phn COOPERATIVE

An Australian Government Initiative

Response to Working Better for Medicare – Distribution Levers Review

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Primary Health Network (PHN) Cooperative

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Executive Summary

The PHN Cooperative was formed in 2017 by the CEOs of the 31 PHNs as a joint initiative committed to collaboration with a focus to deliver on the national agenda in primary health priority areas. Together with the PHN Regional Health Working Group, we submit this paper to provide additional context and information to the current *Working Better for Medicare – Distribution Levers review*.

In recognition of the complex policy, service and community environments that affect general practitioner distribution and the application of the levers in regional, rural, and remote Australia, the Cooperative has coordinated PHN contributions to provide local context across our jurisdictions.

We have focussed on addressing mechanisms at a national and policy level, whilst drawing on local context to identify areas of unique challenge. This enables us to exemplify the importance of local contextualisation, whilst remaining true to the survey questions posed.

We recognise the objectives of the review and understand that review of Medicare Benefits Schedules (MBS) and amendments to payments under MBS are out of scope. We are aware that this Review is being undertaken alongside wider policy reviews of General Practice including the Scope of Practice, and Incentives reviews. The recommendations from these reviews, and the mechanisms that stem from them must be interconnected to streamline their use for practitioners, business owners and consumers.

Recognition must be made that the distributions levers operate within a wider health ecosystem that is currently experiencing fail states in many areas. However, the PHN Cooperative believes that ultimately **the distribution levers are no longer fit for purpose.**

We are using the levers in a system for which they were not designed, which is producing poorer results year on year. The inflexibility of these blunt mechanisms is increasingly resulting in inadequate reflection of local challenges and context, leading to disproportionate consequences in areas of highest need.

This is exacerbated by sectoral factors such the changing nature of primary care, and an acute and growing general practitioner workforce shortage. The need for more GPs is being felt everywhere, with already critical workforce shortages being most strongly felt in areas with the least resilience. We need to embed levers that support **contemporary, place-based** and **forward-looking** models of care.

At a high level, the PHN Cooperative recommends that:

1. The Department conduct a comprehensive review and overhaul of the application and integration of levers, which considers the changing nature of community need and primary healthcare;
2. Establish mechanisms the drive place-based modelling to meet targeted need; and
3. Improve granularity of data to better target distribution mechanisms and incentives.

Alongside further detail on these, the PHN Cooperative has suggested recommendations for the individual levers.

As a combined response, the PHN Cooperative has structured our submission such that each of the Survey Questions are identified and responded to directly. Recognising the need for broader context, we have then provided additional responses beneath each Survey Question response.

Finally, we note that this is a submission from the PHN Cooperative that is deliberately framed at a mechanistic and high-level point of view. Many of the individual PHNs and state-based PHN groups are submitting responses which will provide more granular data and examples to support their findings.

Section 1: Challenges for our primary care system

The Strengthening Medicare Reforms acknowledge that general practice is at the heart of primary care for most Australians. In the same breath, it is acknowledged that there are not enough General Practitioners (GPs), and that primary care funding is insufficient. Consistent amongst messaging is that there is a complex interplay of challenges that is failing GPs and the system more broadly.

Whilst not an exhaustive list, critical challenges facing the primary care system as the PHNs see them include:

- Demand for GPs has increased significantly whilst supply of services has not kept pace. Research by the Australian Medical Association (AMA) estimates that Australia will have an undersupply of 10,600 FTE GPs by 2031-32 if current training, recruitment, and retirement trends continue.
- There are significant 'pipeline' issues for general practice, with medical students choosing general practice reducing from 50% to 20% in the last 10 years. Combined with estimates that a third of GPs intend to retire in the next 5 years, there is a fundamental shortage of GPs in Australia.
- Costs associated with providing care are unsustainable at a small scale, which is leading to unaffordable costs to accessing care in some areas. The small business model for general practice is increasingly becoming financially unsustainable and unfit for operation, even in some metropolitan or outer-urban areas. This is only exacerbated in rural and remote areas where the effects of workforce gaps are felt more acutely. E.g., whilst highly variable, in Western NSW, PHN data shows that 42 of 110 (38%) practices will close in the next 5 years, and 22 (20%) will close in the next 12 months.
- The nature of primary care and the current models that we use to provide healthcare and respond to health needs at a local level are no longer fit for purpose.
- Care needs are changing rapidly across most population groups, requiring greater capacity and skills to support chronic or complex care needs and psychological distress.
- Culturally, primary care (and general practice) is decreasingly considered a rewarding career and is perceived as offering a poor lifestyle and being particularly subject to worker burnout.
- Continuing underinvestment and lack of reform in general practice has increased overall health expenditure, reduced access and quality of healthcare, and widened the gap in health outcomes for vulnerable communities.

The PHN Cooperative has a unique sectoral and system overview through our ability to drive contextual conversations and understanding of metropolitan, urban, outer-urban, regional, rural, remote, and very remote areas.

To ensure this knowledge is filtered through the report, we have identified key challenges and areas of need based on rurality in Table 1 below.

Table 1. Key primary care challenges and drivers of needs based on rurality.

Rurality	Key challenges
Metropolitan	• GP workforce shortages. • Highly competitive training environment with registrar uptake not meeting available positions, which are below projected levels of need. • GP Supervisor capability and capacity is highly inconsistent. • Increasing chronic or complex care needs. • Increasing drive for multidisciplinary care arrangements that offer continuity of care.

Outer- Urban	• GP workforce shortages. • Fastest growing demographic/geographic catchments in Australia. • Aging consumer population with increasing incidence of chronic or complex care needs. • Pockets of extremely high health need due to demographic characteristics. • Poor attractiveness for registrar placement, leading to few new training placements despite supervisor capacity. • GP Catchments are often balanced or grouped as MM1; sometimes inappropriately so. • Increasing wait times to see a GP (with some general practices having closed their books due to 3-4 week wait times).
Regional	• GP workforce shortages. • Aging consumer population with increasing incidence of chronic or complex care needs. • Limited access to Multidisciplinary Teams (e.g. Allied Health or Mental Health) and specialists. • Important avenue for provision of specialised care, servicing a regional catchment with limited local capability. • MMM Classifications are based on geography and do not reflect population health need or levels of disadvantage.
Rural	• GP workforce shortages. • Poor perception of placement due to remoteness, liveability index, and lack of Social Infrastructure (e.g. amenities, partner job opportunities, childcare availability, housing availability and a range of other areas. • Often experience thin markets with insufficient population and GPs. • Aging consumer population with increasing incidence of chronic or complex care needs. • Limited financial sustainability for general practices. • High practice closure rates (e.g. 42 of 110 practices closing in the next 5 years in Western NSW PHN area). • Unsustainable financial/operating models for general practices.
Remote	• GP workforce shortages. • Unsustainable financial/operating models for general practices. • Increasing wait times to see a GP (e.g. in Broken Hill this wait time is currently 12 weeks). • High locum GP costs (upwards of $4000 per day in some areas) • Few/no registrar placements occur. • Poor perception of placement due to remoteness, liveability index, amenities. • Aging GP Workforce with one in three looking to retire in the next 5 years. • Aging consumer population with increasing incidence of chronic or complex care needs.
Very Remote	• GP workforce shortages.

	• Poor financial sustainability for practices. • High locum GP costs (upwards of $4000 per day in some areas). • Few/no registrar training placements occur. • Poor perception of placement due to remoteness, liveability index, amenities. • Aging GP Workforce with one in three looking to retire in the next 5 years. • Aging consumer population with increasing incidence of chronic or complex care needs.

The distribution levers must be considered in the context of a broader set of system enablers. In their current state, the levers are inequitable and are either:

- Too restrictive and inflexible to enable workforce distribution driven by community need and local influences; or
- Not restrictive enough to mandate registrar or GP movements to areas of highest need (i.e. the New Zealand model by which GPs receive a license to practice in a specific location that is based on need).

Further, the levers do not appear to fundamentally align to the current policy direction (particularly of the Strengthening Medicare Reform). Additionally, conflicting elements of the system are set up to compete for the same resources. The result is that in some cases the levers (including the 19(2) Exemption) are used in ways which erode current arrangements and in opposition to good quality clinical outcomes.

1.1 Changing nature of primary care

Intersecting with these challenges is the fundamentally changing nature of primary care. Considered against the broader system and reforms, efforts must encompass the diminishing GP workforce and the changing models of care that are being driven by this shortage. As noted above, there a range of factors that are driving this change, such as:

- The medical model is architecturally based upon servicing injury and illness, however there is an increasing need for multidisciplinary models of care.
- Growing consumer demand for continuity of care, transparency, and simplicity of healthcare interaction. There is a growing need to shift the availability model and skill needs required to deliver basic levels of care in order to minimise burden on GPs and create coordinated care environments.
- Increasingly unsustainable financial and operational models of general practice.
- Changing perceptions of primary care jobs, with General Practice rapidly becoming an unattractive career choice for medical students. These include a wide range of factors such as misinformation about remuneration, actual remuneration and access to entitlements during training compared with hospital-based specialties, lack of respect of GPs within the system, lack of exposure to general practice and the negative public narrative about Medicare.

Ultimately however, the distribution levers are not the most pressing issue – **that Australia simply does not have enough primary care workers currently, in training, or in the 'pipeline'**.

A substantial pool of qualified GPs could be found among our own medical graduates, if general practice was incentivised to be a more secure, sustainable, and rewarding career option.

In this context, the PHN Cooperative view the current distribution systems and mechanisms as no longer fit for purpose nor forward facing to work alongside the evolving primary care system. We believe there is an opportunity to move away from generic mechanisms toward collaborative, place-based solutions that minimise competitive poaching of the workforce.

Section 2 – Considering the distribution levers

How do the workforce distribution levers being reviewed…

It is critical to assess the efficacy and impact of the distribution levers within the context of varying primary care markets, from metropolitan through to very remote. To achieve this, the PHN Cooperative has gathered data and input from various PHNs representing these jurisdictions.

The PHN Cooperative has segregated our responses in keeping with the order and form of questions set by the Review.

2.1 How do the levers *help or support access?*

… help or support access to primary care, GPs and/or medical specialists?

2.1.1 General comments

The success of the distribution factors in helping or supporting access is inherently tied to rurality. In some cases, the levers have been effective in certain regions in unlocking workforce movement or incentives in areas of need.

Across metropolitan, select outer-urban and even some regional catchments, the levers are deployed effectively to improve and incentivise access to GPs, access and reach of primary care, training pathways and a range of other elements. This is, in large part, due to the supporting structures, workforce and amenities that are absent in country and remote areas.

Where non-metropolitan areas can compete for 'attractiveness' and meet social infrastructure requirements, they can effectively use the distribution levers to incentivise GPs to the region. Where this attraction factor or level of social infrastructure is lacking, the levers become irrelevant in their application.

2.1.2 19AA and 19AB

It is the general belief of the PHN Cooperative that 19AA and 19AB have been broadly effective in their implementation and effectiveness as core distribution levers. Combined, they provide a solid foundation by which GPs, overseas trained doctors, and international medical graduates (IMGs) are funnelled to areas of need in Australia.

The levers have been primarily effective in areas where they are combined or aligned with the existing 'attractiveness' of the location, governed by the level of social infrastructure. Where a particular location can combine both the levers as well as local structural factors (e.g. housing, good employment prospects, connectivity, good schools, career options, way of life), the levers have opened opportunities to access workforce in areas of need.

Structures such as the scaling moratorium for overseas trained doctors and IMGs have previously been highly successful in incentivising rural and remote placements under 19AB. This worked well in the past but in an increasingly competitive international market, it is not sufficient to entice IMGs. Thought needs to be given to how these could be enhanced, such as offering priority pathways to citizenship to restore interest.

However, the levers and incentives upon which the 19AA and 19AB rely are not sufficient to meet the original objectives (or the scope of need) that these levers were implemented to address.

2.1.3 Distribution Priority Areas

As one of the core mechanisms by which distribution is evaluated and targeted, the Distribution Priority Area (DPA) classification has seen significant revisions since its implementation. For the most part, DPA has provided a useful tool in identifying patient services access and workforce needs across Australia.

There is also appreciation that it is more sophisticated in its calculation, with the addition of socio-economic and demographic factors, than the previous District of Workforce Shortage (DWS) classification. However, there is still limited clarity over how data is used to decide DPA.

The change to automatically include MM2-4 as DPA both supported greater access and classification, whilst also significantly diluting the relevance of DPA classification. With this change, nearly 80% of catchments across Australia became DPA, which resulted in it becoming irrelevant in many catchments due to their inability to attract GPs or registrars. This is explored further below.

Overall, the DPA has helped improve access to GPs and primary care in certain contexts (particularly outer-metropolitan and regional areas). However, the DPA has not substantially improved access to primary care in rural and remote regions, and can often be detrimental.

2.1.4 Monash Modified Model

The Monash Modified Model (MMM) has provided a structural framework by which incentives and supports can be scaled and applied. In combination with the DPA, MMM has preferentially funnelled incentives to areas of critical need through training, placements, relocation support and a range of other mechanisms.

Similarly to DPA and other levers, the MMM has been effective in providing access to incentives and support that has increased access to GPs and primary care **for select areas**. From one context to another, the MMM may be highly beneficial to ineffectual. This has been consistently based on the broader environmental, community and cultural factors of the location.

From a wider perspective, the MMM has been applied to guide and incentivise targeted government-funded workforce models, trials, and programs. This has, and continues to give rise to innovative and targeted initiatives within the wider primary care system.

2.2 How do the levers *hinder or limit access*?

… hinder or limit access to primary care, GPs and/or medical specialists?

2.2.1 General comments within a geographic context

Following from the commentary in *Section 2.1*, in many cases the levers have been completely irrelevant or at worst disadvantageous to certain regions. Due to the changing nature of primary care, the current mechanisms are seeing us incrementally moving farther from the solution we need. As rurality increases (or as the healthcare market thins), the efficacy of the levers rapidly decreases, to the point where in most rural, remote, or very remote regions they become ineffectual.

Uncoupled from any 'force factor', the levers are not able to overcome the structural gaps in the attractiveness of a region to entice GPs or registrars to work there. This is exacerbated by changing workforce patterns, with many GPs looking to work fewer days to reduce burnout, or take up additional roles (e.g. medical research) to maintain skills and relevance in these areas.

Additionally, the fundamental data that the levers are built on is neither broad enough nor granular enough to reflect the challenges and characteristics of individual communities. This is particularly

evident in the MMM, which often places highly disparate community contexts into the same 'bands' despite significant differences in their needs.

Broadly, it is the view of the PHN Cooperative that the current levers are not fit for purpose in many areas of Australia, and no longer meet their original objectives. They are intentionally limited distribution mechanisms that operate within a much larger ecosystem that is facing systemic challenges. As the model becomes increasingly outdated, impacts will be disproportionately observed in the regions that can least afford market failure.

2.2.2 19AA and 19AB

Intrinsic to the design of the 19AA and 19AB levers is the application of and access to Medicare benefits, with the levers being the primary drivers to 'gatekeep' this access. What the discussion on these levers often fails to consider is that neither Medicare nor the levers apply equally. From a wider perspective, Medicare billing (and by extension the levers) does not account for the scaling costs of delivering care as rurality increases.

For example, in the Western Queensland PHN region, upwards of 25% of the population are unable to access MBS which results in patients missing out on significant cycles of care due to a lack of access (e.g. financial). Context and care are rarely considered in areas where the population don't have access to healthcare through MBS.

19AB in particular introduces significant impediments to workforce growth through IMGs due to 'red tape'. During consultation, many practices highlighted the significant barriers to recruitment of overseas trained medical staff. In metropolitan areas, the lack of DPA classification was a prohibitive factor as IMGs are required to work in DPA catchments. For those where this was an option (i.e.: DPA classified practices), the time it takes from commencement of the process to having the IMG working in the practice routinely takes over 12 months.

Cost of recruitment agencies to assist in the process of navigating immigration and registration is also expensive. Large or corporate practices often pay significant retainers to attract and retain IMGs, which is not viable for smaller practices. In rural areas this experience is mirrored, with one practice in Manjimup highlighting that it took 2.5 years to get their IMG to the practice and the financial costs of over $25,000, as well as the administrative burden, was challenging.

Tied to the broad classification system of the DPA, 19AB does not do enough to incentivise overseas trained doctors and IMGs to move to or stay in rural and remote areas. With too much local complexity and a lack of leverage, areas of high need are compared 'like-for-like' with outer-metro regions. Unless social infrastructure is developed, IMGs and overseas trained doctors are often planning their post-moratorium exit from their commencement.

It also reinforces a divide between IMGs and Australian-trained GPs, with IMGs delivering services where '*locals*' won't go. The Bonded Medical Program was overhauled to its current form due to perceptions that it was unfair, however IMGs are effectively bonded for up to the 10-year moratorium.

It is imperative to highlight the contribution, value and scale that the IMG workforce brings to primary care in rural and remote Australia. The presence (or absence) of even a single IMG can be the difference between a stable healthcare market and a failing market in these regions.

However, 19AA is not excluded from these issues. As a result of 19AA, temporary resident, non-Fellow doctors can work in MM1 areas, whilst permanent residents/citizen non-VR doctors are unable to work in the same area due to training pathways under the 3GA program being unavailable.

2.1.2.1 Medical specialists under 19AB

In addition, the DPA and DWS often directly work against each other with regard to distribution of IMGs. DWS provides greater incentives for IMGs to become specialists (e.g. an anaesthetist) than a GP, and as such pushes even those who want to become a GP toward specialist positions.

There is a long list of medical specialties in acute shortage that can apply for a 19AB exemption to work in any location and the 5-year overseas trained doctor scheme. However general practice is not in the list, and this exacerbates the maldistribution by specialty by drawing IMGs away from general practice.

The 19AB list of specialties also does not align with Department of Health and Aged Care's identified specialties in undersupply (e.g. general practice and psychiatry) and oversupply (e.g. anaesthetics, emergency medicine and cardiothoracic surgery) outlined in the National Workforce Strategy.

2.2.3 Distribution Priority Areas

Of the 827 GP Catchments, 657 hold DPA classification and a further 50 hold Partial classification. This means that only 15% of GP Catchments across Australia do not hold DPA. As noted above, this means DPA classification now extends to almost 80% of GP catchments. However, as a binary system (yes/no) this negates much of the 'power' of the DPA to incentivise IMGs or overseas trained doctors into areas of highest need.

With no other consideration of drivers, the DPA cannot overcome structural, environmental, or cultural deficits in local communities to incentivise GPs or registrars to take up positions.

As the lever has become 'too accessible', it has increasingly become ineffectual. As a relatively blunt instrument, and as the primary driver by which 19AB is applied, the uniformity of the DPA classification renders the lever irrelevant in much of Australia.

Ostensibly, this results in the scalability of MMM incentives being the sole driver for GP distribution under 19AB, which severely hinders the ability for many communities to entice GPs. This has been felt in all regions, from metropolitan to remote, though the most significant effects are observed in rural, remote, and very remote areas.

In direct contrast, the exclusion of some MM1 catchments has adversely affected many urban and outer-urban areas, resulting in maldistribution through exclusion. For example, North Canberra has significantly fewer GP FTEs per 1000 population than the regional towns of Bega, Wagga Wagga or Goulburn in NSW but is not considered as DPA.

2.1.3.1 A lack of granularity in the DPA

The introduction of MMM and DPA has seen improvements in classification of areas of medical workforce shortage. However, the application of these policies does not allow for individual circumstances and anomalies in locations and across regions. Many areas face pressure in attracting and retaining medical workforce that are not reflected in existing DPA and MMM measures.

DPA classification does not take into consideration current landscape and health of workforce e.g., ageing GP population and practice closure rates, and difficulty attracting GPs to lower socioeconomic areas. This results in a cycle of shortage of GPs, particularly in outer metropolitan communities with growing populations. It also increases the burden on existing GPs and their likelihood of burnout, creating more gaps, resulting in a cyclical and systematic issue.

Due to this, areas with significant population and economic growth are at risk, e.g., Penrith in NSW which is expected to grow by 25% in the next two decades and is seeing economic growth through projects such as the Western Sydney Airport. Despite the significant change in demographics, Penrith is still classified as non-DPA, which will increasingly see practices struggle to recruit GPs.

Finally, the effectiveness of the DPA depends on stakeholders understanding its objectives, methodology and process of implementation, as well as the workforce incentives and programs which hang off it. Despite efforts to clarify the purpose and application of the DPA during 2022 and 2023, significant confusion still exists regarding the role in improving GP access. Unnecessarily complex and interconnected mechanisms such as this only further disincentivise medical students from the GP pathway.

2.2.4 Monash Modified Model

Due to its heavy reliance on a geographical indexation system and grouping systems, the PHN Cooperative believe that the MMM does not currently consider a deep enough understanding of demographic or population health needs. It does not adequately reflect the different challenges faced by individual communities within the MM banding.

As the central mechanism to scale incentives, much of a GP's decision-making around their practice sustainability is reliant on the MMM and the incentives it provides. With the blanket classification of DPA, this means that the MMM and local context (e.g. social infrastructure) are the key drivers behind distribution and practice sustainability. The result is that in many areas, the levers are irrelevant to the point of being unable to assess their efficacy.

Simply put, if you can't entice the workforce to the region, then the incentives are irrelevant.

Further, disadvantage is often exacerbated as a consequence of MM banding, with 'bulk' classifications hindering the smaller towns or centres within the classification. This is perhaps best exemplified by the Tjuntjuntjara Community, which resides in the Great Victoria Desert close to the border with South Australia, north of the Nullarbor Plain and 560 kilometres north-east of Kalgoorlie. It is considered to be one of the most remote communities in Australia. However, as this location falls into the Kalgoorlie – Boulder catchment, it is classified as an MM3 location.

This is but one of numerous examples across the PHN footprint, even ranging to MM1 misclassification of towns such as Kurri Kurri in NSW, to Kallangur in Brisbane's North. Ultimately, we feel the foundational structures and algorithms by which the MMM is allocated aren't as sensitive or responsive as they need to be to effectively govern the levers.

This will become increasingly important in the context of the Strengthening Medicare Reform and updates to My Medicare. As more incentives become available to practices with registered patients under My Medicare, the opportunities for imbalances in distribution increase.

For example, in Western NSW, GPs and registrars are incentivised to work in Dubbo (MM-3) to similar levels to Parkes (MM-4) or Forbes (MM-5). Due to the minimal incentive scaling between MM-3 to MM-5, the significant demographic, and structural gaps between towns such as Dubbo and Parkes result in few GPs or registrars electing to live and work there.

Finally, the MMM is only reviewed and updated after each Census (5-year cycle), which propagates data inaccuracy (e.g. population estimates or environmental effects), which leads to drastic impacts on communities that observe rapid shifts in demography.

Expanded below, we recommend that the application of MMM and incentives need to be carefully considered within the context of the Strengthening Medicare Reform Budget Measures.

2.3 How do the levers *impact the availability of training opportunities?*

… impact the availability of training opportunities for primary care, GPs and/or medical specialists?

2.3.1 Survey Response (250 words)

Ultimately, the impact of the distribution levers on the availability of training opportunities is reflective of the broader deficiencies within the general practice training model. In short, fewer general practitioners means fewer supervisors and fewer placements.

Similarly to their ability to drive access to GPs and care, the distribution levers affect training pathways to varying levels based on the rurality and 'attractiveness' of the location. Even if an area has the DPA and MMM status to claim or incentivise more, in areas that are not desirable for a registrar, these levers have little to no effect.

Across Australia, various state-based consortia of PHNs deliver the GP Workforce Planning and Prioritisation Program. Under this program, work to inform the distribution of GP registrars has uncovered significant challenges and structural gaps within the model. Independently, the WPP Offices have noted that the levers are primarily irrelevant to registrar placement, as there are overriding local factors that inhibit registrars going to areas they are needed most. Whilst not an exhaustive list, these include:

- Supervisor capability, capacity, and scope of practice.
- Availability of mentoring and peer-support networks.
- Social infrastructure within the community that is relevant to a registrar.
- Remuneration and career pathways, which have become increasingly important as the cost of living and housing shortfalls increase.

Where any or all these factors are not adequately met, registrars are unlikely to take up positions. The result is an imbalance in registrar placements, available positions, supervisor training and availability that only exacerbates maldistribution and care gaps.

2.3.2 Expanded PHN Response

Expanding on the synopsis above, the effect that the distribution levers have on training availability and pathways is tied to far more wide-ranging contextual factors.

Essentially, training can't occur in the absence of accredited general practice training sites and accredited supervisors, so mechanisms that support general practice viability will support training. This remains in context of rapidly decreasing numbers of students choosing general practice. Whilst not a direct effect of the levers, the perception of general practice as a career is a key factor in the sector's continuing workforce decline.

However, the levers do indirectly disincentivise or impact efforts to make general practice (or primary care) more attractive. The limitations on training programs, numbers of registrars, complexity of reciprocal competency assessments and inflexibility of the levers (on aspects such as career choice) hinder efforts to improve perception of general practice.

This is primarily driven by the Colleges' (RACGP/ACCRM) use of MMM to set placement requirements, prioritisation, and timings. As such, the challenges and issues surrounding the MMM also directly impact registrar prioritisation and placement. Whilst our current system protects Australian graduates, it is detrimental to community and care.

The PHN Cooperative believes that the combination of barriers to entry, restricted training pathways and overly complex requirements on registrars is hindering workforce growth. There needs to be

focus placed on streamlining the process and reducing barriers into training for both registrars and IMGs. Alongside this, we must ensure the employment context is beneficial and attractive, or students will avoid areas of need.

2.3.2.1 Consideration of mandated training pathways

The levers have direct and significant consequences to the uptake, provision, and requirements of GP training. The MMM in particular often directly impacts registrar training location requirements, and even minor changes (e.g. from a MMM7 to an MMM6) can significantly effect regional availability of training. This is evidenced by the example below.

"Northern Territory General Practice Education (NTGPE) has a training location requirement for GP registrars to work in a MMM7 region for 6 months and/or a MMM6 region for 12 months. The change in MMM classification [from an MM7 to MM6] will make the community much less attractive for GP registrars. NTGPE has already seen a reduction in the number of GP registrars working in Katherine since the introduction of the training location requirement."

Excerpt from Letter to Assistance Secretary, Rural Access Branch on Oenpelli (NT) change of MMM classification.

From this example, the PHN Cooperative believe it is important to note that the sector cannot afford to further disincentivise medical students and junior doctors from choosing careers as general practitioners. Expanding on the example, the Northern Territory enforced a mandatory rural training pathway for registrars denoted above, which saw **a critical reduction in applications over the course of the mandate**.

Numbers dropped from 65+ new registrars per year in 2016, to less than 10 new registrars in 2022 and 2023. The inflexibility and forced remote rotations were regularly cited as the reasons for the reduction. Access to childcare and support for family in remote areas, distance from family, lack of portability of benefits, were all raised repeatedly as issues with a forced approach.

2.3.2.2 Geographic discrepancies in supervisor capability

A key challenge observed by PHNs is the mismatch in registrar attraction and supervisory capacity and capability. In metropolitan areas, registrars are often fiercely competed for and significantly easier to attract due to higher remuneration, presence of experienced supervisors, peer support, mentoring programs, proximity to amenities and social infrastructure, and career pathways.

In contrast, in non-metropolitan cases, GP Supervisors with appropriate skills and capacity are often overlooked due to desirability of the location.

In the role of some PHNs as GP Workforce Planning and Prioritisation Offices, we collect data on behalf of the Royal Australian College of General Practitioners (RACGP). In Queensland in particular, data has demonstrated that if registrars don't have to travel to undesirable locations (e.g. outer-urban areas such as Caboolture or Bribie Island), they won't. The result is that, whilst there are registered Supervisors in these locations, they are rarely enticing registrars for training.

Compounding this issue is registrar-led vetting, with most registrars reviewing the track record of supervisors and practices before choosing a position. This has a direct feedback loop into Supervisor track record, whereby Supervisors with no established track record are unable to build that track record.

2.3.2.3 Financial sustainability through registrar training

It has also been noted that registrars often form a significant component of practice's financial sustainability. Within the broader context of the challenges faced by general practices, registrars' ability to bring additional revenue, capacity and financial viability means that they are in demand by larger and metropolitan practices.

With the competitive lure of metropolitan amenities, lifestyle, wages and career development, registrars are increasingly less likely to choose rural, remote, or even outer-urban placements. Despite this, outer-urban areas are some of the fastest growing catchments in the country, with areas such as Caboolture West adding eight new suburbs.

As such, the efficacy of the distribution levers in attracting registrars to non-metropolitan placements often directly influences the financial sustainability of general practices and access to care.

We note that the impact of financial incentives on registrar placement is being assessed by the Colleges and may be useful to inform broader distribution incentives into the future.

2.4 How do the levers impact the quality of practice?

… impact the quality of practice of primary care, GPs and/or medical specialists?

2.4.1 Survey Response (250 words)

Following the common theme of this response, the effect of the distribution levers upon quality of practice of primary care is inherently tied to the local context. Where the levers are ineffectual, and few (or no) GPs can be incentivised to an area, quality of practice suffers in direct correlation to the workforce.

However, assessing practice quality is difficult to measure. The only current measures of meeting a minimum standard of care are the Accreditation Standards established by the Colleges and the National Community and Primary Health Care Standards; of which few practices accredit. General Practices, GPs, and Medical Specialists are not required to collect outcome measures.

Where the levers have often been observed having direct effects are in cases where classifications are adjusted, rescaled, or removed. MMM is of note here, with even single-point reclassifications having drastic effects on sustainability of primary care. Whilst it is not limited to these areas, it is most obvious in remote and very remote areas, where single GPs are responsible for communities or even groups of communities.

A specific example of this is the remote community of Oenpelli in NT, which was reclassified from an MM7 to an MM6. This both undermined the financial viability of the practicing GP such that they were forced to leave the community and drastically reduced attractiveness to registrars. From a stable primary care arrangement, Oenpelli lost both a GP and registrar to become a failing market.

2.4.2 Expanded PHN Response

Firstly, significant workforce challenges and pipeline issues for general practice, combined with rising multidisciplinary care needs means that the nature of primary care is changing. Fundamentally, the distribution levers in question are devised for general practitioners and medical specialists, and do not account for (nor consider) the broader primary care workforce.

As such, the distribution levers in question have somewhat contra-indicative effects on quality of primary care in regions. As the 'rate-limiting step', GPs are the most significant link in the care journey for most consumers. As a result, in areas that struggle to attract GPs, quality of care and continuity of care can be significantly reduced due to long wait times, the use of locums, poor inter-disciplinary communication or lack of specialist availability.

For example, Fairfield in the South West Sydney PHN has one of the highest rates of disadvantage in NSW and a large CALD population. However, as an MM1 classification, it cannot attract IMGs through DPA who may have the cultural skills and knowledge to meet community needs. A more comprehensive discussion needs to be had – including with community - to determine if this situation is equitable.

Despite this, areas without general practice have had to innovate and design new models of care that operate in the absence of GPs. As such, there is a clear need for the distribution levers to consider and support the broader primary health workforce in their design and application.

Additionally, the levers are being applied in a system that they weren't designed for, and often in perversity to their intent – due in large part to the rapid changes and evolving challenges of the primary care system. Sometimes these levers are being applied to meet business needs that don't inherently support good clinical outcomes. For example, a practice in an outer-metropolitan area (unnamed) have been noted using 19AB to attract overseas trained doctors and IMGs but failing to provide quality experiences or training. In the absence of appropriate checks and balances, these situations can be propagated.

The levers have also historically proven ineffective at adapting rapidly to evolving workforce needs and drivers, or adopting novel data sets that could improve efficacy. For example, annual revision of the DPA does not accommodate the rapid changes that can occur in GP workforce numbers, particularly within rural and remote areas. In many remote locations, the loss of even one GP can cause significant care deficiencies or even market failure.

As noted in the synopsis, there are also no requirements on general practitioners to collect patient outcome measures. This is further exacerbated by some 95% of general practices being private businesses, which means that there are also no obligations to publish outcomes measures. As a result, understanding and measuring quality of practice of primary care and GPs is a difficult task.

Finally, the overtly complex scaling model of incentives places significant pressure on the GP or practice to capitalise on them. This results in an imbalance in uptake due to the resources and availability of time required to understand, apply for, and manage the incentives/support. For many general practices, a dedicated Practice Manager is not feasible, which means that these opportunities are not a feasible option.

Section 3: Recommendations and solutions

What are possible solutions to the issues you have highlighted that could improve access to primary care, GPs and/or medical specialists? What needs to change about the workforce distribution levers or how they are used?

3.1 General comments

Firstly, recognition needs to be made that the distribution levers in question do not operate in a vacuum, rather they are mechanisms designed to address challenges in an evolving system. Moreover, the primary care system is fundamentally changing, requiring greater flexibility, agility, and a more granular understanding to drive outcomes.

Considering this, it is the belief of the PHN Cooperative that the *Distribution Levers* in review do not have sufficient contextual fluency or flexibility to effectively address the nuance of primary care needs in Australian communities. Through no fault of their design, the levers are being applied in a system that they weren't designed for, and often in perversity to their intent – due in large part to the rapid changes and evolving challenges of the primary care system.

Recognising these factors; a key question for the PHN Cooperative becomes ***'Is it effective reform to cordon off small elements of a wider system beset by deep structural problems and focus only on those?'***

At a high level, the conclusions of the PHN Cooperative are:

- In the absence of systemic changes, the PHN Cooperative does not believe that retaining the levers in their current form adds sufficient value to warrant continuation. There is an urgent need to contemporise the levers to meet the needs of the system and policy.
- The distribution levers do not adequately align to evolving policy direction and are not fundamentally designed to be forward focussed.
- Distribution doesn't effectively encourage resources to go to the places of highest need due to local complexity and a lack of leverage to force (or incentivise) GPs or registrars to these areas. Whilst workforce supply continues to reduce, blanket approaches are not effective.
- The levers do not adequately account for the range of dimensions, such as employment prospects, remuneration, training quality and capacity, experience in terms of supervision and support, career advancement, lifestyle, local amenities and supports (e.g. child-care), or partner or spousal supports. Whilst not an exhaustive list, these and many other factors directly impact registrar and GP choice.
- As a result of systemic workforce challenges and the actions of the levers, conflicting elements of the system are having to compete for the same resource.
- The 'one-size-fits-all' approach is not viable. Solutions need to ensure that the context of individual markets are considered and embedded in any levers to ensure that parts of the system are not supported to detriment of others.

Opportunities identified have been grouped below into general recommendations and lever-specific recommendations to improve clarity of response. The PHN Cooperative has attempted to link these recommendations to the Strengthening Medicare Reform agenda wherever possible to ensure that the levers are considered as part of the broader reform.

Recommendation	Explanatory Notes
Conduct a comprehensive review and overhaul of the application and integration of levers that consider broader factors in those areas where they are deemed ineffectual.	As noted throughout, the distribution levers are overlaid on the current healthcare system. However, structurally, the way we provide care is increasingly failing to meet need for both patients and healthcare providers. The PHN Cooperative recommends that this Review inform a foundational redefinition of how we approach need and the understanding of local need. These must be central tenets to the redevelopment of the distribution levers and incentive bundles. This should consider the efficacy of the levers in a 'like-for-like' fashion, aligned to the parameters of thin markets and the context of the places that need the levers the most. This should further overlay the dimensions of *Quality*, *Access*, and *Equity* as foundational tests of good practice.
Establish mechanisms for place-based modelling to meet targeted need.	We believe there is an opportunity to move away from generic or 'catch-all' mechanisms toward collaborative, place-based solutions that minimise competitive poaching of the workforce. Creating bundled approaches that consider the broader need in a place-based manner will more effectively incentivise GPs or registrars than overlayed individual incentives. Conceptually, establish a concentric set of rings that consider social infrastructure, attractiveness of a region, opportunity and other factors that are graduated according to different contexts. These include, but are not limited to access to childcare, local amenities/tourism, accommodation or housing availability, lifestyle balance, cultural support, spouse/partner employment, friend networks, travel options, related industries, cultural alignment, remuneration, career opportunities, career trajectory, supervisor/peer/mentoring capability. A key element of this is a reflection of practice sustainability. As models of care evolve, the traditional small business model will become obsolete, leading to a dearth of opportunity commensurate to the extent of market failure. In many cases, there needs to be an ability to employ place-based solutions and funding to support them. This would also enable us to embed greater flexibility in the application of levers and incentives to accommodate and address workforce shortages.
Improve granularity of data to better target distribution and incentives.	To achieve these suggestions (e.g. place-based, concentric modelling), data quality must be improved to inform modelling. Mechanisms to identify areas of largest need in close to real-time need to be established to ensure flexibility of levers and rapid responses to failing markets. Drawing on broader data sets (e.g. HeaDS UP, Primary Health Insights, National Workforce Agency) will ensure analysts can both:

	• Look at the needs and demographic characteristics of the community at a discrete level; and • Stratify or classify the types of need. A significant dimension around access to care that is not considered in the current levers is the fragility or sustainability of current providers (e.g. general practices). The capacity of health provision in rural, remote, and very remote areas is inherently tied to highly unstable business structures.

3.1.1 System-wide collaboration is needed to address systemic challenges

Overarching this, the PHN Cooperative believes that key system stakeholders need to be more aligned and collaboratively focus on key challenges at hand. We are collectively focussed on trying to make the current systems and mechanisms work; focussing on "*how to stretch the rubber band*".

To define and introduce new models or mechanisms that have the potential to meet the rapidly evolving consumer and system needs, we need greater integration and alignment. As a collective system, arrangements can be designed that are attractive from an employment and flexibility perspective whilst also meeting GPs and registrar's basic needs, career, and life aspirations.

Understanding total health capacity at a local level should be combined with alignment of State-funded acute services and Commonwealth primary care. This would inherently dovetail with coordination at a regional level, which is critical to building sustainable capacity, and finally to integration at the community level to embed more multi-disciplinary capability.

Regardless of the solutions or approach, the PHN Cooperative firmly believes that greater collaboration between the Commonwealth and State Governments, Colleges (RACGP/ACCRM), Local Health Districts, Local Health Networks, Primary Health Networks, and local practices must occur. Driving genuine collaboration through an 'honest broker' approach has the potential to drive systemic changes necessary to address primary care's challenges.

The PHNs are uniquely positioned to fill this role, with established workforces and infrastructure, relationships, aligned service streams, extensive data systems and information gathering sources, and no inherent commercial conflicts of interest.

3.2 Recommendations and solutions to 19AA and 19AB

In addition to the general recommendations and comments noted above, the following recommendations apply to 19AA and 19AB.

Recommendation	Explanatory Notes
a) **Expand the 19AA and 19AB clauses to incorporate other primary care professionals;** and b) **Undertake regular review of 19AB listed specialties to ensure alignment with broader research and policy (e.g. the National Workforce Strategy).**	More needs to be done to encourage Australian trained GPs to want to work in areas of need and this can be enhanced by rural training pathways, but these need to be for medical students, not just GP registrars. The more medical students that complete their training in rural areas, the more are likely to put down roots/build relationships and stay in rural communities. Enabling and improving care outcomes through multidisciplinary teams is a key policy driver. However, the policy is currently in conflict with funding and workforce availability. By incentivising other health professionals through the 19AA and 19AB distribution levers, there is an opportunity to significantly enhance

	uptake and meet consumer care needs. This would also reduce GP workload, reduce burnout through shared care, and improve attractiveness of rural/remote locations.
Review the incentives and implementation of 19AB in the context of Australia's immigration policies for IMGs and overseas doctors.	In an increasingly competitive landscape, both domestic and international, general practitioners are a limited and highly sought-after resource. Australia is no longer seen as a 'country-of-choice' due to the impact of distribution levers such as 19AB and the process through which IMGs and immigrating practitioners are assessed. A key consideration is that the incentives do not have to be financial. The scaling moratorium reduction was a successful incentive, that has only been outstripped due to international competition. Embedding accelerated citizenship, reducing red-tape or wait times on registration could all be key small-scale improvements to 19AB.

3.3 Recommendations and solutions to DPA

Whilst a recent mechanism to address distribution factors, the DPA has received significant changes in the few years since implementation. However, systemic challenges still exist with the classification that result in its lack of efficacy.

As noted above, with nearly 80% of Australia classified as DPA, the PHN Cooperative **does not believe that this lever is effective or relevant in its current design.**

Key recommendations regarding the DPA include:

Recommendation	Explanatory Notes
Implement a mechanism to review or dispute foundational GP Catchment allocation.	The GP Catchments that inform the DPA often group together suburbs that have significantly different profiles of need or disadvantage. Often seen in outer-urban areas, the result is suburbs that classify as MM1 due to their proximity to more affluent suburbs. For example, the suburbs of Kallangur and Dakabin in Brisbane North are classified as an MM1 due to its grouping with the more affluent Forest Lakes.
Greater transparency needs to be provided over the formula and methods by which DPA classifications are set.	Whilst information has been provided regarding the DPA's methodology, including the data streams that are used, the PHN Cooperative does not believe there is sufficient transparency.

3.4 Recommendations and solutions to MMM

In addition to the general recommendations and comments noted above, the following recommendations apply to the MMM.

Recommendation	Explanatory Notes
Expand datasets for MMM calculation and embed more	MMM is calculated based on availability of health care, proximity to health care and health needs of the community. In relation to availability of health care, there are still limited national datasets

localised profiling and contextual data.	available for non-GP services and so availability is based solely on GP Medicare data which does not accurately reflect the situation in remote Aboriginal communities in the NT. GPs in Aboriginal Community Controlled Health Services (ACCHS) are salaried and Medicare forms a very small part of income for the services. Additionally, there is no indication of health needs or availability in relation to nursing and allied health. As an example, NT PHN provides the community with fly in, fly out (FIFO) access to allied health services including Physiotherapy and Podiatry under the Medical Outreach for Indigenous Chronic Disease Program. These health needs are not captured nor considered in the calculation of MMM. The MMM also takes a retrospective approach to profiling based on ABS census data. Leveraging the work of groups such as the GP Workforce Planning and Prioritisation Offices would enable more granular, up-to-date and contextual information.
Expand MMM classifications to accommodate the degrees of difference between communities, towns, or localities.	The current MM1-7 bands do not provide sufficient breadth to adequately represent the differences between Australian communities. This is observed across the spectrum, from MM1 through to MM7 with examples such as: • Darwin being MM2, compared to areas less than 40 minutes from Melbourne CBD also holding MM2. • Mandurah being classified as MM1, despite being 1 hour out of Perth. • Gunbalanya, a remote community of 1,100 people 300km east of Darwin being classified as MM6. This is equivalent to Alice Springs which has a commercial airport, Kmart, Target, Woolworths, and Coles. However, Alice Springs needs to be MM6 to compete nationally. These and myriad other examples simply demonstrate that the MMM is too blunt an instrument to effectively classify need in its current form. Efforts need to be taken to redefine, expand or otherwise accommodate these differences.
Implement a transparent mechanism by which individual towns, centres or catchments can apply for exemptions, dispute or alter their MMM status.	The comparative classification hierarchy of MMM creates opportunities for disadvantage or areas of need to be overlooked due to geographical proximity. Suburbs are grouped to GP Catchments that feed the MMM, with the result being that sometimes suburbs are artificially 'gentrified' due to grouping, and catchments or whole towns are disadvantaged due to their proximal classification. For example, the small town of Kurri Kurri (~6,000 people) in NSW is classified as MM1 due to its proximity to Maitland and as such does not have access to a range of subsidies.
Improve transparency over changes to MMM classifications.	In rural, remote, and very remote locations, MMM reclassification has often exhibited a lack of transparency in both the decision-making and the exemption process. In these locations, even a

	single classification change can prove sufficient to drastically change the primary care landscape for a town or region. Current mechanisms to understand and dispute these changes are obscure and often result in impacted primary care markets.