialist registration can be one measure of the efficiency of a training program. Within the AGPT program, differences in program length must be recognised, i.e. the RACGP program leading to a Fellow of the Royal Australian College of General Practitioners

(FRACGP) is 3 years, with the advanced rural skills training an additional year to achieve the Fellowship in Advanced Rural General Practice (FARGP). The ACRRM program includes the advanced skills training year and is 4 years. Some GP Fellows attain their core specialist registration and then seek to add to it, e.g. FRACGP and then their Advanced Skills Training (AST), resulting in a FRACGP and FARGP. Others enrol with both Colleges and obtain both specialist registrations simultaneously.

Table 2.5 demonstrates that under the AGPT program, about 28% of registrars complete the FACRRM in 4 years, with the majority completing it within 5 years. About one-third of candidates take six years or more.

For the FRACGP, 40% complete it within 3 years, with about the same proportion taking 4 years (i.e. approximately three-quarters of RACGP candidates complete the FRACGP in 4 years). For RACGP candidates training toward an advanced skill (FRACGP & FARGP), the majority (77%) achieve this within 5 years, similar to (Fellowship of the Australian College of Rural and Remote Medicine) FACRRM.

Table 2.5: Time to complete the AGPT specialist registration program

AGPT Time to specialist registration	FACRRM		FRACGP		FRACGP & FACRRM		FRACGP & FACRRM & FARGP		FRACGP & FARGP		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	
3 or less years	22	7.7%	2,949	40.2%	0	0.0%	0	0.0%	14	5.4%	2,985
4 years	60	21.1%	2,739	37.3%	0	0.0%	0	0.0%	90	34.9%	2,889
5 years	114	40.0%	950	12.9%	8	47.1%	7	50.0%	96	37.2%	1,175
6 or more years	89	31.2%	701	9.6%	9	52.9%	7	50.0%	58	22.5%	864
Total	285	100%	7,339	100%	17	100%	14	100%	258	100%	7,913

Source: Non-GP specialist workforce statistics, Department of Health and Aged Care 2024. Data is based on the number of providers who provided services while on a 3GA program, with a monthly derived major speciality as a GP while providing the service.

Time to specialist registration for candidates on the rural pathway is comparable to candidates on the general pathway (72% and 76% in 4 years, respectively), recognising all ACRRM candidates are in the rural stream (*Table 2.6*).

Table 2.6: Time to complete AGPT specialist registration in general and rural pathways

AGPT Time to specialist registration	General		Rural		Total	
	No	%	No	%	No	%
3 or less years	1,673	39.0%	1,312	36.3%	2,985	37.7%
4 years	1,594	37.1%	1,295	35.8%	2,889	36.5%
5 years	560	13.0%	615	17.0%	1,175	14.8%
6 or more years	468	10.9%	396	10.9%	864	10.9%
Total	4,295	100%	3,618	100%	7,913	100%

Source: National Health Workforce Data request. No time frame indicated - cumulative years

Approximately 22% of AGPT trainees are IMGs (*Table 2.5*: 1,753 IMG trainees of 7,913 total AGPT trainees).

Table 2.7 demonstrates that the time to specialist registration under the AGPT program for IMGs (76.9% within 4 years) is comparable (albeit slightly higher) than that of Australian and New Zealand medical graduates (AMG/NZMG, 72.2% within 4 years).

Since its inception in 2000, RVTS has achieved specialist registration rate of 77% (which includes doctors who have withdrawn from the program as they have moved from an eligible location) with an average time to specialist registration of 3.6 years¹¹.

An international study indicates that IMGs have lower pass rates in postgraduate examinations than doctors who complete medical and specialist qualifications in the same country¹². In Australia, IMGs studying outside the AGPT program had lower pass rates than IMGs in the AGPT program¹³.

While our data reports time to specialist registration as a proxy for pass rates, it indicates that where IMGs are on well-supported training programs such as AGPT and RVTS, completion time is comparable to that of domestic medical graduates. However, the eligibility for the AGPT requires doctors to have General Registration with AHPRA, while other training pathways such as the Independent Pathway (IP) (ACRRM) and Fellowship Support Program (FSP) (RACGP) accept doctors with Provisional or Limited Registration (which necessitates higher levels of supervision for trainees).

Longer times to specialist registration in pathways other than the AGPT may also reflect the higher supervision needs of trainees.

Earlier Section 3GA workforce programs, including the Rural Locum Relief Program (which provided some financial support for IMGs to access education and upskilling opportunities) had lower progression rates to specialist registration (less than 50%) compared to AGPT (80%) in 2016¹⁴.

Table 2.7: Time for IMGs and AMG/NZMGs to complete AGPT specialist registration

AGPT Time to specialist registration	AMG/NZMG		IMG		Total	
	No	%	No	%	No	%
3 or less years	2,274	36.9%	711	40.6%	2,985	37.7%
4 years	2,253	36.6%	636	36.3%	2,889	36.5%
5 years	900	14.6%	275	15.7%	1,175	14.8%
6 or more years	733	11.9%	131	7.5%	864	10.9%
Total	6,160	100%	1,753	100%	7,913	100%

Source: National Health Workforce Data request. No time frame indicated - cumulative years

11 Department of Health, *Quality and Distribution of the General Practice Workforce - Impact of ss19AA and 19AB*, 2017.

12 Andrew. RF, "How do IMGs compare with Canadian medical school graduates in a family practice residency program?," *Canadian Fam Physician*, pp. 56:e318-322, 2010.

13 Wearne SM, Brown JB, Kirby C, Snadden D. International medical graduates and general practice training: How do educational leaders facilitate the transition from new migrant to local family doctor? *Med Teach*. 2019 Sep;41(9):1065-1072. doi: 10.1080/0142159X.2019.1616681. Epub 2019 Jun 19. PMID: 31215285.

14 Department of Health, *Quality and Distribution of the General Practice Workforce - Impact of ss19AA and 19AB*, 2017.

Findings

- Most GP registrars complete the AGPT within three to four years with comparable time to specialist registration (based on four years) between rural and general training pathways.
- Commonwealth-supported GP training programs (such as AGPT and RVTS) have shorter time to specialist registration than other GP training programs. Although the time to specialist registration cannot solely be accredited to the financial, professional and peer supports available from Commonwealth supported training pathways, provision of equitable support for all medical practitioners (AMGs and IMGs) across all GP training pathways may improve time to specialist registration and hence enable a more streamlined GP workforce.

Section 3GA workforce programs

Section 3GA workforce programs allow non-vocationally recognised doctors who do not have specialist registration to access Medicare benefits (higher level A1 items at non-VR rates) through an approved program at an eligible location for a defined period. These programs serve a dual purpose: to effectively prepare doctors to undertake general practice vocational training and to distribute doctors to workforce shortage areas.

There have been numerous Section 3GA workforce programs over the years with varying intent. Typically, these programs focused on providing short-term medical services to areas in need, including after-hours GP programs and supervised placement for prevocational doctors. The Special Approved Placements Program offered access to Medicare for non-VR doctors who must work in metropolitan areas (exceptional circumstances).

Current workforce programs are focused on prevocational experience in rural and remote areas and the provision of after-hours GP services (including metropolitan areas). The sections below review the effectiveness of these programs in fostering the attainment of specialist registration and distributing doctors to workforce shortage areas.

More Doctors for Rural Australia Program (MDRAP)

The MDRAP supported non-VR doctors to gain general practice experience in rural and remote communities before joining a College specialist registration pathway. The Commonwealth Government funded the program as a component of the Stronger Rural Health Strategy, offering a supportive first step towards College specialist registration training. MDRAP participants were required to complete one of the two general practice Colleges' education modules and gain additional skills and experience to be better candidates for GP training through the AGPT, FSP, IP or RVTS.

The MDRAP was open to Australian citizens, permanent residents, and temporary resident doctors. Eligible applicants fell into the following categories:

- doctors with prior general practice experience
- doctors without prior general practice experience
- doctors providing locum services (some requirements will be based on prior general practice experience)
- junior doctors gaining exposure to general practice Post Graduate Year (PGY 3–5).

MDRAP was administered by the Rural Workforce Agencies. It was limited to two years and included access to \$13,600 for individual doctors to develop a learning plan, access education activities and resources, and prepare for exams; up to \$30,000 per annum to the practice to pay for supervision. Differing levels of supervision were required depending on prior experience in general practice. Doctors had to apply and be accepted onto the MDRAP to access a provider number.

To be eligible for an MDRAP placement, the practice location had to meet the following criteria:

- in an area with DPA status; and
- in an area classified as MM2–7; or
- classified as an Aboriginal Medical Service or be the subject of a Ministerial direction under Section 19 (2) or Section 19 (5) of the Act.

From July 2020 to December 2023, 1,241 doctors participated in the program. Just over two-thirds (68.7%) of doctors participated in the program for 12 months, with others remaining for the full two years or discontinuing (Rural Health Workforce Agencies).

Of the 1,241 participants who commenced the program, 922 transitioned to a training program. Of the doctors taking up GP training, 78.2% transitioned to the RACGP PEP/ FSP pathway, while others transitioned to RVTS (6.3%), ACRRM IP (3.0%), AGPT (2.2 %), and just under 10% have gained specialist registration.

Nearly all MDRAP participants (97%) were in MM2–5, with higher proportions in MM5 (32%) and MM3 (28%). Less than 2% of MDRAP participants worked in MM6-7 areas (*Table 2.8*).

Table 2.8: Distribution of MDRAP participants

MM	2019	2020	2021	2022	2023	5 year average	%
MM1	NP	11	13	5	NP	5.80	1%
MM2	31	94	109	84	128	89.20	19%
MM3	33	118	156	163	182	130.40	28%
MM4	23	80	102	102	120	85.40	18%
MM5	37	166	217	180	142	148.40	32%
MM6		8	NP	8	11	5.40	1%
MM7	NP	4	NP	4	NP	1.60	0%
Total	124	481	597	546	583	466	100%

Source: GP workforce statistics, Department of Health and Aged Care 2024. data is based on the number of providers who provided services while on a 3GA program, with a monthly derived major speciality as a GP while providing the service.

In April 2024, the MDRAP program will be replaced with the Pre-Fellowship Program, which will be managed by the Rural Workforce Agencies. The new program includes some changes, including increased supervision resourcing and the ability for doctors working in outer metropolitan MM1 areas to access it. Some stakeholders were concerned that this change may diminish the potency of this program as a distribution lever for the rural workforce.

Finding

While the MDRAP appeared to effectively support doctors (IMGs and AMGs) in successfully gaining a place on a vocational training program in MM2–7 locations, the majority are in MM2-5 locations.

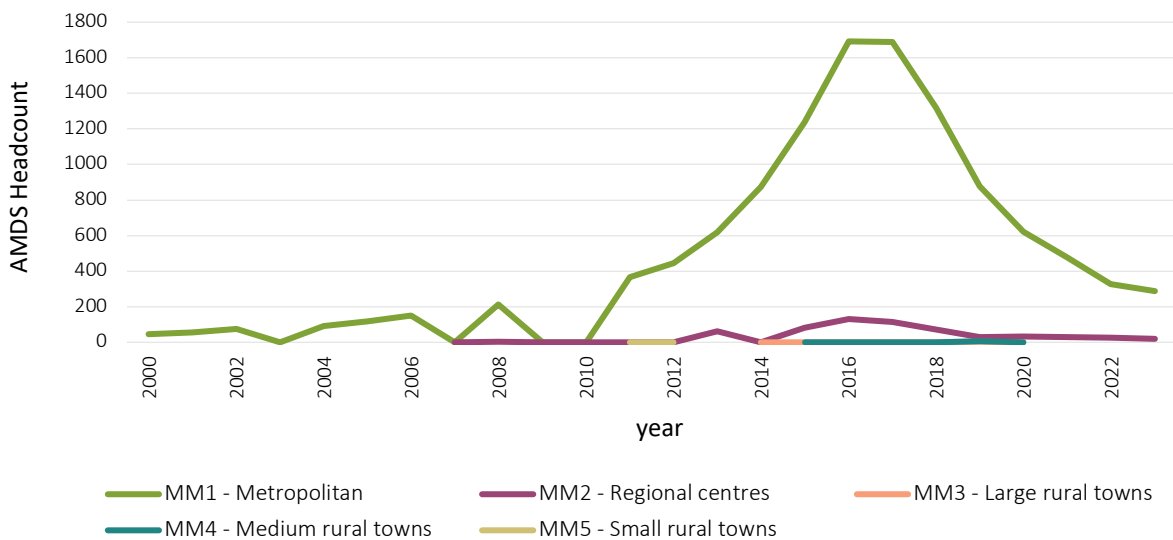
Approved Medical Deputising Services (AMDS) and After Hours Only Clinics (1999)

The AMDS program is a 3GA workforce program allowing non-VR doctors to work in approved deputising services. Most deputising services operate in metropolitan areas, with several known to operate in large regional cities, as shown in *Figure 2.4*.

While the AMDS program guidelines require doctors participating for longer than six months to be supervised, mentored, and supported following College standards, a 2010 evaluation indicated that this varies with providers, is difficult to monitor and that rates of progression to specialist registration are low (around 20%). The specialist registration status for AMDS program participants currently sits at 1,546 non-Fellows (77%)¹⁵.

Analysis of the specialist registration status of Section 3GA programs also noted that, in many cases, there is a huge gap between the provider’s end date on the program and the specialist registration date.

Figure 2.4: Participation in AMDS



Source: GP workforce statistics, Department of Health and Aged Care 2024. data is based on the number of providers who provided services while on a 3GA program, with a monthly derived major speciality as a GP while providing the service.

Finding

The AMDS program does not align with Section 19AA’s intent as a driver toward attaining specialist registration and meeting professional standards. In some circumstances, it appears that the AMDS program has become a loophole to enable access to MBS benefits without specialist registration.

15 GP workforce statistics, Department of Health and Aged Care 2024

Factors impacting the effectiveness of Section 19AA

The intent of Section 19AA is clear in that it seeks to ensure medical practitioners working in Australia meet professional standards, as evidenced by the attainment of a medical College specialist registration and compliance with continued professional development requirements to access the MBS. However, using various Section 3GA training and workforce programs as workforce distribution levers has limited impact in rural and remote areas, creating confusion and complexity for general practices, supervisors, and domestic and international graduates in all locations, particularly where they intersect with Section 19AB requirements.

Section 3GA programs

Over the last decade, several Section 3GA programs have ceased (including the Rural Locum Relief Program, Special Approved Placement Program, and 5-Year Overseas Trained Doctors Program) while others have started and been discontinued (More Doctors for Rural Australia Program (commenced 2019 and ceases 2024) being replaced with Pre-Fellowship Support Program). These programs have different rules in relation to the doctor's residency status, registration requirements, geographic locations in which they can work and variations in the financial and training supports available to the doctor and the GP supervisor and practice.

In addition, the GP training pathways are complex and have also changed in recent years, as follows:

- The Commonwealth-funded RVTS commenced in 2000 and continues training registrars in MM4–7 and within placements in ACCHS.
- The Commonwealth-supported AGPT program is delivered by both Colleges, with ACRRM registrars placed on the rural pathway and RACGP registrars allocated to general and rural pathways. In addition to financial support to AGPT registrars to access education and training resources, Commonwealth funding is also allocated for supervision under the AGPT program.
- The RACGP PEP – Standard Stream and PEP – Specialist Stream commenced in 2019, with some Commonwealth-funded support available to PEP – Standard Stream participants to support training. However, this program ceased taking applicants and was replaced with the Fellowship Support Program in 2023 – a totally self-funded program.
- The ACRRM Independent Pathway has been in place since the establishment of the College and is self-funded.
- The ACRRM Rural Generalist Training Scheme commenced in 2020 and is Commonwealth-funded, but registrars do not have access to the Flexible Funding pool, which is available to ACRRM and RACGP registrars on the AGPT program.

Except for the AGPT program, the programs listed above require registrars to be in MM2–7 practices.

Finding

There are a range of GP training programs with different funding streams and limited workforce distribution levers. The FSP and IP training programs are user pays requiring the registrar to meet all their training costs with no remuneration for supervisors. While the College fees of the RVTS are funded by the Commonwealth, these registrars do not have access to the Flexible Funding pool. This is acting as a disincentive to entry and completion to these GP training programs.

Inequitable access and support to vocational education

IMGs and AMGs not on the Commonwealth-supported GP training programs face considerable costs in undertaking their training. This includes College fees (approximately \$30,000) and travel and accommodation costs to access workshops and courses. While supervisors and accredited training practices receive payments to support the supervision of AGPT registrars (under the National Consistent Payment Framework), there is no provision from the Commonwealth for supervising FSP or IP registrars or access to the flexible funding pool. It is at the discretion of the GP Colleges whether a portion of College fees paid by registrars is distributed to supervisors or practices.

Furthermore, under the current guidelines and DPA rules, the Section 3GA training programs have limited impact on the distribution of IMGs and AMGs, with most of the training occurring in MM1–3, suggesting alternative positive levers could be applied.

The current GP training environment is complex, fragmented, difficult to navigate and for IMGs, exacerbated by their immigration status. The literature and consultations identified specific challenges for IMGs, including:

- Professional isolation working in an area where there are fewer colleagues to provide professional and peer support or mentoring
- Learning in isolation with limited opportunities to learn with Australian-trained peers to develop an understanding of professionalism within the context of Australian general practice
- Cultural and system differences: IMGs are challenged by language and communication skills and style and by a change in status from the perspective of a ‘doctor in training’, as well as the status of medical professionals within the Australian culture compared with their own culture.

There is also poor alignment of the training and service pathways for IMGs as a result of how the different geographic levers apply

Submission from Professor Richard Murray

Consultations indicated that IMGs could take longer to achieve general practice specialist registration than AMGs, which is supported by the literature¹⁶. However, data presented in this review demonstrates that IMGs participating in the well-supported AGPT program and RVTS achieve specialist registration in a comparable timeframe to AMGs. Currently, however the RVTS is the only training program that is allowed to take IMGs on temporary visas.

Finding

The different levels of support for GP trainees to achieve specialist registration across GP training programs leaves IMGs at a disadvantage regarding financial, professional and peer support.

16 KBC Australia, “An Integrated Education and Support Program to assist International Medical Graduates achieve general practice Fellowship. Rural Health West,” 2013.

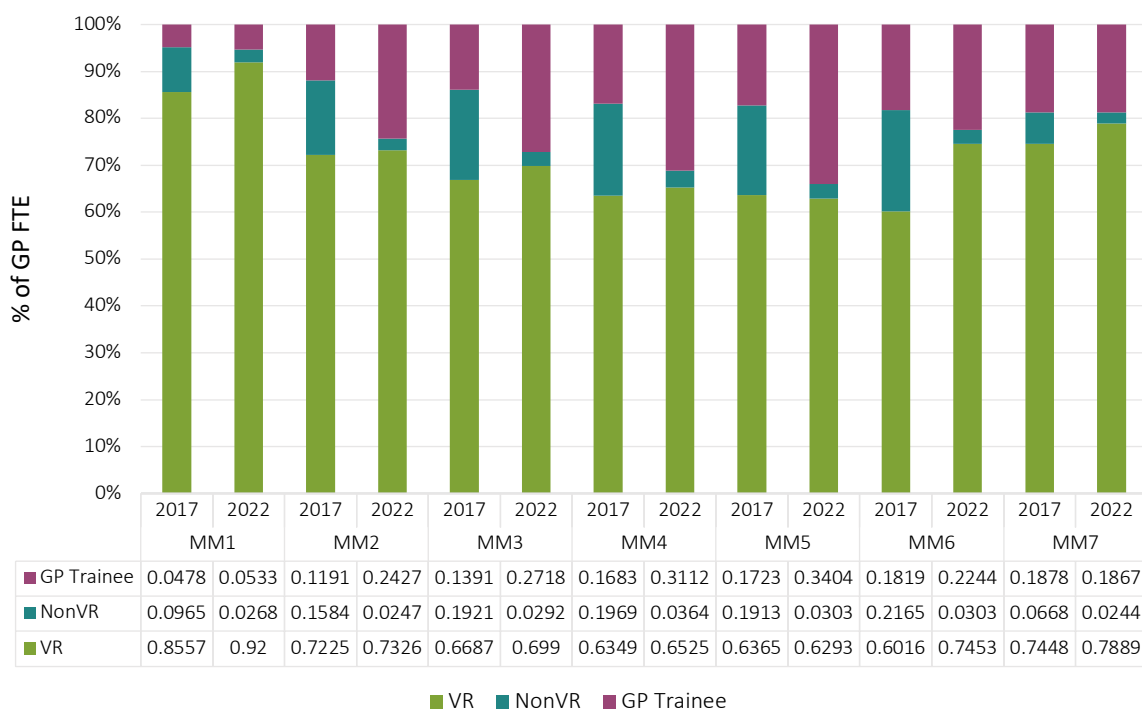
Supervision

Between 21% and 37% of primary care services in MM2–7 is provided by GP registrars and non-VR doctors, compared with 8% in MM1 (Figure 2.5). MM3-5 areas have the highest proportion of GP registrars and non-VR doctors at 40, 35 and 37 per cent, respectively. Therefore, regional, rural, and remote VR GPs bear a greater supervision burden than their metropolitan counterparts.

Furthermore, regional, rural, and remote GPs and practices have additional supervision responsibilities, often supervising medical students during their rural clinical school placements and prevocational doctors under the John Flynn Prevocational Doctor Program. Supervision incentives could be scaled based on demand to reflect additional supervision activities undertaken at some practices, often in rural and remote areas (e.g. concurrent supervision of medical students, interns, registrars and IMGs).

Funding for supervision comes through various avenues, and remuneration arrangements with supervisors are variable. Heavy caseloads and practice responsibilities further impact supervision capacity. Funding is required to support supervision and underpin blended supervision models (mix of on-site and remote supervision) including infrastructure, IT and supervision payments.

Figure 2.5: GP FTE by VR status across MM settings



Source: Health Workforce Dataset GP workforce by calendar year 2017 to 2022

In addition, training programs and activities often focus on the new workforce. However, for a sustainable primary care service system in a regional, rural, remote, or metropolitan area, it is essential to recognise, value, and support GP supervisors and training practices and ACCHS seeking to attain supervision and training capacity and capability.

The National Aboriginal Community Controlled Health Organisation (NACCHO) written submission to the *Working Better for Medicare Review* identified ongoing difficulties recruiting and retaining GP registrars for salary-supported training places in ACCHS.

Training places are often unfilled. In addition, ACCHS often cannot supervise general practice year 1 registrars where a higher level of supervision is required. RVTS can also have difficulties filling AMS places (See Section 7 for further discussion).

A NACCHO workforce census of our ACCHS Members and Affiliates to identify workforce gaps and training needs across the sector identified that 94.4% of ACCHS face challenges with workforce recruitment and 69.6% of ACCHS face challenges with workforce retention.

Submission from NACCHO

Findings

- VR GPs in rural and remote areas (particularly MM3-5) bear a greater supervision burden than their metropolitan counterparts, with a higher proportion of non-VR GPs and GP trainees. This may be compounded by the additional scope of practice responsibilities, including urgent care and procedural services.
- ACCHS experience significant ongoing challenges in attracting, training, and retaining GP registrars and providing adequate supervision.

Section 19AB class exemptions

The complexity of the training environment is further increased for IMGs where it intersects with Section 19AB. A Section 19AB class exemption for IMGs accepted into the AGPT program gives the College discretion about the training location. However, for IMG registrars on the FSP and IP, 19AB rules apply, requiring registrars to be in locations of workforce shortage as determined by the DPA.

However, this is largely a moot point now, with DPA status changing from blanket MM5-7 in 2019 to blanket MM 3-7 in 2021 and then blanket MM2-7 in 2022. For AGPT registrar placement, since 2023, the WPPPOs have advised the GP Colleges to direct the placement of AGPT registrars to meet workforce needs. With the establishment of the Single-Employer Model trials in most jurisdictions in 2024, there is the potential for further complexity in the GP training environment where registrars will be employed by a Local Health Network (LHN) or equivalent while training in a rural, remote, or regional general practice that opts into the trial.

Mandatory distribution levers

Strong messages from consultations included the need for a more incentive-based approach to building the rural and remote health workforce, noting that this applies to all professions, not just medical practitioners. Policies and programs that force people to work rurally create the perception that they must 'serve time' before being able to return to a more urban practice, further entrenching the view of rural training as less desirable.

Opportunities

The opportunities set out in this section inform recommendations that seek to reduce the complexity of the GP training environment and provide positive and well-supported training experiences for GP registrars targeted to areas of workforce need.

Supervision

Remote supervision/mentoring models have been proven safe and effective through programs such as RVTS. Remote and blended supervision/mentoring are emerging as innovative approaches by the GP Colleges to increase capacity and as a mechanism to support general practices.

ACCHS become accredited training practices where they do not have consistent access to GP supervisors. Utilising remote supervision from suitably qualified supervisors who have experience working in and understanding rural and remote work to complement onsite supervision could increase supervision capacity, reduce the impact on local supervisor(s) to manage caseload and improve the registrar training experience.

Policy considerations:

- Remote supervision models requires relevant rural experience for supervisors
- Additional funding may be required for rural and remote practices and ACCHS to attain and maintain training accreditation.

Targeted strategies to develop and sustain training capacity in ACCHS

The Department, in conjunction with NACCHO, the State affiliates, GP Colleges, and RVTS, should develop targeted strategies to enable the Aboriginal Community Controlled Health sector to develop supervision and practice capacity and capability to recruit, train and retain GP registrars from General Practitioner Training (GPT) 1 to specialist registration tailored for rural, remote, and regional locations.

Equitable access to vocational education

Harmonise 3GA training programs to incentivise and support all registrars undertaking GP training through:

- Provision of fee relief to registrars enrolled in FSP and IP training programs—scaled to remoteness to support the intent of 19AA as both a professional standards lever and a distribution lever.
- Remuneration of GPs supervising FSP and IP registrars in line with the National Consistent Payment Framework.
- Consider expanding the flexible funding pool to incentivise and support registrars' training in more rural and remote areas.

Policy considerations:

- Specialist registration requirements determined by relevant medical Colleges would require a collaborative review process
- Need to maintain professional standards while considering flexible pathways to specialist registration.

Recognition of prior learning (RPL) and experience

With the varied professional experience, clinical skills and expertise, and cultural backgrounds of Australian-trained doctors and IMGs entering GP training in Australia, a greater emphasis on competency-based training and assessment was identified as an approach to offering more flexible and individualised training.

Furthermore, a growing cohort of hospital non-specialist doctors may consider a general practice career if recognising prior learning or access to bridging programs that can address identified training gaps (such as skin conditions, obstetrics and gynaecology, Medicare billing, etc) might streamline their training. While both general practice Colleges have time-based training requirements, competency-based assessments are incorporated into the curricula in various formats.

Recognition of prior learning coupled with a competency-based approach to training will enable flexibility in training to be responsive to a doctor's previous learning and experience. This may include streamlined attainment of specialist registration for IMGs with existing skills and capabilities from comparable training and experience. It may also include promotion of general practice to hospital non-specialists with recognition for comparable prior learning and experience.

It is important to note that a competency-based learning approach is not an accelerated learning program. It places the doctor in the appropriate stage of learning in the training pathway. Competency-based training must still ensure sufficient skills and knowledge to apply professional standards.

Selection of rural origin and background

Under current immigration arrangements, there are limited opportunities, if any, to proactively influence the selection of IMGs into Australia. In line with the evidence for AMGs, the Medical Education and Training Survey (2023) indicates that international students with a rural background are more likely to choose to work in rural areas than students with a metropolitan background. Considering emerging evidence, IMGs from rural backgrounds are also more likely to work rurally.

Enhancing IMG recruitment processes to filter for IMGs with a background or interest in rural and remote areas may result in more IMGs choosing to practise in rural and remote areas rather than being forced to. Similarly, general practice Colleges should consider selecting IMGs and AMGs of rural origin or background in rural training pathways. This issue is discussed more fully in *Section 7*.

Section 3GA programs

Finding

Several non-GP specialist Colleges suggested exploring the expansion of Section 3GA programs. For this to be undertaken, amendment to Medicare legislation will be required.

Evidence of outcomes

Current Key Performance Indicators for general practice Colleges are process measures. Assessment of the effectiveness of 3GA training programs to promote workforce distribution and retention is not routinely measured, evaluated, or reported. While multiple professional, personal, and community factors influence rural retention, a sharp focus on registrar selection, training experience, and retention of new fellows in the regions is required to better inform investment in training.

Developing key performance measures to provide insight into program outcomes will aid in targeting future investment. For example, doctor practice locations 1-, 3-, and 5 years post-fellowship (or specialist registration) provide insight into the effectiveness of rural training pathways to improve workforce maldistribution.

Policy considerations:

- Revision of reporting requirements for Commonwealth-funded programs, including AGPT, to include evidence of meeting objectives
- Flexibility to move funding over time to those programs achieving stated objectives. Expansion of Section 3GA training programs to other specialist streams

General practice is the only specialty where registrars can access Medicare during training. Some specialties undertake a large proportion of work in private practice. A Section 3GA training program for registrars in these specialties would expand and enhance training opportunities, particularly in rural and regional areas where the consultant supervisors usually work across public and private sectors.

Promotion of rural general practice

Known impediments to junior doctors choosing a general practice training pathway include limited exposure to general practice during medical school and pre-vocational training. Strategies are in place to increase exposure to general practice through modifications to the curriculum of some university medical programs and prevocational placements in rural general practice under the John Flynn Prevocational Doctor Program. Losing employment entitlements when doctors leave public hospital employment to train in private practice is another impediment. The Single-Employer Model trials seek to mitigate this barrier, with LHNs offering a duration of a training contract for registrars as they transition to GP training. National trials commenced in 2023 and run to the end of 2027. A model such as this could be considered for hospital non-specialist doctors to transition to GP training.

The outcomes of the Single-Employer Model trials should be reviewed to consider their application to promote recruitment and retention in GP training. Such a Model should enable the portability of entitlements, such as maternity leave, between different employers of GP registrars.

Recommendations

Specific improvements are recommended to address the challenges described and improve Section 19AA to achieve its intended purpose, as follows:

Recommendation 2

Section 19AA should be retained to ensure training and practice standards, currency of knowledge and skills are maintained across all medical professions. The intent of Section 19AA should focus on the specialist registration of all medical practitioners who are Australian citizens or permanent residents, and who are seeking to access Medicare. This should include specialist registration and /or enrolment in a training program under Section 3GA.

Recommendation 3

Key performance indicators for GP training programs that demonstrate rural workforce outcomes during training and at 1,3 and 5-years post fellowship (or specialist registration) should be developed. These will provide insight into the effectiveness of rural training pathways and enable Commonwealth investment to be targeted and monitored.

Recommendation 4

Financial, professional and peer supports should be made available to all GP registrars- both Australian Medical Graduates (AMGs), and IMGs to match what is currently available under the Australian General Practitioner Training (AGPT) pathway, regardless of training pathway. This will provide the best opportunity for GP registrars to attain timely speciality registration.

Recommendation 5

Supervision of all GP training should be remunerated in line with the National Consistent Payment Framework and remote or blended (i.e. mix of remote and on-site) supervision models should be used to increase and sustain supervision capacity and capability in rural and remote areas.

3. Section 19AB

Section 19AB of the Health Insurance Act 1973 sets out the rules for IMGs regarding where they may work in Australia. It operates by allowing payment of Medicare benefits to IMGs only if they work in a DPA or DWS location for up to 10-years from the date of their first registration as a medical practitioner in Australia (“the 10-year moratorium”).

Section 19AB also works in conjunction with Section 3GA of the Health Insurance Act 1973 (Section 3GA), which allows medical practitioners working towards vocational recognition to access Medicare benefits if they are enrolled in approved workforce or training programs.

It should be noted that all IMGs who have completed their 10-year moratorium under Section 19AB are still subject to Section 19AA whereby, if they have not gained fellowship or specialist registration, they will continue to be subject to restrictions regarding access to Medicare benefits under Section 19AB.

Section 3GA

Medical practitioners who do not have specialist registration can apply for an approved program under Section 3GA of the Act that allows them to bill Medicare whilst they work towards fellowship or specialist registration¹⁷. IMGs and temporary residents may also be eligible to participate in 3GA programs, but they need to satisfy the requirements of Section 19AB or qualify for a Section 19AB exemption.

These programs are only available for a defined period. They include:

- **Approved Medical Deputising Services (AMDS) Program:** enables non-vocationally recognised doctors to access Medicare benefits for providing after-hours services on behalf of other doctors. This helps them get general practice experience, while ensuring people can access healthcare after-hours¹⁸. Participants are able to sit for their fellowship or specialist registration exam whilst on this program.
- **Pre-Fellowship Program (PFP):** supports non-vocationally recognised doctors gain general practice experience in a DPA before they join a GP College-led specialist registration pathway¹⁹. The PFP is open to IMGs and other non-vocationally registered doctors who are either Australian citizens, permanent residents or temporary residents. IMGs with provisional or limited registration also receive funding support for supervision and learning and development. If participating in

17 Australian Government Department of Health and Aged Care. Fellowship requirements under section 19AA. 5 March 2024. <https://www.health.gov.au/topics/medicare/access-practitioners-industry/doctors-and-specialists/19aa?language=und>

18 Australian Government Department of Health and Aged Care. Approved Medical Deputising Services (AMDS) program. 1 June 2023. <https://www.health.gov.au/our-work/amds>

19 Australian Government Department of Health and Aged Care. Pre-Fellowship Program. Accessed from: <https://www.health.gov.au/our-work/pre-fellowship-program>

this program, doctors must work in an area that is classified as a DPA or MMM2-7²⁰. This program was formerly known as the More Doctors for Rural Australia Program (MDRAP), which is no longer taking new applications. A doctor is not eligible to join PFP if they have previously been on a 3GA program or are currently on MDRAP. Participants are not able to sit for their fellowship or specialist registration exams whilst on this program.

Exemptions to Section 19AB

Exemptions to Section 19AB requirements can allow IMGs to access Medicare rebates before the end of their 10-year moratorium.

Currently, there are 12 exemption categories for non-GP specialist IMGs subject to Section 19AB that allow them to work in non-DWS areas²¹. They include:

- **Locum:** doctors may practice at a non-DWS location as a locum in their medical speciality for a one-off period of up to six months at each practice location. The doctor must not have had a locum exemption at the requested location previously approved.
- **Academic:** doctors must have an appointment with an Australian medical school and may practice at a location where they perform clinical services as part of their academic appointment.
- **Assist at operations:** doctors are granted access to a single set of Medicare items, allowing them to assist in an operation or invasive specialist procedure under the supervision of a fully qualified surgeon in a non-DPA or non-DWS area.
- **Replacement rules:** the doctor may practice at a non-DPA or non-DWS location to replace another doctor who was subject to Section 19AB, who has left the practice and area²².
- **Spousal:** the doctor may practice in a non-DWS area within a reasonable distance of their spouse and the spouse is a skilled migrant or doctor not prevented by Section 19AB from accessing Medicare.
- **Prior employment negotiations:** the doctor entered employment negotiations with a location that was a DPA or DWS before the location was reclassified as non-DWS.
- **Commonwealth-funded Aboriginal and Torres Strait Islander primary care health service:** the doctor is practising at such a service that is in a non-DWS area.

20 Australian Government Department of Health and Aged Care. More Doctors for Rural Australia Program. 29 February 2024. <https://www.health.gov.au/our-work/more-doctors-for-rural-australia-program>

21 Australian Government Department of Health. Factsheet: Section 19AB - Access to Medicare Provider Numbers for Overseas Trained Doctors. 2021.

22 This is subject to a number of assessment criteria, including:

- held an indefinite s19AB(3) exemption that enabled unrestricted Medicare access at the medical practice
- provided consistent Medicare-subsidised services at the medical practice within the last 12 months
- ceased practicing at all locations in the catchment area, having closed each of the related provider numbers
- provided a written statement to confirm that they have ceased, and have no intention of returning to, private practise within the catchment area.

See: <https://www.health.gov.au/sites/default/files/documents/2021/08/19ab-restricted-doctors-access-to-medicare-provider-numbers.pdf>

- **After-hours:** where the doctor provides after-hours medical services. After-hours is defined as 6pm to 8am Monday to Friday and all-day Saturday, Sunday and Public Holidays. The exemption applies only for after-hours services.
- **Discretionary:** an exemption to Section 19AB may be granted in consideration of “any other matters the Minister considers relevant”. An example is where the doctor provides evidence that they are caring for an immediate family medical condition that requires them to be in a metropolitan area.
- **Specialty in acute shortage:** the doctor may practice anywhere across Australia in a specialty in acute shortage. This exemption grants access to Medicare benefits in any location if the doctor is registered with AHPRA as a specialist in an approved specialty.²³
- **Placement on a workforce or training program:** a doctor has an approved placement on workforce or training program at a given location (these programs have their own location restrictions).
- **5-year International Medical Graduate Recruitment Scheme (formerly the 5-year Overseas-Trained Doctor Scheme):** IMGs can reduce the period of their ten-year moratorium to as little as 3 years by working in an eligible rural or remote location for a set period and by obtaining permanent residency and fellowship or specialist registration during their time on the program.
- **Competent Authority Pathway Exemption:** doctors can access Medicare benefits in the location listed on their Australian Health Practitioner Regulation Agency (AHPRA) registration if they are on the competent authority pathway, specialist pathway- area of need, or specialist pathway-specialist recognition. Requested locations must be in a DPA/DWS area, except in exceptional circumstances.
- **Movement within catchment:** doctors who hold an unrestricted exemption for one practice can apply for access to Medicare when working in other practices within the same DWS/DPA catchment.

Data supplied by the Department shows that there were 2,558 exemption requests to Section 19AB in 2023, with 70% of these approved. A further 2,545 exemptions were approved by Services Australia in 2023 for a total of 4,349 approved exemptions in 2023. While some of these applications might reflect one IMG with multiple exemptions granted in a calendar year, these exemptions could represent as much as 13% of all IMGs (n=32,706)²⁴ across GPs and non-GP specialties.

23 The following specialties are approved for this exemption: cardiothoracic surgery, dermatology, emergency medicine, endocrinology, geriatric medicine, gastroenterology, general medicine, haematology, intensive care medicine, nephrology, neurology, neurosurgery, orthopaedic surgery, otolaryngology, paediatric medicine, paediatric surgery, palliative medicine, pain medicine, plastic and reconstructive surgery, rehabilitation medicine, rheumatology, sports and exercise medicine, thoracic medicine, urology, vascular surgery.

24 Based on data sourced from the National Health Workforce Data Set

Should Section 19AB be retained?

Based on the findings of the Review, it is recommended that Section 19AB be retained in the short-to-medium-term until Australia is closer to self-sufficiency in meeting medical workforce needs and there are distribution incentives in place to ensure sufficient doctors practise in regional, rural, and remote areas.

Impact on distribution of medical workforce

Stakeholders largely agreed that despite the ongoing challenges with workforce maldistribution, Section 19AB has contributed to improving the distribution of medical workforce across Australia.

The positive impact of Section 19AB in distributing the non-GP specialist medical workforce is reflected in Table 3.7 which shows the proportion of total headcount in each specialty for both domestic and overseas-trained GP and non-GP specialists. This table shows individual and aggregate (row G) distribution data for the specialties currently considered under DWS as well as the aggregate of all other non-GP specialties (row H). It is reasonable to assume that Section 19AB would be achieving the desired impact on a given specialty if:

- The proportion of IMGs in MM1 areas is lower than the overall proportion of IMGs in Australia for that specialty's percentage of total (column E), and/or
- The proportion of IMGs in MM2 to MM7 is higher than the overall proportion of IMGs in Australia for that specialty (column E) that specialty's percentage of total (column E).

Cells where these conditions are met for DWS specialties are highlighted in green. The data shows that:

- for all DWS specialties, there is a lower (equal for ophthalmology) proportion of IMGs in MM1 areas than their proportional headcount nationally. This suggests that specialists in these disciplines are being directed to areas outside of major cities as a result of Section 19AB.
- furthermore, for all DWS specialties (except for ophthalmology), there are higher proportions of IMGs in MM2-3 than their overall proportion of headcount nationally (also true for MM4 for general surgery and obstetrics and gynaecology).
- for non-DWS specialties except GPs aggregated there is also a lower proportion of IMGs in MM1, and higher proportions in MM2-4 and MM6 than the overall proportion of headcount nationally. Therefore, although 19AB produces the desired results for DWS specialties, a similar result is obtained for the aggregate of all non-DWS specialties (excluding GPs), although there are several non-DWS specialties where the relationship does not hold true.
- for GPs, where the IMG distribution lever is DPA (not DWS), there seems to be less (than non-GP specialists) redistribution to regional, rural and remote areas (row F). The data shows that for MM1-2 areas, the proportion of IMG GPs is relatively consistent with the total percentage of IMG GPs (column E) and IMGs are less represented in MM3-7 areas relative to their overall representation in the GP workforce.

Finding

Despite the ongoing challenges with workforce maldistribution, based on stakeholder views and analysis of the available data, it appears that Section 19AB has contributed to improving the distribution of the non-GP specialist medical workforce across Australia by directing IMGs to work in areas of workforce shortage where they may otherwise have not.

Table 3.1: Proportion of Australian and IMG doctors by medical specialties and MM, 2022

Specialty (A)	Headcount (2022)		% of total headcount		% of IMGs in MM area						
	Domestic (B)	IMGs (C)	Domestic (D)	IMGs (E)	MM1	MM2	MM3	MM4	MM5	MM6	MM7
General practice (F)	18,835	12,910	59%	41%	42%	39%	37%	33%	37%	32%	30%
Anaesthesia	3,950	1,305	75%	25%	23%	33%	43%	-	-	-	-
Psychiatry	2,499	1,525	62%	38%	36%	53%	46%	0%	0%	0%	-
Radiology-diagnostic radiology	1,732	706	71%	29%	27%	48%	37%	-	-	-	-
Surgery-general surgery	1,493	423	78%	22%	20%	29%	32%	60%	0%	-	-
Obstetrics and gynaecology	1,139	616	65%	35%	33%	36%	56%	100%	-	-	-
Physician-cardiology	1,105	355	76%	24%	23%	44%	30%	-	-	-	-
Ophthalmology	799	149	84%	16%	16%	11%	19%	-	-	-	-
Physician-medical oncology	614	166	79%	21%	18%	38%	49%	-	-	-	-
All DWS specialties (aggregated) (G)	13,331	5,245	71.8%	28.2%	26.5%	38.7%	42.2%	48.8%	0.0%	0.0%	0.0%
All non-DWS specialties excluding GPs (aggregated) (H)	17,866	6,382	73.7%	26.3%	24.9%	37.4%	39.1%	50.0%	0.0%	43.2%	0.0%
Overall (all specialties) (I)	50,032	24,537	67.1%	32.9%	31.9%	38.6%	38.2%	33.7%	36.7%	32.7%	29.9%

Source: HealthConsult analysis on MBS data provided by Department of Health and Aged Care

Note: orange shading reflects areas/specialties where Section 19AB appears to be having a positive impact on improving workforce distribution

Movement of IMGs to metropolitan areas

Without Section 19AB, there is a concern that many IMGs would choose to practice in metropolitan areas, leading to further concentration of medical professionals in major cities. The workforce migration that has occurred due to the recent designation of all MM2 areas as DPAs was cited as evidence of what would likely happen.

To address relatively minor workforce shortages in MM2 and outer urban areas, the scheme was extended last year to support employment in these areas. Within a short space of time, this triggered significant movement of IMG doctors out of MM3-7 to take up positions in MM1-2 and has made it substantially harder to recruit to MM3-7 vacancies.

Submission from ACRRM

When the Australian borders re-opened after COVID, there was a major policy shift by the Commonwealth Government allowing new IMGs coming into Australia, to access cities and especially outer urban areas (MMM2/3 areas). This has worked against the needs of rural and remote locations and negatively impacted on the access to GPs in many Aboriginal communities in the NT.

Submission from Aboriginal Medical Services Alliance Northern Territory (AMSANT) Aboriginal Corporation

Large regional centres, classed MMM2, being defined as rural within Government programs or initiatives targeted at rural and remote health services significantly disadvantages those services based in 'Real Rural' communities.

Submission from Rural Doctors Association of Australia (RDAA)

Additionally, this effect is already seen by the movement of IMGs to city areas post-moratorium according to feedback from stakeholders consulted during the Review

The impact of Section 19AB is evidenced by the fact that IMGs generally seek to move to major cities when their 10-year moratorium is completed. This suggests that if it were not for Section 19AB, that many of these professionals would have otherwise chosen to work in a major city from the time they arrived in Australia.

Consultation with the Aboriginal Health and Medical Research Council

Removing Section 19AB completely will worsen workforce maldistribution and result in most OTDs/FGAMS setting up practices in metropolitan areas where there is no workforce shortage. This will worsen workforce shortages in regional Australia and increase the disparity in access to healthcare services between metropolitan and regional areas.

Submission from RANZCO

The RACGP's long held the position is one of opposition to the ten-year moratorium. However, the College also acknowledges it is currently the key instrument for distributing IMGs into regional, rural and remote Australia and areas of identified workforce need (DPA and DWS) and any sudden removal of the moratorium could cause unintended consequences for the rural and remote workforce and the communities they support.

Submission from RACGP

This widespread feedback from stakeholders highlights that without the moratorium imposed under Section 19AB, there would be an exacerbation of the existing shortages of medical professionals in rural and remote areas, where access to healthcare services is already limited. Residents in these areas would face greater challenges in accessing timely medical care, leading to further disparities in health outcomes between urban and rural populations.

Finding

Many stakeholders believed that abolishing Section 19AB would result in a significant and immediate exacerbation of medical workforce maldistribution challenges. Without Section 19AB, there is a concern that many IMGs would choose to practice in metropolitan areas, leading to further concentration of medical professionals in major cities.

Regulation of workforce distribution compared to incentivisation

Although positive levers were identified as being desirable to improve medical workforce distribution, there is already a wide range of incentives available to attract the workforce to areas of need that have not resolved the persistent challenge of maldistribution. Negative levers such as Section 19AB were considered to still be required (at least in the short-to-medium-term) to address the preference of both domestic and overseas-trained doctors to work in major cities.

A range of suggestions were received for more targeted incentives, such as improved training, remuneration arrangements, social and professional networking opportunities, and logistical supports (e.g. childcare, housing) to make rural and remote areas more attractive for all medical professionals (not just IMGs). Section 19AB could still be retained in the short-to-medium-term while incentives and workforce policies were further developed to increase uptake of positions outside of major cities by the domestic medical workforce.

In summary, while ongoing challenges and the need for more targeted support mechanisms remain, the analysis suggests that Section 19AB has, and continues to play, an important role in directing medical professionals towards areas of workforce shortage. Retaining Section 19AB is viewed as essential in the short-to-medium-term to address medical workforce maldistribution and improve access to doctors in rural and remote regions of Australia.

Finding

Whilst there is a preference towards increasing positive levers to address workforce maldistribution, negative levers such as Section 19AB were considered to still be required (at least in the short-to-medium-term) to address the preference of both domestic and overseas-trained doctors to work in major cities.

Have the objectives of 19AB been achieved?

Whilst evidence gathered throughout the Review indicated that Section 19AB has had some positive impact on addressing workforce maldistribution, the other original objectives of Section 19AB are no longer priorities within the current health workforce policy landscape. Table 3.2 summarises the Review findings in relation to whether the objectives of Section 19AB have been met.

Table 3.2: Summary of findings in relation to whether Section 19AB has achieved its original objectives

Original objective of Section 19AB	Has this objective been met?	Rationale
Equitable distribution of the medical workforce	Yes	The available data and stakeholder input suggests that Section 19AB has, and continues to have, a positive impact on addressing medical workforce maldistribution. Most stakeholders agreed that medical workforce maldistribution would be worse if Section 19AB was not in place. However, workforce maldistribution remains a challenge and the National Medical Workforce Strategy sets out improving the equitable distribution of the medical workforce as a clear priority.
Containing cost pressures on the MBS	No	This objective is less of a focus of current workforce policies. Recent Government funding announcements (including as part of the 2023-24 Budget) have made significant investments in Medicare to meet urgent needs and begin reforms to strengthen Medicare.
Promote IMGs to take up positions in public hospitals	Of limited relevance	This objective is of limited relevance within the context of Section 19AB. Recent research has argued that hospital medical workforce headcount has increased substantially more than the increase in public hospital beds. This research contends that there is an overprovision of specialist training positions in public hospitals. No current policy was identified that specifically seeks to increase the availability of IMGs in public hospitals. Given that Section 19AB works by constraining access to MBS, an objective focused on public hospital positions is somewhat out of place within its remit.

Distribution of the medical workforce

Despite the evidence suggesting that Section 19AB has helped to address maldistribution of the medical workforce, the available data and documentation demonstrates that medical workforce maldistribution remains a significant issue across both different geographic areas and medical disciplines. *Table 3.3* shows that on a per-capita basis, the availability of non-GP specialists decreases with remoteness. Except for general surgery, the highest levels of FSE per-capita for all specialties are in major cities.

Table 3.3: Comparison of average FSE per 100,000 in each Remoteness Area (RA) per non-GP specialty

Remoteness Area	Average total FSE per 100,000							
	Anaesthetics	Cardiology	Diagnostic Radiology	General Surgery	Medical Oncology	Obstetrics & Gynaecology	Ophthalmology	Psychiatry
RA1 - Major Cities of Australia	6.20	6.20	20.33	2.99	4.10	4.22	4.15	5.76
RA2 - Inner Regional Australia	3.48	3.88	16.45	3.17	3.91	1.96	1.96	1.88
RA3 - Outer Regional Australia	1.76	3.01	14.31	2.00	1.71	1.14	2.03	0.93
RA4 - Remote Australia	0.05	1.16	10.64	1.02	0.17	0.28	0.59	0.58
RA5 - Very Remote Australia	0.06	0.64	4.86	0.07	0.00	0.08	0.28	0.16

Source: HealthConsult analysis on MBS data provided by Department of Health and Aged Care

Note: green/red shading indicates the highest/lowest FSE per-capita in each specialty and RA combination

This analysis was confirmed during stakeholder consultations. Stakeholders agreed that while IMGs are currently heavily relied upon to ensure service provision in specific underserved areas, the levers under review have not completely addressed the issue of workforce maldistribution. Key stakeholder feedback included that:

Maldistribution of the medical workforce however, both in terms of location and specialisation, continues to result in pervasive workforce shortages across rural and remote Australia. These shortages are contributing to unacceptable inequities in terms of healthcare outcomes for the people affected by them

Submission from ACRRM

We have never had so many doctors, and yet we are short everywhere.

Consultation with Deans of Medicine

Finding

Whilst evidence presented showed that Section 19AB has helped to mitigate workforce shortages outside of metropolitan areas, data and stakeholder feedback indicate that disparities persist across geographical regions and medical specialties. This is reflected by the uneven distribution of specialists nationwide, particularly in rural and remote areas.

Medicare costs and distribution of funding

Based on the available information, there is limited evidence to suggest that the objective of controlling Medicare expenditure through Section 19AB has been met or is a continuing priority today. Several factors contribute to the difficulty in assessing the precise impact of Section 19AB on MBS expenditure:

Population Growth: With a growing population, it would be reasonable that demand for healthcare services would increase that would contribute to higher Medicare expenditure over time.

Health Care Complexity: As our ability to treat chronic diseases grows the number of people with comorbidities grows and the cost and complexity of services per person has become the major driver of increasing health care costs.

Policy Decisions: Policy decisions regarding the number of items listed on the Schedule and funding allocation also affect MBS expenditure. Changes in policy can influence the availability and accessibility of healthcare services, thereby impacting expenditure.

Furthermore, Medicare expenditure has been increasing at a rate much faster than population growth over the past decade. This trend is reflected in budgetary estimates and commitments, which prioritise increasing Medicare expenditure.

Finding

Stakeholders consulted did not indicate a strong position on the objective of controlling Medicare expenditure through Section 19AB, and it was generally regarded to be a less relevant objective in considering contemporary challenges in healthcare service provision.

IMGs taking up positions in public hospitals

Many stakeholders reported regional and rural public hospitals are often under resourced in some medical specialties. As a result, many submissions highlighted that staffing these hospitals is often reliant on IMGs.

However, while still subject to the 10-year moratorium, there is no restriction in where an IMG can work if they undertake a salaried position in a public hospital that does not access MBS. This requirement only applies to doctors that wish to bill Medicare.

A recent paper has argued that hospital medical workforce headcount has increased substantially more than the increase in public hospital beds²⁵. This research contends that there is an overprovision of hospital-based and specialist care in public hospitals. This paper points to per-capita growth in hospital medical Full-Time Equivalent (FTE) of 149% between 1996 and 2022; a 51% growth in non-GP specialists and a six per cent contraction in GPs.

While this research acknowledges some findings run against the popular perception that there are too few training positions to meet demand, it concludes that “the imbalances in Australia’s medical workforce are leading to an over-emphasis on hospital and medical specialists care, a medical workforce oversupply (where there are too many doctors in cities and too few elsewhere), a lack of domestic medical graduates outside of major cities and (an unethical) over-dependence on foreign trained doctors”. No current policy was identified that specifically seeks to increase the availability of IMGs in public hospitals.

Findings

- Encouraging IMGs taking up positions in public hospitals is still relevant, however, Section 19AB does not restrict nor incentivise them to work in public hospitals in any way, so it is somewhat out of place as an objective of the legislation.
- Addressing the maldistribution of the medical workforce by limiting access to Medicare benefits to DWS areas is the most relevant and important function of Section 19AB. The objectives of containing the number of IMGs contributing to cost pressures on the MBS and promoting IMGs to take up positions in public hospitals are not considered priorities in today’s health policy context.

Key considerations impacting on Section 19AB’s appropriateness and effectiveness

A wide range of factors are highlighted in this Chapter as impacting on the effectiveness and appropriateness of Section 19AB. Some of these factors, such as the breadth of exemptions available to Section 19AB requirements, reduce the ability of Section 19AB to achieve its objectives. Others, such as stakeholder concerns about quality, equity and training suggest that other approaches are required (in addition to Section 19AB) to ensure the Australian medical workforce is sustainable over the long-term.

These impediments, their impacts, and recommendations to address them are summarised in *Figure 3.1* and described in this Section.

25 Moynihan M. Australia’s medical workforce: maldistributed and lately never enough - research report. The Australian Population Research Institute; October 2022.

Figure 3.1: Key considerations impacting Section 19AB



Exemptions to Section 19AB

Finding

While exemptions to Section 19AB provide flexibility to respond to specific circumstances, the Review has found that the breadth of available exemptions are undermining efforts to address workforce maldistribution.

Different exemption types are processed by Services Australia and the Department, and in some cases, each agency could process exemptions under the same exemption category with one responsible for temporary residents and the other permanent residents (such is the case for IMGs applying for the 'Assistance at operations' exemption).

In analysing and making recommendations for 19AB exemptions, the following assumptions and limitations were noted:

- The two datasets provided by each of the Department and Services Australia represent different cohorts of IMGs
- 'Permanent residents' and 'temporary residents' are both considered IMGs for the purpose of Section 19AB
- Some exemption categories such as 'Locum' and 'Assist at operations' do not have a 1:1 exemption per IMG because multiple exemptions may be granted per calendar year
- Data provided by the Department did not include the specialty type granted an exemption nor their location
- Services Australia included additional data such as provider numbers and types of specialists, but did not include the location granted for the exemption
- The exemption category, 'No exemption type determined', could not be considered in the analysis.

The 19AB exemptions data is provided in *Table 3.4* (Department processed exemptions) and *Table 3.5* (exemptions processed by Services Australia). In total, 4,336 exemptions to Section 19AB were granted in 2023. It is possible that these exemptions could represent up to 13% of the OTD workforce (n=32,706 including GP specialists), without adjusting for the fact that some of them might reflect one OTD with multiple exemptions granted in a calendar year (i.e. 'Assistance at operations' exemption).

Table 3.4: Section 19AB exemptions (by type) processed by the Department in 2023

Exemption type	Total Applications	Approved (%)	Declined (%)
Assistance at Operations	1,214	99%	1%
No exemption type determined	357	13%	87%
Locum	289	83%	17%
Spousal	153	97%	3%
Replacement Provisions	114	36%	64%
3GA-Fellowship Support Program	98	100%	0%
Specialty in Acute Shortage	93	96%	4%
Movement within catchment	59	91%	9%
Specialist trainee	47	100%	0%
Competent Authority Pathway	34	82%	18%
Discretionary	30	56%	44%
Withdrawn and duplicate applications	28	0%	100%
Remain at training placement post Fellowship	17	41%	59%
Prior Employment Negotiations	11	64%	36%
Aboriginal Controlled Community Health Service	7	100%	0%
3GA-Practice Experience Program	4	100%	0%
3GA-Australian General Practice Training (AGPT) Program	2	100%	0%
Exceptional Circumstances	1	0%	100%
Total	2,558	70%	30%

Source: Department of Health and Aged Care data provided March 2024.

Table 3.5: Section 19AB exemptions (by type) approved by Services Australia 2021-2023

Exemption type	2021 Total approved	2022 Total approved	2023 Total approved
3G-DPA	101	71	70
3GA-DWS	0	5	0
Academic	185	161	157
AGPT ^a	13	57	106
Approved Medical Deputising Service (AMDS) ^a	23	26	4
Approved Private Emergency Department (APED) ^a	9	11	0
Specialist after-hours	486	489	390
Assist at operations- permanent residents	183	131	171
Aboriginal Controlled Community Health Service	11	18	7
DWS ²⁶	1,012	851	865
NT ^b	14	41	29
Remote Vocational Training Scheme (RVTS) ^a	4	4	4
Specialist Trainee	760	683	740
Temporary resident- After-Hours	18	4	2
Total	2,819	2,552	2,545

Source: Services Australia data provided May 2024.

^a These relate to the exemption category, 'Placement on a workforce training program' under 3GA.

^b This represent IMGs in the Northern Territory, which is automatically included as a DWS and DPA under s19AB.

Finding

Stakeholders were broadly critical of the use of exemptions to Section 19AB to circumvent the 10-year moratorium. It was widely acknowledged that there are very few IMGs who serve the full 10-year moratorium, and that private recruiters are well versed in how to use certain exemptions to their advantage.

26 As per the Department, this represents general practitioners who were issued with a DPA class exemption through Health Professional Online Services.

There is an array of exemptions allowed under the Act, notably the '6 month locum' exemption, but also spousal exemptions, after-hours exemption and surgical assisting exemptions. The phenomenon of IMG GPs who settle into a country town only to be actively recruited by a GP corporate provider to work for serial '6 month locum' periods across a network of metropolitan practices is widely recognised.

Submission from Dr Richard Murray, Dean of Medicine, James Cook University

The number of people who receive exemptions seems to be growing, allowing them to move to urban centres. This goes against the reason for the policy in the first place.

Submission from the National Rural Health Alliance

The Replacement exemption is not appropriate for areas with a surplus workforce making this exemption unnecessary.

Consultation with Royal Australian and New Zealand College of Ophthalmologists

There are so many exemptions...the example of being an academic in a university - why does that count as an exemption? The same with a partner exemption. These are crazy ideas."

Consultation with Council of Presidents of Medical Colleges

19AB GPs more often bounce to the cities as soon as they Fellow...many find exemptions or secure academic exemptions.

Anonymous public survey response

Below is a summary of findings on each exemption category and the rationale for being retained, tightened or removed.

Finding

Some exemptions to Section 19AB continue to be appropriate in the current environment. These include the placement on a workforce training program, 5-Year International Medical Graduates Recruitment Scheme, Commonwealth-funded Aboriginal and Torres Strait Islander primary health care service, Competent Authority Pathway and Movement within catchment exemptions.

Some exemptions to Section 19AB continue to be appropriate in the current environment and should be retained. These include:

Commonwealth-funded Aboriginal and Torres Strait Islander primary health care service is still a necessary exemption category in line with the National Medical Workforce Strategy (NMWS), which sets out Indigenous health as a key priority. In 2023, 7 applications under this exemption were approved each by the Department and Services Australia. There was a suggestion by some stakeholders that to further encourage IMGs to take up roles in Aboriginal and Torres Strait Islander health services, this exemption should eliminate the restriction to 'Commonwealth-funded' and

instead, the exemption should extend to IMGs seeking positions in Aboriginal health services regardless of funding source. This potentially warrants further discussion with National Aboriginal Community Controlled Health Organisation (NACCHO) and other stakeholders; however, no change is being recommended as a result of this Review.

Placement on a workforce training program appears to make up most of the exemptions approved by both the Department and Services Australia. This includes Section 3GA programs, with specific training pathways represented in the data including AGPT, AMDS, Approved Private Emergency Department (APED) and RVTS. Exemptions which support training pathways continue to be appropriate to allow IMGs to specialise where places in a workforce training program are available.

5-Year International Medical Graduates Recruitment Scheme also continues to be appropriate in the context of the objectives of Section 19AB. Stakeholders acknowledged that this exemption was a driver of supply in rural and remote Australia, however noted that as soon as mandatory periods have been served, most IMGs will relocate to major city areas. It is recommended that this exemption category be retained pending further discussion below.

Competent Authority Pathway exemptions generally require IMGs to practice in a DWS or DPA area unless in exceptional circumstances. The exemption continues to remain appropriate as it enables IMGs on this pathway to access the required supervision in the most appropriate location.

Movement within catchment mostly applies to GP specialists moving *within* DPA catchments, and should be retained in order to allow mobility within DPA areas. 59 exemptions were received in 2023, with only 9% declined.

Finding

Stakeholder feedback indicated that some exemption categories are open to interpretation and unclear, which encourages attempts to 'game the system' to avoid moratorium requirements. These include the Spousal, Locum, Assist at Operations, Replacement, Academic, After-Hours, and Discretionary exemption categories.

Improving clarity and refining a number of exemption categories will streamline the process and ensure exemptions are only granted in appropriate circumstances. These include:

Locum exemptions represented a significant portion of the exemptions granted based on 2023 data and were frequently noted by stakeholders as a way to circumvent the 10-year moratorium. Additionally, the NMWS highlighted an over-reliance on locums to fill workforce gaps in public hospitals, primary care settings and specialist outreach services. Access to this exemption should be reduced to prevent IMGs performing back-to-back six-month locum positions in non-DWS/DPA areas indefinitely. It is recommended to limit this exemption to a total of six months across the duration of the moratorium.

Academic exemptions accounted for 157 exemptions in 2023, diverting a significant portion of the OTD workforce away from DWS/DPA areas. This exemption was consistently criticised by stakeholders and they indicated that it was being used strategically by IMGs to avoid obligations under 19AB, particularly in instances where an OTD might obtain a title only affiliation with an academic institution such as an adjunct role. One submission to the online survey noted that

“many find exemptions or secure academic exemptions”. It is recommended that this exemption be restricted to doctors who have a minimum of 0.4FTE of academic workload to exclude those who are affiliated with academic institutions but not involved directly in teaching or research work.

Assist at operations accounted for a significant number of exemptions granted in 2023 (1,373, 32%). However, limitations in the available data mean it is not possible to define conclusively how many doctors this represents, as information from the Department indicates that the number of hospitals the exemption is applicable for varies based on the individual practitioner/exemption request. In the Services Australia data, of the 171 requests approved in this category in 2023, 97 unique provider numbers are represented. This level of data is not available for the remaining 1202 exemptions processed by the Department in 2023, however they have indicated that most of the applicants defined as temporary residents in this category do not hold specialist registrations and are not specialists. Where specialty is indicated (i.e. only in the Services Australia data), applications are predominantly from GPs and to a lesser extent obstetricians and gynaecologists. Feedback from the Department indicates that this exemption might be overused, and it is recommended that a limit of 2 years be applied for which these exemptions can be granted for an individual OTD. This means an OTD can only work under this exemption category for a total of up to 2 years, before either going onto a training pathway or seeking a role under the 19AB moratorium. This limit may need to be amended after further data analysis and consultation with Services Australia.

Replacement Rules only represent a small number of exemptions granted in 2023 (41) and a high proportion of applications were declined in 2023 (64%). While initial stakeholder feedback was critical of this exemption, in practice it supports communities with retiring specialists who would ultimately be classified as DWS/DPA without a replacement specialist being approved for a provider number. It is recommended to retain this exemption, but to provide clarification to ensure that it is only granted where a region would be classified as DWS/DPA if not for the replacement being approved.

Spousal exemptions were often criticised by stakeholders and accounted for 148 approved exemptions in 2023. Some feedback was received that this category of exemption was being used strategically by IMGs to avoid obligations under 19AB. However, other stakeholders considered that an OTD's family circumstances is a key issue that can impact their retention in each role/location and argued that flexibility required by the spousal exemption is important to incentivise attraction of medical workforce to Australia. It is recommended to retain this exemption category, but to define what a 'reasonable distance' is between a non-DWS/DPA work location and a spouse's work location.

After-hours exemptions represent a significant portion of approved exemptions (392, 9% in 2023), 68% of these after-hours exemptions were granted to GPs, with 17% granted to anaesthetists and a further 17% granted for diagnostic radiology services. Stakeholder feedback was received that this exemption is not appropriate outside of general practice as after-hours services are not relevant in many specialties and almost always delivered in hospitals for non-GP specialties (and hospital posts are already excluded from the 10-year moratorium requirement). It is recommended that subject to the outcome of the Department's Review of after-hours primary care policies and programs²⁷ this exemption category to be available only to GP services.

27 Department of Health and Aged Care. Review of after hours primary care policies and programs, 2024. Available at <https://consultations.health.gov.au/primary-care-mental-health-division/the-review-of-after-hours-policies-and-programs/>

Discretionary exemptions are not granted in high volume and are often declined (30 applications, 46% decline rate in 2023). There was some support to remove this exemption category, and many stakeholders felt that the reasons for application were tenuous, such as care for an unwell family member who may have other support options. It is recommended to retain an option for discretion, but not to include in public documentation so that it is only sought in exceptional circumstances to ensure it is not being used to routinely circumvent the 19AB moratorium. Similar guidelines and request process could be established as is in place for the Pharmacy Location Rules²⁸.

Finding

A number of exemptions to Section 19AB should be removed where there is no strong rationale for their retention or where stakeholder feedback has suggested that exemptions are being used to bypass the obligations mandated under Section 19AB.

For a number of exemptions to Section 19AB, there is no strong rationale for their retention and/or where stakeholder feedback has suggested that exemptions are being used to bypass the obligations mandated under Section 19AB. These exemption categories include:

Prior employment negotiations accounts for only a small number of applications received (11) with many of these applications not approved (36%). This rationale supports the removal of this exemption; however, it is also anticipated that the proposed changes to DWS will also negate the need for this category. It is therefore recommended that this exemption category be removed.

Specialty in acute shortage approximately 89 of these exemptions were granted in 2023, No notable stakeholder feedback was received regarding this exemption. This exemption category is not considered necessary if the proposed changes to DWS are implemented, as the new approach will not exclude specialties from consideration as DWS. Therefore, it is recommended that this exemption category be removed.

Processes related to managing and monitoring 19AB exemptions

Consultations identified that exemptions are often granted at a point in time and are not routinely checked, monitored, or audited to ensure compliance and that they remain appropriate over time. Stakeholder feedback underscored concerns about strategic exemption use to bypass the 10-year moratorium and exploit recruitment loopholes. Therefore, it is recommended the Department and Services Australia establishes a systematic monitoring approach post-approval.

Finding

The full volume and impact of exemptions to 19AB is difficult to evaluate. The split of responsibility between the Department and Services Australia for assessing and record-keeping means that no one team fully 'owns' the exemptions process, causing challenges with strategic oversight.

28 Department of Health and Aged Care. Pharmacy Location Rules - Ministerial discretion guidelines. Available at: [https://www1.health.gov.au/internet/main/publishing.nsf/Content/D6C9A4076D1CBAA0CA25857B000B41E7/\\$File/Ministerial%20Discretion%20Guidelines%20June%202021.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/D6C9A4076D1CBAA0CA25857B000B41E7/$File/Ministerial%20Discretion%20Guidelines%20June%202021.PDF)

By extension, this means there are key differences and inconsistencies in the administration and associated datasets.

There is a need for a clear and transparent process of assessing and granting exemptions to Section 19AB, preferably under one area/team or governance arrangement. This consolidation would facilitate better tracking of exemption data over time, ensuring compliance, identifying and investigating any concerning trends in application data, and better identification of systematic attempts to strategically circumvent 19AB requirements.

This would ensure indefinite approvals for exemptions are reduced and that any exemptions granted remain appropriate over time.

Additionally, as the Department moves towards better oversight, one role of the proposed *Health Workforce Independent Review Panel* (see *Recommendation 1*) would be to take responsibility for approval of exemptions with a role akin to the Australian Community Pharmacy Authority (ACPA). The intention would be to ensure the panel is able to make decisions about exemptions at an arm's length to the Department and Minister, supported by the Department in a secretariat capacity.

Duration of moratorium obligations

10-year moratorium and scaling

From the time of medical registration in Australia, as indicated in Section 1, all overseas trained doctors and foreign graduates of an accredited medical school must work for at least 10-years in a:

- Distribution Priority Area (DPA) for GPs
- District of Workforce Shortage (DWS) for non-GP specialists,

This moratorium and all location restrictions under section 19AB of the legislation:

- end after 10-years for permanent residents or citizens
- continue unchanged for temporary residents.

As discussed above, there are numerous exemptions that allow participants to exit the scheme before the allocated time. This Review has suggested considerable tightening of these exemptions.

Nested in this 10-year moratorium are two programs that can reduce time served in a

DPA or DWS. They are the *5-year International Medical Graduate Recruitment Scheme*, and *Moratorium Scaling*.

5-Year International Medical Graduate Recruitment Scheme: The data indicate that since 2014 there has only been two applications under this Scheme for doctors to work in category A locations (most remote) which would reduce their moratorium to three years if they satisfied relevant criteria (attained fellowship) by the end of the three years.

Moratorium Scaling: Under this Program, an IMG can reduce the time they must work in a DPA or DWS through scaling. Working in eligible locations grants the IMG 'scaling credits'. The more remote the area, the more scaling credits gained, and the more credits attained, the sooner an IMG can work

in locations not classified as DPA or DWS, provided Section 19AA requirements are met. Although the moratorium remains a 10-year minimum, scaling credits can allow IMGs a class exemption to reduce the period of the moratorium.

The data reveals that, despite the incentives, neither of these Programs have been successful in attracting a significant number of IMGs to areas of greater need or into rural and remote settings, and hence, their reintegration back into the overall 10-year moratorium may be appropriate.

While this Report has assessed the possible extension of scaling credits for DWS (*Section 5*), the Review proposes maintenance of the 10-year moratorium, at least for the foreseeable future.

The Reviewers' preferred notion of scaling is enacting the ability to move between DPA/DWS catchment areas *during* the 10-year moratorium. To incentivise this practice in the areas of greatest need for both DPA and DWS, there should be a more organised capacity to move within DPA and DWS catchment areas. For example, an OTD who chose to initiate practice in an area of greatest need would, after a defined period (eg. three years), have priority status to complete the moratorium period in a DPA/DWS area of their choosing. The viability of such a program should be further assessed by the Department.

Finding

It is suggested that the Department consider integrating the above two programs back into the overall 10-year moratorium and better incentivise all IMGs to practise for a least part of their ten years in more disadvantaged areas of DPA/DWS.

The Reviewers' preferred notion of scaling is enacting the ability to move between DPA/DWS catchment areas *during* the 10-year moratorium. To incentivise this practice in the areas of greatest need for both DPA and DWS, there should be a more organised capacity to move within DPA and DWS catchment areas. For example, an OTD who chose to initiate practice in an area of greatest need would, after a defined period (eg. three years), have priority status to complete the moratorium period in a DPA/DWS area of their choosing. The viability of such a program should be further assessed by the Department.

Finding

Most stakeholders did not believe that changes to the length of the 10-year moratorium should be considered in the short-term.

Steps towards domestic medical workforce self-sufficiency (i.e. reduced reliance on IMGs) were considered as pre-requisites before moratorium requirements under Section 19AB could be scaled back without worsening maldistribution.

However, in the long-term, the 'default' duration of moratorium requirements for IMGs should be reduced. Reduction of the moratorium requirement should occur when there has been a demonstrable and sustained move towards national self-sufficiency of the medical workforce. This would be indicated by a reduction of medical specialist maldistribution and an increased propensity of domestic medical graduates to take up positions outside of major cities. Until domestic self-sufficiency can be achieved, the recommendations made later in this Chapter aim to improve the sustainability of Australia's IMG workforce, and the period they practice in areas of workforce shortage.

Perception that Section 19AB reinforces negative views of rural practice

Finding

Strong stakeholder feedback was provided that the requirement for IMGs to practice outside of major cities under Section 19AB perpetuates rural and remote locations as being relatively less attractive places to work, which can influence the intentions of domestically-trained doctors to practice in these locations.

The operation of Section 19AB as a 'negative lever' to influence workforce distribution is perceived by some as a 'penalty'; particularly because this requirement is only imposed upon IMGs (and not domestically-trained doctors). This sentiment was raised in written submissions, and extensively in consultations as creating a dynamic that undermines the objectives and intent of Section 19AB along with other initiatives that seek to address workforce maldistribution.

It (the 10-year moratorium) creates concept that rural practice is a punishment that you must endure before you get to the reward of practising in a metropolitan area. That sets up the wrong culture and a disincentive to long-term rural practice.

Consultation with Rural Health Commissioners and RDAA

Programs incentivising IMG placement in rural areas may inadvertently perpetuate a perception of rural populations being "practiced on" by less experienced clinicians.

Submission from the Royal Flying Doctor Service

While good intentions, there has been unintended consequences of these policies along with those connected to AGPT rural pathway, which have created negative perceptions of rural medicine for training and career, and therefore many have sought to avoid rural practice or do the time they must and then leave.

Submission from the Rural Doctors Association of Australia (RDAA)

This feedback was often associated with suggestions for Section 19AB to be repealed to avoid these impacts. However, most stakeholders considered that removing Section 19AB immediately would significantly worsen workforce maldistribution due to the heavy current reliance on IMGs. Perversely, the impacts would be felt most acutely in rural and remote locations; many of which are widely understood to be dependent on IMGs.

Finding

It was suggested that government policy should aim to phase out Section 19AB out over the long-term, whilst focusing on more positive levers to attract the medical workforce to work outside of major cities.

This would involve maintaining Section 19AB currently while adopting a deliberate, strategic policy focus on 'positive levers' that incentivise both domestic and overseas-trained doctors. The increased focus on positive levers could consider (but not be limited to):

- greater financial recognition of teaching and supervision activities in areas of workforce shortage. This could be achieved by making specific incentive payments under Medicare for specialists to engage in training/supervision activities.
- greater recognition of the financial and clinical (patient complexity) challenges of operating in areas of workforce shortage. This could take the form of 'loadings' to Medicare rebates for services delivered in areas of workforce shortage (similar to remoteness loadings applied within the national acute admitted patient activity-based funding (ABF) model), with higher loadings applicable to areas where there are 'severe and persistent' workforce shortages.
- an increased emphasis on maximising the likelihood that doctors will choose to practice outside of major cities, and long-term retention in these areas, by:
 - expanding requirements for medical schools to select candidates with a rural background to complete undergraduate/postgraduate medical study
 - expanding requirements for medical Colleges to expose domestically-trained doctors to practice outside of major cities as part of training pathways
 - expanding requirements for jurisdictions and medical practices that employ IMGs to prioritise experience and interest in rural/remote practice as part of selection criteria.
- allowing FGAMs to access places at rural clinical schools and other funded rural health training programs to increase exposure and likelihood of staying in non-metropolitan areas post-moratorium.

The impacts of these initiatives on workforce maldistribution should be closely monitored, with defined 'trigger points' for reducing the duration of the 10-year moratorium requirements and/or the scope of medical professionals they apply to.

Training, supervision and supports available to IMGs

Finding

The 10-year moratorium often places IMGs in areas where there is limited or no access to professional support or supervision in highly challenging clinical environments.

IMGs working in areas of workforce shortage have reported deficiencies in training, supervision, and support opportunities. These issues are longstanding and were noted at length in the 2012 *“Lost in the Labyrinth”* Senate Inquiry²⁹. However, deficiencies in training and supervision requirements for IMGs subject to Section 19AB were re-iterated extensively in stakeholder feedback to the Review. Key issues raised in feedback included that:

- There is limited or no access to professional support or supervision in highly challenging clinical environments. These challenges are exacerbated by the fact that IMGs are often provided with limited orientation to the Australian health system, which can mean many are ill-equipped to practice in areas where there is limited infrastructure and professional support mechanisms.
- In the NT at least, IMGs are not allowed to access the training and supports provided to Australian GP registrars working remotely.

IMGs practising rurally need to be supported via mentoring, training, family support and onboarding so that they “choose” to stay rural, and they feel welcome and at home with their families to be part of local communities.

Submission from RDAA

Some IMGs encounter difficulties in adhering to the 10-year moratorium if they struggle with support for training, isolation, discrimination, lack of family support, or find it difficult to develop attachment to the region. Jurisdictions often do not provide the support that they should with learning and upskilling of IMGs. The supervisory requirements of existing rural general practitioners, which are often substantial, are not adequately remunerated, making it challenging for a small rural practice to sustain...the current levers do not acknowledge the necessary support and training for both IMGs and supervising doctors as they transition into rural areas.

Anonymous response to the public survey.

29 Standing Committee on Health and Ageing. *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*. Canberra; March 2012.

The challenges for IMGs practising in Australia also extend to OTDs who migrated from countries with a similar health system. One clinician from the UK submitted to a 2022 Senate Community Affairs Committee hearing³⁰

I can tell you that, if you're coming from the UK in particular, going rural is scary. It is not something that a lot of UK GPs feel comfortable with, because we're not used to that environment. We were never trained in that environment. There may be a few exceptions, but most places in the UK are not anywhere near the rural environment. There are always people around. There are always services around. Working in the bush, being so remote and cut off from other medical facilities, was never something I would have considered.

Submission to the 2022 Senate Community Affairs Committee hearing.

Despite the challenges associated with IMGs working in a new country and an unfamiliar environment, many stakeholders reported that few IMGs are adequately oriented to practice in Australia, or equipped with the specific cultural knowledge and skills to practice effectively. This can mean these IMGs are unable to provide the same level of care as other doctors.

Mandating for overseas-trained doctors and graduates to work in rural and remote areas can also be challenging as these doctors are new to Australia, new to the Australian health care system and often do not have adequate (if any) orientation or cultural safety training to ensure they are delivering quality health care services

Submission from the Australian Primary Care Nurses Association

The capacity of many doctors in rural and remote locations is already stretched, which often leaves them with limited time to provide the level and type of supervision IMGs need to practice effectively.

Communities and other healthcare professionals in underserved areas also suffer because of these issues where they result in turnover of IMGs. It was suggested that the result can be a debilitating turnover of often 'conscripted' doctors and that the arrangement destabilises small communities, makes local workforce planning difficult and often can be exasperating for local clinicians who provide support and supervision to doctors in training, often in the hope that they will stay on as colleagues.

There are further challenges with accessing training and fellowship/specialist registration opportunities post-moratorium. IMGs are still required under Section 19AA to undertake a fellowship or specialist registration even after serving their moratorium and highlighted barriers to accessing these opportunities. Many fellowship or specialist registration programs are supported by the Commonwealth and conducted through the clinical Colleges, however for many IMGs they can only be accessed by self-funding (making it very expensive for them).

30 Senate Community Affairs References Committee. Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians - Interim Report. Parliament of Australia, April 2022

Despite feedback from some stakeholders that many Commonwealth-supported programs are under-subscribed by domestic trainees, there may be opportunities to expand access for OTDs (currently it is only if they meet the eligibility requirements of the Australian Medical Council), and FGAMS (currently it is only if they can meet the requirements of the AGPT Program).

In response, a wide range of stakeholders recommended that training, supervision and support arrangements for IMGs subject to Section 19AB need to be enhanced to improve the quality of care IMGs can provide to regional and rural communities, along with the likelihood of retaining them after the end of their moratorium period. Interventions that were suggested to address these issues were targeted at IMGs, other health professionals and communities themselves. They included:

- financial recognition of the importance of training and supervision to support IMGs to provide high-quality care, and the opportunity costs associated with providing training and supervision in areas of workforce shortage. This could be achieved through additional funding for training programs related to supervision of IMGs in areas of need. Further support needs to be dedicated to resourcing the health professionals that supervise and mentor IMGs and other health professionals coming from overseas to work. This could take the form of incentive payments for practitioners providing training and supervision to IMGs in designated areas of workforce shortage.
- establishing 'baseline' orientation requirements for IMGs to support effective transitions to practice through orientation modules to the Australian health system, cultural considerations for practice in Australia, peer support and networking opportunities (potentially with colleagues in metropolitan areas if limited collegiate support is available where the doctor is working). This program would include, for example, rural and Indigenous culture and history, working with marginalised groups such as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer+ (LGBTIQ+) people, ethical and gender issues in rural practice. It would also include in working in multidisciplinary teams, quality and safety, giving and receiving feedback and professional networks.

I wanted to highlight with you the importance of comprehensive LGBTIQ+ training, in the Australian context, for international Doctors. The Australian context for LGBTIQ+ communities can vary dramatically with other countries. There are many countries where LGBTIQ+ people are criminalised³¹: including the death penalty and life imprisonment. Not only is it important for Doctors to understand LGBTIQ+ people's health needs, it is critical that they understand the protections that are in place and for example the Sex Discrimination Act that makes it unlawful to discriminate on the basis of a person's sexual orientation, gender identity and intersex status.

Another area that requires attention is support for LGBTIQ+ Doctors who come to Australia. It can be overwhelming to have potentially lived in fear and hide who you are and come to another country where this is not the case (noting that homophobia, biphobia and transphobia are alive and well across Australia and we are not always safe). It is important that Doctors are supported to adapt as part of their relocation experience.

Submission from LBGTIQ+ Health

31 <https://database.ilga.org/criminalisation-consensual-same-sex-sexual-acts>

- allowing (and encouraging) FGAMS to undertake training in rural clinical schools. Greater exposure of FGAMS to rural practice was widely considered to increase their likelihood of taking up positions in these locations, provide opportunities for funded supervision and support and better equip them for long-term success (and retention) in areas of need once they receive their fellowship or specialist registration. Opening up access to allow FGAMS with a stated interest in rural practice to undertake full-fee places in rural clinical schools would allow this.
- purposeful selection of IMGs for work in underserved areas based on interest and previous experience of rural or remote practice. Many consultations highlighted the value (and evidence) of supporting the selection of domestic or overseas-trained medical students (or specialist IMGs) based on experience and interest in rural practice. Embedding requirements for previous relevant experience would likely enhance the quality of care provided by IMGs, reduce supervision burdens on existing health professionals and improve the long-term retention of IMGs in areas of need.

These measures aim to support the sustainability of the current and future IMG workforce in areas of need while the implementation of 'positive levers' takes effect. Ideally, these measures would be retained once the 10-year moratorium is removed in the long-term, to ensure that all doctors that choose to practice in areas of need (not just IMGs) are effectively supported to deliver high-quality care.

Two specific initiatives are proposed.

- A Bridging Program should be developed for IMGs wanting to enter GP training and identified as requiring assistance.
- GP training places should be opened up to IMGs on temporary and or non-residency category visas once they have met College clinical requirements for entering training. Supervision of these IMGs be scaled appropriately for maximum support utilising on site and remote supervision models and developing a community of practice for the IMG.

Equity considerations

Finding

The 10-year moratorium can be considered discriminatory by unfairly preventing IMGs from seeking employment outside of DWS, limiting career progression, limiting access to support and development opportunities, as well as impacting on families when the same requirement is not applied to domestically-trained medical graduates.

The 'Lost in the Labyrinth' inquiry³² found that the 10-year moratorium is discriminatory and imposes immense hardship on OTDs and their families. If there is to be a rural service obligation attached to the allocation of Medicare provider numbers, this service obligation should apply to all doctors wishing to practice in Australia, not just those who trained overseas. Mandating for overseas-trained doctors and graduates to work in rural and remote areas can also be challenging as these doctors are new to Australia, new to the Australian health care system and often do not have adequate (if any) orientation or cultural safety training to ensure they are delivering quality health care services.

Submission from the RDAA

Just because one doctor graduated from a different country, he or she should not be discriminated from working in an area where his or her colleague (works) who graduated from an Australian medical school. IMGs are recognised by the Medical Board of Australia having same standard of knowledge and skills as an Australian medical graduate, but unfairly treated by the Government, not allowing them to work where they want. We cannot see such laws exist for any other profession.

For the 25 years I have been here as a Dr I have worked regionally and remotely. I am lucky in that I am from a farming background myself and my husband is a farmer. I have only worked regionally/remotely I have never worked in the city, but this suited me well as it is a lifestyle that I chose, not one that was inflicted on me. Most IMGs that I have worked with for the last 25 years certainly did not have the same motivation and it most certainly led to a lot of family problems and unhappiness for them. Particularly, given the cultural diversity of IMGs - this is not reflected in many of the rural and regional areas they are forced to go to which inevitable leads to issues. Sadly, rural and regional Australia can be extremely racist.

Anonymous responses to public survey from healthcare providers

32 Standing Committee on Health and Ageing. Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors. Canberra; March 2012.

The perceived discriminatory intent of Section 19AB was also linked to the challenges associated with providing training and professional development opportunities. These issues relate to placing IMGs in areas where there is limited or no access to professional support or supervision, in what has been described as some of the most professionally challenging clinical environments.

Finding

There is a risk that extending the application of Section 19AB to domestically-trained doctors could negatively impact the domestic medical workforce pipeline, particularly in primary care, and make it more challenging to achieve national self-sufficiency.

While no stakeholders refuted the fact that the 10-year moratorium imposes different requirements on IMGs than domestically-trained doctors, many highlighted the likely challenges associated with requiring a mandated period of service for domestically-trained doctors given the strong preference for most doctors to work in larger population centres. Specifically, the risk that extending the application of Section 19AB could negatively impact the pipeline of domestically-trained doctors, particularly in primary care, and make it more challenging to achieve national self-sufficiency. On this basis, the option of extending the application of Section 19AB to include domestically-trained doctors has not been pursued.

Instead, measures to increase the voluntary uptake of regional, rural and remote positions by both domestic and overseas-trained doctors should be pursued, given the widespread preference for 'positive levers' as the solution to medical workforce maldistribution. Effective implementation of some of these levers (such as strategic selection of IMGs with interest/experience in rural health, and improved orientation, training and supervision requirements) will support the phasing out of Section 19AB over the long-term. It would also help to address some of the impacts that were raised as being negative consequences of the 10-year moratorium on IMGs.

Future role of Section 19AB

The issues and recommendations presented in this Section demonstrate that there is value in retaining Section 19AB as a lever to address medical workforce maldistribution. Reliance on IMGs – particularly in many rural and remote areas – was consistently highlighted as a feature of Australia's current medical workforce; and that repealing Section 19AB would have significant negative consequences until substantial progress is made towards domestic self-sufficiency.

The recommendations made in this Chapter propose that Section 19AB is retained largely in its current form, with a key focus on reducing medical workforce maldistribution in line with the priorities set out in the NMWS. It is proposed that a moratorium remains; that it applies only to IMGs, and that the duration of moratorium obligation remains at 10-years. It is also suggested that after 10 years, consideration should be given to offering IMGs on temporary visas citizenship with the right to permanently live and work in Australia.

The key change to Section 19AB proposed in this report is to reduce the number of exemption categories to Section 19AB and clarify eligibility for some exemption types. These recommendations seek to reduce 'leakage' of IMGs outside of areas of need and maximise its impact on addressing workforce maldistribution.

However, the recommendations made also recognise broad stakeholder feedback about the unintended consequences of Section 19AB on equity, quality of training, career progression for IMGs and broader concerns that Section 19AB actually reinforces a negative perception of practice outside of major cities. In response, the recommendations seek to establish a more strategic, explicit focus on positive levers (rather than negative levers, such as Section 19AB) as a way of attracting both domestic and overseas-trained doctors to work outside of major cities. Over time, the intention of these recommendations is to reduce the reliance on Section 19AB and IMGs in favour of positive levers and domestically-trained doctors.

These directions are consistent with priorities in the NMWS that seek to reduce the reliance of Section 19AB and IMGs in rural areas and increase in domestically-trained medical workforce (*see Section 7*). Given the extent of reliance on IMGs in these areas, these changes are recognised as requiring a long-term, strategic response with the ultimate intention of reducing the reliance of Section 19AB over time.

Recommendations

Recommendation 6

Section 19AB should be retained as it is widely considered to have mitigated the impacts of both domestically trained doctors and IMGs preferring to work in major cities. The objectives of Section 19AB should be clearly stated as only addressing medical workforce maldistribution.

Recommendation 7

Exemptions should be retained with some modification (see Section 3) that continue to be appropriate in meeting the objectives of Section 19AB should be retained. that continue to be appropriate in meeting the objectives of Section 19AB should be retained. This includes retention of:

- Placement on a workforce training program
- 5 Years Overseas-Trained Doctor Scheme
- Commonwealth-funded Aboriginal and Torres Strait Islander primary health care services
- Competent Authority Pathway
- Movement Within Catchment.

Eligibility for several of the other exemptions to Section 19AB should be clarified and tightened, with robust definitions made publicly available and applied evenly for the following exemptions:

- Spousal
- Academic
- Locum
- After-Hours
- Assist at Operations
- Discretionary.
- Replacement

The exemption categories, 'Specialty in acute shortage' and 'Prior Employment Negotiations' should be abolished as they will be redundant under the proposed changes to DWS.

Recommendation 8

The monitoring of exemption compliance should be enhanced. This will require shared responsibilities with Services Australia for systematic oversight. The proposed Health Workforce Independent Review Panel should be responsible for overseeing the assessment and approval of exemption applications to ensure independent and consistent decision-making.

Recommendation 9

The duration of moratorium requirements for IMGs under Section 19AB should continue to be 10-years, at least for the short-to-medium-term. To better incentivise IMGs to practise in areas of greatest need, there should be capacity for those IMGs who initially practise for a defined period in those areas to have a pathway and priority status to complete their 10-year moratorium in a DPA/DWS area of choice.

Recommendation 10

Training, supervision and support arrangements for IMGs subject to Section 19AB should be enhanced to improve the quality of care IMGs can provide in areas of need. Geographic allocation for training should be graduated to reflect differential areas of need.

Two specific initiatives are proposed.

- A Bridging Program should be developed for IMGs wanting to enter GP training and identified as requiring assistance.
- GP training places should be opened up to IMGs on temporary and or non-residency category visas once they have met College clinical requirements for entering training. Supervision of these IMGs be scaled appropriately for maximum support utilising on site and remote supervision models and developing a community of practice for the IMG.

4. Distribution Priority Area (DPA)

DPA Background

The DPA classification system was introduced in 2019 to facilitate the placement of registered medical practitioners in communities of greatest need across Australia. The DPA replaced the DWS Assessment Areas for IMG GPs and Bonded Doctors in general practice, which was largely based on a GP-to-population ratio determined by Medicare-subsidised services.

DPA classification provides threshold access to a range of programs for general practices to increase their workforce. DPA status is used:

- as part of Section 19AB provisions of the Act to distribute IMGs to regional, rural, and remote areas and to enable temporary resident and permanent resident IMGs to access 3GA Training and Workforce Programs
- as part of Section 19AA provisions of the Act to enable non-vocationally recognised doctors, who are Australian citizens or permanent residents, postgraduate year (PGY) 3–5 and not on a training pathway to access 3GA Workforce Programs
- to identify eligible locations for bonded Australian-trained doctors to complete their ROSO in general practice.

The DPA is more complex than the previous DWS Assessment and is based on a geospatial framework of GP catchments.

GP catchments are constructed with consideration of several factors relating to the MBS and provider-patient data over five years: population demographics; GP workforce and infrastructure – location and number; geographic accessibility and boundaries. There are over 800 non-overlapping GP catchments across Australia.

Identifying if a GP catchment is eligible for DPA status considers multiple factors as follows:

- Medicare billings by gender and age of patients residing in the GP catchment
- demographic of the community including age, gender, and Socio-Economic Indexes for Areas (SEIFA)
- area remoteness (classified using the MMM):
 - DPA for IMG GPs uses a benchmark based on the average MM2-level access to GP services
 - MMM blanket rules are used to assign DPA status automatically.

These data produce a measure of access to GP services within a GP catchment which is then compared with a benchmark, as follows:

- for IMGs, the benchmark is calculated by the average level of GP services (based on weighted average Medicare expenditure) in MM2 locations (adjusted for population levels)
- for the Bonded Medical Programs, the benchmark calculated on the average level of GP services (weighted average Medicare expenditure) at a national level (adjusted for population levels).

If a GP catchment is lower than the benchmark, the catchment receives DPA status and becomes eligible for particular programs. If a GP catchment is higher than the benchmark, DPA status is not assigned unless automatic rules (relating to MMM apply), or an exemption is granted.

When the DPA classification system was introduced in 2019, GP catchments in MM 5–7 were automatically allocated DPA status, as was all of the NT.

GP catchments in inner metropolitan areas were automatically deemed non-DPA status. Following a review of the DPA in 2021 the automatic rule was extended to include all MM3 and MM4 locations from January 2022. MM2 was included in the automatic rule from July 2022.

DPA status of GP catchments is assessed annually.

Currency of original objectives

The original intent of DPA as a workforce distribution lever was to facilitate the placement of registered medical practitioners to deliver general practice services in communities of greatest need across Australia for the following cohorts:

- IMGs accessing Medicare under Section 19AB
- Non-VR doctors (IMGs and domestic) enrolled in Section 3GA programs under Section 19AA
- Bonded Australian-trained doctors to complete their ROSO in general practice (as per the relevant BMP or legacy program criteria which may specify MMM or DPA).

Areas of need

The overwhelming assumption from stakeholders was that DPA is a classification system to determine areas of need in rural and remote areas. Based on review of the original grey literature about DPA, the intention was only to identify priority areas, and not specifically those in remote areas.

This is in contrast with the Nous Review³³ in 2021 which states:

“..the policy intent is to identify areas in regional, rural and remote Australia with unmet need lacking access to GP service”.

33 Nous Group, “Review of the DPA Classification System,” 2021.

Although the Government response³⁴ did not exclude metropolitan areas, stating:

“The DPA’s purpose is to identify areas of Australia experiencing insufficient patient access to GP services and to meet the needs of the community, primarily in regional, rural and remote Australia.”

This suggests that DPA may have an intended application to identify priority areas for all areas of Australia.

The expansion of DPA status to include outer metropolitan areas indicates access issues are felt more broadly than just in regional, rural and remote areas. However, there is firm acknowledgement that access issues in fast-growing, outer urban communities with diverse population needs are not the same as those faced by rural and remote communities.

A model that considers needs of metropolitan areas may also be needed given higher levels of need in some of those areas

Submission from Mental Health Commission

The assignment of DPA status to a GP catchment only signals access to the workforce, such as IMGs under Section 19AB, it does not guarantee recruitment and retention of the medical workforce. Other issues contributing to the recruitment and retention of the medical workforce (particularly in more remote settings) require targeted policy and funding initiatives such as financial incentives for locum relief.

Findings

- Rural and remote areas of Australia have experienced, and continue to experience, persistent challenges in attracting and retaining health workforce. Notwithstanding, the use of DPA to distribute GP workforce to areas of comparative higher need is not limited to these settings.
- Other issues contribute to the recruitment and retention of the medical workforce (particularly in more remote settings). These issues may require targeted policy and funding initiatives outside of DPA.
- There are workforce and access challenges distinct to all geographical settings. More contemporary and granular data is required to improve current and predictive inputs into determining DPA status.

34 The Department of Health and Aged Care, “Australian Government Response: Review of the Distribution Priority Area (DPA) Classification System,” 2022.

Bonded Medical Program

Eligible locations for BMP (and legacy programs) participants from 2004 to 2015 vary depending on their individual Deed of Agreement. Thus, the use of multiple distribution classification systems (DPA, DWS, MMM) is an artefact from the legacy schemes.

The intent of the BMP Schemes has shifted over the years as they were designed and implemented to achieve different intents, or to complement each other (i.e. when BMP and the Medical Rural Bonded Scholarship Schemes ran concurrently). The most recent Explanatory Memorandum was in 2019, which was subsequently amended in 2021³⁵. The stated objective of the current BMP is interpreted as the current intent.

The Explanatory Memorandum from the 2021 Legislative amendment summarises the purpose of the BMP:

“The Government is committed to better distributing the medical workforce to regional, rural, and remote communities, which on average have less access to doctors than people in metropolitan areas”.

Based on the assumption DPA should identify areas (GP catchments) of need across all settings, the current intent of the BMP outlined above does not align with DPA. Given this discrepancy, consideration should be given to using a different classification and/or definition of regional, rural, and remote to identify eligible ROSO locations.

Finding

Based on the assumption DPA should identify areas (GP catchments) of need across all remoteness settings, the current intent of the BMP (which focuses on non-metropolitan areas) does not align with the proposed amendments to DPA.

Appropriateness

The appropriateness of the DPA to distribute the medical workforce to areas of need and the alignment to current health workforce policy have been examined in the following sections.

35 Health Insurance Amendment (Enhancing the Bonded Medical Program and Other Measures) Bill 2021. https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bid=r6765

Alignment to current workforce policy

DoHAC's *National Medical Workforce Strategy*³⁶ and the *Stronger Rural Health Strategy* (SRHS)³⁷ both articulate a goal to rebalance the supply and distribution of doctors across locations, aligning with the fundamental intent of DPA. DPA intends to identify areas with reduced GP services across all levels of remoteness and prioritise an increased distribution of workforce to these areas.

The MM2-7 blanket rule to automatically grant DPA status to many areas with different levels of GP servicing effectively eliminates the ability of DPA to identify true areas of comparative need. Therefore, DPA is no longer effectively addressing the geographical maldistribution of the medical workforce.

Workforce strategy goals to improve doctor wellbeing, adapt to new models of care, and build a flexible workforce are not able to be directly influenced by the DPA. However, the distribution of IMGs areas of need across Australia requires thought on how to most effectively onboard and integrate this cohort to foster a positive experience. The work of the concurrent reviews underway aims in part to address these goals.

Finding

While the intentions of the DPA system are still broadly relevant, the MM2-7 blanket rule results in it no longer being an effective distribution mechanism.

DPA methodology

There are several assumptions and input considerations underpinning the determination of DPA status that include:

- GP catchments are the underlying geographical unit
- MBS billings (patients) in a GP catchment
- Community demographics (e.g. as observed through SEIFA)
- For IMGs, the national benchmark is the average level of GP services in MM2
- GP catchments located in MM2-7 are automatically assigned DPA status
- DPA status is calculated on an annual basis

36 Priority Two of the Strategy is to rebalance supply and distribution to correct the geographic maldistribution of doctors, with a focus on the 29% of the population in rural and remote areas.

37 The strategy has a fourfold focus on teaching, training, recruiting, and retaining. This will provide more options for doctors to train and practise in rural and remote regions.

GP catchments and MMM

GP catchments intend to group populations based on where they are assumed to receive their GP services with minimal travel time (while acknowledging that patients may also choose to access GP services in another GP catchment). The development of GP catchments considers multiple factors, including patient flow, clinics/hospitals, population count, population density, state borders, transport networks, street maps, and the natural environment³⁸.

These factors are considered at a sub-catchment level and averaged across a catchment. However, GP catchments vary in area greatly from 11 km² to 34,4315 km², a variance which is reflected in the heterogeneity of spatial and aspatial dimensions within catchments.

There is poor alignment in the overlay of MMM boundaries and GP catchments, with some GP catchments spanning more than one MMM classification category, as follows:

- 277 GP catchments include two MMM categories
- 70 GP catchments include three MMM categories
- 15 GP catchments include over four MMM categories³⁹.

Within a GP catchment, MMM can vary as widely as MM1 to MM7 (for example the Fremantle catchment in Western Australia and the Redcliffe catchment in Queensland are mostly MM1 but a small portion is MM7).

GP catchments spanning multiple MMM categories can result in some GP catchments with partial DPA status (54 GP catchments with partial DPA status in 2023). For example, the GP catchment of Bellarine ranges from MM1–4. Bellarine GP catchment would be classified as non-DPA if there were no MMM blanket rule as it receives GP services deemed higher than the benchmark.

However, the portions of the Bellarine GP catchment that are MM2–4 are automatically classified as DPA, while the MM1 area is non-DPA. The use of partial DPA status in a catchment may also exacerbate the maldistribution of the GP workforce. The GP catchment spatial unit intends to group populations with similar access to GP services, but partial DPA status suggests (likely incorrectly) that access to GP services differs across a catchment. Therefore, the portion of a GP catchment with partial DPA status may unjustifiably be considered of more need than the non-DPA portion, thus exacerbating the maldistribution of the GP workforce.

Finding

The misalignment between MMM and GP catchments has resulted in partial DPA catchments, potentially compounding health workforce maldistribution.

38 The Department of Health and Aged Care, "GP Catchments Review 2023,

39 The Department of Health and Aged Care. Distribution Priority Area (DPA) for 19AB - July 2023 Update

MBS billing

The level of access to GP services in each GP catchment is determined by patient MBS billing data (weighted for demographic information such as age and sex and converted to a dollar per head of population value). However, MBS billing data is a blunt tool that does not account for other factors such as the complexity of a patient population, consumer access (availability of bulk billing, appointment wait times for a patient to see their GP), models of primary care, other services of GPs in addition to primary care, e.g. visiting medical services to rural and regional hospitals or supervision load noting that rural and regional GPs have a higher supervision burden than metropolitan GPs.

The variation of the MBS landscape is evident from the total weighted expenditure per person in catchments across each MMM class. The minimum amount per person is less in MM6 (\$106) and MM7 (\$15) than in MM1–5 (approximately \$150–\$176 per person in some catchments).

Additionally, reliance on MBS billings can result in anomalies in particular areas reflected in part by absent DPA calculations for some GP catchments, such as:

- the Holsworthy Military Area (New South Wales), MM1, Estimated Resident Population (ERP) 3, \$1,458 per person),
- Koolpinyah (Northern Territory, MM5, ERP 14, \$980 per person)
- the Wilderness (Tasmania) catchment (TAS, MM6, ERP 7, \$58,037 per person) Note: the Tasmanian Wilderness catchment was particularly anomalous with an overall expenditure of \$406,257.50 in July 2023 despite an expenditure of \$342.20 in July 2022.

The MBS billing variations within catchments across MMM classes cannot be purely attributable to SEIFA, age, gender, or ERP, as used to calculate DPA. Across all MMM classes, there is a wide range of weighted expenditures per person (*Table 4.1*).

Finding

The average weighted MBS expenditure (per person) in an MMM category is not an appropriate measure to use as a benchmark. It does not reflect the level of access to GP services or patient complexity/needs and the subsequent level of GP services required to address the catchment needs.

Table 4.1: The total weighted MBS expenditure per person in a catchment, with variation shown across catchments within each MMM class

MMM	Minimum	Maximum	Range	Average
1	\$144	\$1,458	\$1,313	\$334
2	\$168	\$479	\$310	\$332
3	\$150	\$585	\$435	\$377
4	\$176	\$542	\$366	\$363
5	\$169	\$980	\$810	\$386
6	\$106	\$58,037*	\$57,931	\$1,219
7	\$15	\$1,135	\$1,120	\$235

The lowest MM value within a catchment has been used for partial DPA catchments. Source: Department of Health and Aged Care, DPA for 19AB: July 2023 Update - Summary, 2023. *The Tasmanian Wilderness catchment had an overall expenditure of \$406,257.50 in July 2023 despite an expenditure of \$342.20 in July 2022.

DPA benchmarks

The DPA uses benchmarks (one for IMGs and one for bonded Australian doctors) to determine the priority status of each GP catchment.

Benchmarks are based on a calculation of weighted patient MBS expenditure per population within a catchment at a Statistical Area 1 (SA1) level⁴⁰. The methodology does not have sufficient sensitivity to address variations in local models of multidisciplinary care. For example, in many regional areas, local GPs provide hospital-based emergency and inpatient care in addition to primary care. It can be argued therefore that there is a greater baseline requirement in terms of considering the workforce benchmark in such areas compared to metropolitan areas where typically GPs provide primary care services only.

While some population demographics are included in the calculation of DPA benchmarks, there is no consideration for other demographics that alter the population health needs, e.g. Culturally And Linguistically Diverse (CALD) or Indigenous populations, or the incidence of chronic disease. More granular inputs into the benchmark were recommended in the previous review of DPA by Nous in 2021. In response to the Nous Review, the Government supported providing more contextual health workforce data on each catchment, including SEIFA disadvantage scores, number of practices, GP FTE, and supply and demand data. Currently, not all of those inputs are included in the DPA benchmark methodology⁴¹.

40 SA1 are geographical areas defined by the Australian Bureau of Statistics as part of the Australian Statistical Geography Standard. They generally have a population of 200 to 800 people.

41 Health Workforce Division, "Distribution Priority Area (DPA) 2023 Methodology," The Department of Health and Aged Care, 2023.

DPA uses different benchmarks for IMGs and AMGs underpinned by different weighted averages. The benchmark for IMGs is based on the weighted patient MBS expenditure in MM2, while the benchmark for bonded doctors is based on the weighted patient MBS expenditure at the national level (refer to *Appendix B*). Across the jurisdictions, there are wide differences in the actual and benchmark values averaged across catchments, at both the MM2 and national level.

For example, MM2 actual expenditure varies from approximately \$104,000 in Australian Capital Territory to \$15 million in Queensland, and MM1–7 actual expenditure varies from approximately \$2 million in Northern Territory to approximately \$15 million in Victoria. The range of actual expenditure across both MM2 (IMG benchmark) and MM1–7 (bonded benchmark) means that the application of an average weighted benchmark may not be appropriate.

AMGs are potentially eligible to practice in a different number of DPA catchments to IMGs subject to different benchmarks. In 2021, the Nous Review stated that there were a further 11 catchments eligible for BMPs but not IMGs. Based on the 2023 update, this number has drastically increased a further 118 catchments eligible for BMPs, based on the benchmark alone (*Table 4.2*). When the MM2–7 blanket rules are applied, there are equal numbers of eligible catchments for bonded AMGs and IMGs.

Table 4.2. The number of catchments below the national average (BMP) benchmark and the MM2 average (IMG) benchmark, 2023

MMM	Total GP Catchments	Below national benchmark		Below MM2 benchmark	
	No.	No.	%	No.	%
1	233	113	48.5%	57	24.5%
2	80	48	60.0%	40	50.0%
3	69	37	53.6%	26	37.7%
4	84	54	64.3%	44	52.4%
5	224	150	67.0%	127	56.7%
6	63	51	81.0%	45	71.4%
7	74	64	86.5%	60	81.1%
Total	827	517	62.5%	399	48.2%

The lowest MM value within a catchment has been used for partial DPA catchments.

Source: Department of Health and Aged Care, DPA for 19AB: July 2023 Update and DPA BMP: July 2023 Update.

The rationale for using a national average as the benchmark for the BMP Scheme is based on the use of a national benchmark in the DWS as written into the Deed of Agreements. This aligns the BMP benchmark for GP specialist and non-GP specialists. Noting that medical students that enter into the BMP Scheme have not yet selected a speciality pathway, it is important to keep relative equity between locations for Return of Service Obligations (ROSO) for GP and non-GP specialists. If ROSO obligations were more relaxed for e.g. non-GP specialities compared to GP specialities, an unintended consequence could be that bonded students are more enticed into non-GP speciality pathways.

The rationale for using a different benchmark for IMGs practising as GPs (MM2 average rather than national) remains unclear. Stakeholders reported having a poor understanding of how the benchmark was calculated and expressed a desire for more transparency.

We were told that DPA does include SEIFA but there is a lack of transparency on how ... we need transparency to support practices seeking exemption from DPA. Hard to make the case [currently]

Submission from PHN Cooperative

Findings

The range of actual expenditure across both MM2 (IMG benchmark) and MM1-7 (bonded benchmark) means that the application of an average weighted benchmark may not be appropriate.

The rationale for using a national average as the benchmark for the BMP Scheme is based on the use of a national benchmark in the DWS as written into the Deed of Agreements. This aligns the BMP benchmark for GP specialist and non-GP specialists. Noting that medical students that enter into the BMP Scheme have not yet selected a speciality pathway, it is important to keep relative equity between locations for ROSO for GP and non-GP specialists. However, why the DPA benchmark for IMGs was not matched to that for people on the BMP Scheme is not understood. Regardless, use of MMM blanket rules have resulted in the same number of eligible catchments for both cohorts.

MMM blanket rule

Of the 827 GP catchments in Australia, 700 are currently designated DPA. This is determined by the MM2-7 blanket rule.

The MM2-7 blanket DPA rule has resulted in the assignment of DPA status to GP catchments that are above the benchmark (*refer Appendix B*). Of GP catchments in MM2-4, approximately 50% or fewer are below the DPA benchmarks. In MM6-7 there are much higher proportions of GP catchments below the DPA benchmarks (71 % and 81% respectively). The mismatch between the numbers of catchments with DPA status due to blanket MMM rulings and those below the DPA benchmark indicates that remoteness (as determined by MMM) is not an appropriate sole surrogate measure of need. The DPA assignment of priority status using the MM2-7 blanket rule does not consider other factors that influence the variation in workforce demand between otherwise commensurate geographically classified areas.

GP workforce changes between 2017 and 2022 highlight how MM2-7 classifications do not all have equal need or workforce demand (*Table 4.3*). While GP FTE per 100,000 in MM1-5 has either changed little or increased, greater changes are seen in MM6-7. Even though there has been an ERP decline in MM6-7, GP FTEs are declining faster than the MM6-7 population, as has the number of patients serviced by GPs and services per population. Together, these measures show poorer access to GP services in MM6-7 areas and the uniqueness of their workforce needs. Time and distance to GP services must be considered in determining DPA status to be equitable across all MMM classifications.

Table 4.3: The distribution of GPs across MMM classes and the compound annual growth rate (CAGR) from 2017 to 2022

MMM	GP FTE per 100,000		Patients serviced by GPs		Services per population	
	2022	CAGR	2022	CAGR	2022	CAGR
1	119.0	0.5%	17,206,174	1.2%	7.2	1.7%
2	108.3	-0.1%	2,310,467	1.5%	6.3	0.7%
3	125.8	0.1%	1,828,683	0.7%	7.4	1.1%
4	127.6	-0.3%	1,179,970	0.0%	7.6	0.5%
5	79.9	1.2%	1,315,561	1.8%	4.7	2.0%
6	68.9	-3.4%	232,639	-1.9%	3.8	-2.5%
7	65.4	-0.8%	160,740	-1.0%	3.3	-0.4%

Source: The Department of Health and Aged Care, Primary Care GP statistics by Calendar Year

The application of the MMM classification system as a blanket determinant of DPA has contributed to the majority of Australia being classified as a priority area with DPA status, including many GP catchments above the DPA benchmark.

Findings

The use of benchmarks to assign DPA status is largely redundant due to the blanket MM2-7 rule. MM6-7 have unique access challenges that could be more adequately represented by including time and distance inputs to determine DPA status.

Effectiveness

The DPA's effectiveness in accurately identifying areas (GP catchments) of GP workforce shortage and distributing the workforce accordingly (including training) has been examined in the following sections.

Workforce distribution

Evidence from primary care GP statistics demonstrates the change in GP FTE by MMM and jurisdiction over the six years between 2017 and 2022 (Table 4.4). The national distribution of all GP FTEs per 100,000 across jurisdictions by MMM shows the greatest decline in GPs in MM6–7, consistent with reports of the most remote areas struggling to retain doctors. Nationally, MM1–4 changed little (CAGR -0.3% to 0.5%) with a 1.2% CAGR in MM5. However, the CAGR differs by jurisdiction. For example, Western Australia had an approximate 2–4% decline in doctors in MM6–7 and a 2.8% increase in MM2, but Victoria has mostly seen an increase in GPs across MM1–6. Other States showing greater MM6–7 decline than other MMMs include Queensland and South Australia. The variable growth of GP FTE per 100,000 across MMM classifications demonstrates that the introduction of the DPA in 2019 and subsequent reforms have not improved the distribution of GP FTEs across MMMs.

The data also shows that GP distribution varies at a jurisdictional level, suggesting that place-based indicators and/or other distribution levers need to be considered alongside DPA.

Table 4.4: CAGR rate of GP FTE per 100,000 (calendar years 2017–2022) by jurisdiction

MMM	Nat	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
1	0.5%	0.3%	1.8%	-0.5%	-0.6%	0.3%	N/A	N/A	1.4%
2	-0.1%	1.7%	0.3%	-0.3%	0.0%	2.8%	-0.8%	-2.2%	N/A
3	0.1%	0.5%	-0.5%	-1.0%	-0.2%	0.0%	1.0%	N/A	N/A
4	-0.3%	-0.5%	0.5%	-0.6%	-1.5%	-2.2%	N/A	N/A	N/A
5	1.2%	1.7%	1.5%	1.3%	-0.1%	2.2%	-2.3%	6.1%	N/A
6	-3.4%	-1.6%	5.4%	-4.9%	-3.2%	-4.3%	-2.2%	-2.1%	N/A
7	-0.8%	9.1%	N/A	-0.2%	-2.1%	-2.0%	4.5%	-2.4%	N/A

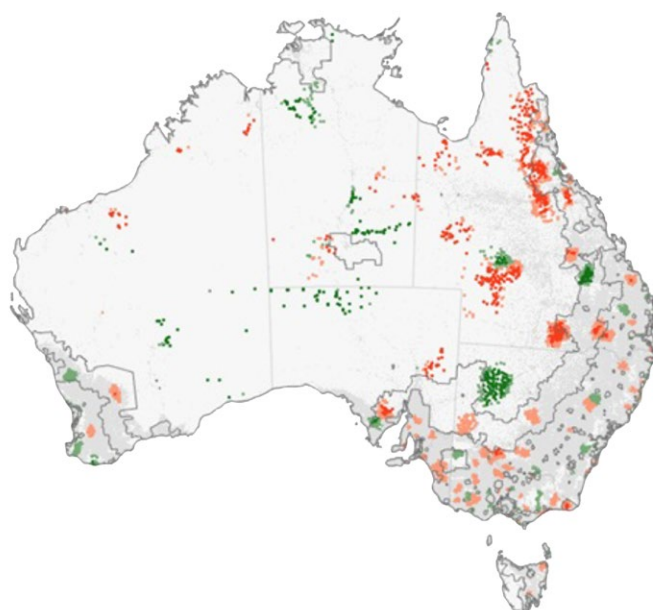
Source: The Department of Health and Aged Care, Primary Care GP statistics by Calendar Year, 2023. N/A = there are no reported GP FTEs per 100,000 in this category

DPA reforms

The successive extension of automatic DPA status to areas that are less remote, as classified through the MMM, has diminished the ability to effectively calculate priority.

The recent declines in GP FTE are greatest in MM3-7 (3.9-8.9%) compared to MM1-2 (3.2-3.5%⁴²). There has been a migration of doctors away from rural areas, moving more towards the coast (*Figure 4.1*). Many residential addresses in rural and remote areas must travel further to the nearest GP practice.

Figure 4.1: Increases (red) and decreases (green) in road distance to the nearest General Practice service from all Australian physical addresses between 2015 and 2023



Source: CARA

At the time of preparation of this Report, there is only limited data on the impact of the inclusion of MM2 to the blanket ruling.

Data comparing the annual growth for GP FTE per 100,000 and the number of services per GP FTE for the financial year before and after the introduction of the MM2 rule in July 2022 is detailed in *Appendix B*. In the financial year following the introduction of the MM2 blanket, the national GP FTE per 100,000 declined more in MM3-6 than MM2. This supports anecdotal evidence from stakeholders that the expansion of the MM blanket rule to include MM2 has resulted in some GP workforce migration from higher to lower MMMs.

The impact of expanding the MM blanket was raised in consultations with State-based health workforce divisions in South Australia, Western Australia, and Queensland. In South Australia, the

42 The Department of Health and Aged Care, "Primary Care GP statistics by Calendar Year," 2023.

Rural Health Workforce Agency detected a loss of interest in rural placements following the MM2 blanket. In Western Australia, there was also the belief that the blanket DPA expansion has seen people move closer to metropolitan areas. In addition, WA suggested that some GPs used distribution levers to fast-track their moratorium and move to metropolitan areas quicker. This, they argued, left rural communities more fragile.

The Queensland Rural Workforce Agency commented that DPA is now irrelevant as a distribution lever. Metropolitan areas are more likely to recruit in the highly competitive international workforce market.

The impact of the MM2 ruling differs across jurisdiction (*Table 4.4*). This reflects the heterogeneity of locations within MM2 and highlights the use of blanket MMM rules as inappropriate.

There are many factors contributing to the movement of GPs across MMM classifications. For example, the COVID-19 pandemic may have impacted the health workforce and is not accounted for in the data period reviewed. The National Health and Medical Research Council (NHMRC) report following COVID-19, emphasised the impact of COVID-19 on the physical and psychological health of the Australian healthcare workforce, however, no comment was made concerning their declining numbers⁴³.

Findings

- Progressive application of blanket MM rules over recent years, whereby 700 of the 827 GP catchment areas are now classified as DPA, has resulted in DPA being an ineffective lever to distribute the finite pool of IMGs to areas of comparatively higher need.
- The effectiveness of DPA differs across jurisdictions, with Queensland and Western Australia being the most impacted the most maldistributed jurisdictions across DPA catchments.

43 National COVID-19 Health and Research Advisory Committee, "Strengthening Australia's health system post COVID-19," National Health and Medical Research Council, 2022.

Distribution of IMG GPs

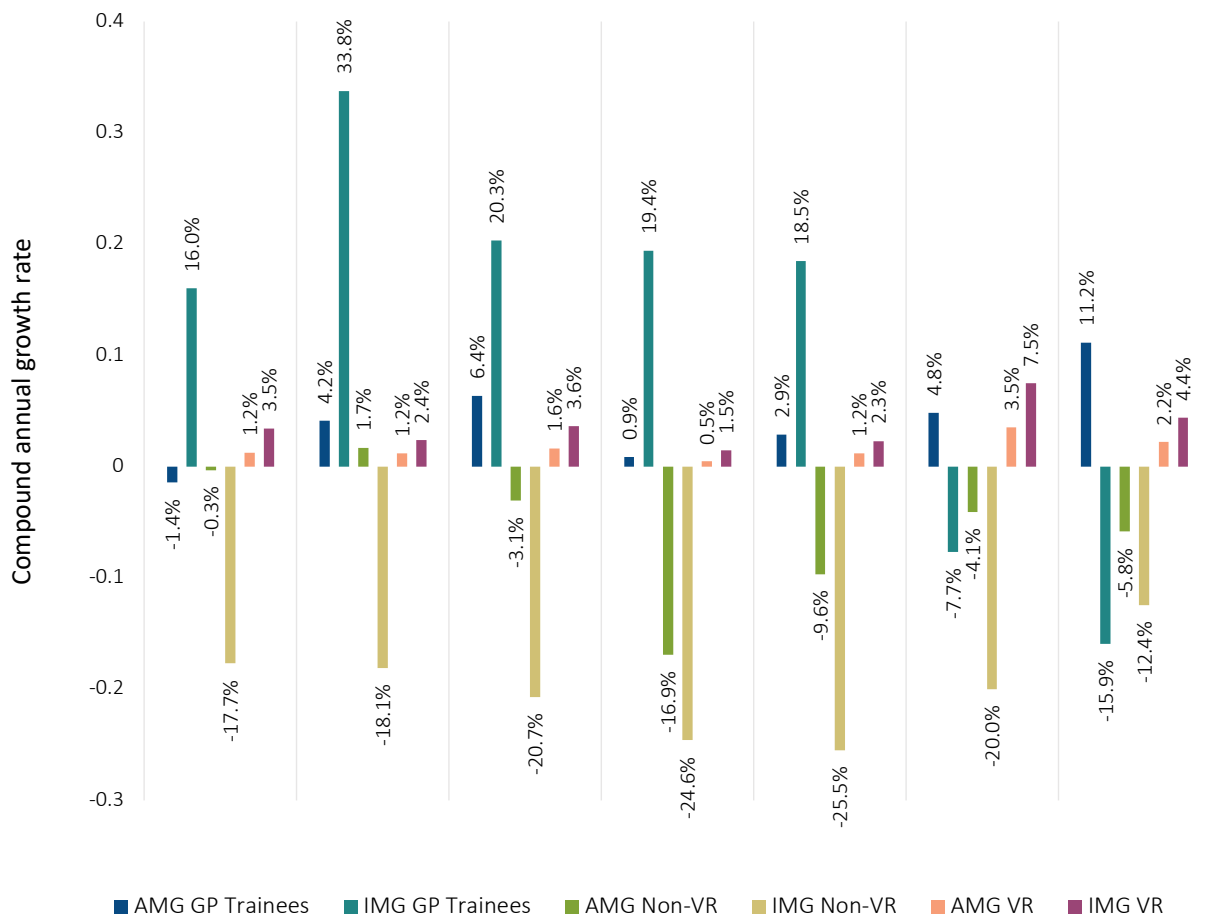
IMGs are an important component of the rural General Practice workforce representing approximately 39% of doctors working in MM4–7 (*Appendix B*). Although there are more vocationally registered AMGs, overseas-trained doctors make up the majority of:

- GP trainees in MM2–5
- non-VR GPs in MM4–5.

The greater proportions of IMGs in these MMs may reflect some efficacy of the 19AA and DPA distribution mechanisms. IMG distribution trends within different GP cohorts show changes in the distribution of the workforce within DPA areas (Figure 4.2).

IMGs will typically transition from non-VR GP to GP trainee and then VR-GP. Given the expansion of automatic DPA status to include MM3-4 in 2021 and MM2 in 2022, it may be plausible to suggest newer IMGs gravitated towards lower remoteness areas to complete training and settle.

Figure 4.2. The change in the distribution of IMG GP types from 2019 to 2023



Source: GP Workforce Statistics 2019–2023

Vocationally recognised IMGs

Across all MMM classifications, there is an increased reliance on IMGs after they finish their GP training. There was higher growth between 2019 and 2023 of VR-GP IMGs across all MMM classifications (3.3%) than VR-GP AMGs (1.3%). The proportional increase of IMGs practising as VR GPs between 2019 and 2023 was highest in MM6 (7.5%) and lowest in MM4 (1.5%). Similarly, for AMGs, the increase was highest in MM6 (3.5%) but lowest in MM4 (0.5%). Given the national reduction in GPs in MM6–7 overall, the IMG VR-GP workforce is an important cohort to distribute to the most rural and remote regions through a distribution lever such as DPA.

Non-vocationally recognised IMGs

In contrast to the growth of VR-GP IMGs from 2019 to 2023, the proportion of non-VR IMGs has decreased across all MMM classifications. Between 2019 and 2023, there was a greater decline in non-VR IMGs (-19.1%) than non-VR AMGs (-1.0%) across all MMM classifications. Thus, given the smaller numbers of non-VR IMGs, DPA has a lessened effect on this cohort.

IMG GP trainees

Variation across MMM classifications is seen for the growth of GP trainee IMGs across different MMM classifications. While the growth of IMG GP trainees between 2019 and 2023 increased by 19.9% overall, there were still decreases in MM6 (-7.7%) and MM7 (-15.9%). The number of IMG GP Trainees in MM6–7 is comparatively low and may reflect other issues, including fewer training places and difficulty finding supervision. The highest proportion of GP trainees for 2023 was in MM2 (64.9%), with the highest growth rate between 2019 and 2023 (33.8%). The expansion of the DPA MMM blanket rule to include MM2 may have contributed to this growth of IMGs in MM2. This suggests the maldistribution of GPs overall is more influenced by the distribution of GP trainees.

The GP trainee cohort is most impacted by the introduction of DPA in 2019 and subsequent reforms.

The demand of [rural and remote] community stifles supervision requirements – need to have more people funded to have the capacity to do training education and supervision.

Consultation with Rural Workforce Australia Network

Findings

There was proportional growth of VR IMG GPs (compared to non-VR) between 2019 and 2023 with the biggest increase in distribution to MM6. This highlights some utility in a mechanism such as DPA to help address workforce maldistribution.

There was growth overall of IMG GP trainees between 2019 and 2023, however, there was a decrease in distribution to MM6–7. This may be attributed to the expansion of DPA to include MM2 and/or potential issues with available training places and supervision.

Distribution of bonded Australian doctors

The evidence examined in this Review suggests that using DPA for the bonded scheme does not guarantee an improved workforce distribution. Under the BMP and the legacy schemes, the completion rate is 10.8% as of April 2024⁴⁴, and 6.1% have withdrawn, with many AMGAs either in the process of completing or yet to complete their program. A bonded rural scholarship alone can increase long-term rural retention of GPs by 7.87-fold. The combination of a rural background, rural clinical school and a rural placement experience through a bonded program can increase the likelihood of GPs remaining in rural areas long term by 3.5-fold, compared to specialists⁴⁵.

The World Health Organization's guidelines for health workforce development emphasise the importance of multi-faceted policies to improve rural retention, including compulsory service agreements⁴⁶. However, the certainty of evidence for compulsory service agreements alone is low. The Senate Inquiry into the provision of GPs in outer metropolitan, rural, and regional areas found that BMPs were ineffective, with low rural retention after their service period⁴⁷.

It is difficult to determine if the BMP Scheme is effectively distributing the workforce or if the DPA classification system that supports it is reducing its effectiveness. DPA status is only one of the eligibility criteria for doctors in the BMP. Any area in MM2-7 or designated DWS is considered eligible; inner metropolitan areas are not eligible. Any changes to the DPA system application on this cohort would warrant a review of the other eligibility criteria, particularly in cohorts reliant on DWS or DPA and not rural remote and metropolitan areas (RRMA) areas. For example, specialists who signed a Deed of Agreement for one of the legacy bonded schemes in 2010 must work in a DWS or DPA area for their vocational placement. Changes to DPA could reduce the attractiveness of the GP training pathway to bonded doctors and further reduce interest in general practice.

Finding

There is limited publicly available evidence to demonstrate the effectiveness of the bonded doctor scheme within the current scheme parameters and DPA.

44 Workforce Distribution Branch of the Department of Health and Aged Care, "Statistics on Bonded Participants," 2024.

45 M.M.S. Kwan, S. Kondalsamy-Chennakesavan, G. Ranmuthugala, M. Toombs and G. Nicholson, "The rural pipeline to longer-term rural practice: General practitioners and specialists," *PLoS One*, vol. 12, no. 7, p. e0180394, 2017.

46 World Health Organization, "WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas," 2021.

47 Senate Standing Committees on Community Affairs, "Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians," 2022.

Opportunities to improve DPA

National Assessment Tool

The Department uses the National Assessment Tool (NAT) to assess workforce needs across Australia for the GP Workforce Planning and Prioritisation Program (WPPP) using GP catchments. The WPPP uses the NAT to assign priority based on ranking catchments into five percentiles within each jurisdiction, resulting in equal numbers of priority 1, 2, 3, 4, and 5 catchments. This calculation does not account for differences in health workforce needs between jurisdictions.

The following four categories are used to calculate a *Workforce Need Score* for each GP catchment (refer to *Appendix C* for the full list of inputs):

- Community and Health
- Location Servicing
- GP Supply, and
- Unmet Needs

Each of the four categories has a series of inputs which are then ranked in percentile out of 10, meaning that the minimum possible Workforce Need Score is 0 and the maximum is 40.

Adjustments to the NAT for DPA

The NAT (as described above) includes a comprehensive set of data inputs that are used to determine supply and demand for GP services in GP catchments. This tool can also be used to assess workforce need at a national level (rather than by jurisdiction) and calculate a DPA threshold to identify GP catchments that should be prioritised for workforce distribution under Section 19AB and Section 3GA programs.

The following methodology should be followed to compare GP catchment scores across Australia:

- Apply equal weighting to all inputs (pending further evidence and validation of any differential weighting to calculation inputs)
- Apply equal weighting of the four categories (pending further evidence and validation of any differential weighting to categories)
- Rank GP catchments by Workforce Need Score nationally.

Additional workforce input data could also be considered in the calculations. Suggested additional inputs for consideration include the following (some potential data sources provided in brackets):

- Waiting time for GP appointments
- Average distance from residential address to nearest GP service in the GP catchment (CARA)
- Average time from residential address to nearest GP service in the GP catchment (CARA)
- Years of life lost: Public Health Information Development Unit (PHiDU), and
- My Medicare enrolments.

CALD status was also considered as another input measure, but discounted because it is a proxy measure for three indicators already measured within the NAT (SEIFA Index of Relative Socio-Economic Disadvantage IRSD, refugee, Indigenous population).

Understanding the adjusted NAT score distribution

The distribution of the Workforce Need Score across GP catchments, as derived from the NAT shows how the data is distributed across GP catchments as well as the median score (*Table 4.5*) and the mean score (*Table 4.6*).

Table 4.5: The range, quartiles, and median health workforce need scores

	Workforce need score
Minimum	0.0
Lower quartile	12.3
Median	22.0
Upper quartile	28.1
Maximum	38.4

Source: National Assessment Tool modelling for DPA, Department of Health and Aged Care

Table 4.6: The mean and given standard deviations (SD) away from the mean of the workforce need score

	Workforce need score
Mean minus 2 SD	1.1
Mean minus 1 SD	10.7
Mean	20.2
Mean plus 1 SD	29.7
Mean plus 2 SD	39.3

Source: National Assessment Tool modelling for DPA, Department of Health and Aged Care

Setting a DPA threshold

The current methods of determining DPA status (automatic application of MMM blankets) mean that 700 of the 827 GP catchments are assigned priority status. There are 399 GP catchments below the current benchmarks for all MMM settings while 301 GP catchments are assigned DPA status based on the MMM setting alone.

The current DPA benchmarks are based on weighted average Medicare expenditure and do not necessarily represent the minimum requirements for a GP catchment to be adequately serviced in terms of primary care services. Minimum service requirements will vary depending on the case-mix of the population and reasonable access to other services. The current one-size-fits-all approach does not account for how needs differ between GP catchments.

Therefore, it is proposed that the DPA no longer use an average benchmark to estimate the minimum service requirements, but instead assess the relative workforce need of each catchment based on the supply and demand inputs. This would allow the DPA classification system to be used to aid in distributing a GP workforce to areas of comparatively higher need. The DPA should flag GP catchments that are a priority to make effective use of a finite IMG doctor workforce pool.

A DPA threshold is required to identify GP catchments of comparatively higher need (i.e. catchments that score above the threshold receive DPA status). GP catchments of comparatively higher needs should consider the needs of the population and the workforce, i.e. a supply and demand model concept.

Calculation of the DPA threshold

DoHAC's Workforce Data Intelligence Unit would be the best placed agency to model the calculation for an appropriate DPA threshold using the NAT.

The Workforce Need Score calculated from the NAT provides a score for each GP catchment between 0 and 40. These values have been used to determine how many catchments are classified as DPA status using the mean or median as the threshold (*Table 4.7*).

The number of catchments with DPA status using the **mean** Workforce Need Score is 477 (57.7%), which is slightly fewer than using the **median** Workforce Need Score, 423 (51.2%). The number of catchments with DPA status using quartiles or standard deviations away from the mean is displayed in *Appendix D*. *Table 4.7* shows that if the mean or median Workforce Need Score is used to set the DPA threshold, GP catchments with MM1-4 classification would be the most affected (i.e. loss of DPA status) compared to the current benchmark/MMM blankets.

Table 4.7. The number of catchments with DPA status currently, compared to the number above different workforce need score thresholds

MMM	July 2023 (full/partial)	% in MMM	Mean	% in MMM	Median	% in MMM
1	81	38.9%	12	5.7%	9	4.3%
2	63	100.0%	35	55.6%	31	49.2%
3	61	100.0%	27	42.9%	22	34.9%
4	78	100.0%	49	57.0%	38	44.2%
5	270	100.0%	223	84.5%	197	74.6%
6	67	100.0%	53	86.9%	51	83.6%
7	80	100.0%	78	98.7%	75	94.9%
Total	700		477		423	

Source: the National Assessment Tool modelling for DPA, and DPA for 19AB: July 2023 Update, Department of Health and Aged Care
 Note: the modelling used the updated GP catchments which were compared to previous GP catchments where four new catchments have been created and five catchments combined into existing catchments, in addition to other minor amendments.

Table 4.8 shows the number of GP catchments with DPA status under the proposed new DPA threshold methodology (using the Mean as the threshold), in comparison to the current DPA status using Benchmark calculations only. This shows that overall there would be more winners compared to losers, with a notable increase in GP catchment with DPA status in MM5 and notable decrease in MM1.

From a review of using the median as the threshold for DPA, some very remote catchments requiring RFDS GP services were not deemed DPA in the modelling (e.g. Kowanyama in Queensland). Further considerations are required to determine a DPA threshold along with validation of the weighting of data inputs.

One limitation of the NAT data modelling is the difficulty ranking catchments with insufficient MBS billing or insufficient population. As a result, there were 22 catchments classified as DPA status that did not have a workforce need score (e.g. Ouse in Tasmania, Yunta in South Australia, and Boulia in Queensland). Further validation would be required to determine the appropriateness of DPA status for these catchments.

Table 4.8. The number of catchments with DPA status currently (based on benchmark only), compared to the proposed DPA threshold set at the Mean (with the number of GP catchment winners and losers) by MMM

MMM	Current DPA set at Benchmark only		proposed DPA (threshold set at Mean)		
		DPA	DPA	Gains	Losses
MM1		51	12	8	47
MM2		29	35	21	17
MM3		20	27	16	10
MM4		44	49	26	21
MM5		138	223	102	19
MM6		40	53	18	6
MM7		64	78	14	0
Total		386	477	205	120

Source: the National Assessment Tool modelling for DPA, and DPA for 19AB: July 2023 Update, Department of Health and Aged Care
 Note: the modelling compared the winners and losers using the updated GP catchments, where four new catchments have been created and five catchments combined into existing catchments, in addition to other minor amendments.

It is suggested the Health Workforce Data Intelligence Unit could further examine the relationship between the NAT Workforce Need Score and GP FTE per 100,000. As an alternative, a DPA threshold could be set for GP catchments that display a high Workforce Need Score and have low GP FTE per 100,000 population numbers. Further information on the proposed concept is provided in *Appendix D*.

Findings

The IMG workforce pool is finite (totals 6,000 to 7,000) and should be distributed to areas of greatest comparative need for the greatest effect. Currently, 700 of the 827 catchments (85%) have full or partial DPA status. Before the Nous Review and the MM2-4 blanket rule, 565 of the 829 catchments (69%) had DPA status (Nous Group). Given reports the global pool of IMGs is shrinking, setting a more stringent DPA threshold to assign DPA status (e.g. 40% to 50% of catchments result in DPA status) may be appropriate.

Further testing with the Health Workforce Data Intelligence Unit and key sector stakeholders is necessary to validate a new DPA threshold in line with best practices used to validate the NAT Workforce Need Score indicators and criteria.

Application of the DPA using the NAT

The DPA threshold can be used to set the binary classification of DPA status. Above the threshold (i.e. an area representing high workforce need score) will be counted as DPA status. The DPA threshold will determine DPA status. No MMM blanket rules should be applied as the Remoteness Area is a weighted indicator in the NAT. An Exceptional Circumstances review process should continue with clear criteria.

Use of a graduated priority scale can be used to indicate how GP catchment scores relate to the threshold, which can highlight GP catchments that may cross the threshold soon and should be investigated with local agencies. This may be useful to inform any reviews by DoHAC and the proposed Health Workforce Independent Review Panel. It can also flag GP catchments in which the needs are considered to be 'severe' (i.e. highest above the threshold). A validation process should be undertaken to articulate the graduated priority, but for example, severe could be set at 15% above threshold, or +one standard deviation from the mean or median. The graduated priority scale could be further enhanced to reflect persistent needs (e.g. three or more years in priority 1 or 2) to flag where further review is required, or additional incentives could be targeted.

One measure of severity and persistence could be adapted from the Grattan Institute's 2016 *Perils of Place Report*⁴⁸ methodology to define and categorise hotspots of potentially preventable hospitalisations (how hot and for how long).

The graduated priority scale concept can be used more broadly beyond DPA and Health Workforce areas require an understanding of workforce distribution and population needs. The priority scale could be adapted to reflect program-specific inputs or incentives.

Use of the NAT to establish a Workforce Need Score for each GP catchment can be used to set a threshold for DPA status, as well as establishing a graduated priority scale that could be used for program specific incentives.

48 Perils of Place: Identifying hotspots of health inequalities," Grattan Institute, 2016.

Policy implications

Transition to a new DPA system based on the NAT Workforce Need Score for GP catchments will require careful planning and consideration of aspects such as:

- validating the data inputs, weighting, method to set the DPA threshold and frequency of update
- modelling the impact of the DPA methodology by identifying catchments that would change DPA status
- grandfathering arrangements for existing areas with DPA status that would no longer have DPA status under the new system
- consideration of business planning timeframes and continuity (if DPA subject to annual update) as it can take over a year for IMG recruitment and arrival of the recruited IMG
- consideration of automatic DPA status rules for ACCHS, regardless of GP catchment status.

Further analysis to understand barriers to GP access in inner and outer metropolitan areas, and how they differ to access issues in regional, rural and remote locations is required in order to design appropriate policy for metropolitan areas.

Many general practices rely on workforce incentive payments as part of their business model. Detailed business modelling would need to be undertaken to determine the impact of any proposed changes to workforce incentive payment funding mechanisms (e.g. if they were to be based on the graduated priority scale) to avoid any unintended consequences (such as reduced viability of existing business) that may further impact on GP access.

Recommendations

The Reviewers make the following recommendations

Recommendation 12

A distribution mechanism to aid in distributing the GP workforce (under Section 19AB) should be retained. A distribution lever is still required as maldistribution of the medical workforce – specifically GPs – remains an important issue. However, the DPA should focus on distributing GPs to areas of comparatively higher need (rather than only identifying areas of GP workforce shortage). This will prioritise the distribution of the finite pool of IMG GPs to the areas of most need across Australia. Recommendation 12 The Department should use the GP catchment area as the prime building block to establish DPA status (as defined in Recommendation 13); and cease the use of MMM categories as a blanket rule to define DPA status.

Recommendation 13

The Department should move to progressively use the GP catchment area as the prime building block to establish DPA status. (as defined in Recommendation 14). MMM should no longer be used as a primary criterion for DPA status (i.e. remove all MMM blanket rules) and DPA status should not automatically apply to any location.

Recommendation 14

A new DPA classification methodology should be considered based on the existing National Assessment Tool (NAT), with consideration of additional indicators such as average distance and time from residential addresses to the nearest general practice. The new DPA threshold that determines whether a GP catchment has DPA status should be based on the NAT Workforce Need Score for GP catchments (calculated at a national level, not for each State/Territory). This approach will enable a simple and transparent mechanism to set the threshold for DPA status.

The Health Workforce Independent Review Panel should be used to assess any GP catchment anomalies that are not captured by the new DPA threshold.

Recommendation 15

Mechanisms should be incorporated to review DPA status annually.

In addition, mechanisms to review applications for access to IMG workforce in areas without DPA status should be developed. This should be overseen by the proposed Health Workforce Independent Review Panel in collaboration with State and Territory Health Authorities, Primary Health Networks (PHNs) and local stakeholders.

Recommendation 16

Bonded Medical Program (BMP) Return of Service Obligation (ROSO) objectives will no longer align with DPA objectives and therefore, in future, should not be determined using DPA status. Instead, ROSO should align with the BMP intent which currently is regional, rural and remote areas.

5. Districts of Workforce Shortage (DWS)

This Chapter presents findings and recommendations in response to the Review questions related to the DWS.

The DWS was introduced to support the workforce distribution aims of Section 19AB⁴⁹. For IMGs who are non-GP specialists, they may only access Medicare benefits if they practice in a DWS during their 10-year moratorium period.

What are the original objectives of DWS?

The main aims and objectives of the DWS classification are to:

Identify underserved areas: The DWS classification is used to identify geographical areas in Australia where people have poor access to specialist medical practitioners. These areas are typically characterised by a shortage of medical practitioners, particularly non-GP specialists.

Identify maldistribution of the medical workforce: The DWS classification helps identify medical specialties and locations across Australia where there is a maldistribution of the medical workforce. Identification of an area as a DWS informs targeted efforts to address workforce shortages in specific areas and specialties.

Facilitate access to Medicare billing for specialist IMGs: Specialist IMGs subject to Section 19AB may obtain access to Medicare benefits if they practice in a DWS. This aims to encourage specialist doctors to work in underserved areas where they are most needed.

Target incentives and improving access: The DWS classification is used to target incentives such as the Bonded Medical Program (and potentially other workforce programs) aimed at attracting health practitioners to underserved areas and improving access to healthcare in those areas.

Whilst not in-scope for this project, DWS is also used to determine where Bonded Doctors can work. The Bonded Medical Program aims to address the shortage of medical professionals in regional, rural, and remote areas by providing a Commonwealth-Supported Place (CSP) in a university medical course in exchange for participants working in those areas after they graduate. Participants are required to work in a regional, rural, or remote area for three years after they complete their course. The Bonded Medical Program applies to at least 28% of all CSP medical school places in Australia and imposes an obligation for up to three years for students taking up those places - also known as a Return of Service Obligation (ROSO). Eligible areas are all MM locations 2 to 7, as well as in MM1 (outer metropolitan) locations classified as DWS or DPA.

49 Mason J. Review of Australian government health workforce programs. 2013

What is the methodology by which DWS is determined?

DWS are determined by the Department. The DWS describes areas using the Australian Bureau of Statistics Statistical Area 3 (SA3) level classification where people have poor access to specialist medical practitioners. Currently, SA3s classified as DWS are measured by assessing the Full-Service Equivalent (FSE) per 100,000 population in the area⁵⁰.

A SA3 area is classified as a DWS if:

- it has an Australian Statistical Geography Standard RA classification of RA3 to RA5 (that is, it is classified as rural to remote), or
- its ratio of specialists to population is less than the national average FSE for that speciality *and* a national FSE greater than 3 per 100,000 population is calculated for the speciality.

Additionally, all the Northern Territory is considered a DWS area regardless of its ratio of specialists or RA classification (as stipulated in the Act in Section 19AB) and an exemption is provided by Services Australia.

DWS classifications are updated annually and can change when there have been significant shifts in the distribution of doctors since previous annual updates. Changes in DWS classifications may result from changes in the workforce or in the size or make up of the population⁵¹. The most recent update to the DWS took effect on 21 July 2022.

Whilst DWS could be used to determine shortages for all non-GP medical specialties, it currently applies to the following eight specialties:

- Anaesthetics
- Cardiology
- Diagnostic radiology
- General surgery
- Obstetrics and gynaecology
- Ophthalmology
- Medical Oncology
- Psychiatry.

It should be noted that general surgery is listed as a DWS specialty even though its FSE per 100,000 population is below 3. This is because the Department chooses to 'round up' the reported FSE to 3 if it is above 2.5 per 100,000 nationally.

50 Department of Health and Aged Care. District of Workforce Shortage. Available at <https://www.health.gov.au/topics/rural-health-workforce/classifications/dws>

51 Department of Health and Aged Care. District of Workforce Shortage. Available at <https://www.health.gov.au/topics/rural-health-workforce/classifications/dws>

Has DWS achieved its intended objectives?

Finding

Findings from data analysis and stakeholder consultations suggest that some of the objectives of the DWS have been achieved.

While some of the objectives of DWS have been achieved, there is clear evidence (both in the available data and through stakeholder feedback) that the current construct of the DWS is limiting its effectiveness and should be overhauled. *Table 5.1* summarises the Review findings in relation to whether the objectives of the DWS have been met.

Table 5.1: Summary of findings in relation to whether Section the DWS has achieved its original objectives

Original objective of the DWS	Has this objective been met?	Rationale
Identify underserved areas	To a limited extent	<p>Data analysis suggests that the DWS does identify many catchments that are underserved by certain specialties. However, many areas in major cities that can access specialists more readily than rural and remote areas are also classified as DWS catchments (see Table 5.2). Stakeholders considered that the granting of DWS status to many areas in major cities ‘dilutes’ the impact DWS can have by allowing IMGs to work in major cities even though there are areas that experience much more significant challenges accessing specialist services.</p> <p>Additionally, some areas outside of major cities (in RAs 3 to 5) are automatically classified as DWS catchments, even though some of these catchments have better access than the national average (see Table 5.4). This also has the effect of providing an incentive for IMGs to practice in areas where access is already sufficient, which reduces the ‘pool’ of IMGs that are available to work in areas of workforce shortage.</p>
Identify maldistribution of the medical workforce	To a limited extent	<p>As per the objective above, the DWS is only limited in its ability to identify maldistribution of the medical workforce. Some areas that can access specialists more readily (than many rural and remote catchments) are classified as DWS, which limits the utility of the DWS for identifying medical workforce maldistribution.</p> <p>The limitations of the DWS in identifying maldistribution is partly related to how specialties that are ‘in-scope’ for DWS are chosen. Currently, only specialties with a national average FSE greater than 3 per 100,000 population are eligible to be classified as DWS. Although intuitively sensible as a marker (there should be sufficient doctors to contemplate Australia-wide distribution), the Review found that there is limited evidence to support application of the threshold, which means that some specialties where maldistribution exists are not considered for eligibility under DWS.</p>

Original objective of the DWS	Has this objective been met?	Rationale
Facilitate access to Medicare billing for specialist IMGs	Yes	This objective has been achieved for IMGs that practice in areas of workforce shortage.
Target incentives to improve access	To a limited extent	The DWS is currently not used to inform the implementation of a limited range of incentive programs such as the 5 Year IMG Recruitment Scheme. Although not an incentive program, DWS also informs the Bonded Medical Program. There are opportunities to use DWS to inform targeting (and ideally, segmentation) of initiatives into different ‘tiers’ that provide greater incentives in areas of greater need.

The Review findings suggest that there is scope to change the design of the DWS to better support the objectives of Section 19AB (i.e. to identify and address workforce maldistribution). At the same time, opportunities exist to use a more robust DWS classification as the basis for targeted implementation of ‘positive levers’ such as incentive programs, for which stakeholders expressed widespread support. It is recommended that the future objectives of the DWS are targeted to achieving the refocused objectives of Section 19AB.

Currently, the DWS is used to identify areas of workforce shortages for non-GP specialties. The DPA classification is used to identify areas with a shortage of GPs. Consultations generally (though not universally) found that separate considerations apply to identifying areas of workforce shortage for GPs and non-GP specialists.

This feedback supports the retention of separate workforce shortage / priority area classifications for GPs (i.e. DPA) and non-GP specialists (DWS).

Finding

Consultations generally (though not universally) found that separate considerations apply to identifying areas of workforce shortage for GPs and non-GP specialists.

Key issues impacting the effectiveness of the DWS

Despite the implementation of DWS almost three decades ago, many regional, rural, and remote areas in Australia continue to experience shortages in medical professionals compared to major cities. As recognised in the NMWS, medical workforce maldistribution persists across both geographies and different specialties. This suggests that there is scope to improve the DWS, an initiative which was strongly supported by almost all stakeholders.

Finding

Stakeholders generally characterised the DWS classification system as a 'blunt instrument' and agreed that the current system is not an accurate reflection of areas of need for some specialties and locations.

The widespread granting of DWS status to metropolitan locations makes it very difficult to attract new internationally trained specialists to regional and rural locations.

Submission from the South Australian Department of Health and Wellbeing

Queensland maintains that DWS classifications in Queensland are not reflective of non-GP specialist medical workforce shortages, especially in areas outside of Southeast Queensland.

Submission from Queensland Department of Health

Major urban centres and large regional cities are attractive places to live and work, and continue to have aberrant DWS zones within them, so it is not surprising that more regional, rural, and remote areas cannot compete to attract OTD/FGAMS workforce.

Submission from the Royal Australian and New Zealand College of Ophthalmologists

The key issues that are impacting the effectiveness of the DWS are summarised in *Figure 5.1*. The options considered to address these issues are discussed in the following subsections.

Figure 5.1: Issues impacting the effectiveness of the DWS classification



Approach to identifying specialties eligible for DWS

- There is limited evidence to support the application of 3 FSE per 100,000 population as a threshold for identifying specialties eligible for DWS classification.
- This approach 'rules out' several specialties that arguably should be considered within scope for DWS.



Level of geography at which DWS is defined

- Defining DWS locations at SA3 level reportedly results in 'boundary issues', where one side of the street can be a DWS location, and the other side of the street is not. This issue was often reported in major cities and regional areas.
- Using smaller areas such as SA3 may also be contributing to some areas in major cities being classified as DWS locations (i.e. Hawthorn in Melbourne or the Northern Beaches in Sydney), even though residents are readily able to travel to access specialist medical care.



Application of 'blanket' rules for identifying DWS eligibility

- Currently, locations in RA3 to RA5 are automatically classified as DWS. However, for some specialties, several SA3s in these locations have an FSE per 100,000 population that is higher than the national average. This means that some locations are automatically classified as DWS even though the availability of medical specialists in these areas is greater than the national average.



Measure used to construct the DWS benchmark

- Documentation provided by the Department indicates that FSE will no longer be available and updated by Medical Benefits Division. If this is the case, a new way of identifying areas of workforce shortage will need to be determined.



Benchmark used to identify areas of workforce shortage

- The current criteria used to classify DWS locations results in some areas with reasonable levels of workforce availability being classified as DWS.
- This means that it is easier to recruit doctors to areas that already have sufficient, which potentially exacerbates shortages in areas of need.

Stakeholders strongly supported a new (or substantially revised) classification for identifying areas of workforce shortage in medical specialties. Overall, a more nuanced approach was desired that better reflects workforce availability and community health needs rather than the 'blunt' approach that is in place now. However, while stakeholders wanted a more nuanced approach to the DWS, many people also recognised the need to avoid additional administrative burden as a part of the design of a new DWS.

Consultations with the Department also highlighted a need to balance the adoption of a more 'discipline-specific' approach to determining areas of workforce shortage with minimising the administrative and data burden required to implement and update a future workforce shortage classification. Achieving this balance strongly influenced the Review's thinking and although using population health need measures and adopting specialty-specific benchmarks were considered for the revised DWS, it was concluded that both measures would be too onerous to identify and maintain.

Identification of specialties that can be classified as DWS

Currently, the medical specialties deemed eligible to be considered for DWS are based on whether they have a FSE of higher than 3 per 100,000. There are no restrictions to accessing Medicare benefits for the other non-GP medical specialties (i.e. for these specialties, effectively all of Australia is regarded as a DWS).

Finding

Although intuitively reasonable (i.e. there must be enough doctors available to contemplate redistribution), the Review identified no clear evidence for why 3 FSE per 100,000 is used as the threshold to identify the medical specialties to be subject to DWS. Neither the available documentation, nor consultations with Departmental officers could identify a compelling rationale for application of this threshold.

The available documentation suggests that some specialties with a FSE per 100,000 lower than 3 have been classified as DWS after being 'rounded up' to 3. This was the case for general surgery (which reported a national FSE per 100,000 of 2.85). No evidence was identified that explained the reason for 'rounding up' the FSE per 100,000 for general surgery when it is below the threshold. Also, stakeholders submitted and analysis showed that where the medical workforce is currently located does not provide a true picture of where they should be located nor where there are specialties of potential undersupply.

Feedback submitted to the Review noted that the current methodology for determining DWS specialties lacks transparency and risks missing out areas of unmet community need. It was highlighted there are additional specialties in undersupply that DWS could be extended to outside of the eight in-scope.

DWS subspecialties not current. These should include rheumatology, endocrinology, neurology, gastroenterology, infectious diseases, urology, ENT, paediatric surgery, orthopaedics as they are sorely lacking in public hospitals in regional, rural and remote areas.

Submission from the Royal Australasian College of Physicians

Rheumatology in Australia is currently experiencing a workforce crisis. The potential of overseas-trained rheumatologists to address this urgent workforce shortage is evident. However, as outlined in the recent Independent Review of Overseas Health Practitioner Regulatory Settings (The Kruk Review), the current processes for overseas-trained specialists to gain residency and work as a rheumatologist are practically insurmountable.

Submission from Australian Rheumatology Australia

Feedback from some stakeholders also highlighted examples of where the broad categorisation of the specialty impedes their ability to recruit an IMG with a specific sub-specialisation. For example, it was noted that calculating DWS based on the FSE equivalent for all diagnostic radiology and not considering the subspecialties risks areas of workforce shortage being left out. The Australian Diagnostic Imaging Association submitted to the Review that, “*Subspeciality shortages are common: most pronounced in women’s imaging, interventional radiology and musculoskeletal subspecialties.*” In the Geelong area, it was raised by one local provider that they cannot hire an IMG for a breast radiologist position, despite the sub-specialty being in persistent workforce shortage nationally, because the area is not considered a DWS for radiology.

Expanding the application of DWS to all non-GP specialties would offer a comprehensive approach, ensuring that no area of medical practice is overlooked in the assessment of workforce shortages and demonstrates a commitment to addressing healthcare needs across all medical disciplines. However, several stakeholder submissions and consultations highlighted that some specialties can only be delivered in major cities or large population centres and should not be subject to DWS.

This was mostly the case for highly specialised professions such as neurosurgery, cardiothoracic surgery, or paediatric oncology, some of which are currently subject to the ‘Specialties in acute shortage’ exemption. For these professions (and others), the facilities, supporting workforce and patient volumes required to operate such services safely and efficiently were commonly regarded to be only in major cities.

Finding

Safety and quality considerations are and should continue to be, of paramount importance in identifying specialties that should be subject to DWS. There are some specialties that can only be delivered in major cities or large population centres, and thus not appropriate for DWS.

Stakeholders frequently emphasised population health needs as a crucial factor when determining the necessary workforce in a specific area to address demand. However, accurately capturing and robustly assessing indicators of health needs across various non-GP medical specialties within defined geographic regions poses significant challenges. Integrating population health data with workforce availability metrics would create a complex DWS classification. Consequently, the Review concluded that the identification of workforce shortage areas should prioritise supply-side metrics, focusing on workforce availability, rather than relying on demand-side considerations such as population health needs.

A consideration that emerged in the Review was that the NMWS has already identified which specialties can practice to their full scope in different geographic locations. This work provides a reasonable foundation for considering in-scope specialties for DWS.

Therefore, the Review has developed the following principles to guide how a specialty is determined in-scope for inclusion in DWS classification in the short-to-medium-term:

The specialty must be able to practice their full scope in regional, rural and remote settings – the NMWS proposes a range of medical specialties that can work to their full scope of practice in rural and remote areas. Given the focus on improving distribution of the workforce to regional, rural and remote areas, if the specialty is able to practice in an MM1 only (i.e. can only be delivered face-to-face in a major centre), it is considered out of scope for DWS.

The specialty is considered ‘large enough’ to be redistributed to regional, rural and remote areas – underpinning this principle is the need for specialties to be able to practice safely and viably outside of non-metropolitan areas. This includes ensuring IMGs are supported effectively with supervision from other trained medical practitioners, as well as there being enough patient volumes for the services to be viable financially. In considering the size of a specialty to determine whether it would be in-scope, analysis of the current workforce distribution showed a significant drop in number of practitioners in areas outside of MM1s when the specialty headcount was less than 600 nationally, as demonstrated in *Appendix E*.

The specialty must provide direct clinical care to patients – given the core problem is equity of access to healthcare, if a specialty does not provide direct clinical care, it should be considered out of scope for DWS. This rules out specialties such as medical administrator and public health medicine.

In applying these principles, the specialties which emerged for inclusion as in-scope for DWS consideration are as follows:

- Anaesthesia
- Psychiatry
- Emergency medicine
- Diagnostic radiology
- General paediatrics
- General surgery
- Obstetrics and gynaecology
- General medicine
- Cardiology

- Orthopaedic surgery
- Geriatric medicine
- Gastroenterology and hepatology
- Ophthalmology
- Pathology-anatomical pathology (including cytopathology)
- Intensive care medicine
- Endocrinology
- Respiratory and sleep medicine
- Medical oncology
- Neurology
- Haematology
- Nephrology

An analysis of all these specialties against the proposed principles is available in *Appendix F*.

This proposition increases the number of in-scope specialties from the current eight up to 21. Many of these additions are based on the removal of the 'Specialties in acute shortage' exemption and from discarding the 3 FSE per 100,000 benchmark. This principles-based approach aims to ensure all specialties can be considered under the DWS classification, thereby providing a more transparent approach to the determination of specialties to be subject to DWS.

The Review recognises that this list, while simple to compile, is still somewhat arbitrary. As such it is proposed as an initial list to be used for the revised DWS. It is noted that changes to rural models of care, the interplay between the private and public hospital setting in non-metropolitan areas, and increases in virtual provision of specialist care will impact on the range of specialties to be considered in-scope for DWS. Accordingly, a process should be established to ensure regular review (at least every two years) of the list.

Level of geography at which DWS catchments are defined

'Place-based solutions' were emphasised during consultations and written submissions as being required to ensure that local circumstances and workforce availability are prime considerations in how the medical workforce is distributed. Implementation of place-based solutions would require DWS to apply within defined geographic areas that are large enough to mitigate 'boundary issues' that may create unintended consequences, while also being small enough to consider local needs and circumstances. Many stakeholders commented that for non-GP specialties, the ASGS SA3 level that is currently used to determine DWS areas may be too small to achieve this balance.

Currently, many SA3 locations in major cities are identified as DWS, for every specialty (*Table 5.2*) even though most medical professionals practise in major cities, and the number of doctors per-capita is higher in major cities than all other RA classifications, for almost all specialties.

Finding

Classification of major city SA3s as DWS dilutes the ability of s19AB and DWS to direct IMGs to more regional, rural, and remote areas, because there are so many DWS locations in major cities where IMGs can work instead. Table 5.2: Percentage of SA3s in each RA classified as DWS per non-GP specialty.

Table 5.2: Percentage of SA3s in each RA classified as DWS per non-GP specialty

Remoteness Area	% of SA3 locations in each RA classification classified as Y or Partial DWS							
	Anaesthetics	Cardiology	Diagnostic Radiology	General Surgery	Medical Oncology	Obstetrics & Gynaecology	Ophthalmology	Psychiatry
RA1 - Major Cities of Australia	74%	64%	57%	69%	73%	73%	63%	70%
RA 2 - Inner Regional Australia	92%	90%	89%	88%	90%	96%	89%	96%
RA3 - Outer Regional Australia	100%	100%	100%	100%	100%	100%	100%	100%
RA4 - Remote Australia	100%	100%	100%	100%	100%	100%	100%	100%
RA5 - Very Remote Australia	100%	100%	100%	100%	100%	100%	100%	100%

Source: HealthConsult analysis on MBS data provided by DoHAC

Stakeholders generally did not support how SA3s are used in the current DWS classification. This was largely because one SA3 location “on one side of the street” could be classified as DWS and another practice “on the other side” may not be DWS, which created challenges for the non-DWS locations in attracting workforce. As a result, several alternative geographic classifications were considered as the basis for defining Districts of Workforce Shortage. The advantages and disadvantages of these options are summarised in *Table 5.3*.

Table 5.3: Options for geographic classifications where DWS could be applied

Geographic classification	Number of locations	Advantages	Disadvantages
Statistical Area Level 3 (SA3)	359	Mostly stable over time	Variation in DWS classification between neighbouring catchments creates inequities and recruitment issues
Statistical Area Level 4 (SA4)	108	Mostly stable over time Larger areas than SA3 – likely to cause fewer ‘boundary issues’ Allows aggregation of FSE benchmarks over larger geographic areas increases reliability and robustness compared to SA3.	Larger geographic areas creates risks by reducing the level of nuance for specific local needs within areas (particularly areas in the same SA4 far away from and close to large hospitals)
Local Government Areas (LGA)	566	May allow for more nuance in the classification system.	Change frequently over time Generally smaller areas than current SA3 – will likely cause ‘boundary issues’
State Electoral Districts (SED)	452	May allow for more nuance in the classification system.	Change frequently over time Generally smaller areas than current SA3 – will likely cause ‘boundary issues’
Postal Areas	2,644	Mostly stable over time.	Always smaller areas than current SA3 – will likely cause ‘boundary issues’

The widespread dissatisfaction with the ‘boundary issues’ that were reported in usage of SA3 areas suggest that DWS catchments should be defined by larger geographic boundaries.

Finding

Larger geographic boundaries and populations make sense for non-GP specialists who typically need to draw on higher population catchments than GPs to ensure a safe, effective, and financially viable practice.

However, as shown in *Table 5.3*, the options for achieving larger areas and populations within the current Australian Statistical Geography Standard are limited. All other classifications result in a higher number of locations across Australia. In the absence of developing a new spatial classification, SA4 is the only option for defining a larger geographic catchment. On this basis, SA4 is recommended as the classification used to define areas of workforce shortage into the future. The larger geographic area of SA4 (compared to SA3) is likely to produce fewer ‘boundary issues’ in major cities and large regional towns, will result in a more robust benchmark for distinguishing areas of workforce shortage from others, and the larger resident population is more aligned with the typically greater catchment areas needed for non-GP specialists to have a safe, effective and viable practice.

Application of 'blanket rules to identify DWS catchments

Currently, all locations in RA3 to RA5 are automatically classified as DWS. In this report, this approach has been termed a 'blanket rule', as it applies to all locations based on a single condition, without regard to other factors (i.e. it is like throwing a blanket over all locations, as they are all treated the same way). However, some SA4s locations that are automatically classified as DWS because they are in a RA3-5 and have a FSE per-capita that is higher than the national average. This is mostly evident for RA3s in diagnostic radiology, medical oncology, cardiology and ophthalmology in *Table 5.4*.

Table 5.4 Proportion of SA4s in each RA above the national average FSE, by DWS specialty

Remoteness Area	Anaesthetics	Psychiatry	Diagnostic Radiology	Obstetrics & Gynaecology	Cardiology	Ophthalmology	Medical Oncology
RA1 - Major Cities of Australia	74%	76%	100%	74%	90%	96%	84%
RA 2 - Inner Regional Australia	68%	18%	95%	36%	77%	77%	82%
RA3 - Outer Regional Australia	15%	15%	46%	15%	38%	38%	46%
RA4 - Remote Australia	0%	0%	0%	0%	0%	0%	0%
RA5 - Very Remote Australia	0%	0%	0%	0%	0%	0%	0%

Source: HealthConsult analysis on MBS data provided by DoHAC

Note: Many SA4s span multiple Remoteness Areas. For this analysis, a SA4 has been assigned to a RA based on where the majority of the SA4's population lives.

Finding

Although the avoidance of 'blanket rules' was preferred, analysis of the proposed benchmark at SA4 level identified anomalies in some large, remote geographic locations that would not be classified as DWS catchments.

This likely occurs because the reported FSE value is heavily influenced by factors such as the presence of a regional hospital in one part of the catchment, a low population in the region (which when used as a denominator in a FSE per-capita calculation would result in a relatively higher level of FSE than some other areas) or high levels of remote or visiting doctor service delivery.

As a result, although it is desirable, as with DPA, for 'blanket rules' to be avoided, the retention of a blanket inclusion of RA3-5 areas is proposed. The rationale for retaining this 'blanket' is to ensure that the most remote locations and underserved areas are always able to access the benefits associated with the application of DWS classification.

Measure used to construct the DWS benchmark

For specialties that are currently eligible for classification as DWS, SA3s are currently classified as DWS if they report a FSE per 100,000 lower than the national average for that specialty. However, documentation obtained from the Department suggests that FSE will no longer be available and updated by Medical Benefits Division. This would mean that an alternative measure would be required as the basis for identifying DWS.

Several alternative measures were considered to develop a more robust and objective benchmark for classifying DWS catchments (*Table 5.5*). Noting the need to contain administrative burden, only measures that could be generated through routine data available to the Department have been considered. To provide a consistent basis for comparing workforce availability across geographies, the only measures that were evaluated were expressed on a per-capita basis.

Table 5.5: Options to define the measure used to identify DWS catchments

Option	Advantages	Disadvantages
FSE per-capita (status quo)	<ul style="list-style-type: none"> Based on Medicare billing data, which is updated routinely at a higher cadence than FTE or headcount Can currently be easily generated by the Department FSE provides an indication of the level of service provided in a location (including on an outreach basis). This is arguably a better measure of access than the number of doctors resident within a given location. 	<ul style="list-style-type: none"> Departmental documentation suggests that FSE will not be updated into the future. Only captures healthcare providers that bill Medicare. It does not capture healthcare providers that work in hospital settings. Services provided via telehealth are likely to appear as though they are provided from the service provider’s originating location (which is likely to be a metropolitan area), rather than the location where the consumer receives them. This will impact specialties that use telehealth as a significant delivery modality (e.g. psychiatry) more than others.
Headcount per-capita	<ul style="list-style-type: none"> Would consider all healthcare providers in a location across settings (hospital and community-based) Focuses on workforce availability within a location, rather than services that may be provided ‘into’ a location by telehealth or on a ‘fly-in-fly-out’ basis. 	<ul style="list-style-type: none"> Difficult to obtain reliable, up-to-date data on headcount at an individual profession level across all specialties. Due to prevalence of part-time work, headcount is likely to over-state the amount of time each professional spends providing services in a location, which may result in inaccurate DWS determinations. Likely lag in lead time to provide this data, as it is updated annually.
FTE per-capita	<ul style="list-style-type: none"> Captures all healthcare providers in a location across settings (hospital and community-based). More nuanced than headcount to provide a measure of the time spent providing services in a location. Focuses on workforce availability within a location, rather than services that may be provided ‘into’ a location by telehealth or on a ‘fly-in-fly-out’ basis. 	<ul style="list-style-type: none"> Difficult to obtain reliable, up-to-date data on headcount at an individual profession level across all specialties. Likely lag in lead time to provide this data, as it is updated annually.

Finding

FSE measures the level of service delivered into an area and is objective (based on billing data), readily available and is flexible enough to capture services that are provided by visiting medical professionals from outside the region where services are delivered (e.g. on a fly-in-fly-out basis).

In contrast, FTE and headcount reflect the primary practice location that is disclosed by medical professionals. These measures do not consider the mobility of many medical professionals.

Analysis of data provided by the Department shows that in many rural and remote SA4 locations (and across all specialties), there are zero FTE but a positive FSE (*Table 5.6*). This is likely to mean that FSE will provide a more robust benchmark if the distribution of data points across locations will be the focus of the benchmark. On this basis, FSE is more likely to provide a reliable and robust benchmark for comparing access to medical care.

Table 5.6 Number of zero FTE and FSE values at SA4 level in 2022, by specialty

Specialty	Zero FTE (number of SA4s)	Zero FSE (number of SA4s)
Anaesthetics	5	0
Cardiology	11	0
Diagnostic Radiology	6	0
General Surgery	3	0
Medical Oncology	16	0
Obstetrics and Gynaecology	4	0
Ophthalmology	8	0
Psychiatry	3	0

Benchmark used to identify DWS catchments

Finding

As the majority of SA4s in Australia are in major cities, using the national average for a specialty means it is heavily influenced by the FSE in major city locations.

For eligible specialties, an area is currently defined as a DWS if it reports a FSE per 100,000 population that is lower than the national average. However, 56% of Australian SA4s are in major cities (*Table 5.7*). As a result, the national average for any specialty is heavily influenced by the FSE reported in major city locations. The FSE per 100,000 is higher in major cities for almost all DWS specialties, compared to other areas, so the overall benchmark will be heavily influenced by FSE reported in major cities.

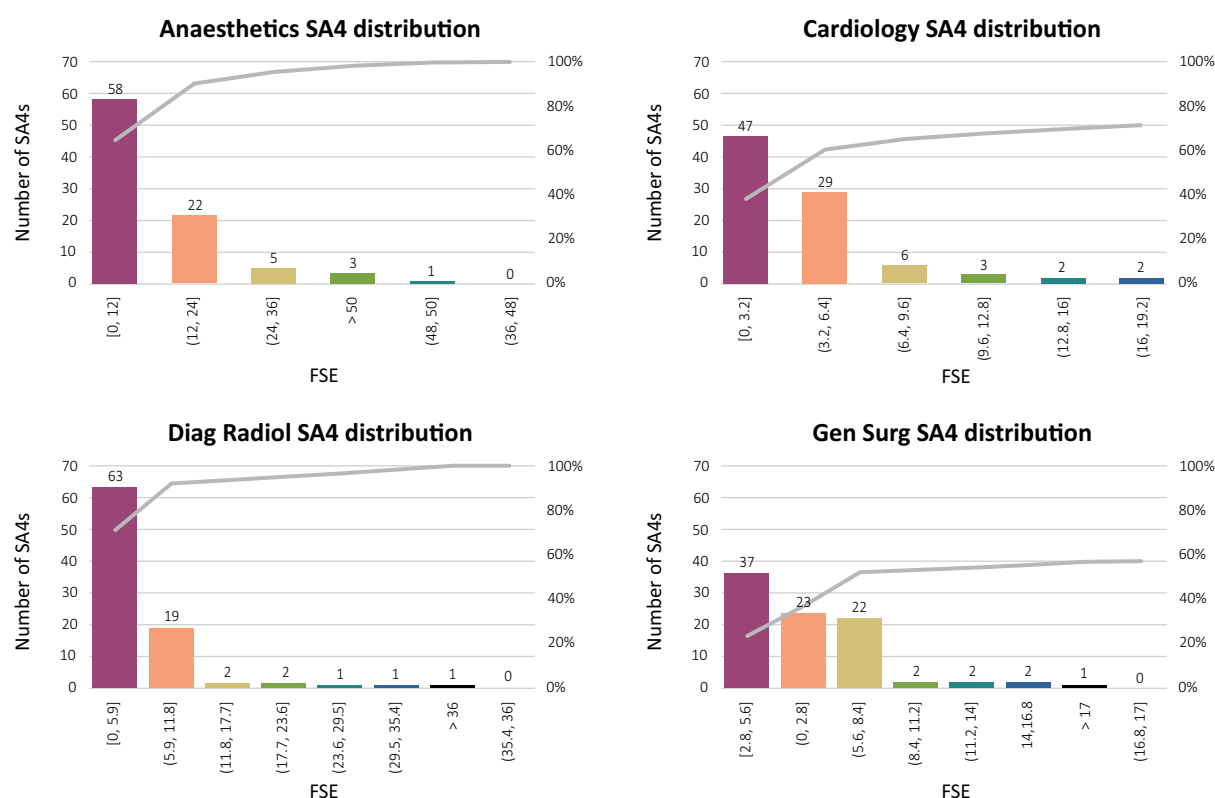
Table 5.7: Profile of Australian SA4s by RA

Remoteness Area	Number of SA4s	% of total
Major Cities of Australia	50	56.2%
Inner Regional Australia	22	24.7%
Outer Regional Australia	13	14.6%
Remote Australia	2	2.2%
Very Remote Australia	2	2.2%

Source Australian Bureau of Statistics

Stakeholder feedback proposed that the benchmark used to define DWS areas should be transparent, evidence-based and simple to derive using readily available data. The distribution of potential workforce measures was investigated to inform the development of options. This analysis showed that the distribution of the FSE values in SA4s was heavily ‘right skewed’, which means most FSE values in SA4s are close to zero, with many fewer SA4s reporting very high FSE. Further analysis showed that many of the SA4s in the lower part of the distribution for each specialty are outside of major cities, whereas the locations with the highest FSE per 100,000 population were almost all located in major cities. The location of many principal referral hospitals in capital cities heavily influences this result.

Figure 5.2: Distribution of FSE value for SA4s in Anaesthetics and Cardiology



Four options were explored to define a benchmark that could be used to identify areas of workforce shortage, including:

- national average for each profession (status quo): the national average FSE for each eligible profession would be used as the benchmark. Locations below the national average would be identified as areas of workforce shortage.
- national median value for each profession: the national median (i.e. the middle value of all FSE per 100,000 values, ordered from highest to lowest) for each profession would be used as the benchmark. Locations below the median would be identified as areas of workforce shortage.
- more nuanced approach using national average for each profession, based on the approach set out in the Grattan Institute's *Perils of Place Report*⁵². Desktop research conducted early in the project identified, as an option, an approach in this 2016 report that focused on identifying 'hot spots' of preventable hospital admissions. This approach could be adapted to introduce multiple categories of workforce shortage based on how 'severe' and 'persistent' the undersupply are in different geographic areas. The Grattan approach took a multiple of 1.5 times the State average as the threshold for identifying areas where there were 'severe' issues. This approach could be adapted so that areas with a FSE per 100,000 lower than the national average divided by 1.5 would be identified as areas of 'severe' workforce shortage. 'Persistent' workforce shortages could be defined as areas that met this threshold for three or more years in a row.
- more nuanced approach using national median for each profession based on the approach set out in the Grattan Institute's *Perils of Place Report*. This approach would look at the distribution of FSE values per 100,000 across SA3s to identify 'quartiles'. Quartile 1 contains the lowest 25% of data points, once they were ordered from lowest to highest. Quartile 2 includes the data points from 25-50%, so the upper bound of quartile 2 is the median. Quartile 3 includes the data points from the median to the 75th percentile, while Quartile 4 includes the top 25% of values.
 - This approach initially examined using the median as the threshold for identifying areas of workforce shortage, but this resulted in many major city locations being classified as DWS locations. On this basis, it was not considered a practical option, as it would likely produce a similar result to the current DWS unless a 'blanket' exclusion of MM1 locations was applied.
 - 'Blanket' rules were criticised by stakeholders as being undesirable. Stakeholders reported that some locations in metropolitan areas (principally growth areas on the metropolitan fringe or outer suburbs) often struggle to recruit medical specialists, so excluding all MM1 locations as potential DWS areas would also be likely to produce an undesirable result.
 - An alternative approach was formulated using the median as the threshold for identifying DWS areas outside of major cities, with the quartile 1 value used as the threshold (i.e. the lowest 25% of data points) for identifying DWS areas in major cities. Proposing a lower threshold for major cities sought to recognise the relatively greater accessibility of specialist care in major city locations, compared to regional, rural, and remote areas, where people may need to travel hours to see a specialist in person. Areas outside of major cities with a FSE per 100,000 lower than the quartile 1 value could be classified as areas of 'severe shortage'.

The advantages and disadvantages of these options are presented in *Table 5.8*.

52 Duckett, S. and K. Griffiths, 2016, *Perils of place: identifying hotspots of health inequalities*, Grattan Institute. Available from: <https://grattan.edu.au/report/perils-of-place-identifying-hotspots-of-health-inequality/>

Table 5.8: Options to define the measure used to identify DWS catchments

Option	Advantages	Disadvantages
National average (status quo)	<ul style="list-style-type: none"> Current approach, simple to calculate using existing administrative data. 	<ul style="list-style-type: none"> National average is composed largely of major city locations, which means it is more reflective of workforce availability in these areas. Many stakeholders considered that the current approach is 'too blunt'.
Median	<ul style="list-style-type: none"> More sensitive to the distribution of the chosen benchmark measure compared to the national average. 	<ul style="list-style-type: none"> Using the median is a similarly 'blunt' approach to using the national average (only with a different measure).
More nuanced approach based on national average	<ul style="list-style-type: none"> Can be applied flexibly to any benchmark, using any measure (FSE, FTE or headcount) Allows for 'grading' of areas of workforce shortage according to their severity. 	<ul style="list-style-type: none"> Using the (adapted) Grattan approach (i.e. national average divided by 1.5) is not based on any evidence or relationship to the distribution of data points. While it provides a more nuanced methodology for the benchmark, it lacks the transparency in evidence base which stakeholders desired. Data analysis using this approach resulted in many major city areas being classified as DWS catchments. This would produce a similar result to the current approach unless a 'blanket' restriction was applied that excluded any major city locations from being classified as DWS.
More nuanced approach based on median and Q1	<ul style="list-style-type: none"> This approach considers the distribution of the measure selected as the basis for describing DWS. Can be applied flexibly to any benchmark, using any measure (FSE, FTE or headcount). Allows for 'grading' of areas of workforce shortage according to their severity. Removes the need for 'blanket' rules for metro areas and still provides for any significant underserved metro areas to be considered as DWS. 	<ul style="list-style-type: none"> Using the median and Q1 value is not based on any evidence (although it does consider the distribution of data points for each specialty).

A more nuanced methodology based on the median FSE per-capita is recommended as the best approach to define the benchmark for identifying areas of workforce shortage.

Finding

No clearer, more objective, and evidence-based alternative measure was identified through the Review that would be preferable to the median. Using the median allows the distribution of FSE per-capita values to be considered in how the benchmark is defined, which is the best evidence currently available.

It is proposed that the benchmark for identifying areas of workforce shortage is defined with a lower threshold for metropolitan areas compared to non-metropolitan areas. This approach recognises:

- the relatively greater level of service accessibility in most major cities, due to the (typically) smaller travel distances required to access specialist services
- the higher level of FSE per-capita in most specialties in major cities, compared to non-metropolitan locations.

Finding

Excluding MM1 areas as being eligible for DWS status would result in some areas of workforce shortage in major cities (such as growth areas on urban fringes) being automatically disqualified from consideration as a DWS.

Therefore, applying a differential benchmark is a preferable alternative to applying an 'exclusion blanket' to MM1 areas.

The benchmark should also be used to construct a 'graded' system for classifying areas of workforce shortage based on the classifications adopted in the Grattan Institute's *Perils of Place Report*. These gradings would then be used as the basis for targeting incentives and other levers (positive or negative) to areas of severe and persistent shortage (as a priority), then areas of persistent shortage and areas of severe shortage. The proposed benchmarks based on the median would be defined as set out in Table 5.9.

Table 5.9: Proposed approach to grading workforce shortage using the median FSE per-capita

DWS grading	Major cities	All other locations
• Area of workforce shortage	• Lower than Quartile 1 value (lowest 25%) for each specialty in most recent year	• Lower than median value (50th percentile) for each specialty in most recent year
• Area of severe shortage	• Not applicable	• Lower than Quartile 1 value (lowest 25%) for each specialty in most recent year
• Area of persistent shortage	• Classified as an area of shortage for three or more years in a row	• Classified as an area of shortage (or severe shortage) for the three most recent years
• Area of severe and persistent shortage	• Not applicable	• Classified as an area of severe shortage for the three most recent years

Recommended construct of the DWS

The Review found significant issues with the construct of the DWS that are impacting its effectiveness and ability to direct IMGs to work in areas of need. There was widespread agreement among stakeholders that too many areas within major cities are classified as DWS. Like the issues that were noted in exemptions for Section 19AB, the current construct of the DWS is resulting in a 'watering down' of its ability to addressing workforce maldistribution.

Consultations with the Department highlighted a need to balance a more 'discipline-specific' approach to benchmarking areas of workforce shortage with minimising the administrative and data burden required to implement and update a future workforce shortage classification. In response, several changes are recommended to how DWS catchments are identified to address these issues (*Table 5.10*). Key changes include:

- a more nuanced approach to selecting specialties that are eligible for consideration as DWS. Rather than being based on a threshold with limited evidence, a broader range of considerations is proposed to identify which specialties should be considered for DWS, and which specialties should not.
- defining DWS at SA4 level rather than SA3. This will result in larger DWS catchment areas, which is expected to provide a more robust measure of specialist access (consistent with the greater catchment areas typically required for non-GP specialists) and fewer boundary issues than defining DWS at SA3 level.
- updating the benchmark used to identify areas of workforce shortage to be based on the median FSE per-capita, rather than comparing FSE to the national average. Further changes are recommended to use this benchmark to establish a system for 'grading' areas of workforce shortage to support a focus on more positive distribution levers.

Table 5.10: Summary of recommended changes to construct of the DWS

Characteristic	Current approach	Recommended approach
1. Identification of specialties eligible for DWS	<p>All specialties with lower than 3 FSE per 100,000 nationally are automatically classified as being in workforce shortage and are eligible for DWS.</p> <p>Other specialties with more than 3 FSE per 100,000 are evaluated against a benchmark (see Step 5).</p>	<p>Use the NMWS to identify specialties eligible for DWS.</p> <p>Adopt a principles-based approach for DWS inclusion, focusing on the ability of doctors in the non-GP specialties to exercise their scope of practice in regional, rural, and remote settings, having enough specialists available to contemplate redistribution, and only including specialties that provide direct clinical care to patients.</p> <p>Remove the 3 FSE per 100,000 benchmark as the basis for identifying eligible specialties.</p>
2. Application of automatic eligibility rules	<p>All SA3 locations in RA3-RA5 are automatically classified as DWS.</p>	<p>No change. All locations in RA3-RA5 should be automatically classified as DWS.</p>
3. Level of geography used to define DWS	<p>Statistical Area Level 3.</p>	<p>Statistical Area Level 4 is recommended as the level of geography used to define DWS. SA4 provides a larger geographic area than SA3 and is expected to reduce the 'boundary' issues that were reported in relation to SA3.</p>
4. Measure used to construct the DWS benchmark	<p>FSE per-capita in a given SA3.</p>	<p>No change. FSE per-capita is recommended to be retained as the approach to identifying areas of workforce shortage. FSE is a more suitable measure of access to non-GP specialist care than measures such as FTE or headcount, which relate more to a doctor's primary practice location.</p> <p>The Department should continue to calculate and update FSE to support the implementation of this measure.</p>
5. Benchmark used to define areas of workforce shortage	<p>SA3s with a lower FSE per-capita than the national average in a given specialty.</p>	<p>Change to a more nuanced approach based on evaluating SA4s against the median FSE per-capita. Different benchmarks in major cities and non-metropolitan SA4s, so that areas of shortage would be identified:</p> <p>in non-metropolitan areas, where FSE per 100,000 in a given SA4 is lower than the national median for that specialty</p> <p>in metropolitan areas, where FSE per 100,000 in a given SA4 is lower than the 25th percentile (Quartile 1) value for that specialty</p> <p>Using these benchmarks, areas of workforce shortage would be 'graded' based on their severity and persistence. These gradings would then be used to focus the broader implementation of positive levers to influence workforce maldistribution, and to 'scale' back moratorium requirements for IMGs that work in areas of greater need.</p>

Impact of proposed revisions to the DWS

The following section considers the impact resulting from the proposed changes for DWS, providing guidance on what needs to be considered in the transition to a new way of defining DWS areas for the purposes of Section 19AB.

Specialties classified as eligible for DWS

A wider range of specialties would be considered in-scope for DWS, meaning a potential increase in the number of IMGs seeking out positions in DWS areas. The proposed approach increases the number of in-scope specialties from eight to 21 specialties as previously outlined. This increase is due to considering additional specialties in-scope that could benefit from the application of DWS for their workforce and removal of the 3 FSE per 100,000 benchmark.

The Department is still developing models for workforce oversupply and undersupply as per the NMWS. Continuous review and adaptation of the DWS approach will be necessary as new data and insights emerge, including new models of care in rural areas and the impact of telehealth on service provision.

Benchmarks used to identify Districts of Workforce Shortage

Table 5.11 presents the benchmarks that would be used to calculate DWS areas under the current approach and the proposed revised approach based on the median. Data for the current eight DWS specialties are presented because data on the other specialties are not available. Although the current approach is classified at SA3 level, this report has recommended that DWS catchments are defined at SA4 level instead. As a result, the median values for SA4 level are shown for the recommended approach.

By comparing the national average and median, this analysis shows that the recommended approach results in a lower benchmark being applied for all specialties. Proportionally, the benchmark decrease is most significant for psychiatry (-61%), obstetrics and gynaecology (-49%) and anaesthetics (-50%).

For major city locations, applying the quartile 1 value means that the benchmark for FSE to qualify as a DWS is significantly smaller than the national average for most specialties, except diagnostic radiology (although still 27% smaller).

Table 5.11: Comparison of FSE benchmarks for current DWS specialties - current approach and proposed changes

Speciality	Current approach	Recommended approach	
	National average FSE per 100,000	Median FSE (SA4)	Quartile 1 FSE (SA4)
Anaesthetics	5.29	2.65	1.02
Cardiology	5.75	4.80	2.11
Diagnostic Radiology	19.36	18.09	14.07
General Surgery	2.85	2.76	1.33
Medical Oncology	3.91	3.44	1.12
Obstetrics and Gynaecology	3.51	1.79	0.90
Ophthalmology	4.01	3.48	2.01
Psychiatry	4.38	1.71	0.73

Source: HealthConsult analysis on data provided by the Department of Health and Ageing

Number of catchments classified as DWS

Applying the recommended methodology results in a significant reduction in the number of locations that would be classified as DWS for all specialties (*Table 5.12*). The reduction is most pronounced for Psychiatry (-49%) and Anaesthetics (-54%).

Table 5.12: Comparison of SA4s classified as DWS using current vs recommended approach to DWS

Speciality	Number of SA4 DWS FSE less than national average	Number of SA4 DWS Recommended approach
Anaesthetics	63	34
Cardiology	55	39
Diagnostic Radiology	56	37
General Surgery	47	36
Medical Oncology	52	31
Obstetrics and Gynaecology	64	39
Ophthalmology	53	34
Psychiatry	70	36

Source: HealthConsult analysis on data provided by the Department of Health and Ageing

Importantly, the recommended approach reduces the number of DWS catchments in major cities, which was a significant issue raised by many stakeholders. There are also significant reductions in the proportion of DWS catchments in inner regional areas for most specialties, except general surgery. Since both the current and recommended approach automatically include RA3-5, 100% of SA4s in these locations would be classified as DWS and are not shown in the table.

Table 5.13: Current distribution of DWS catchments at SA4 level, by RA

Speciality	Current approach		Recommended approach	
	Major Cities of Australia	Inner Regional Australia	Major Cities of Australia	Inner Regional Australia
Anaesthetics	56%	82%	18%	36%
Cardiology	44%	73%	18%	59%
Diagnostic Radiology	46%	82%	14%	59%
General Surgery	50%	32%	24%	32%
Medical Oncology	54%	41%	16%	27%
Obstetrics and Gynaecology	56%	86%	18%	59%
Ophthalmology	52%	50%	16%	41%
Psychiatry	66%	91%	10%	64%

Source: HealthConsult analysis on data provided by the Department of Health and Ageing

The impact of the recommended changes to DWS is clearly illustrated in Appendix I, which provides maps that show which SA4s would be classified as DWS using the current versus recommended approach for each of the eight current DWS specialties:

- across Australia, and
- in Australia's three main population centres; Sydney, Melbourne and Brisbane

Appendix F shows which SA4s would be classified as DWS in each specialty using the recommended approach, for each of the eight current DWS specialties.

Grading of DWS catchments

The result of the proposed grading system for classifying DWS catchments is shown for some of the current DWS specialties below (additional results provided in *Appendix F*). This analysis would need to be replicated for all specialties eligible for DWS classification under the revised DWS construct proposed in a previous Section. This analysis shows that:

- severe and persistent shortage exist in all RA4 and RA5 locations, for all current DWS specialties
- no major city locations are in severe and persistent shortage
- some RA2 and RA3 locations are in severe and persistent shortage for all specialties
- the proportion of RA2s and RA3s in persistent shortage varies by specialty, but is typically between 30% to 50%
- no locations are in persistent shortage for diagnostic radiology
- some major city locations are in persistent shortage, for all specialties (except diagnostic radiology)
- typically, no shortage is reported in 80% or more of major city SA4s
- there are no SA4s that are in severe shortage only (which is why it has been removed from tables below) – all these SA4s fall within the severe and persistent shortage category based on 2022 data.

Appendix K shows the results for each SA4, by specialty.

Table 5.14: Result of proposed revision to DWS grading system for Anaesthetics

Level of shortage	RA1	RA2	RA3	RA4	RA5
Severe and persistent shortage	0%	14%	38%	100%	100%
Persistent shortage	16%	41%	38%	0%	0%
Shortage only	0%	5%	0%	0%	0%
No shortage	84%	41%	23%	0%	0%

Source: HealthConsult analysis on data provided by the Department of Health and Ageing

Table 5.15: Result of proposed revision to DWS grading system for Cardiology

Level of shortage	RA1	RA2	RA3	RA4	RA5
Severe and persistent shortage	0%	23%	46%	100%	100%
Persistent shortage	10%	55%	38%	0%	0%
Shortage only	0%	0%	8%	0%	0%
No shortage	90%	23%	8%	0%	0%

Source: HealthConsult analysis on data provided by the Department of Health and Ageing

Table 5.16: Result of proposed revision to DWS grading system for Diagnostic Radiology

Level of shortage	RA1	RA2	RA3	RA4	RA5
Severe and persistent shortage	0%	27%	62%	100%	100%
Persistent shortage	0%	0%	0%	0%	0%
Shortage only	2%	5%	8%	0%	0%
No shortage	98%	68%	31%	0%	0%

Source: HealthConsult analysis on data provided by the Department of Health and Ageing

Table 5.17: Result of proposed revision to DWS grading system for General Surgery

Level of shortage	RA1	RA2	RA3	RA4	RA5
Severe and persistent shortage	0%	9%	54%	100%	100%
Persistent shortage	18%	45%	46%	0%	0%
Shortage only	0%	5%	0%	0%	0%
No shortage	82%	41%	0%	0%	0%

Source: HealthConsult analysis on data provided by the Department of Health and Ageing

Proposed applications of DWS gradings

Finding

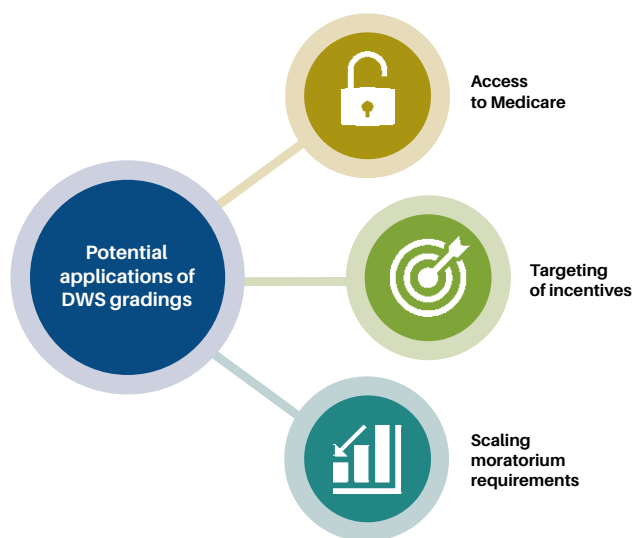
Establishment of a graded DWS classification will provide opportunities to apply more nuanced policy responses to medical workforce maldistribution.

This could include:

- supporting the development of a targeted implementation of incentives and other positive levers, which were widely desired among most stakeholders and are recommended as a key direction in this report
- addressing some of the issues that resulted in consistent feedback that the current DWS classification being too 'blunt', and
- providing a more explicit point of linkage between areas of workforce shortage and the implementation of Section 19AB, through applications such as scaling of moratorium requirements, or differential access to Medicare benefits.

Potential applications of DWS gradings are summarised in *Figure 5.3* and discussed below.

Figure 5.3: Potential applications of DWS gradings



Access to Medicare

Currently, Section 19AB requires that non-GP specialist IMGs deliver care in DWS catchments to access Medicare benefits. DWS gradings could be used to provide a more nuanced approach to Medicare access by providing for full MBS access to IMGs practising in greater areas of workforce shortage. More restricted access could be allowed for those practising in DWS areas that are not classified as having severe, persistent or severe and persistent shortages. This proposal would require changes to Section 19AB of the Health Insurance Act. Table 5.18 sets out how gradings could be applied to achieve these outcomes.

Table 5.18: Proposed workforce shortage ‘gradings’ for DWS and their application in differential access to Medicare

Proposed workforce shortage level	Potential application - differential access to Medicare
1. Area of workforce shortage	IMGs operating in these catchments would be allowed to access the MBS to bulk bill services only .
2. Severe shortage only	IMGs operating in these catchments would be allowed to access the full MBS on a bulk billing and fee-for-service basis .
3. Persistent shortage	IMGs operating in these catchments would be allowed to access the full MBS on a bulk billing and fee-for-service basis .
4. Severe and persistent	IMGs operating in these catchments would be allowed to access the full MBS on a bulk billing and fee-for-service basis .

Targeting incentives and positive levers to address workforce maldistribution

A stronger focus on incentives and positive levers to address maldistribution was strongly endorsed by most stakeholders. However, Section 19AB, the DWS and some current incentive programs were commonly described as ‘blunt instruments’ during consultations and stakeholder submissions. The proposed gradings for the DWS could be used as a linkage point to tie the level of incentives for attraction and retention of medical workforce to the level of shortage that is being faced by a given location. Further on in this Section discusses options for how DWS gradings could be used to inform the establishment of a stronger focus on positive levers that is recommended in this report, through:

- **differential levels of financial incentives** for medical workforce attraction and retention. These levels could be adapted to any type of incentives that may be linked directly to remuneration, such as those focused on higher education repayment discounts or tax-related incentives
- **loadings to MBS services provided.** This could involve progressively higher ‘loadings’ being applied to MBS services delivered by IMGs who provide specialist services in higher areas of need. This could operate in a similar way to the remoteness loadings applied to hospital funding under the National ABF models. This would be a new approach to use of loadings in MBS and requires further consideration.

Although *Table 5.19* focuses on incentives related to IMGs, these gradings could also be applied to domestically-trained doctors as part of a national strategy to attain greater domestic self-sufficiency.

Table 5.19: Proposed workforce shortage ‘gradings’ for DWS and their application in incentives

Proposed workforce shortage level	Potential application –incentives	Loadings to Medicare services
1. Area of workforce shortage	IMGs working in these catchments would be eligible for the lowest tier of workforce attraction / retention incentives under a ‘graded’ incentive structure to establish a stronger focus on positive workforce distribution levers.	IMGs operating in these catchments could access a small MBS loading to specialist services they deliver – potentially five to 10% of the scheduled fee.
2. Severe shortage only	IMGs working in these catchments would be eligible for a middle level of workforce attraction / retention incentives under a ‘graded’ incentive structure to establish a stronger focus on positive workforce distribution levers.	IMGs operating in these catchments could access a moderate MBS loading to specialist services they deliver – potentially 20% of the scheduled fee.
3. Persistent shortage	IMGs working in these catchments would be eligible for a middle level of workforce attraction / retention incentives under a ‘graded’ incentive structure to establish a stronger focus on positive workforce distribution levers.	IMGs operating in these catchments could access a moderate MBS loading to specialist services they deliver – potentially 20% of the scheduled fee.
4. Severe and persistent	IMGs working in these catchments would be eligible for the highest level of workforce attraction / retention incentives under a ‘graded’ incentive structure to establish a stronger focus on positive workforce distribution levers.	IMGs operating in these catchments could access a high MBS loading to specialist services they deliver – potentially 30%-40% of the scheduled fee.

Scaling moratorium requirements

Currently, IMGs subject to Section 19AB can reduce their 10-year moratorium period by working in a more remote location. Doing so provides access to 'scaling credits' that are automatically applied based on Medicare billing data (once the billing MBS threshold of \$5,000 per month is reached). As shown in *Table 5.20* scaling credits are currently tied to the RA classification, with more remote practice attracting a larger reduction in the 10-year moratorium.

Table 5.20: Current scaling credits to reduce the 10-year moratorium requirement

RA classification	Category	Monthly scaling benefit (where billing threshold is met)	Reduced moratorium period
RA 1	Major cities	Nil	Not reduced
RA 2	Inner regional	3.37 days	9 years
RA 3	Outer regional	13 days	7 years
RA 4	Remote	20.3 days	6 years
RA 5	Very remote	30.4 days	5 years

Source: Department of Health and Ageing, accessed from <https://www.health.gov.au/topics/doctors-and-specialists/what-we-do/19ab/moratorium>

Table 5.21 presents a proposal for how the graded DWS classification could be used as an alternative to the current approach to scaling. This approach follows the same principle whereby practice in greater areas of need attracts a higher 'discount' to the moratorium requirement. Similar discounts / scaling benefits to the current approach are proposed for illustrative purposes, although these could be adapted in response to specific policy initiatives. The key benefit to this approach is that it provides a more explicit linkage between scaling benefits and areas of workforce shortage. To align with the current approach, it would be expected that scaling credits only be applied to IMGs working in RA 2-5 locations, and that no reduction in the moratorium period would be available to those working within a RA 1 DWS location.

Table 5.21: Potential use of a graded DWS classification in scaling the 10-year moratorium for IMGs working in RA 2-5 locations

Proposed workforce shortage level	Potential scaling benefits
<ul style="list-style-type: none"> Area of workforce shortage 	IMGs working in these catchments would access a small scaling benefit . This could be between the current scaling benefits applicable to RA2 locations (9 years) and RA3 locations (7 years).
<ul style="list-style-type: none"> Severe shortage only 	IMGs working in these catchments would access a moderate scaling benefit . This could be between the current scaling benefits applicable to RA3 locations (7 years) or RA4 locations (6 years).
<ul style="list-style-type: none"> Persistent shortage 	IMGs working in these catchments would access a moderate scaling benefit . This could be between the current scaling benefits applicable to RA3 locations (7 years) or RA4 locations (6 years).
<ul style="list-style-type: none"> Severe and persistent 	IMGs working in these catchments would access a large scaling benefit . This could be aligned to the current maximum benefit for IMGs working in Very Remote locations (5 years).

Considering the use of the proposed new DWS grading system to inform the design of new and improved workforce distribution levers will ensure stronger and more transparent linkages between the ‘new’ DWS and Section 19AB that are based on the levels of workforce shortage that exist for specific specialties/locations. This will also provide a foundation for a more nuanced approach to address medical workforce maldistribution to address criticisms of Section 19AB and the DWS as a blunt instrument.

Other options to incentivise working in areas of greatest need, while still retaining the timeframe for the 10-year moratorium, are discussed in *Section 7*.

Implementation of proposed DWS

Finding

The full impact of the proposed changes to DWS is not yet fully understood and still requires modelling.

To effectively implement the proposed changes to DWS, it is essential to conduct a robust modelling study. This study should comprehensively analyse the geographic areas and non-GP specialties that will be included or excluded under the new framework. By understanding the potential impact on various regions and fields, policymakers can ensure that the adjustments to DWS are both equitable and efficient.

Furthermore, the modelling study should be leveraged to identify the necessary administrative and data infrastructure resources required to support a broader range of specialties under DWS. This includes evaluating current systems and determining the enhancements needed to manage the

expanded scope effectively. Whilst it is expected that additional resources may be needed to support the proposed changes, the quantum of this is not yet fully understood.

In addition to the technical and administrative requirements, it will also be vital to consult with medical professionals, healthcare administrators, and community representatives. Their input will be important in understanding the real-world impacts of the proposed changes in DWS status, ensuring that the new strategy meets the needs of both healthcare providers and the communities they serve.

Recommendations

The Reviewers make the following recommendations

Recommendation 17

A modified form of the DWS should be retained as the approach to classifying workforce shortage for non-GP specialists. The objectives of the DWS should continue to focus on identifying areas where there are low levels of access to non-GP specialist medical care, to support Section 19AB. Current DWS objectives related to targeting incentives to improve access should also be retained and emphasised more strongly, to align with the widespread support for more positive levers to address workforce maldistribution. As with DPA (see Recommendation 16), DWS should no longer be used for determining locations for ROSO under the Bonded Medical Program.

Recommendation 18

A principles-based approach should be adopted to establish a revised and expanded list of specialties for inclusion in DWS and implement a process of regular (at least every two years) review of the list.

Recommendation 19

SA4 should be adopted as the geographic catchment to define the DWS classification.

- Blanket inclusion rules for Remoteness Area (RA) 3-5 locations should be retained in the DWS classification.
- FSE per-capita should continue to be used as the measure for defining DWS locations as it provides the most reliable and robust measure of access to non-GP specialist services across Australia.
- A more nuanced methodology based on the median FSE per capita is recommended as the basis for identifying areas of workforce shortage. Different benchmarks should be applied to metropolitan and non-metropolitan areas to establish severity 'gradings' for workforce shortage that would be used to inform incentives and moratorium scaling credits.

6. Modified Monash Model (MMM)

The MMM measures remoteness and population size using a scale of MMM categories MM1 to MM7. MM1 is a category that describes *metropolitan areas* and MM7 describes *very remote communities*.

MMM classifications are based on the Australian Statistical Geography Standard - Remoteness Area (ASGS-RA) framework. The MMM results from a series of input aggregate spatial units. Any change in the preceding inputs changes how the MMM units can be designed. The MMM is reviewed and updated after each census, which the Australian Bureau of Statistics (ABS) conducts every five years.

The MMM classification was developed using six indicators from the Medicine in Australia: Balancing Employment and Life (MABEL) survey data. These indicators were identified to influence rural medical workforce recruitment and retention. The indicators were mapped to geographical settlements (i.e. town size) likely to reflect these and subsequently the MMM categories.

The MMM classification therefore assumes the number of doctors who will work in population areas based on these indicators. The MABEL survey began in 2008 and concluded in 2018–19 (a short online survey was conducted in 2020).

Rural health policy in Australia first used the MMM 2015 to target health workforce programs to attract GPs to more rural and remote communities with limited access and resources⁵³. This first iteration of the MMM was based on data collected during the 2011 Census of Population and Housing. The latest publicly available iteration, MMM 2019, is based on data collected in the 2016 census.

Before the introduction of the MMM, Australian Government rural health programs, such as the Rural Health Workforce Strategy, provided financial incentives to GPs, using the ASGC-RA structure to define incentive eligibility and payment amounts according to geographic remoteness. The targeted financial incentives were to support GPs who practise in underserved rural and remote areas for a considerable period and to encourage relocation and retention⁵⁴.

The original intent of the MMM classification system was to guide rural health policy funding to incentivise the distribution of the GP workforce to more remote settings. MMM is now used across at least 58 programs within DoHAC to aid decision making. It is also used in a number of other government agencies such as NDIS.

53 The Department of Health and Aged Care. GP Catchments Review 2023

54 The Department of Health and Aged Care. Distribution Priority Area (DPA) for 19AB - July 2023 Update

Generally, for these programs, stakeholders reported that a remoteness measure for ongoing policy planning is still needed and MMM is better than previous measures.

We agree [MMM] is probably the best classification we currently have

Consultation with Stakeholders

While MMM does address isolation of towns, it does not address the desirability of the place as a residence or work, desirability of a location, distance from a tertiary hospital or major metro site, or the difficulty in attracting GPs and staff to certain locations.

Submission from Department for Health and Wellbeing South Australia

It is recognised that the MMM system will not perfectly reflect need and there may be requirements for additional mechanisms to accommodate outliers... We would be strongly opposed to any efforts to dismantle the MMM structure which has enabled major improvements to the effective allocation of funding and support and see significant risk that an alternative framework would lead to worsening rather than improvement to equity.'

Submission from ACRRM

The findings of this Review do not support the continued blanket application of MMM to identify DPA or DWS, favouring a more nuanced approach based on individual GP catchment areas.

As such, the use of MMM is not proposed for the ongoing application and usage of Sections 19AA, 19AB, DPA and DWS. It was beyond the brief of this Review to recommend MMM levers on the broader continued usage across other DoHAC programs.

Finding

All MMM is currently used across many government programs to aid decision making. The findings of this Review do not support the continued blanket application of MMM to identify DPA or DWS, favouring a more nuanced approach based on individual GP catchment areas.

It is beyond the brief of this Review to recommend on the appropriateness of the continued use of MMM across the many other DoHAC programs.

7. Complementary Strategies

The extent and rationale of proposed changes to the construct and application of Sections 19AA & 19AB, DPA, DWS and MMM, have been highlighted in the previous Sections. The changes are designed to improve the distribution levers in order to better attract and direct the medical workforce to areas of need.

The seventh Term of Reference for this Review states:

Consider and, where appropriate, make recommendations on alternative approaches to the Department for achieving the intent of the distribution levers.

The following outlines some alternative approaches that have been identified. These should be considered as complementary to the proposed changes to the existing distribution levers. For some of these approaches, such as increasing the supply of the domestically trained workforce, there is a long lead time from increasing student places to impacting on workforce supply.

Increase domestically trained medical practitioners and other health professionals

The evidence presented earlier in this Report, supported by many submissions and consultations, pointed to the critical importance of the OTD medical workforce to Australia's health care system. This emphasised the need to continue to depend upon, better induct, support and incentivise this workforce for the foreseeable future. Nevertheless, as the Royal Flying Doctor Service (RFDS) submission emphasised, the anomaly of this workforce is that it is a key provider of Australian primary medical services in the most challenging circumstances.

Current workforce distribution initiatives that place IMGs in rural and remote areas of workforce shortages ultimately sees these clinicians with the least experience of the Australian health system in the most isolated settings with the highest burden of disease, lowest levels of health literacy, the least clinical support, and in the most challenging environments (e.g. heat, social isolation, sparse populations, cultural considerations).

Submission from RFDS

These same submissions also highlighted the ethical issues associated with ongoing high dependency on OTDs and other overseas-trained health professionals. The ethics of recruiting from countries who themselves may have health professional shortages is gaining increasing focus both within Australia, and internationally⁵⁵. Meeting and monitoring Australia's obligations under *WHO Global Code of Practice on the International Recruitment of Health Personnel*.⁵⁶ is important. Should

55 Australia plans to hire more overseas doctors. Is it ethical to recruit from countries with doctor shortages? The Conversation. https://theconversation.com/australia-plans-to-hire-more-overseas-doctors-is-it-ethical-to-recruit-from-countries-with-doctor-shortages-230975?utm_source=linkedin&utm_medium=bylinelinkedinbutton

56 WHO Global Code of Practice on the International Recruitment of Health Personnel. National Reporting Instrument 2021.

this overseas workforce availability to Australia diminish, longer-term risks are evident, such as those that occurred during COVID-19.

While acknowledging the importance of IMGs to rural and remote communities, there have been the unintended consequence of this continual dependency on increasing *metropolitan* labour supply. The submission by Professor Richard Murray, Dean of the College of Medicine and Dentistry, James Cook University succinctly emphasises the consequence:

While the continued importation of IMGs is predicated on workforce shortage in the regions, the reality is that Australia's reliance on IMGs for the regions ends up mostly contributing to burgeoning metropolitan workforce growth. Medical workforce in the city was at a record 4.6 doctors in clinical practice per 1000 population in 2022 and, with the number of doctors growing at 3.7% per annum. IMGs comprise one third of the annual growth in city medical workforce stock.

The stock of IMGs in clinical practice increased by around 1000 each year between 2015 and 2022, 79% of which was into major cities. IMG workforce in major cities is growing at 3.9% per annum, compared to 2.9% in the regions.

In effect, Australia's regional deployment of IMGs by various program levers is a leaky bucket that requires constant top-up, whilst ultimately adding mostly to metropolitan labour supply

Submission from Professor R Murray, James Cook University.

The recommendations of this Report in better identification of DPA/DWS area of need, coupled with reducing exemptions, are designed to decrease the movement of IMGs to well supplied locations during the 10-year moratorium period. Equally important is achieving a better balance between OTDs and domestically trained practitioners.

The intent of reducing the reliance of IMGs was also a theme highlighted in the DoHAC *National Medical Workforce Strategy 2021-2031*⁵⁷.

The Strategy recognises that IMGs form an important part of the medical workforce, but that there are risks in continuing our heavy reliance on them. While the total number of IMGs working within the public hospital system is unknown, international border closures in response to COVID-19 have highlighted vulnerabilities in a system that relies on temporary and permanent international migration.

The Strategy supports working towards an agreed definition of national self-sufficiency, the first step of which is understanding and modelling the domestic supply through the Data Strategy. Australia, like many other countries, will likely always benefit from some IMGs, and some doctors may choose to migrate or gain experience overseas, but the ability to deliver care without a significant reliance on IMGs is important.

Extract from DoHAC National Medical Workforce Strategy 2021-2031.

57 Australian Government Department of Health. National Medical Workforce Strategy 2021– 2031. <https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031>

There is not yet an agreed definition of national self-sufficiency. Whilst beyond the brief of this Review, defining national self-sufficiency depends on an agreed view of medical workforce capacity, capability, location and timing needed – including in preparation for heightened, sudden and/or high impact service requirements such as a pandemic or mass health emergencies.

Key factors to consider include models of care, differences in local needs, workforce demographics, population changes and the infrastructure and technology available to deliver high quality care. Improved data and evidence, alongside collaboration in workforce planning with governments and key sector stakeholders will assist in defining and achieving self-sufficiency.

Clearly within this definition will be a need to redress the existing imbalance between overseas trained and domestically trained medical practitioners.

Increasing the proportion of domestically trained medical graduates should be targeted to best contribute to current shortages. With respect to rural areas of need, a recent Medical Journal of Australia (MJA) article states:

Although we acknowledge that universities have an economic interest in medical school places, rural medical workforce is an urgent priority. Additional medical school places should be deployed regionally into programs that apply the best evidence for delivering rural and primary care workforce outcomes. This should involve admissions policies, program design, and clinical training experience that emphasises learning in and for the following settings: rural and primary care, Aboriginal Community Controlled Health Services (ACCHS), rural hospitals, aged care services, disability care services, community mental health services and other community-based services⁵⁸.

Article by Murray et.al, 2023.

Finding

Overseas trained doctors are a critically important component of Australia’s medical workforce both in primary care and hospital settings. Nevertheless, the National Medical Workforce Strategy 2021-2031 proposes the identification of a national self-sufficiency target for the Australian Medical workforce which:

- Guides a reduced dependency on OTDs and
- Should be with training specifically targeted to areas of workforce shortage

58 Murray RB, Craig H. A sufficient pipeline of doctors for rural communities is vital for Australia’s overall medical workforce. Med J Aust 2023; 219 (3 Suppl): S5-S7.

Multidisciplinary Teams

The ambition of national self-sufficiency for the medical workforce equally applies to other primary care workers.

Since the distribution levers examined in this Review were first put into place over two decades ago, contemporary primary care has evolved. In addition to medical practitioners, optimal primary care now requires vibrant and skilled multidisciplinary teams. These teams appropriately span the range of primary care allied health personnel^{59,60}. It is proposed, to enhance multidisciplinary teams, that any alteration to the cap for medical student places, to improve self sufficiency and better align domestic medical training numbers to regional shortages, should also consider the workforce needs of other health professionals.

The Australian College of Nursing submission highlighted that in those areas where there is little likelihood of attracting and retaining GPs, the role of nurses, as one example, is particularly important.

Bolstering those general practices or primary care services that struggle to recruit or retain GPs with additional nursing resources at an appropriate professional level now would ensure the population would have timely access to care and be more sustainable in the short to medium term. The rural and remote generalist nursing pathway can provide the framework for this.

A deliberate strategy to fast track the primary care nurse practitioner workforce is urgently required.

Submission from Australian College of Nursing

Strategies and investment are recommended to further develop the primary care nursing and allied health workforce pipeline from undergraduate immersion through placements, graduate programs and post graduate rural generalist training. Postgraduate training and support is particularly important for rural and remote allied health workforce to aid retention in these locations.

Important strategies of aligning the increased health workforce training places more closely with designation of areas of need and ensuring continued funding support for training bodies, is predicated on delivering optimal distribution outcomes.

59 Wakerman, J. et.al. Overcoming access and equity problems relating to primary health care services in rural and remote Australia.

60 The Ngayubah Gadan Consensus Statement – Rural and Remote Multidisciplinary Health Teams.

<https://www.health.gov.au/resources/publications/the-ngayubah-gadan-consensus-statement-rural-and-remote-multidisciplinary-health-teams?language=en>

Two possible approaches are suggested to assist identification of “hotspots” in need. One approach, adapted from the Grattan Institute’s *Perils of Place Report*⁶¹ report (See Sections 4/5 & Appendices G/H) classified areas of DPA/DWS workforce shortage gradings according to:

- Severe and persistent
- Severe shortage only
- Persistent shortage only
- Area of undersupply
- All others

A similar approach is evolving from in the National Health Reform Agreement (NHRA) 2025-2030 whereby categorisation of graduating levels of service delivery sufficiency is according to

- **Having sufficient supply:** meaning service delivery arrangements are sustainable.
- **Being at risk markets:** in some or all care sectors having the potential to impact on delivery of the minimum level of service in the next one to six months.
- **Being temporarily failed markets:** in some or all care sectors with impacts being experienced in the minimum level of service.
- **Being irretrievably failed markets:** in some or all care sectors with impacts being experienced in the minimum level of service long-term.
- **Absence of market:** in areas where there is no market and no prospect of establishing one.

Development of such a classification system nationally should help guide prioritisation of additional medical and other health professional training places and funding support.

Primary Care Teaching, Training and Research

The Reviewers believe that there is a need to build the capacity of Australia’s primary care sector to support teaching, training and research. The need for strengthening primary health care education and training programs was also emphasised in the *2022 Strengthening Medicare Taskforce Report*⁶². This will require additional investment in both the supervisors in training and the multidisciplinary workforce receiving the training. The geographic allocation of additional monies should be graduated by the above classification of relative need.

Such an enhanced capacity is a key element to building a more robust, sustainable and skilled primary care workforce throughout Australia, and more specifically in areas of relative need.

Finding

The capacity to recruit and retain primary health care professionals to areas of need is enhanced by the access to teaching, training and participation in research. This could include support for both supervisors, those in training and the multidisciplinary workforce receiving it.

61 Duckett, S. and K. Griffiths, 2016, *Perils of place: identifying hotspots of health inequalities*, Grattan Institute

62 *Strengthening Medicare Taskforce Report*, 2022.
<https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en>

Alignment with Migration Strategy

As part of this Review, discussions were held with officers of the Department of Home Affairs. Four pathways currently exist for the approximately 15,000 overseas health professionals to migrate to Australia each year. These pathways exist through:

Employer Nomination Visa Scheme: This visa lets skilled workers, who are nominated by their employer, live and work in Australia permanently.

Distinguished Talent Visa Scheme: This is a permanent visa for people who have an internationally recognised record of exceptional and outstanding achievement in an eligible field.

Skilled Nominated Visa Scheme: This visa lets skilled workers, who are nominated by a State or Territory agency live and work in Australia as permanent residents.

Skilled Regional Visa Scheme: This visa is for people who have lived and worked in specified areas of regional Australia on a previous, eligible visa.

The Skilled Regional Visa Scheme, designed to include workforce for regional and rural areas have a much lower uptake than the other three pathways.

Two issues emerged from submissions to this Review which have relevance to Home Affairs.

The first reaffirms the findings of the Kruk *“Independent Review of Australia’s Regulatory Settings Relating to Overseas Health Practitioners”*⁶³

Applicants and employers view the current end-to-end journey – which includes navigating registration, migration, Medicare and employment requirements – as inefficient, complex, costly and slow. General practitioners surveyed by the review told us they spend up to 2 years navigating this journey and most incur more than \$33,000 in costs. The experience is frustrating, duplicative, and demeaning, particularly for experienced, mid-career and specialised practitioners.

Kruk Review of Australia’s Regulatory Settings Relating to Overseas Health Practitioners

It was reported to the Reviewers that many OTDs who have come to Australia, particularly via employer sponsored programs claimed a lack of knowledge of the requirements to practice in a DPA/DWS locality in order to access Medicare payments and attain their Specialist Registration. Given the recommendations of this Review to maintain DPA/DWS with much stronger adherence to limiting exemptions to the requirement for OTDs to practise in areas of need/workforce shortage, it is important that there is greater clarity of the requirements prior to arrival in Australia.

63 Kruk, 2023. Independent Review of Australia’s Regulatory Settings Relating to Overseas Health Practitioners. <https://www.regulatoryreform.gov.au/priorities/health-practitioner-regulatory-settings-review>

The second issue relates to improved harmonisation of migration with Australia's ongoing requirement for overseas trained medical practitioners (and other health professionals). This need for harmonisation is highlighted in the recently released *Australian Government Migration Strategy*⁶⁴.

Finding

The Australian Government Migration Strategy identified eight key actions, two of which are directly relevant to this Review re

- Planning migration to get the right skills to the right places, and
- The prioritisation of visas for regional Australia

It is proposed that consultations occur between DoHAC and the Department of Home Affairs to assess how to best implement the recommendations of this Review which pertain to migration of health professionals.

Blended funding models

The capacity to attract and retain primary care services in areas of persistent workforce shortages is inhibited by the predominant dependency on private practices (small businesses) relying on MBS fee for service funding. A number of reforms, underpinned by a registered population (MyMedicare) are in train to balance this dependency with a blend of alternative payment types, including block and bundled payments.

The "Scope of Practice Issues Paper No.2: Funding and payment models incentivise multidisciplinary care teams working to full scope of practice"⁶⁵ proposed an alternative model for building an improved system of primary care in areas of workforce shortage.

This mechanism involves expanding alternative funding models to complement MBS funding, including a combination of different funding types to support different types of care, increasing choice for primary health care services in how they are funded.

It is proposed to expand, refocus and blend a number of existing programs and payments into a flexible, population specific and risk-based payment to support local access by consumers to care based on their needs. The new blended payment would be aligned with Strengthening Medicare reform direction of a primary health system serviced by multidisciplinary care teams working to their full scope of practice. This payment would be available to practices and primary care providers to fund and support a flexible mix of health services to meet the local health needs of their enrolled population.

64 Australian Government Migration Strategy. <https://immi.homeaffairs.gov.au/what-we-do/migration-strategy>

65 Cormack, M. Scope of Practice Issues Paper No.2: Funding and payment models incentivise multidisciplinary care teams working to full scope of practice.

It will build on existing good practice examples of block funding primary health care in rural and remote health settings (i.e. under the Section 19(2) exemption Initiative through which funding flows directly to States and Territories, and block funding of primary health care provided by local health networks in some jurisdictions), and ACCHS which provide effective culturally safe primary care under a blended (mix of MBS fee-for-service, grant and program funding).

To target and strengthen multidisciplinary care teams, the revised blended payment should be available to support access to a wider range of health professionals and services. This involves funding being made available to the GP, who is responsible and accountable for initiating care, with funding flowing to other members of the multidisciplinary care team who deliver care autonomously, consistent with the plan and further guided by their specific scope of practice and ongoing assessment of care needs. In this way, the collective multidisciplinary care team is empowered to contribute to the overall care needs of the consumer and practice population.

Cormack, M. Scope of Practice Issues Paper No.2: Funding and payment models incentivise multidisciplinary care teams working to full scope of practice.

The Scope of Practice proposal for reform is supported by the Reviewers. The selection of appropriate communities should be guided by the recommended changes to DPA.

Strategies to improve access to primary care could include block funding to those practices serving high needs population with workforce shortages to employ nurses to enhance primary care delivery, particularly in areas of chronic disease and young families.

Finding

The synergy between this Review and the Scope of Practice Review – which advocates an extension of blended funding mechanisms, will enable multi-disciplinary care teams to work to full scope of practice in areas of need.

Technology Application

Whilst the Review is focussed on supporting the physical provision of GP and other specialist care in areas of workforce shortage throughout Australia, access to virtual care and support is an essential enabler.

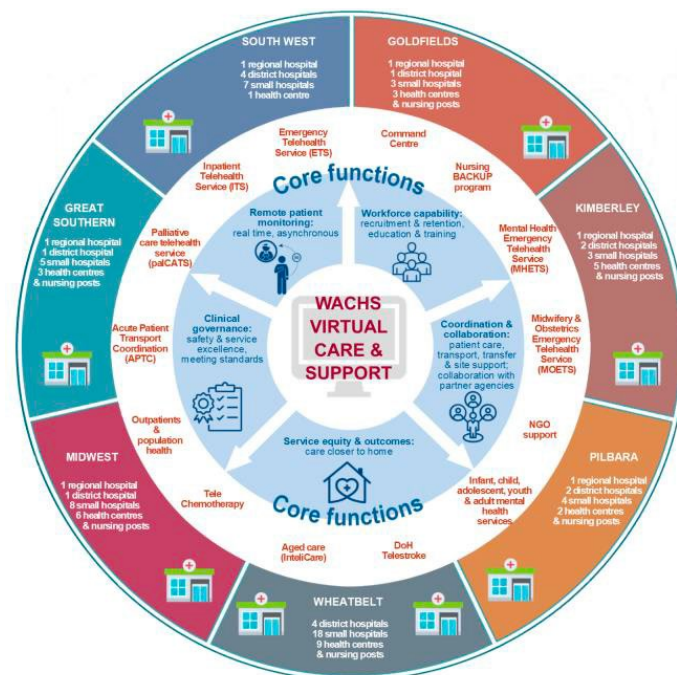
All State and Territory health authorities (and other agencies such as the RFDS), provide telehealth services supporting their rural and remote hospital systems. Some jurisdictions (*see the Western Australia Country Health Service WACHS model below*) extend this support to ACCHS, private primary care providers and other related non-State Government providers.

The Reviewers believe that there is considerable potential to extend the use of jurisdictional infrastructure in virtual support of primary care. There, should be a consideration of how best the funding model supports these initiatives.

The Western Australia Country Health Service (WACHS) Command Centre now routinely supports the care of patients in regional and remote areas on a 24/7 basis. Hospitals and nursing posts that previously had limited or no access to medical care due to staffing issues (exacerbated during COVID) are now assisted in the provision of all levels of care every day, and clinicians based in country WA are supported to provide GP and non-GP specialist level care by the system’s digital platform.

These virtual care services delivered by WACHS are not limited to the provision of State responsibility hospital care. WACHS’ virtual services also fill a crucial role in addressing unmet patient needs resulting from insufficient primary care, including insufficient GP resourcing in Country WA.

WACHS virtual care system



Aboriginal Community Controlled Health Services (ACCHS)

The National Aboriginal Community Controlled Health Organisation (NACCHO) as the national peak body representing the 145 ACCHS throughout Australia highlighted to the Reviewers the deleterious impact of the current distribution levers on the recruitment and retention of GPs by ACCHS.

The weakening of the distribution levers over time has reportedly impacted those ACCHS, particularly in remote locations.

Currently, for example, Central Australian Aboriginal Congress (CAAC) has reported ten full time equivalent (FTE) GP vacancies out of 28 FTE GP positions, together with only three GP registrars, compared to a normal workforce of ten registrars.

Congress currently has 10 FTE GP vacancies out of a total workforce of 28 FTE GPs. We only have 3 GP registrars compared to a period for many years when we had more than ten. The combined impact of this is that Aboriginal people in Central Australia are not getting the level of care that they need and in particular preventive care has declined in terms of access to Adult Health Checks and care plans. Urgent Care is being provided but the planned, preventive care is less available than it should be. It is unacceptable that once again we are in a GP workforce crisis and all of the solutions that have been put in place up to now have not been sufficient.

Submission from CAAC

NACCHO argued in their submission that strategies to achieve more equitable distribution of doctors and health workers align with and support the National Agreement on Closing the Gap⁶⁶ and its four Priority Reform Areas.

Of particular relevance to this Review is Priority Reform Area 2 – Building the Community Controlled Sector.

This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services.

Submission from NACCHO

66 National Agreement on Closing the Gap. <https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap>

Supporting the continual growth to the ACCHS sector in metropolitan, rural and remote settings is a vital contribution to Closing the Gap.

Across Australia and more so in the more remote parts, Aboriginal Health sector GP training places are undersubscribed including funded training places. All efforts should be made to fill these training positions as a priority.

The pipeline from undergraduate to GP training is long and while awaiting a fuller flow of willing domestic graduates, the reliance on IMGs in Aboriginal health will continue for the foreseeable future.

The Aboriginal Community Controlled Health Services sector reported great difficulty in filling their registrar positions⁶⁷. They identified that IMGs who are temporary residents are ineligible to join GP training and they do not have supervision capacity for a doctor in isolation of a training program given the complexity of health care in their contexts. The support provided by being accepted into an AGPT training position enables these IMGs to more rapidly progress to Fellowship level which helps them provide higher quality care to people in areas of high need.

The sector indicated that they would be willing to take IMGs on temporary visas into their service if they were eligible to enter a training program and met the requirements for conditional registration as GPs. This could either be in the rapid assessment pathway over 6 or 12 months or for the full 3 years of training depending on eligibility. If this was then coupled with a guarantee for citizenship and permanent residency after a required period of time in an area of need there would be many applications from IMGs who are already experienced GPs to take up unfilled positions in the Australian training program.

The RACGP and ACRRM utilise a National Program in Aboriginal Health underpinned by post graduate curriculum. This will form the basis for training places in Aboriginal health settings.

This Aboriginal Health Curriculum will further support the registrar's development in their GP and Aboriginal health practice.

The proposed bridging program discussed earlier in this Section can prepare IMGs for this setting. Appropriate supervision and orientation to the context and setting is critical to the success of these registrars and the impact of their practice in improving people's lives.

Coupled with the proposal described above, a number of strategies proposed elsewhere in this report will help improve recruitment and retention to ACCHS. These include:

- Introduction of more nuanced DPA/DWS distribution levers which will also benefit those ACCHS in areas of greatest need.
- Support for GP practices, including ACCHS, building capacity to supervise and support GP registrars in recognised training programs.
- Closing loopholes in DPA exemptions during the 10-year moratorium
- Phased changes to exemptions from the 10-year moratorium so that IMGs can progress from areas of greatest need to have priority areas of appointment after a designated period (eg. five years).

67 AMSANT Submission to *Working Better for Medicare Review*

Geographic restriction of provider numbers and billing restrictions

A number of alternative strategies are recommended in this Review to better identify areas of need, to provide greater incentives to practice in these areas and to restrict exemptions for IMGs. Similarly, the progressive shift from sole fee for service medicine to better accommodate other payment systems coupled with incentivising G under the Strengthening Medicare Reforms should contribute to fairer access to health care.

By contrast, a number of submissions argued a more direct approach of restricting geographic access to provider numbers in well serviced areas (even for a defined period such as three to four years) should be considered. In the first instance, the Reviewers favour the recommended strategies of this Review to be implemented and assessed prior to consideration of a strategy such as provider number restrictions.

There are currently a range of incentive payments to bulk billing scaled to regional, rural and remote communities.

One suggestion put forward to the Review team to complement the bulk billing incentives proposed that for out of hospital services provided by IMGs during their 10-year moratorium was,

- if the bulk billing incentive is available, the service must be bulk billed, and
- if not, the service must be charged at the schedule fee.

Potentially this might reduce number of applicants for these areas, as income aspirations will be lower for the first 10-years or whatever, but this is likely to be marginal as the increased bulk billing incentive leaves only a small gap (if any) in the higher MMM regions, and there are plenty of applicants in lower MMM regions.

Special Needs Groups

In the Introductory Section, a Health Workforce Independent Review Panel was proposed, to oversight the operations and undertake regular reviews of the application of DPA. It is suggested that this Panel should also assess any special circumstances whereby a service could arguably claim access issues whilst not being located in a DPA area of workforce shortage.

One example which the Reviewers were made aware of related to a Brisbane based multicultural health service for marginalised migrants, refugees and people seeking asylum.

Whilst located in a geography well supplied with GP services (ie. not DPA), the service claims a significant disadvantage in being able to attract and retain an adequate GP workforce to sustain the service.

World Wellness Group is an independent multicultural not-for-profit primary health service.

WWG was founded in 2011 and we are based in Brisbane. We believe that health is a human right. Our mission is to reduce multicultural health inequity with a focus on migrants, refugees and people seeking asylum who are often marginalised by the health system. Our social enterprise is our GP clinic. We struggle to run the GP clinic at break-even for complex reasons.

Our clinic is a bulk billing clinic with a registered patient load that is more than 70% from non-English speaking backgrounds. Our clinic sees 2.2 patients per hour per GP. In comparison, other GP clinics of similar size in our region see 6 to 7 patients. The use of professional interpreters essentially doubles or triples our consultation times with patients. Having a high proportion of complex patients – with a background of trauma, refugee and/or asylum seeker status and unmet complex mental and physical health needs, also impacts on the appointment length. In turn all these complexities disadvantage us in being able to effectively utilise Medicare item numbers to recoup the actual cost of delivering accessible and equitable primary healthcare.

In the past five years our clinic has seen patients representing 145 ethnicities including Iranian, Afghan, Indian, Chinese, Syrian, Congolese, Iraqi, Tamil, Vietnamese and Papua New Guinean as our biggest client groups. The average travel distance to our service which is based in an inner-city location (Woolloongabba), is 20km with an average travel time of 25 minutes. Only 54% of clients live in Brisbane South, the local PHN region.

Submission from World Wellness Group

It may be appropriate in a very limited number of services with a specific client group focus, that an exemption is provided for the specific practice despite the DPA status of the GP catchment area. This assessment should be the responsibility of the proposed Health Workforce Independent Review Panel.

Recommendations

Recommendation 20

As first proposed in the *National Medical Workforce Strategy 2021 – 2031* there should be a national self-sufficiency target for the Australian medical workforce. Such a target will guide the progressive reduced dependency on IMGs, coupled with growth in domestic medical school places targeted to best address current shortages. DoHAC should progress this as a priority.

Recommendation 21

Any alteration to the cap for medical student places to better align medical training numbers to regional shortages should also consider the workforce needs of other health professionals.

Recommendation 22

A program of post-graduate training and support for other primary care providers including remote and rural nurses, midwives and nurse practitioners, in areas of need, should be developed.

Recommendation 23

Discussions should occur between DoHAC and the Department of Home Affairs to enable best implementation of those recommendations arising from the *Australian Government Migration Strategy* which pertain to migration of health professionals.

Recommendation 24

The revised, more nuanced application of the DPA distribution levers to better identify and incentivise medical practice in areas of workforce shortages should be used to prioritise locales for implementation of the recommendations arising from the *Scope of Practice Review*.

Recommendation 25

The strategies to achieve more equitable distribution of doctors and other health professionals across Australia should align with the *National Agreement on Closing the Gap* and its four Priority Reform Areas. These strategies should thus concur with the Priority Reform Area for continued growth and support for ACCHS.

Recommendation 26

IMGs who have met the training requirements for AGPT Level 2 supervision should be eligible to take up unfilled funded training positions in the Aboriginal Health sector.

Attachment 1: Key Stakeholder Consultations

Aboriginal and Torres Strait Islander Health

Aboriginal Health Council of Western Australia (AHCWA)
Australian Indigenous Doctors Association (AIDA)
Aboriginal Health and Medical Research Council (AHMRC)
Congress Aboriginal and Torres Strait Islanders Nurses and Midwives (CATSINaM)
Central Australian Aboriginal Congress (CAAC)
Indigenous Allied Health Australia (IAHA)
National Aboriginal Community Controlled Health Organisations (NACCHO)
National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP)
Nganampa Health Council - SA

Consumer Advocacy

Consumers Health Forum of Australia
Health Care Consumers Association (HCCA)
Isolated Children's Parents' Association
LGBTIQ+ Australia
Remote Australians Matter
WA Local Government Association (WALGA)
World Wellness Group (WWG)

Federal Government Departments & Agencies

Australian Bureau of Statistics
Australian Institute of Health and Welfare (AIHW)
Department of Finance
Department of Home Affairs
DoHAC Access and Distribution Branch
DoHAC Allied Health and Service Integrity Branch
DoHAC Australian Chief Allied Health Officer
DoHAC Australian Chief Nursing and Midwifery Officer

DoHAC Cancer Screening Programs Branch
DoHAC Health Workforce Data Intelligence Unit
DoHAC Health Workforce Distribution Branch
DoHAC Health Workforce Executives
DoHAC Health Workforce Planning and Strategies Branch
DoHAC Health Workforce Training Branch
DoHAC Incentives and Innovation Branch
DoHAC Medical Workforce Reform Advisory Committee (MWRAC)
DoHAC Primary Care Access Branch
DoHAC Primary Care After Hours Programs
DoHAC Primary Care Reform Branch
DoHAC Residential Care Funding Reform Branch
DoHAC Reviews of General Practice Incentives
DoHAC Senior Medical Advisers
DoHAC Thin Markets Branch
DoHAC Unleashing the Potential of our Health Workforce – Scope of Practice Review
DoHAC Urgent Care Clinics Branch
Mental Health Commissioner
Services Australia

Health Professions Accreditation & Regulatory Agencies

Australian Health Practitioner Regulation Agency (AHPRA)
Australian Medical Council (AMC)

Independent Advisers

Expert Advisory Panel

Luke Sloan, Steve Hambleton, Wally Jamal, Isabelle Skinner, John Boffa, Richard Murray, Stephen Duckett, Jennifer May, Katie Pennington, Mish Hill, Mark Cormack, John Wakeman

Professional Peak Bodies & Health Organisations

Australian Diagnostic Imaging Association
Australian Medical Association (AMA)
Australian Nursing and Midwifery Federation (Rural Members)
Australian Primary Health Care Nurses Association
CRANA-Plus
National Primary Health Network Alliance
National Rural Health Alliance (NRHA)
National Rural Health Commissioner & Deputies
Northern Territory Primary Health Network (NTPHN)
Remote Vocational Training Scheme (RVTS)
Reynella Family Care
Royal Flying Doctors Service (RFDS)
Rural Doctors Association of Australia (RDAA)
Rural Health Commissioners
Rural Workforce Agencies Network (RWAN)
Services for Australian Rural and Remote Allied Health (SARRAH)
Sonic Healthcare Australia
WA Primary Health Alliance

University Sector

Council of Presidents of Medical Colleges (CPMC)
Deans of Medicine/Midwifery/Health Sciences/Nursing

Specialist Colleges

Australasian College of Dermatologists (ACD)
Australian College of Midwives (ACM)
Australian College of Nurse Practitioners (ACNP)
Australian College of Nursing (ACN)
Australian College of Rural and Remote Medicine (ACRRM)
Council of Presidents of Medical Colleges (CPMC)
Royal Australasian College of Surgeons (RACS)

Royal Australian and New Zealand College of Ophthalmologists (RANZCO)

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Royal Australian College of General Practitioners (RACGP)

Royal Australasian College of Physicians (RACP)

State & Territory Government

ACT Health

ACT Health Workforce Strategy

Alice Springs Hospital (ASH) Executive

Chief Nursing and Midwifery Officers Forum

Health Chief Executive Forum

Health Workforce Taskforce

NSW Health Bilateral Regional Health Forum

NSW Ministry of Health

NT Health

Queensland Health

Department of Health and Wellbeing South Australia

Department of Health Tasmania

Government of Western Australia Department of Health

WA Country Health Service (WACHS)

Organisations providing written submissions

Aboriginal Medical Service's Alliance NT

Adelaide Primary Health Network (PHN)

Australian College of Midwives

Australian College of Rural and Remote Medicine

Australian Diagnostic Imaging Association

Australian Private Hospital Association

Australian Psychological Society

Australian Rheumatology Association

Australian Society of Anaesthetists

Brisbane North PHN

Brisbane South PHN
Campbelltown City Council
Central Australian Aboriginal Congress
Dean of the College of Medicine and Dentistry James Cook University - Professor Richard Murray
Department of Health New South Wales
Department of Health and Wellbeing South Australia
Department of Health Tasmania
Department of Health Victoria
East Grampians Health Service
For Health
Hunter New England and Central Coast PHN
Isolated Children's Parents Association
Mental Health Commission
Meryl Swanson, MP
National Aboriginal Community Health Organisation
National Rural Health Alliance
Primary Care Business Council
Public Pathology Australia
Queensland Health
Remote and Isolated Pharmacy Association
Royal Australasian College of Physicians
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australian and New Zealand College of Radiologists
Royal College of Pathologists
Royal Flying Doctors Service
Rural Doctors Association of Australia
Rural Pharmacists Australia
Western Sydney Health Alliance
World Wellness Group