

The Allen Consulting Group

## **Review of the Training for Rural and Remote Procedural GPs Program**

**April 2008**

Final Report to the Department of Health and Ageing

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## Executive summary

The Department of Health and Ageing (DoHA) has engaged the Allen Consulting Group to undertake an evaluation of the Training for Rural and Remote General Practitioners (TRRPGP) Program (the Program). The major objectives of this evaluation are to:

- assess the effectiveness of the Program in maximising the potential of procedural GPs to maintain their skills;
- assess the appropriateness and efficiency of the Program;
- measure the extent to which the Program's goals and objectives have been achieved; and
- identify the consequences (both positive and negative) of the Program.

In addition, the evaluation provides suggestions for possible changes to improve the Program.

Assessing the Program in this way will assist DoHA to determine whether the Program is meeting its objective and how it can be improved to further enhance the training of procedural GPs in rural and remote areas of Australia.

### **Project approach**

The evaluation of the Program was undertaken by completing three specific tasks. These tasks were:

- *desktop review* — considering information from DoHA, the Australian College for Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practitioners (RACGP), and Medicare Australia;
- *stakeholder consultations* — with key stakeholders in response to a brief discussion guide. In addition to this consultation process, ACRRM and RACGP provided the results of a recent survey of procedural GPs and emergency medicine practitioners in rural and remote areas of Australia who were registered for the Program. Where possible we draw upon the results of the surveys in the evaluation of the Program; and
- *analysis and assessment* — of the effectiveness, efficiency and appropriateness of the Program. In order to complete the analysis and assessment task, a framework was developed using Australian National Audit Office administration of grants best practice as a guide. This stage of the evaluation also included the consideration of the consequences (both positive and negative) of the Program and the discussion of possible changes to improve the Program.

### **Evaluation of the TRRPGP Program**

The key findings from the evaluation of the Program are summarised below, in terms of the effectiveness, efficiency, appropriateness, barriers to participation and consequences of the Program.

## Effectiveness

### **Key finding 1: eligibility and use of the Program**

*In 2006-07, around 70 per cent of eligible GPs were registered with the Program.*

*Since the addition of the emergency medicine component to the Program, there has been a rapid increase in GPs registering for the Program each year, with an average increase in registrations across the Program of 66 per cent each year.*

*A high proportion (up to 92 per cent) of these registered GPs, go on to participate in the Program, using grant payments to support approved training activities.*

*The value and duration of training undertaken by procedural GPs is on average 2.1 days with a value of \$3800. This is greater than the grants accessed by emergency medicine practitioners (an average of 1.3 days with a grant of \$2400), in line with the Program policy.*

### **Key finding 2: Program awareness and understanding**

*There appears to be a high level of awareness and understanding of the Program among eligible GPs. This is supported by a high proportion of eligible GPs being registered for the Program, complemented by the views of stakeholders. There is limited information about those GPs who are not registered for the Program and whether a lack of awareness prevents participation or that some GPs choose not to participate.*

### **Key finding 3: ease of use**

*Procedural GPs generally found the Program relatively easy to use. Specific strengths of the current arrangements include the relatively low level of administration required by GPs accessing the Program and the ease of access to grant payments.*

### **Key finding 4: types of training courses**

*The types of training courses that have been accessed by GPs through the Program to date are in accordance with the Program's objectives, namely approved training in procedural and emergency medicine.*

*An increasing number of registered GPs are using the Program to support emergency medicine training (55 per cent of all grants in 2007-08), however procedural GP training still accounts for 57 per cent of grants by value.*

*The most frequently accessed procedural training courses are for obstetrics (40 per cent) and anaesthetics (34 per cent). Of all training completed by procedural GPs, 77 per cent undertook formal training and 23 per cent completed a clinical attachment.*

*Formal training was also the preferred delivery mode for emergency medicine training — 72 per cent, with 28 per cent of emergency medicine practitioners completing a clinical attachment.*

**Key finding 5: skill attainment**

*Training courses supported by the Program enable GPs to maintain existing skills and develop new skills in approved procedural and emergency medicine disciplines, and instil them with ongoing confidence in their abilities.*

*Between 70 and 80 per cent of procedural GPs surveyed identified that the training provided under the Program assisted in maintaining knowledge and skills to a great extent. Around 70 per cent of emergency medicine respondents agreed with this statement.*

*Approximately 53 per cent of all survey respondents identified that training provided under the Program increased their knowledge and skills to a great extent.*

**Efficiency****Key finding 6: administrative costs**

*The costs of administering the Program are considered to be efficient relative to the total grants disbursed. The funds paid to Colleges to administer the Program, while increasing in absolute terms, have declined as a proportion of total grants disbursed over recent years to 4.2 per cent in 2006-07.*

*Medicare Australia's involvement in the Program appears to be administratively efficient, noting that the continuing appropriateness of current data platforms may need to be reviewed should the Program's growth continue.*

**Key finding 7: timeliness**

*Stakeholders widely consider the Program to be administered in a timely manner. This timeliness extends to responses to enquiries and applications lodged with the Colleges, determinations made by the Collaboration, and grant payments made by Medicare Australia.*

*All GPs receive their grant payment within two to six weeks of claiming a grant through one of the Colleges.*

**Key finding 8: management process**

*Those agencies involved in the management of the Program have a clear understanding of the roles of each agency, with strong working relationships between agencies.*

*There were some process efficiency issues raised concerning the registration of GPs, and administration of grant claims. Some participating GPs are confused as to the information they are required to send to each College and there is some duplication and inconsistency in the data collected and analysed by each College.*

*There was general agreement among stakeholders that the Colleges' reporting requirements to DoHA could be streamlined.*

*Most stakeholders believed that any process inefficiencies in the current model could be addressed directly, rather than by implementing a new management structure.*

## Appropriateness

### Key finding 9: equal access

*The majority of GPs in RRMA 7 locations register with the Program (89 per cent). The lowest registrations (around 64 per cent) are in RRMA 6 and 4 locations.*

*However, for those procedural GPs who go on to participate in the Program, GPs in RRMA 3, 6 and 7 locations have the lowest training rate at between 84 and 87 per cent, below the average of 91 per cent. Procedural GPs in RRMA 5 locations have a 94 per cent training rate.*

*The training rates drop across all RRMA locations for the emergency component, with an average training rate of 85 per cent. GPs in RRMA 3 locations had the lowest training rate at 79 per cent.*

*For the procedural component, Victoria has a 94 per cent training rate, closely followed by Queensland, Tasmania and South Australia, all above 92 per cent. Northern Territory has the lowest procedural training rate (83 per cent). The training rates drop across all jurisdictions for the emergency component. Tasmania has the lowest emergency medicine training rate at 71 per cent, followed by the Northern Territory at 75 per cent.*

### Key finding 10: a suitable training grant

*A small proportion of GPs utilise the maximum grant available (between 11 per cent and 26 per cent).*

*Survey respondents identified that one of the key strengths of the Program was that it made professional development financially viable. Stakeholders commented that reducing the size of the grant would undermine this strength.*

*Stakeholders identified that moving to a three-year period would provide GPs with more flexibility as to when they undertake their training. However, Budget processes require all grant funding to be distributed in each financial year.*

### Key finding 11: usefulness

*Overall, GPs find the Program useful. 48 per cent of GPs have attended more than one training course, indicating a willingness to continue participating in the Program.*

### Key finding 12: Program exclusions

*A number of specialist areas are not currently covered by the Program, including Indigenous health, mental health and child health.*

*Another specific program exclusion is the eligibility of distance education training courses, which would be especially useful for GPs practicing in remote locations given the cost of travel and availability of locums.*

### *Barriers and consequences*

#### **Key finding 13: availability of course information**

*Registered GPs find it difficult to access course information, including what their training options are, and what courses are available at any one time (including formal training and clinical attachments).*

*Both Colleges publish information relating to the Programs they run and accredit, however there is no central information source or compilation of relevant training options.*

#### **Key finding 14: waiting lists**

*Although not under the Program's responsibility, surveyed GPs identified extensive waiting lists for some courses that prevented their participation in the Program.*

#### **Key finding 15: availability of locums**

*Although not under the Program's responsibility, the difficulty of sourcing a locum for a short period of time, and the expense of a locum, are the primary barriers for rural and remote registered GPs to participate in the Program.*

#### **Key finding 16: geographic constraints**

*Procedural GPs in RRMA 6 and 7 have training rates lower than the national average. One reason for this is the length of travel time from these locations to a regional centre for training and the associated cost of travel.*

#### **Key finding 17: consequences of the Program**

*Overall, the consequences of the Program are positive. The Program supports GPs to maintain and improve their skills. This supports and encourages the retention of rural and remote GPs and enhances the quality of the medical workforce and the provision of health services in rural and remote locations.*

### **Suggestions for improvement to the Program**

In addition to the findings above, a number of suggestions were presented that may improve the efficiency and appropriateness of the Program in the future. These suggestions are outlined below.

#### **Suggestion for improvement 1: revise reporting requirements**

*DoHA could revise reporting requirements for the Colleges. DoHA could retain the number of reports required in each financial year — one data report and two progress reports — however, the extent of data required in the data reports could be streamlined to only include the information that DoHA will find useful to monitor the Program and make Program policy decisions.*

**Suggestion for improvement 2: create a central registration database**

*DoHA could commission a central database of registered GPs for the Program. This database would remove any double counting of registered GPs across the two Colleges and would assist in clearing up any confusion for GPs as to where they should apply for a grant. This database could be created and managed by the Secretariat of the Collaboration within current funding (if reporting requirements are reduced). Registration and claims for the Program could be made through a dedicated website that would feed into the central database.*

**Suggestion for improvement 3: include Indigenous, mental and child health**

*DoHA could review the eligible disciplines included in the Program if the future funding environment allows capacity in the Program. New disciplines, including Indigenous health, mental health and child health could be included in a similar format to the emergency medicine component.*

**Suggestion for improvement 4: include distance education as training**

*DoHA could include distance education as an option for GPs in all rural and remote areas (in particular, RRMA 6 and 7 locations). This will help to alleviate travel and cost concerns from these locations and may improve their participation in the Program.*

**Suggestion for improvement 5: a database of approved courses**

*DoHA could commission a database of previous courses that have been approved by the Colleges. This will help GPs understand which training courses they could undertake and could include links to contacts that can help them enrol in courses. This database could be managed by the Secretariat of the Collaboration within current funding (if reporting requirements are reduced). As part of this database, a list of hospitals and specialists that have previously agreed to a clinical attachment could be included to increase the awareness of potential clinical attachments.*

*This additional information could be made available to GPs through a dedicated website, where other program information could also be made available.*

**Suggestion for improvement 6: increase the level of the grant for GPs in RRMA 6 and 7 locations**

*DoHA could revise the maximum grant for GPs in RRMA 6 and 7 locations to include a set rate for travel per day (in addition to the maximum grant). This additional grant for GPs in the most remote locations will assist with additional travel expenses that they incur and allow for the maximum base grant to be utilised for training purposes. This increase in the level of the grant could be absorbed within current funding given the current program underspend.*

## *Chapter 1*

# Background

### **1.1 Introduction**

This report presents the findings of the review of the Training for Rural and Remote General Practitioners (TRRPGP) Program (the Program). This Chapter describes the Program and its administration and provides some background information on General Practitioners in rural and remote Australia. It also outlines the objectives of the evaluation and summarises the structure of the remainder of the report.

### **1.2 General Practitioners in rural and remote Australia**

General Practitioners (GPs) play a vital role in the Australian health care system. They are the first point of contact for the majority of people seeking health care, and provide primary medical care to individuals, families and communities around Australia. In 2006-07, there were approximately 25 500 accredited GPs providing primary care medical services (DoHA 2007b).

The role of GPs in rural and remote areas of Australia is critical to the provision of health services, given the limited number of services readily available in rural and remote locations. For example, rural and remote communities rely upon GPs to provide surgical, anaesthetic, obstetric and emergency services, which in urban areas of Australia are provided by specialists and emergency professionals.

In 2006-07, there were around 7300 GPs practicing in rural and remote areas of Australia, making up 28 per cent of all practicing GPs (DoHA 2007b). In the five years to 2006-07, the number of rural and remote GPs increased by 8 per cent. The proportion of GPs practicing in rural and remote locations compared to urban areas remained stable over the same time period (DoHA 2007b).

There are two specific types of GPs in rural and remote areas that are most relevant to this review — rural and remote procedural GPs and emergency medicine practitioners. The characteristics that define these GPs are provided in Box 1.1.

Box 1.1

**CHARACTERISTICS OF RURAL AND REMOTE PROCEDURAL GPs AND EMERGENCY MEDICINE PRACTITIONERS****Procedural GP:**

A procedural GP provides non-referred services normally in hospital theatres, a maternity setting or other appropriately equipped facilities that in urban areas are typically the province of a specific referral-based specialty. Most commonly this refers to the fields of surgery, anaesthetics and obstetrics. Elements essential to procedural medicine are the:

- use of appropriately equipped facilities and resources;
- involvement of a team of health professionals; and
- active engagement of the practitioner in an appropriate skills maintenance program in the relevant procedural areas.

GPs must also meet specific criteria to be eligible as a doctor performing surgery. Surgery is defined as:

abdominal surgery (including appendectomy), gynaecological surgery (including dilatation and curettage, termination of pregnancy, ectopic pregnancy, abdominal masses and cysts) requiring general anaesthetic, endoscopy, orthopaedics requiring major regional blocks or GA including definitive treatment of fractures, dislocations and tendon repairs. Removal of simple cysts or aspiration of pleural effusions are not covered, and skin surgery including flap or graft repairs is excluded (ACRRM 2006).

**Emergency medicine practitioner:**

An emergency medicine practitioner in rural and remote locations is a GP or medical officer who provides emergency medicine for non-referred services in an accident and emergency facility that is available for:

- 24 hour triaging — a hospital or other appropriately equipped facility, which provides a minimum equipment list of, but not restricted to, intubation, cannulation and defibrillation equipment; and
- rapid diagnosis and management of the acute and urgent aspects of illness and injury such as those typically brought to the door by ambulance.

Source: Medicare Australia 2007

In 2005, there were 965 procedural GPs and 1859 emergency medicine practitioners practicing in rural and remote areas of Australia, making up approximately 40 per cent of all GPs practicing in rural and remote locations in that year (Health Workforce Queensland and NSW Rural Doctor's Network 2006; DoHA 2007b).

These GPs require continued training in specialist areas, including anaesthetics, obstetrics, surgery and emergency medicine in order to be able to provide these health services to patients in their local communities.

**1.3 The TRRPGP Program**

One Australian Government program to assist the training of procedural GPs and rural and remote emergency medicine practitioners is the Training for Rural and Remote General Practitioners (TRRPGP) Program (the Program). The Program was introduced in 2003-04, with an objective to *support GPs in rural and remote areas to access a grant to attend relevant training, upskilling and skills maintenance activities* (DoHA 2007a). Support is provided through a grant payment, which is designed to assist with the cost of attending training, including course costs, locum relief and travel expenses.

The Program was extended in 2005 to include training for GPs practicing emergency medicine in rural and remote locations, which was funded within the initial budget.

The Program caters for medical professionals operating outside urban areas, generally with a population less than 100 000. These rural and remote areas are categorised by the Rural and Remote Metropolitan Areas (RRMA) index. RRMA locations are defined in Box 1.2.

Box 1.2

#### RURAL AND REMOTE METROPOLITAN AREA LOCATIONS

Rural and Remote Metropolitan Areas (RRMA) locations are defined as:

- RRMA 1 — capital cities;
- RRMA 2 — other metropolitan centres with urban centre population of more than 100 000;
- RRMA 3 — large rural centres with population between 25 000 and 99 000;
- RRMA 4 — small rural centres with population between 10 000 and 24 999;
- RRMA 5 — other rural areas with population less than 10 000;
- RRMA 6 — remote centres with population more than 5 000; and
- RRMA 7 — other remote areas with population less than 5 000.

Source: DoHA 2005

The Program has two components. It provides financial support for:

- procedural *GPs practicing in surgery, anaesthetics, and obstetrics* in RRMA locations 2 to 7.<sup>1</sup> For these procedural GPs, the grant payment is calculated on a maximum of 10 days training or skills maintenance activities. From 16 April 2007, the total grant payable is calculated based on a rate of \$2000 per day — a maximum grant of \$20 000;<sup>2</sup> and
- *GPs practicing emergency medicine* in RRMA locations 3 to 7. For these GPs the grant payment is calculated on a maximum of 3 days training or skills maintenance activities.<sup>3</sup> The same daily rates apply as those for procedural GPs outlined above — with a maximum grant of \$6000.

GPs are eligible to access the payment multiple times within a financial year up to the maximum grant in any one financial year. GPs may access both grants if their clinical and training needs deem them eligible (Medicare Australia 2007).

<sup>1</sup> In May 2007 the Program was expanded to include procedural GPs in RRMA 2 localities who practice surgery, anaesthetics or obstetrics and whose work is rural in nature even though they are based in urban locations. Such applications are reviewed by the Collaboration for approval and are subject to strict criteria. (Medicare Australia 2007).

<sup>2</sup> Prior to 16 April 2007 a daily rate of \$1 500 was used.

<sup>3</sup> Prior to 1 January 2007 only two days training in any financial year was funded.

### **Application process**

To receive grants under the Program, GPs are required to register with either the Australian College of Rural and Remote Medicine (ACRRM) or the Royal Australian College of General Practitioners (RACGP).<sup>4</sup> The Colleges assess an applicant's eligibility to participate in the program, notify Medicare Australia of successful applications, and the College to which an application was addressed advises the applicant of the success or failure of their application.

Upon completion of eligible training by the GP, ACRRM or the RACGP notify Medicare Australia, which processes the grant payment. Since the inception of the program to December 2007, approximately \$27 million in grants have been provided to GPs in rural and remote areas of Australia. Table 1.1 shows the number of grants approved and the value of grants by the Colleges since the inception of the Program.

Table 1.1

#### **NUMBER AND VALUE OF GRANTS OVER TIME — JULY 2005 TO DECEMBER 2007**

<b>College</b>	<b>Number of grants</b>	<b>Value of grant (\$ million)</b>
ACRRM — procedural	3053	\$12.190
ACRRM — emergency	950	\$2.538
RACGP — procedural	2140	\$7.660
RACGP — emergency	1951	\$4.472
<b>Total</b>	<b>8094</b>	<b>\$26.860</b>

Source: Data provided by Medicare Australia.

### **Program administration**

ACRRM and the RACGP administer the Program on behalf of the Department of Health and Ageing (DoHA). ACRRM and the RACGP are responsible for:

- assessing GP eligibility for the Program;
- maintaining a register of eligible GPs registered by each College;
- assessing training programs eligible to be accessed under the Program;
- ensuring Medicare Australia is advised of eligible GPs; and
- ensuring claims for payments are supplied to Medicare Australia (Medicare Australia 2007).

For the financial year 2007-08, the Colleges received \$0.484 million in funding to administer the Program.

Medicare Australia is responsible for maintaining a register of GPs that have received a grant under the Program and for making grant payments to GPs on completion of eligible training.

<sup>4</sup> For the purposes of this report the ACRRM and the RACGP are referred to as 'the Colleges'.

DoHA also funds the TRRPGP Collaboration (the Collaboration). The Collaboration was created to consider appeals on matters relating to GPs' eligibility for the Program, provide advice to DoHA on program policy, and also to review the eligibility of training programs. The Collaboration is made up of three procedural GP representatives from RACGP and three rural procedural medical practitioners representing ACRRM, as well as an emergency medicine representative from each College, and a representative of the Rural Doctors Association of Australia (RACGP 2006).

Since its inception, Program funding has continually been underspent relative to the budget. Table 1.2 outlines the program budget relative to the funding spent to June 2007.

Table 1.2

**PROGRAM BUDGET AND SPENDING (\$ MILLION)**

Year	Program budget	Program spending	Proportion underspent
2004-05	\$23.018	\$4.934	81.0%
2005-06	\$23.616	\$6.847	71.1%
2006-07	\$24.182	\$9.967	58.8%
2007-08	\$24.765	—	—
2008-09	\$25.259	—	—

Source: Data provided by DoHA.

Although there has been a program underspend in the past, the current financial environment may have an impact on funding for the Program.

#### 1.4 This Project

DoHA engaged Allen Consulting Group to undertake an evaluation of the Program. The major objectives of this evaluation are to:

- assess the effectiveness of the Program in maximising the potential of procedural GPs to maintain their skills;
- assess the appropriateness and efficiency of the Program;
- measure the extent to which the Program's goals and objective have been achieved; and
- identify the consequences (both positive and negative) of the Program.

In addition, the evaluation provides suggestions for possible changes to improve the Program in both the short and long term.

Assessing the Program in this way will assist DoHA to determine whether the Program is meeting its objective and how it can be improved to further enhance the training of procedural GPs in rural and remote areas of Australia.

## 1.5 Project approach

The evaluation of the Program was undertaken by completing three specific tasks. Firstly, a *desktop review* of information and data on the Program was completed. The desktop review considered information from DoHA, ACCRM, RACGP and Medicare Australia.

Following the desktop review, key *stakeholder consultations* were completed to provide input into the evaluation. An initial consultation was conducted with the Collaboration, from which contact was made with other key stakeholders to respond to a brief discussion guide, including:

- representatives from the DoHA rural workforce section;
- ACCRM;
- RACGP;
- Medicare Australia; and
- the Rural Doctors Association of Australia (RDAA).

The discussion guide is provided in Appendix A and a full list of stakeholders who were consulted as part of the evaluation is provided in Appendix B.

In addition to this consultation process, the Colleges provided the results of a recent survey of GPs in rural and remote areas of Australia who were registered for the Program.<sup>5</sup> In late 2007 ACCRM and RACGP separately conducted the *Outcome Evaluation Survey* — a survey of the respective procedural GPs and emergency medical practitioners registered in the Program with their College. Both Colleges received a similar response rate — a 57 per cent response rate for RACGP and a 56 per cent response rate for ACCRM (RACGP 2008c, p. 3; ACCRM 2008a, p. 5). The survey response rates ensure that the survey results provide an accurate reflection of GPs' opinions of the Program.

The survey aimed to assess the extent to which the Program has achieved an increase in the skill levels of GPs and enhanced the retention of rural and remote GPs (RACGP 2008c, p. 3). The survey was also able to analyse responses from procedural GPs and emergency medical practitioners separately in order to highlight differences between the components. The questionnaire gathered information from eight broad areas outlined in Box 1.3.

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<sup>5</sup> Each College conducted a similar survey in 2007 and provided the results to the Collaboration in early 2008.

Box 1.3

**INFORMATION AREAS COVERED BY THE ACCRM AND RACGP SURVEYS**

The surveys conducted by ACCRM and RACGP in 2007 asked respondents questions in the following categories:

- reasons GPs participate in the Program;
- disciplines of training courses undertaken;
- impact of training courses on the knowledge, skills and confidence of GPs;
- retention of GPs in rural and remote practices;
- perceived strengths of the Program;
- suggestions to improve the Program;
- inability of GPs to access training grants; and
- an opportunity for GPs to put forward other comments.

Source: RACGP 2008c; ACCRM 2008b.

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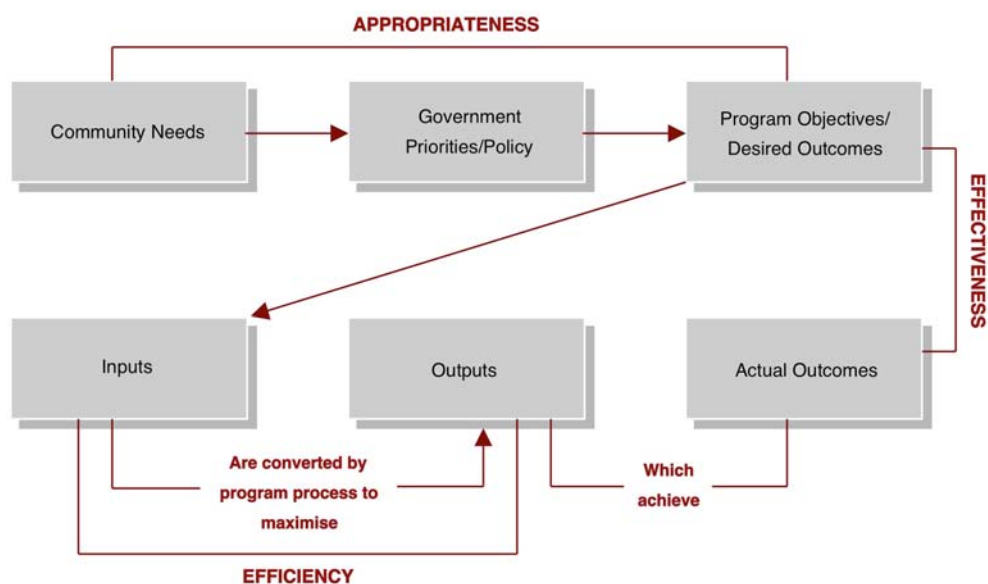
Where possible we draw upon the results of the surveys in the evaluation of the Program.

The final task of the evaluation was the *analysis and assessment* of the effectiveness, efficiency and appropriateness of the Program. In order to complete the analysis and assessment task, a framework was developed using the Australian National Audit Office best practice guide for the administration of grant programs as a basis. For example, the purpose of the evaluation of a grant program includes assisting administrators to assess:

- the continued relevance or appropriateness of the program;
- the effectiveness of the programs in achieving its objective; and
- whether there are better ways — including more cost-effective ways — of achieving program objectives (ANAO 2002).

On this basis, a schematic representation of the broad evaluation framework that brings together the critical analytical elements for this project is depicted in Figure 1.1.

Figure 1.1

**FRAMEWORK FOR ASSESSING PROGRAM EFFECTIVENESS, APPROPRIATENESS AND EFFICIENCY**

Source: Allen Consulting Group

Using this framework, the following could be evaluated:

- the *effectiveness* of the Program — effectiveness is assessed in relation to how well a program achieves its objective;
- the *efficiency* of the Program — an analysis of the efficiency of the Program includes an assessment of the level of Program inputs compared to Program outputs. For example, the administrative cost to run the Program and the timelines of grant payments; and
- the *appropriateness* of the Program — appropriateness is assessed in relation to the continued relevance of a program and to how well it meets the needs of clients, in this case how well the Program meets the training needs of procedural GPs, and also their practical needs to allow them to undertake the training.

This component of the evaluation also included the consideration of the consequences (both positive and negative) of the Program and the discussion of possible changes to improve the Program in both the short and long term.

## 1.6 Report structure

The remainder of this report is structured as follows:

- Chapter 2 analyses the effectiveness and efficiency of the Program, including the overall use of the Program, the types of training courses undertaken, and the extent of GPs' understanding of the Program. This Chapter also considers the administrative cost to run the Program, the timelines of grant payments and the efficiency of the management process;

- Chapter 3 considers the appropriateness of the Program, including access to the Program across Australia, the usefulness of the grant and the extent to which the program is limited. This Chapter also considers the consequences (both positive and negative) of the Program and the overall impact of the Program on the maintenance of skills for GPs in rural and remote areas of Australia; and
- Chapter 4 brings the parts of the evaluation together by summarising the key findings from Chapter Two and Chapter Three and discussing some suggestions for possible changes to improve the Program in both the short and long term.

## *Chapter 2*

# Effectiveness and efficiency of the TRRPGP Program

### **2.1 Introduction**

This Chapter considers the effectiveness of the Program in terms of several dimensions, including Program participation and usage, Program awareness and understanding, ease of use and types of training courses and skill attainment of Program participants. In addition, this Chapter considers program efficiency in terms of administrative costs, the timeliness of grant payments and the efficiency of management processes.

In summary, our assessment is that the Program is broadly effective and efficient at achieving its objective, with some areas where there may be opportunities for improvement in the future.

### **2.2 Effectiveness**

This section evaluates the effectiveness of the Program, which is assessed in relation to how well a program achieves its objective. The effectiveness of the Program is assessed using the following criteria:

- do eligible GPs participate in the Program?
- are GPs aware of the Program and do they understand how it works?
- is the Program easy to use?
- do the types of training courses available meet the objective of the Program?
- do the training courses undertaken aid skill development?

#### ***Do eligible GPs participate in the Program?***

Participation and usage reflect the awareness, uptake and adoption of the Program among eligible GPs, all of which are crucial measures of the effectiveness of the Program in achieving its objective. There are two aspects to determine the extent of GPs participation in the program:

- the number of GPs that register with the Program; and
- the number of GPs that then participate in the Program by undertaking some training and receiving a grant payment.

To estimate participation rates in the Program, we first need to estimate the relevant population (i.e. those GPs eligible to participate in the Program). Table 2.1 details the number of practitioners providing procedural or emergency care in RRMA locations 3 to 7 in 2005.

Table 2.1

**NUMBER OF PRACTITIONERS PROVIDING PROCEDURAL OR EMERGENCY CARE — 2005**

Practitioner type	RRMA 3*	RRMA 4	RRMA 5	RRMA 6	RRMA 7	National
Procedural GPs	36	237	543	75	74	965
Emergency care practitioners	72	423	1036	153	175	1859
<b>Total</b>	<b>108</b>	<b>660</b>	<b>1579</b>	<b>228</b>	<b>249</b>	<b>2824</b>

Source: Health Workforce Queensland and New South Wales Rural Doctors Network 2006.

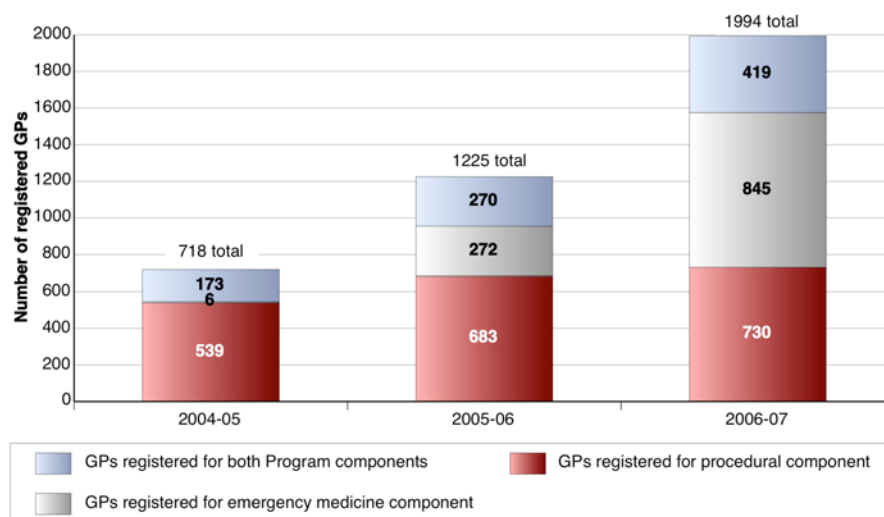
Note: Due to non-respondents, this data represents a lower bound estimate of the actual number of practitioners. Data correct as at 30 November 2005.

\* Estimates calculated by Allen Consulting Group based on average Program participation rates observed in RRMA locations 4 to 7.

### *GPs registered with the Program*

From this base of GPs in rural and remote areas, Figure 2.1 shows those GPs registered for the Program, disaggregated by the Program component for which they are registered. There has been a significant increase in GPs registering for the Program over time, with an average annual increase in registration of 66 per cent. While there have been smaller annual increases in those GPs registering for the Program's procedural component each year (on average 17 per cent), the annual increases in the number of GPs registering for the emergency medicine component of the Program has increased each year since its inception in 2004-05 with an increase of 211 per cent between 2005-06 and 2006-07.

Figure 2.1

**GPS REGISTERED FOR THE PROGRAM, CUMULATIVE TOTAL — TO JUNE 2007**


Source: Data provided by Medicare Australia.

In addition, Table 2.2 sets out those GPs registered in the Program by each College and RRMA to 30 June 2007. This table shows that each college has more than 1200 GPs registered for the Program (2417 GPs in total), which is greater than the total number of GPs registered for the Program outlined in Table 2.1 (1994 GPs). The reason for this difference is that some GPs (approximately 17.5 per cent) are registered with both Colleges for the Program.

Although these GPs are registered with both Colleges, they are not able to receive the same grant payment through both Colleges. Medicare distributes all payments to GPs through their Medicare Provider Number, preventing GPs from accessing payment for a claim more than once.

Table 2.2

**GPS REGISTERED, BY COLLEGE AND RRMA, TO 30 JUNE 2007**

College	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7	Total
ACRRM	51	240	700	107	115	1213
RACGP	43	275	660	72	154	1204
Registered with both Colleges	—	—	—	—	—	423
<b>Total</b>	<b>94</b>	<b>515</b>	<b>1360</b>	<b>179</b>	<b>269</b>	<b>2417</b>

Sources: RACGP 2008b; ACRRM 2008b.

To determine a robust estimate of the registration rate, the effects of dual registration have been removed from the data. These calculations produce an average registration rate of 70 per cent among eligible GPs in 2006-07 (i.e. the proportion of eligible GPs that register with the Program).<sup>6</sup> The average registration rate has increased from 35 per cent of eligible GPs in 2004-05 (procedural GPs only).

#### *Program participation*

Among those GPs who are registered for the Program, a significant proportion have participated in the Program, accessing grants to support their training and skill attainment activities. Among those GPs participating in the Program:

- for *procedural GPs* — 92 per cent of those GPs registered with the RACGP have attended one or more training activities to February 2008 (comparable ACRRM data is not available); and
- for *emergency medicine practitioners* — 82 per cent of those GPs registered with the RACGP have attended one or more training activities to February 2008, compared with 81 per cent of those GPs registered with ACRRM (RACGP 2008b; ACRRM 2008b).

Table 2.3 sets out the average grant and length of training for those GPs participating in the Program. This data shows that those GPs accessing the Program's procedural component tend to undertake longer training periods on average and receive higher grants than those accessing the Program's emergency medicine component. For example, those procedural GPs registered with ACRRM have an average length of training of two days, with an average grant of \$4023, representing a 53 per cent increase in training duration and 36 per cent increase in grant value compared with emergency medicine grants accessed through ACRRM.

<sup>6</sup> It should be noted that these calculations exclude analysis of GPs in RRMA location 2. This figure was calculated taking the number of GPs registered in the Program (accounting for registrations at both Colleges) as a proportion of the total estimated number of procedural GPs and emergency medicine practitioners in RRMA 3 to 7 location in 2007 (using a 2005 estimate and inflated by the average increase in procedural and emergency medicine GPs between 2002 and 2007). The use of this estimate should be considered with these assumptions in mind.

This result is in line with Program policy — greater training days and funding available to procedural GPs compared to emergency medicine practitioners. However, this data shows that for both the procedural and emergency medicine components of the Program, GPs are not utilising the maximum grant. This is discussed further in Chapter 3.

Table 2.3

**AVERAGE GRANT AND LENGTH OF TRAINING**

College	Average grant	Average length of training
<b>Procedural component</b>		
ACRRM	\$4023	2 days
RACGP	\$3584	2.2 days
<b>Emergency medicine component</b>		
ACRRM	\$2575	1.3 days
RACGP	\$2306	1.3 days

Source: RACGP 2008b; ACRRM 2008b.

Some stakeholders suggested that the likelihood that a rural or remote GP would participate in the Program may be linked to the GPs age. It was suggested that:

- those GPs that are nearing the end of their careers are less likely to access the Program, as they are less inclined to want to acquire new skills, and are well practiced in those skills they already possess; and
- young GPs, just commencing their careers may also be less likely to access the Program, as they have only recently entered practice and are therefore less likely to undertake skills maintenance training.

However, an analysis of the ages of Program participants does not support either conjecture. The average ages of those GPs participating in the Program are consistent with the average age of the population of GPs practicing in rural and remote areas — around 45 to 48 years of age (data provided by ACRRM, RACGP, and Health Workforce Queensland and New South Wales Rural Doctors Network 2006).

**Key finding 1: eligibility and use of the Program**

*In 2006-07, around 70 per cent of eligible GPs were registered with the Program.*

*Since the addition of the emergency medicine component to the Program, there has been a rapid increase in GPs registering for the Program each year, with an average increase in registrations across the Program of 66 per cent each year.*

*A high proportion (up to 92 per cent) of these registered GPs, go on to participate in the Program, using grant payments to support approved training activities.*

*The value and duration of training undertaken by procedural GPs is on average 2.1 days with a value of \$3800. This is greater than the grants accessed by emergency medicine practitioners (an average of 1.3 days with a grant of \$2400), in line with the Program policy.*

### **Are GPs aware of the Program and do they understand how it works?**

Program awareness and understanding reflects the effectiveness of efforts to promote the Program to eligible GPs, and the extent to which it is understood by those it is intended to assist. The relatively high proportion of eligible GPs who are registered for the Program (outlined above) suggests high levels of Program awareness and understanding. Beyond this, however, there is limited data available to estimate the proportion of eligible GPs who are aware of the Program, but who choose not to participate.

However, the RDAA suggested that, of the host of programs available to rural and remote GPs, the Program was among the most visible and well known. Another stakeholder suggested that having the Program ‘designed for the profession and run by the profession’ aided Program awareness and understanding among eligible GPs. Using specialist training colleges to administer the Program was also thought to assist program awareness, as the Colleges form part of established networks in rural and remote medicine.

### **Key finding 2: program awareness and understanding**

*There appears to be a high level of awareness and understanding of the Program among eligible GPs. This is supported by a high proportion of eligible GPs being registered for the Program, complemented by the views of stakeholders. There is limited information about those GPs who are not registered for the Program and whether a lack of awareness prevents participation or that some GPs choose not to participate.*

### **Is the Program easy to use?**

Designing a program that is easy to use is vital if the Program is to be used in a way that supports the achievement of its objective. Survey and consultation findings suggested that eligible GPs have a good understanding of the Program’s terms of access and usage. The process and timeframes for receiving grants were widely understood. However, several stakeholders and survey respondents suggested that improving the availability of course information supported by the Program would assist GPs to identify training that may be of interest to them.

Stakeholders identified the Program’s ease of administrative arrangements as being among its strengths. These claims are supported by findings from surveys of Program participants undertaken by the Colleges. For example:

- in the ACRRM survey, the third most frequently identified strength of the Program (16 per cent) was the ‘ease of grant access / lack of red tape’ (ACRRM 2008a); and
- similarly, in the RACGP survey the third most frequently identified strength of the Program (12 per cent) was the ‘ease of access to the Program and grants’ (RACGP 2008c). Other procedural GPs commented that the Program had a ‘low amount of bureaucracy’ and that it was ‘quick and easy to get a claim’.

Several stakeholders observed that administrative requirements for GPs were significantly less burdensome than those for similar grant programs. As a result, this Program has not attracted criticisms that are often levelled at similar programs, such as being overly bureaucratic or difficult to apply for. However, some stakeholders did recount GPs experiencing some confusion in the different arrangements each college has for lodging claims through the Program.

Despite generally strong endorsement for the Program's accessibility and administrative efficiency, 5 per cent of RACGP survey respondents (RACGP 2008c) suggested that the Program could be improved by reducing paperwork requirements.

### **Key finding 3: ease of use**

*Procedural GPs generally found the Program relatively easy to use. Specific strengths of the current arrangements include the relatively low level of administration required by GPs accessing the Program and the ease of access to grant payments.*

### **Do the types of training courses available meet the objective of the Program?**

The types of training courses that the Program supports are central to achieving the Program objective of maintaining and developing procedural and emergency medicine skills among GPs in rural and remote areas.

Training courses for both procedural GPs and emergency medicine practitioners are available to support skills maintenance and improvement, through formal courses and informal modes (such as workshops and clinical attachments) (Medicare Australia 2006). ACRRM survey responses suggested that registered GPs shared these aims. When asked about what prompted their participation in the Program, leading survey responses included:

- 42 per cent of survey respondents cited 'update / increase skills and knowledge';
- 27 per cent of survey respondents cited 'maintain skills and knowledge'; and
- 17 per cent of survey respondents cited 'increase knowledge and skills in a specific area' (ACRRM 2008a).

Table 2.4 outlines the number and type of grants received to December 2007. Rural and remote GPs are increasingly accessing the Program to support both procedural and emergency medicine training. In terms of the use of the program for each component in 2007-08:

- 45 per cent of grants (by number) were for the procedural component of the Program, with 55 per cent for emergency training; and
- 57 per cent of grants (by value) were for the procedural component of the Program, with 43 per cent for emergency training.

Table 2.4

**TRAINING GRANTS: PROCEDURAL AND EMERGENCY MEDICINE TRAINING**

Period	Procedural grants		Emergency medicine grants		Total grants	
	Number	Value (\$ million)	Number	Value (\$ million)	Number	Value (\$ million)
2004-05	946	\$3.729	0	–	946	\$3.729
2005-06	1447	\$5.295	67	\$0.144	1514	\$5.439
2006-07	1806	\$6.170	1490	\$3.144	3296	\$9.314
2007-08 (grants to 31 Dec 07)	952	\$4.399	1171	\$3.359	2123	\$7.758
<b>Total</b>	<b>5151</b>	<b>\$19.593</b>	<b>2728</b>	<b>\$6.647</b>	<b>7879</b>	<b>\$26.240</b>

Note: The number of grants in this table will not equal the data in Table 2.6 and 2.7 as the data is provided by a different source. Source: Data provided by Medicare Australia.

*Procedural training courses*

The Program provides support for procedural GPs practising in surgery, anaesthetics and/or obstetrics. Table 2.5 identifies the number of GPs accessing training through the Program by procedural discipline. This data shows that among those GPs attending procedural training, the most frequently attended procedural discipline training sessions pertain to obstetrics (40 per cent) and anaesthetics (34 per cent), rather than multiple disciplines or surgery.

Table 2.5

**GPS ATTENDING TRAINING BY PROCEDURAL DISCIPLINE — TO FEBRUARY 2008**

Procedural discipline	Number of GPs	Proportion of total training
Anaesthetics	282	34%
Obstetrics	325	40%
Surgery	57	7%
Two or more areas	157	19%
<b>Total</b>	<b>821*</b>	<b>100%</b>

\* Note: ACCRM data omits 112 training claims for which procedural discipline data was not recorded. Source: ACCRM direct data request; RACGP 2008b.

Furthermore, Table 2.6 illustrates the relatively low utilisation of clinical attachments relative to formal training. A clinical attachment is ‘a period of attachment in another clinical or hospital setting where a participant can observe and engage in hands on clinical practice, with the aim of either learning new specific skills or updating specific skills or areas of knowledge’ (ACCRM 2007). Of all approved procedural training, 23 per cent are provided in the form of clinical attachments.

Table 2.6

**PROCEDURAL GP GRANTS — CLINICAL ATTACHMENTS VS FORMAL TRAINING —**

Type of training	Number of grants	Proportion of total training
Formal training	4902	77%
Clinical attachments	1468	23%
<b>Total</b>	<b>6370</b>	<b>100%</b>

Note: The number of grants in this table will not equal the data in Table 2.4 as the data is provided by a different source.

Source: RACGP 2008b p. 9 & 13; ACCRM 2008b p. 12; ACCRM 2008c p. 12.

**Emergency medicine training courses**

In addition, the Program provides support for emergency medicine practitioners. Emergency medicine training can be undertaken through either clinical attachments or more formal training modes. As Table 2.7 shows, formal training remains the most frequently accessed type of training for those GPs registered through the RACGP, with 77 per cent of grants appropriated for this type of training.

Table 2.7

**EMERGENCY MEDICINE GRANTS — CLINICAL ATTACHMENTS VS FORMAL TRAINING**

Type of training	Number of grants	Proportion of total training
Formal training	2132	72%
Clinical attachments	813	28%
<b>Total</b>	<b>2945</b>	<b>100%</b>

Note: The number of grants in this table will not equal the data in Table 2.4 as the data is provided by a different source.

Source: RACGP 2008b p. 9 & 13; ACCRM 2008b p. 12; ACCRM 2008c p. 12.

**Key finding 4: types of training courses**

*The types of training courses that have been accessed by GPs through the Program to date are in accordance with the Program's objectives, namely approved training in procedural and emergency medicine.*

*An increasing number of registered GPs are using the Program to support emergency medicine training (55 per cent of all grants in 2007-08), however procedural GP training still accounts for 57 per cent of grants by value.*

*The most frequently accessed procedural training courses are for obstetrics (40 per cent) and anaesthetics (34 per cent). Of all training completed by procedural GPs, 77 per cent undertook formal training and 23 per cent completed a clinical attachment.*

*Formal training was also the preferred delivery mode for emergency medicine training — 72 per cent, with 28 per cent of emergency medicine practitioners completing a clinical attachment.*

### *Do the training courses undertaken aid skill development?*

Training courses supported by the Program enable GPs to maintain existing skills and develop new skills in approved procedural and emergency medicine disciplines, and instil them with ongoing confidence in their abilities. The extent to which GPs attain skills through training supported by the Program are identified in responses to the ACRRM and RACGP survey, as shown in Table 2.8. Of the survey responses:

- between 70 and 80 per cent of procedural GPs commented that the grant had assisted in maintaining knowledge and skills to a great extent. An additional 19 to 29 per cent of respondents identified this result has occurred to some extent;
- around 55 per cent of emergency medicine practitioners commented that the grant had increased their knowledge and skills to a great extent, with an additional 43 per cent of respondents identifying that this result had occurred to some extent; and
- approximately 40 per cent of all surveyed GPs identified that participation in the Program had increase their confidence to perform new procedures to a great extent.

Table 2.8

#### **KNOWLEDGE, SKILLS AND CONFIDENCE GAINED THROUGH TRAINING SUPPORTED BY THE PROGRAM**

Impact of training	Extent	Procedural GPs		Emergency medicine practitioners	
		ACRRM	RACGP	ACRRM	RACGP
Grant approved training had assisted in maintaining knowledge and skills	To a great extent	80%	70%	72%	67%
	To some extent	19%	29%	28%	32%
Grant approved training had increased their knowledge and skills	To a great extent	51%	50%	57%	54%
	To some extent	47%	46%	42%	44%
Grant approved training had been instrumental in maintaining their confidence to continue performing procedures	To a great extent	69%	63%	57%	58%
	To some extent	29%	34%	42%	30%
Participation in this Program increased their confidence to perform new procedures	To a great extent	42%	38%	42%	—
	To some extent	49%	52%	50%	—

Sources: ACRRM 2008a; RACGP 2008a.

Views expressed by stakeholders affirmed these impacts of Program-approved training. In particular, several stakeholders emphasised the implications of these impacts for retaining and attracting GPs to rural and remote areas, and for ensuring the provision of procedural and emergency skills to these communities. As survey respondents have commented:

Without this Program I am unsure as to whether or not I would have remained doing [emergency medicine] — with this Program I intend to remain a service provider for the next ten years (ACRRM 2008a).

[This Program has] kept me undertaking obstetrics for one to two extra years.

The Program is the main reason I have been able to maintain working as a part time locum (GP Anaesthetics) following maternity leave.

Without the Program I would most likely have ceased being a procedural GP about 2 years ago, after 8 years of full time rural and remote work.

The Program has helped retain me in an RRMA 7 town and be on call for the Emergency Department (RACGPa).

As these comments illustrate, the impacts of training supported by the Program have a direct bearing on the intentions of GPs to remain in rural and remote practices, and to provide procedural and emergency medicine services.

#### **Key finding 5: skill attainment**

*Training courses supported by the Program enable GPs to maintain existing skills and develop new skills in approved procedural and emergency medicine disciplines, and instil them with ongoing confidence in their abilities.*

*Between 70 and 80 per cent of procedural GPs surveyed identified that the training provided under the Program assisted in maintaining knowledge and skills to a great extent. Around 70 per cent of emergency medicine respondents agreed with this statement.*

*Approximately 53 per cent of all survey respondents identified that training provided under the Program increased their knowledge and skills to a great extent.*

### **2.3 Efficiency**

This section evaluates the efficiency of the Program, which includes an assessment of the level of program inputs compared to the program outputs. The efficiency of the program is assessed using the following criteria:

- are administrative costs high?
- are grants paid in a timely manner? and
- is the management process efficient?

#### ***Are administrative costs high?***

A grant program with relatively low administrative costs is commonly seen as an efficient one, allocating a greater amount of funding to the provision of grants, rather than on program management.

Table 2.9 sets out the funding provided to the Colleges, disaggregated by Program component and financial year. The costs of the Colleges administering the Program have increased each year (23 per cent between 2006-07 and 2007-08). This increase is largely due to the Program's expansion since its inception, in terms of increasing maximum allowable grants, widening Program eligibility, and introducing the emergency medicine component, as well as due to increases in the Consumer Price Index.

Table 2.9

**PROGRAM ADMINISTRATION COSTS**

Funding component	2004-05	2005-06	2006-07	2007-08	Total
Procedural GPs	\$237 684	\$239 273	\$241 000	\$281 050	\$999 007
GPs practicing emergency medicine	—	\$58 973	\$116 628	\$158 935	\$334 536
GST	\$23 769	\$29 824	\$35 763	\$43 999	\$133 355
<b>Total</b>	<b>\$261 453</b>	<b>\$328 070</b>	<b>\$393 391</b>	<b>\$483 984</b>	<b>\$1 466 898</b>

Source: Data provided by the Department of Health and Ageing 2008.

As a proportion of Program grants disbursed, however, the relative costs of the Colleges administering the Programs have declined over time. This decline might be expected due to the economies of scale generally associated with program administration, and efficiency gains resulting from process improvements made over time. As shown in Table 2.10 below, the costs of the Colleges as a proportion of Program grants disbursed have decreased from 7.0 per cent in 2004-05 to 4.2 per cent in 2006-07, with an average of 5.3 per cent in the three years to June 2007. The United Kingdom's Audit Commission has, in the past, identified that the average level of contract management costs as a proportion of total funding is between one per cent and nine per cent (Domberger 1998). Relative to this benchmark, the extent of administrative costs for the Program is efficient. Similarly, stakeholders identified that the administrative costs for GPs participating in the Program are generally considered to be low.

Table 2.10

**ADMINISTERING COLLEGES' COSTS AS A PROPORTION OF PROGRAM GRANTS DISBURSED**

	2004-05	2005-06	2006-07	Total
Administration costs	\$261 453	\$328 070	\$393 391	\$982 914
Program funds disbursed	\$3 729 000	\$5 439 500	\$9 314 500	\$18 483 000
<b>Administering Colleges' costs as a proportion of funds disbursed</b>	<b>7.0 per cent</b>	<b>6.0 per cent</b>	<b>4.2 per cent</b>	<b>5.3 per cent</b>

Note: 2007-08 data has not been included as total grants for the financial year have not yet been finalised.

Source: Data provided by the DoHA and Medicare Australia 2008.

Furthermore, the administrative costs of Medicare Australia's involvement in the Program are low relative to total grants disbursed through the Program. The effort required by Medicare Australia to perform its administrative functions for this Program is set out in Table 2.11. This table shows that Medicare Australia's administrative effort for this Program is low, requiring less than one full time equivalent (FTE) worker to disburse grants through the Medicare system.

Table 2.11

**MEDICARE AUSTRALIA ADMINISTRATION EFFORT**

Location	Staff	Proportion of time
South Australia	1 FTE	50 per cent
National Office	1 FTE	20 per cent

Source: Data provided by Medicare Australia 2008.

Stakeholders suggested that Medicare Australia's administrative processes for this Program were efficient and effective in their present form, which uses spreadsheets as the primary data platform. However, one stakeholder suggested that the appropriateness of this platform might need to be reviewed should the Program continue its growth to date. Potential shortfalls, while not apparent at the Program's current level of activity, may include double counting of GPs, or incorrect payments being made to GPs. A more reliable and efficient means of entering, storing and retrieving data may be to implement a Program-specific database.

**Key finding 6: administrative costs**

*The costs of administering the Program are considered to be efficient relative to the total grants disbursed. The funds paid to Colleges to administer the Program, while increasing in absolute terms, have declined as a proportion of total grants disbursed over recent years to 4.2 per cent in 2006-07.*

*Medicare Australia's involvement in the Program appears to be administratively efficient, noting that the continuing appropriateness of current data platforms may need to be reviewed should the Program's growth continue.*

**Are grants paid in a timely manner?**

Timeliness measures the adherence of Program administration processes to reasonable time periods. As noted previously, respondents to surveys from both Colleges observed Program administrators to be responsive and helpful. Several stakeholders also viewed the Collaboration as being prompt and decisive on those applications requiring determinations.

A range of stakeholders, including GPs participating in the Program, commented favourably on the promptness of Medicare Australia's grant payments. Stakeholders identified the following reasons as underpinning the prompt payment of grants to Program participants:

- the operation of regular monthly payment cycles — claims that are received by Colleges by the 9<sup>th</sup> of the month are submitted to Medicare on the 10<sup>th</sup> for payment. Medicare complete all payments by the end of each month;
- close working relationships between the administering Colleges and Medicare Australia; and
- clearly communicating the timeframes for grant payments to participating GPs.

Several stakeholders identified the primary causes of delays in grant payments to GPs as being delays in GPs submitting claims to colleges, or GPs providing insufficient evidence with their claims.

For both Colleges, all GPs receive their grant payment within two to six weeks for lodging their claim form, provided the GP has provided adequate supporting documentation.

#### **Key finding 7: timeliness**

*Stakeholders widely consider the Program to be administered in a timely manner. This timeliness extends to responses to enquiries and applications lodged with the Colleges, determinations made by the Collaboration, and grant payments made by Medicare Australia.*

*All GPs receive their grant payment within two to six weeks of claiming a grant through one of the Colleges.*

#### **Is the management process efficient?**

Management process efficiency refers to the efficiency of the structure and processes through which the Program is managed. Those agencies involved in the management of the Program have a clear understanding of the roles of each agency, a view widely expressed through stakeholder consultations. Several stakeholders noted the strength of the working relationships between agencies. For example:

- the Colleges work collaboratively to administer the Program;
- there are clear processes for the Colleges to send approved grant applications to Medicare for payment, with direct follow-up taking place as required; and
- the Collaboration provides an effective forum to resolve most Program issues and ‘grey areas’ in a timely fashion.

Several stakeholders also described Medicare Australia’s role in providing grant payments as being both clear and efficient.

However, there were some process efficiency issues raised concerning the registration of GPs and the administration of grant applications:

- some participating GPs are confused as to the information they are required to send to each College. Clearer communications and harmonisation of information requirements between Colleges could rectify this; and
- there is some duplication and inconsistency in the data collected and analysed by each College. In particular, GPs registering for the Program through both Colleges have caused some administrative complications at the payments stage in the past. As discussed above, approximately 17.5 per cent of all registered GPs are registered with both Colleges to 30 June 2007.

Administrative efficiencies could be achieved if there was greater collaboration and systems integration between the Colleges, in areas such as GP registration and data collection and analysis.

Furthermore, there was general agreement among stakeholders that the Colleges’ reporting requirements to DoHA could be streamlined, reducing the data collection, analysis and reporting burden and improving the quality of information available for DoHA policy analysis. The reports currently required by the Colleges, their content and their frequency, are set out in Box 2.1.

Box 2.1

**CURRENT REPORTING REQUIREMENTS**

The current reporting requirements impose a significant burden on the Administering Colleges, and could be updated and made better aligned with the information needs of the DoHA. Each Administering College is required to provide the following reports to DoHA each financial year:

- a Progress Report every six months (interim and twelve-monthly reports);
- a Data Report every six months (interim and twelve-monthly reports); and
- Audited Financial Statement.

A comprehensive catalogue of data items must be included in the Data and Progress Reports, including, *inter alia*:

- the total number and value of payments made to GPs;
- the number of GPs attending training activities and total registrants by discipline of training;
- the number and percentage of doctors accessing the maximum grant within the financial year;
- the number of ineligible applications assessed;
- the number of GPs attending formal training activities instead of clinical attachments; and
- a list of training activities accessed since the beginning of the Program and the number of GPs accessing each.

Note that all of this data above is provided by the Colleges in two forms — since the inception of the Program and on an annual basis.

Additional reporting information is also required relating to the Collaboration's activities.

Source: Information provided by DoHA.

A number of stakeholders recognised the existence of some process inefficiencies, which could be eliminated by adopting a single administering entity. However, most stakeholders believed that such inefficiencies could be addressed through other means (such as by promoting greater collaboration and integration between the Colleges), rather than by implementing a new model. Indeed, stakeholders identified several benefits of the current structure, including:

- breadth of professional perspective the current structure supports through the Collaboration; and
- alignment of interests of all stakeholders with those of the Program under the current model.

As one stakeholder observed, 'the benefits of having two colleges involved outweigh the drawbacks'.

**Key finding 8: management process**

*Those agencies involved in the management of the Program have a clear understanding of the roles of each agency, with strong working relationships between agencies.*

*There were some process efficiency issues raised concerning the registration of GPs, and administration of grant claims. Some participating GPs are confused as to the information they are required to send to each College and there is some duplication and inconsistency in the data collected and analysed by each College.*

*There was general agreement among stakeholders that the Colleges' reporting requirements to DoHA could be streamlined.*

*Most stakeholders believed that any process inefficiencies in the current model could be addressed directly, rather than by implementing a new management structure.*

## *Chapter 3*

# Appropriateness of the TRRPGP Program

### **3.1 Introduction**

This Chapter considers the appropriateness of the Program in terms of several dimensions, including access to the Program across Australia, the suitability of training, the usefulness of the Program and the extent of program exclusions. Overall, the Program is appropriate in meeting the needs of GPs in rural and remote areas. However, there are some areas where improvements to the appropriateness of the Program could be made.

In addition, this Chapter considers the barriers to the Program operating at its full potential, including the availability of course information, lack of locum GPs, and geographic constraints. Finally, this Chapter looks at the consequences (both positive and negative) of the Program to both GPs and the communities within which they practice.

### **3.2 Appropriateness**

This section evaluates the appropriateness of the Program by determining the continued relevance of the Program and the extent to which it meets the needs of clients — in this case the extent to which the Program meets the training needs of rural and remote procedural GPs and emergency medicine practitioners.

The criteria used in this chapter to analyse the appropriateness of the Program includes:

- is there equitable access to the Program across Australia?
- is the training grant suitable to the needs of GPs?
- is the Program useful? and
- are there exclusions to the Program that should be included?

#### ***Is there equitable access to the Program across Australia?***

The geographic distribution of the registered GPs is important to an analysis of the appropriateness of the Program, for access to the Program by geographic classification identifies if there are any rural and remote areas of the country where access to the Program is limited.

As illustrated in Figure 2.1, there has been a significant increase in the number of GPs registering in the Program over time. This increase in participation over time is a substantial indication that GPs themselves view the Program to be appropriate.

A breakdown of registrations by RRMA location should also be considered as this indicates the extent of access across remote locations. Table 2.2 displays combined College registrations by RRMA location since the Program's inception in 2004.<sup>7</sup> In summary:

- a very high proportion of GPs in RRMA 7 locations register with the Program (89 per cent);
- although the majority of absolute registrations come from RRMA 5 locations (59 per cent), only 71 per cent of GPs in RRMA 5 locations register with the Program; and
- around 64 per cent of GPs in RRMA 4 and RRMA 6 locations register with the Program.

Table 3.1

**GP REGISTRATIONS BY RRMA LOCATION — TO 30 JUNE 2007**

RRMA	GP population*	Registered GPs	Distribution
RRMA 4	660	425	64%
RRMA 5	1579	1122	71%
RRMA 6	228	148	65%
RRMA 7	249	222	89%
<b>Total</b>	<b>2715</b>	<b>1917</b>	<b>—</b>

\* Includes number of GPs providing procedural or emergency medicine in RRMA 4 to 7 locations. Source: RACGP 2008b p. 3; ACCRM 2008b p. 4-6; ACCRM 2008c p. 4-6.

Continuing an analysis by RRMA location, Table 3.2 shows the percentage of registered procedural and emergency medicine practitioners who have participated in training courses by RRMA location.<sup>8</sup> This indicator of access is a particularly important indicator of the appropriateness of the Program, as it demonstrates how many GPs choose to access training courses. For example:

- for procedural GPs, GPs in RRMA 3 and 6 locations have the lowest training rates, at 84 per cent and 85 per cent respectively, followed by RRMA 7 locations, at 87 per cent. These rates are lower than the national training rate of 91 per cent;
- RRMA 5 locations have a 94 per cent training rate, likely due to the geographic proximity of such locations to regional centres, facilitating travel to training centres and the sourcing of a greater number of locums; and
- for emergency medicine practitioners, GPs in RRMA 3 locations have a 79 per cent training rate, which is below the national training rate of 85 per cent. RRMA 6 and 7 locations are slightly higher, both at 87 per cent.

<sup>7</sup> Note that this information is only available in an aggregated form, not by procedural and emergency medicine, and does not include information on RRMA 3 locations.

<sup>8</sup> RACGP has not registered any procedural GPs in a RRMA 2 location (RACGP 2008b p.3).

Table 3.2

**REGISTRANTS WHO PARTICIPATED IN TRAINING BY RRMA LOCATION — TO FEBRUARY 2008**

RRMA	Number of registrants	Number of registrants who attend training	Per cent who attend training (training rate)
<b>Procedural Component</b>			
RRMA 3	61	51	84%
RRMA 4	284	257	90%
RRMA 5	652	613	94%
RRMA 6	110	93	85%
RRMA 7	140	122	87%
Total	1247	1136	91%
<b>Emergency Medicine Component</b>			
RRMA 3	78	62	79%
RRMA 4	358	293	82%
RRMA 5	1030	873	85%
RRMA 6	135	118	87%
RRMA 7	254	222	87%
Total	1855	1568	85%

Source: ACRRM direct data request; RACGP 2008b p. 5 & 12.

In addition to analysing the accessibility of the Program by RRMA, Table 3.3 shows the percentage of registered procedural and emergency medicine GPs who have participated in training courses by jurisdiction. Table 3.3 shows that:

- procedural GPs from the Northern Territory have the lowest training rate in the Program, at 83 per cent. This is well below the average procedural training rate in all other states, and the national procedural training rate of 91 per cent. Victoria has the highest training rate at 94 per cent; and
- Tasmania, Northern Territory and Victoria have the lowest training rates for emergency medicine practitioners at 71 per cent, 75 per cent, and 81 per cent respectively — all below the national emergency training rate of 85 per cent. Queensland has the highest training rate at 88 per cent.

Table 3.3

**REGISTRANTS WHO PARTICIPATED IN TRAINING BY JURISDICTION — TO FEBRUARY 2008**

State	Number of registrants	Number of registrants who attend training	Per cent who attend training (training rate)
<b>Procedural Component</b>			
NSW	265	235	89%
NT	30	25	83%
QLD	231	214	93%
SA	182	168	92%
TAS	12	11	92%
VIC	280	264	94%
WA	247	219	89%
Total	1247	1136	91%
<b>Emergency Medicine Component</b>			
NSW	414	357	86%
NT	56	42	75%
QLD	319	281	88%
SA	356	303	85%
TAS	35	25	71%
VIC	365	295	81%
WA	310	265	85%
Total	1855	1568	85%

Source: ACRRM direct data request; RACGP 2008b p. 5 & 12.

**Key finding 9: equal access**

*The majority of GPs in RRMA 7 locations register with the Program (89 per cent). The lowest registrations (around 64 per cent) are in RRMA 6 and 4 locations.*

*However, for those procedural GPs who go on to participate in the Program, GPs in RRMA 3, 6 and 7 locations have the lowest training rate at between 84 and 87 per cent, below the average of 91 per cent. Procedural GPs in RRMA 5 locations have a 94 per cent training rate.*

*The training rates drop across all RRMA locations for the emergency component, with an average training rate of 85 per cent. GPs in RRMA 3 locations had the lowest training rate at 79 per cent.*

*For the procedural component, Victoria has a 94 per cent training rate, closely followed by Queensland, Tasmania and South Australia, all above 92 per cent. Northern Territory has the lowest procedural training rate (83 per cent). The training rates drop across all jurisdictions for the emergency component. Tasmania has the lowest emergency medicine training rate at 71 per cent, followed by the Northern Territory at 75 per cent.*

***Is the training grant suitable to the needs of GPs?***

Determining whether the size and length of the grant addresses the needs of rural and remote GPs is an indicator of the appropriateness of the grant, and in turn, the Program.

In terms of the *size of the training grant*, the Colleges report the number of GPs utilising the maximum available financial grant. As shown in Table 3.4, only a small proportion of registered GPs have utilised the maximum grant available through the Program, however this varies across Program components. Around 17 per cent of eligible GPs registered with ACCRM utilise the maximum grant, whereas around 13 per cent of procedural GPs registered with RACGP do so.

The proportion of GPs who utilise the maximum grant is substantially higher for emergency medicine GPs registered with ACCRM, although no data is currently available for GPs registered with RACGP. Nevertheless, in 2005-06 52 per cent of GPs registered with ACCRM used the maximum grant, with 26 per cent doing so in 2006-07. This result is expected given that the maximum grant for emergency medicine practitioners is significantly less than the grant for procedural GPs (\$3000 per year compared to \$20 000 per year).

Table 3.4

**REGISTERED GPs ACCESSING MAXIMUM GRANT PER FINANCIAL YEAR**

	2004-05	2005-06	2006-07	Average grant
ACRRM — procedural GPs	18%	16%	17%	\$4023
RACGP — procedural GPs	12%	11%	11%	\$3584
ACRRM — emergency medicine practitioner	—	52%	26%	\$2575

Source: ACRRM 2008b; RACGP 2008. Note: Data on RACGP emergency medicine practitioners is currently unavailable.

Given such a low proportion of GPs have been accessing the maximum grant, some stakeholders noted that the size of the grant should not be increased until the overall maximum utilisation is increased. One stakeholder also commented that the maximum financial grant is too high. However, the level of maximum financial grant utilisation is not the only indicator of the appropriateness of the grant. A significant proportion of procedural GPs do not utilise the maximum financial grant due to a number of barriers, including the availability of locums and geographic hurdles (discussed in greater detail in section 3.3).

Survey respondents identified that the financial viability of training that stemmed from the Program was a key strength. For example:

- the most identified strength of the Program (33 per cent) of RACGP survey respondents was ‘making professional development financially viable’ (RACGP 2008c p. 9); and
- 38 per cent of ACCRM respondents also noted this financial incentive as a major strength of the Program (ACCRM 2008a p. 6).

A number of stakeholders, including the Colleges, identified that a reduction in the size of the training grant would undermine this key strength.

In addition, a small number of stakeholders raised the fact that, although a small group within the Program, multi-procedural GPs require more time and financial support in order to cover all of their specialities.

The issue of an increase in the cost of training courses was also raised. Anecdotal evidence voiced by stakeholders suggested that the cost of training courses had increased in line with increases in the size financial grant. As discussed in Chapter 1, the grant for the procedural component in RRMA 2 to 7 locations is calculated at \$2000 per day for a maximum of ten days training. This grant increased from \$1500 per day from 1 April 2007.

In terms of the *length of the training grants* stakeholders noted in consultations that the GP Professional Development Program and the Maintenance of Professional Standards — which GPs are required to complete to maintain their accreditation — are based on a three-year cycle, or triennium. The one-year timeframe of the Program therefore does not reflect the timeframe over which GPs plan and undertake their training.

Stakeholders suggested that moving to a three-year period would provide GPs with more flexibility as to when they undertake their training. Such a move would also enable GPs to access those training programs that are offered infrequently (once a year in some cases). However, the Australia Government Budget process requires all grant funding to be undertaken and distributed in each financial year. There are currently no DoHA grant programs with a funding structure longer than one year. This is an external impediment to the operation of the Program and would require significant government-wide change to accommodate.

#### **Key finding 10: a suitable training grant**

*A small proportion of GPs utilise the maximum grant available (between 11 per cent and 26 per cent).*

*Survey respondents identified that one of the key strengths of the Program was that it made professional development financially viable. Stakeholders commented that reducing the size of the grant would undermine this strength.*

*Stakeholders identified that moving to a three-year period would provide GPs with more flexibility as to when they undertake their training. However, Budget processes require all grant funding to be distributed in each financial year.*

#### ***Is the Program useful?***

The Program's usefulness is demonstrated by relatively high levels of participation in training activities by GPs registered in the Program, as discussed in Chapter 2.

RACGP survey respondents gave two main reasons for participating in the Program:

- the most identified reason for participation in the Program (43 per cent) was to maintain and update their skills and knowledge; and

- the second most identified reason for participation in the Program (32 per cent) was to obtain financial support for upskilling (RACGP 2008c p. 4).

One indicator of the usefulness of this Program is the number of times GPs return to the Program and attend training courses. In 2006-07:

- 31 per cent of all GPs attended one training course over the year;
- 22 per cent attended two training courses;
- an additional 20 per cent attended between 3 and 5 training courses; and
- 6 per cent attended more than 6 training courses in the one financial year.

This result shows that a significant number of GPs have a general willingness to continue participating in the Program, with 48 per cent of all participating GPs attending 2 or more training programs in 2006-07.<sup>9</sup>

#### **Key finding 11: usefulness**

*Overall, GPs find the Program useful. 48 per cent of GPs have attended more than one training course, indicating a willingness to continue participating in the Program.*

#### **Are there exclusions to the Program that should be included?**

The extent of any exclusions to the Program is criteria to assess appropriateness because it highlights areas where the Program could better meet the needs of GPs in rural and remote areas.

The Colleges raised several discrete specialties of medicine, which are not currently included as part of the Program. These specialty areas include, but are not limited to:

- *Indigenous health* — including comprehensive primary health care services, as well as specific areas including alcohol and substances abuse, sexual health, social and emotional health, and an understanding of population health, illness prevention, early intervention and effective disease management;
- *Mental health* — including early intervention, assessment, and management of patients with mental illness, as well as providing referral pathways to clinical psychologist and allied mental health service providers; and
- *Child health* — including comprehensive primary health care, as well as general childhood illnesses and age-related and developmental conditions.

The viability of expanding the Program to include at least one of these specialty areas was discussed in a number of consultations, including consultations with the Colleges. If any of these specialties were to be included in the Program in the future they would likely manifest as a third component, in the same way as emergency medicine was incorporated as the second component.

<sup>9</sup> Information was unavailable for the remaining 20 per cent of GPs.

In addition, distance education training courses are currently not offered by the Program. Such training courses would be useful to all participating GPs (but especially for GPs in RRMA 6 and 7 locations) for two reasons. GPs would save on travel time and expenses, and they would avoid the difficulty of sourcing a replacement locum. Most importantly, such distance education would enable more rural and remote GPs to increase their participation in training courses.

#### **Key finding 12: Program exclusions**

*A number of specialist areas are not currently covered by the Program, including Indigenous health, mental health and child health.*

*Another specific program exclusion is the eligibility of distance education training courses, which would be especially useful for GPs practicing in remote locations given the cost of travel and availability of locums.*

### **3.3 Barriers**

This section considers the barriers of the Program that impact on the number of procedural GPs and emergency medicine practitioners that participate in training courses. The major barriers of the Program are:

- availability of course information;
- waiting lists;
- availability of locum GPs; and
- geographic constraints for GPs.

Two of these barriers are due to situations external to the Program — waiting lists and the availability of locum GPs. Each of these barriers is discussed in greater detail below.

#### ***Availability of course information***

One barrier to participation for procedural GPs and emergency medicine practitioners is the extent of available course information. Although both Colleges publish a list of their accredited courses on their websites, there is currently no central database that GPs can access, listing courses from a range of providers that can be funded through the Program. This lack of information hinders the GPs' ability to utilise training grants fully. Stakeholders discussed this lack of information during consultations. This concern was mirrored in survey responses. For example, GPs stated they would like 'more promotion of appropriate courses that are available nationwide so we can plan ahead' and 'greater clarity in what constitutes a training exercise and how many days training that is equivalent to' (RACGP 2008c p. 36 -37).

Furthermore, stakeholders noted that there was minimal information on the existence and availability of clinical attachments. One procedural GP commented that 'doctors currently approach hospitals on an ad hoc basis [to access a clinical attachment]'

**Key finding 13: availability of course information**

*Registered GPs find it difficult to access course information, including what their training options are, and what courses are available at any one time (including formal training and clinical attachments).*

*Both Colleges publish information relating to the Programs they run and accredit, however there is no central information source or compilation of relevant training options.*

**Waiting lists**

Surveyed stakeholders also commented that there are waiting lists for some courses. The Collaboration stated that the length of waiting lists for some emergency medicine courses can be up to 12 months.

GPs stress the difficulty of waiting lists and securing a place in training courses. Of all RACGP survey responses, 37 per cent indicated that ‘difficulty getting into courses and clinical attachments’ was the greatest barrier to participating in the Program (RACGP 2008c p. 13).

**Key finding 14: waiting lists**

*Although not under the Program’s responsibility, surveyed GPs identified extensive waiting lists for some courses that prevented their participation in the Program.*

**Availability of Locums**

The availability and cost of locums is a significant barrier for both procedural and emergency medicine components of the Program. GPs who wish to participate in the Program are obliged to book a locum well in advance or forgo participation in the Program. As one stakeholder commented,

Locums are a big issue. If a GP participates in the Program, they’re looking for a replacement locum with a whole range of skills carried by that GP; for example, they need to be hospital accredited.

Locum costs vary, but are increased in more rural and remote locations. Often the daily cost of a locum is more than the salary of the GP being replaced. For example, the cost of a locum for one week starts from around \$4500 plus accommodation and travel expenses. One stakeholder noted ‘the costs of locums have gone through the roof, they often cost more than the principals themselves earn’.

Locum constraints are particularly prevalent in more rural and remote locations, imposing a barrier on the more rural and remote practitioners — the demographic the Program aims to cater for. One procedural GP commented ‘we have ten days, but we can’t access ten days because we can’t get someone to cover us’.

GPs in RRMA locations 6 and 7 find it is easier to source a locum for an extended period of time, such as a month, than for a shorter periods (it is especially difficult to source locums in these locations for less than one week).

However, as discussed in consultation with the Colleges, locums are increasingly participating in the Program. Locums are eligible to participate if they complete a minimum of 8 rural or remote locum placements or a total of 28 days in rural and remote locations. Approximately 110 locums have completed training through the Program over the last two years.

**Key finding 15: availability of locums**

*Although not under the Program's responsibility, the difficulty of sourcing a locum for a short period of time, and the expense of a locum, are the primary barriers for rural and remote registered GPs to participate in the Program.*

**Geographic constraints**

A final major barrier to participation for GPs is geographic location. One of the main eligibility requirements for the Program is based upon RRMA locations, as discussed in Chapter 1. However, strict adherence to RRMA classifications is a barrier to entering the Program for those GPs in rural and remote locations that fall outside this classification system. For example:

- GPs conduct procedural and emergency work at the health service centre on North Stradbroke Island, Queensland, but are ineligible for the Program because their location is classified as a RRMA 1 because of its close proximity to the Gold Coast; and
- Palm Island, Queensland, is classified as a RRMA 2 location, and so GPs that provided procedural health services may be eligible for the grant. However, GPs in the area are currently providing emergency medicine in a rural setting, yet are not eligible for an emergency medicine grant given their RRMA 2 location (information provided by RACGP).

In addition, the GPs in RRMA 6 and 7 locations find it particularly difficult to secure time to participate in training courses. As discussed in Section 3.2, there are different training rates for both procedural GPs and emergency medicine practitioners by jurisdiction and RRMA location, with training rates in RRMA 6 and 7 for procedural GPs well below the national average (80 per cent and 84 per cent compared to 92 per cent, see Table 3.2).

One reason for this is the length of travel time from RRMA 6 and 7 locations to a regional centre for training and the associated cost of that travel. For example, a regional return flight from Armidale (RRMA 4) to Dubbo costs approximately \$500 and could be undertaken in one day. In contrast, travel from the Streaky Bay (RRMA 7) is difficult and time consuming. Streaky Bay is approximately 730 kilometres from Adelaide — a nine-hour drive. Although Streaky Bay has an airport, there are no regular commercial flights. The nearest airport is located approximately 60 kilometres away in Ceduna. A Regional Air Express return flight from Ceduna to Adelaide costs approximately \$300; however return flights are not available everyday.

One stakeholder summarised the barriers facing the most remote rural and remote GPs, stating 'the more remote you are, the higher the compensation required'. The current grant arrangements do not consider the additional costs for GPs in RRMA 6 and 7 locations to participate in the Program. An increased grant for GPs in RRMA 6 and 7 locations to address this additional cost could be one option to alleviate this issue.

**Key finding 16: geographic constraints**

*Procedural GPs in RRMA 6 and 7 have training rates lower than the national average. One reason for this is the length of travel time from these locations to a regional centre for training and the associated cost of travel.*

### 3.4 Consequences

This section outlines the consequences (both positive and negative) of the Program for GPs and the communities in which they practice. Overall, feedback on the benefits of the Program is positive. One stakeholder stressed ‘anything that supports the GPs who continue to deliver procedural services in pressed circumstances with heavy workloads is a significant benefit to the community’.

The first positive consequence of the Program is that it provides rural and remote GPs with an opportunity to maintain their skills, develop their skills, and learn new skills. These three opportunities facilitate the retention of GPs in rural and remote locations. Retention of the rural health workforce is a key long-term element of the Australian Government’s national health strategy and the key objective of the Program.

Furthermore, the Program provides flexible support to rural and remote GPs, and as such further aids the retention of medical practitioners in these locations. There are a wide variety of courses on offer, including workshops, conferences and clinical attachments, held in different locations at different times through out the year. For example, 63 per cent of ACCRM survey responses indicated that the Program has a ‘positive’ influence on their intention to continue to practice in rural remote and remote regions. (ACCRM 2008a p. 16), with 56 per cent of RACGP respondents indicating the same (RACGP 2008c p. 6).

In addition to these major Program benefits, there are a number of other benefits that stem from the Program, including:

- building the confidence of GPs, allowing them to perform their work with confidence and address situation that arise infrequently in their health services; and
- enhancing the quality of the workforce and provision of medical services in rural and remote locations.

However, all of these benefits need to be considered as part of a broader set of Australian Government initiatives that aim to address the retention of GPs in rural and remote areas of Australia. It is important to note that the objective of the Program is to assist in the maintenance of skills in rural and remote area and not to increasing the willingness of GPs to transfer to rural and remote locations for work.

In contrast, there were few negative consequences of the Program. Typically, stakeholders thought there were no significant disadvantages to the continued operation of the Program.

#### **Key finding 17: consequences of the Program**

*Overall, the consequences of the Program are positive. The Program supports GPs to maintain and improve their skills. This supports and encourages the retention of rural and remote GPs and enhances the quality of the medical workforce and the provision of health services in rural and remote locations.*

## Chapter 4

# Conclusions

The previous two Chapters detail the four major components of the evaluation of the Program:

- assessing the effectiveness of the Program in maximising the potential of rural and remote procedural GPs (and emergency practitioners) to maintain their skills;
- assessing the appropriateness and efficiency of the Program;
- measuring the extent to which the Program's goals and objective have been achieved; and
- identifying the consequences (both positive and negative) of the Program.

This Chapter considers the key findings from the assessment of the Program and highlights suggestions for improvements to the Program in the short and long term.

Firstly, this evaluation considered the *effectiveness* of the Program in maximising the potential of rural and remote procedural GPs (and emergency practitioners) to maintain their skills. The Program is broadly effective at achieving this objective:

- *majority of eligible GPs do participate in the Program* — in 2006-07, around 70 per cent of those GPs eligible to participate in the Program do so with a high proportion (92 per cent) of registered GPs using the Program to support approved training activities;
- *GPs are aware of the Program and understand how it works* — the high level of registrations and the views of stakeholders suggest that the Program is one of the most visible and well known in the rural health sector;
- *Program is easy to use* — specific strengths of the Program include the relatively low level of administration required by GPs to receive the grant and the assistance available from the Colleges to guide GPs through the Program;
- *training courses meet the Program objectives* — the types of training courses that have been accessed through the Program are in accordance with the Program objective. The most frequently accessed procedural training courses are for obstetrics (50 per cent) and anaesthetics (43 per cent). The majority of procedural training is undertaken through formal training (77 per cent). Formal training is the preferred delivery mode for emergency medicine training undertaken as part of the Program (72 per cent); and
- *training courses undertaken aid skill development* — between 70 and 80 per cent of procedural GPs surveyed identified that training provided under the Program assisted in maintaining their knowledge and skills to a great extent. Furthermore, around 53 per cent of all GPs surveyed believed that training had increased their knowledge and skills to a great extent.

These impacts show that the Program assists with the provision of quality procedural and emergency skills in rural and remote communities.

Secondly, this evaluation considered the *efficiency* of the Program. The Program is broadly efficient, in that:

- *administrative costs of the Program are relatively efficient* — given the total grants disbursed. The funds paid to Colleges to administer the Program, while increasing in absolute terms, have declined as a proportion of total grants disbursed over recent years to 4.1 per cent in 2006-07; and
- *grant payments are made in a timely manner* — all GPs received their grant payments within 2 to 6 weeks of submitting their claim form to one of the Colleges.

However, *some aspects of the management process are inefficient* — although the agencies involved in the management of the Program have a clear understanding of the role of each agency, some inefficiencies were identified in the management process, including:

- duplication and inconsistency in the data collected; and
- general agreement among stakeholders that the College's reporting requirements to DoHA could be streamlined.

It is important to note that the inefficiencies in the current model can be addressed directly, rather than by implementing a new management structure. On that basis, DoHA could implement some changes to the administration of the Program to improve efficiency in the future. These suggestions are outlined below.

#### **Suggestion for improvement 1: revise reporting requirements**

*DoHA could revise reporting requirements for the Colleges. DoHA could retain the number of reports required in each financial year — one data report and two progress reports — however, the extent of data required in the data reports could be streamlined to only include the information that DoHA will find useful to monitor the Program and make Program policy decisions.*

#### **Suggestion for improvement 2: create a central registration database**

*DoHA could commission a central database of registered GPs for the Program. This database would remove any double counting of registered GPs across the two Colleges and would assist in clearing up any confusion for GPs as to where they should apply for a grant. This database could be created and managed by the Secretariat of the Collaboration within current funding (if reporting requirements are reduced). Registration and claims for the Program could be made through a dedicated website that would feed into the central database.*

Thirdly, this evaluation discussed the *appropriateness* of the Program. *GPs find the Program to be useful* — 48 per cent of participating GPs attended more than one course in 2006-07, indicating a willingness to continue participating in the Program. However, there are some areas where the Program could better meet the needs of GPs in rural and remote locations, including:

- *there are areas of Australia where access to the Program is not equitable* — while a very high proportion of GPs in RRMA 7 locations register with the Program (89 per cent), in terms of those GPs who go on to participate in the Program, GPs in RRMA 3, 6 and 7 locations have the lowest training rates — well under the national average. In terms of jurisdictions, the Northern Territory and Tasmania have the lowest procedural and emergency training rates respectively;
- *the training grant could be better suited to GPs* — only a small proportion of GPs utilise the maximum allocation financial grant (11 per cent for procedural grants and 26 per cent for emergency medicine grants). Stakeholders identified that moving to a three year timeframe for training would provide GPs with more flexibility on when they undertake training. However, the Australia Government Budget process requires all grant funding to be undertaken and distributed in each financial year, an external impediment to the operation of the Program and would require significant government-wide change to accommodate; and
- *there are some current exclusions to the Program that could be included* — stakeholders identified a number of specialties that are not currently included in the program, including Indigenous health, mental health and child health. In addition, a number of stakeholders identified that distance education was not currently included in the Program, but would be especially useful for GPs practicing in remote locations.

To improve the appropriateness of the Program in the future, DoHA could implement some changes to the structure of the Program. These suggestions are outlined below.

#### **Suggestion for improvement 3: include Indigenous, mental and child health**

*DoHA could review the eligible disciplines included in the Program if the future funding environment allows capacity in the Program. New disciplines, including Indigenous health, mental health and child health could be included in a similar format to the emergency medicine component.*

#### **Suggestion for improvement 4: include distance education as training**

*DoHA could include distance education as an option for GPs in all rural and remote areas (in particular, RRMA 6 and 7 locations). This will help to alleviate travel and cost concerns from these locations and may improve participation in the Program.*

Associated with the appropriateness of the Program are the *barriers* that impact on the success of the Program. There are three major barriers to the Program:

- *availability of course information* — registered GPs find it difficult to access course information, including what their training options are, and what courses are available at any one time. Both Colleges publish information relating to the courses they run and accredit, however there is no central information source or compilation of relevant training options;
- *waiting lists* — although not under the Program's responsibility, surveyed GPs identified extensive waiting lists for some courses that prevented their participation in the Program;

- *availability of locum GPs* — although not under the Program’s responsibility, the difficulty of sourcing a locum for a short period of time, and the expense of a locum, are the primary barriers for rural and remote registered GPs from participating in the Program; and
- *geographic constraints for GPs* — GPs in RRMA 6 and 7 locations have training rates lower than the national average. One reason for this is the length of travel time from these locations to a regional centre for training and the associated cost of travel.

Although, the availability of locums is a factor external to the Program itself, there are some other options that DoHA could consider to reduce, to some degree, the barriers that impact on the success of the Program. These suggestions are outlined below.

#### **Suggestion for improvement 5: a database of approved courses**

*DoHA could commission a database of previous courses that have been approved by the Colleges. This will help GPs understand which training courses they could undertake and could include links to contacts that can help them enrol in courses. This database could be managed by the Secretariat of the Collaboration within current funding (if reporting requirements are reduced). As part of this database, a list of hospitals and specialists that have previously agreed to a clinical attachment could be included to increase the awareness of potential clinical attachments.*

*This additional information could be made available to GPs through a dedicated website, where other program information could also be made available.*

#### **Suggestion for improvement 6: increase the level of the grant for GPs in RRMA 6 and 7 locations**

*DoHA could revise the maximum grant for GPs in RRMA 6 and 7 locations to include a set rate for travel per day (in addition to the maximum grant). This additional grant for GPs in the most remote locations will assist with additional travel expenses that they incur and allow for the maximum base grant to be utilised for training purposes. This increase in the level of the grant could be absorbed within current funding given the current program underspend.*

Finally, this evaluation identified the *consequences* of the Program. Overall, the consequences of the Program are positive. The Program supports GPs to maintain and improve their skills. This supports and encourages the retention of rural and remote GPs and enhances the quality of the medical workforce and the provision of health services in rural and remote locations.

*Appendix A*  
Discussion guide

## *Section A*

# Project overview and context

### **Introduction**

The Allen Consulting Group has been engaged by the Department of Health and Ageing (DoHA) to undertake an evaluation of the Training for Rural and Remote Procedural General Practitioners (TRRPGP) Program.

This document provides guidance for those consultations undertaken as part of the review of this program. Section A outlines the objectives and context for the review, while Section B sets out those questions being asked of stakeholders.

### **Project overview**

The main objectives of this evaluation of the TRRPGP Program are to:

- assess the effectiveness of the TRRPGP Program in maximising the potential of procedural GPs to maintain their skills;
- assess the appropriateness and efficiency of the program;
- measure the extent to which the program's goals and objectives have been achieved; and
- identify the consequences (both positive and negative) of the program.

Assessing the TRRPGP Program in this way will assist the DoHA to determine whether the program is meeting its objectives and how it can be improved to further enhance the training of procedural General Practitioners (GPs) in rural and remote areas of Australia.

### **Project context**

Rural and remote communities rely upon procedural GPs to provide surgical, anesthetic, obstetric and emergency services, which are normally provided by specialists or emergency professionals in urban areas of Australia.

The \$75 million TRRPGP Program was introduced in 2003-04. This program aims to support GPs in rural and remote areas to access a grant to attend relevant training, upskilling and skills maintenance activities (Department of Health and Ageing 2007). Support is provided through a grant payment, which is designed to assist with the cost of attending training, including course costs, locum relief and travel expenses. The TRRPGP Program was extended in 2005 to include GPs practicing emergency medicine.

The TRRPGP Program caters for medical professionals operating outside urban areas, generally with a population less than 100 000. The TRRPGP Program has two components. It provides support for:

- procedural GPs practicing in surgery, anaesthetics, and obstetrics in Rural, RRMA 2 to 7<sup>1</sup>
- GPs practicing emergency medicine in RRMA 3 to 7 (Royal Australian College of General Practitioners National Rural Faculty 2007).

### **Application process**

To receive grants under the TRRPGP Program, GPs are required to register with either the ACRRM or the RACGP, also referred to as Colleges. The Colleges assess an applicant's eligibility to participate in the program, notify Medicare Australia of successful applications, and the College to which an application was addressed advises the applicant of the success or failure of their application.

Upon completion of eligible training by the GP, the ACRRM or the RACGP notify Medicare Australia, who processes the grant payment.

The value of grant payments and the frequency with which GPs are eligible to access them vary between those procedural GPs practicing in surgery, anaesthetics and obstetrics in RRMA 2 to 7, and for GPs practicing emergency medicine in RRMA 3 to 7 (Medicare Australia 2007).

### **Project approach**

Several stakeholder groups are being consulted on a range of issues pertinent to this evaluation. These stakeholders include:

- DoHA representatives from the Rural Workforce Programs section
- the TRRPGP Collaboration
- ACRRM
- RACGP
- Medicare Australia
- RDAA
- a sample of rural and remote procedural GPs.

Information gathered from stakeholder consultations will be supplemented by data analysis and desktop research to inform this review.

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<sup>1</sup> Procedural GPs in RRMA 2 localities are subject to specific eligibility criteria. For example, GPs providing services in rural and remote areas but residing primarily in urban areas, including locums and doctors from the Royal Flying Doctors Service may also be eligible to apply for a grant.

## *Section B*

### **Discussion questions (TRRPGP Collaboration)**

#### ***Effectiveness***

1. Is the program well known, understood and easy to apply for?
2. What are the barriers to accessing the program (e.g. availability of locums)?

#### ***Appropriateness***

3. Does the program target all rural and remote procedural GPs and GPs practicing emergency medicine? Are there are exclusions? And why?
4. Is the grant sufficient? What if it were reduced?
5. Is the training time long enough?
6. Are the grant payments timely?

#### ***Efficiency***

7. Is the program administratively efficient for ACRRM, RACGP, DoHA and Medicare Australia (e.g. are their roles clear and appropriate, and the processes efficient)?
8. How much funding is spent on grant payments and how much is spent on the administration of the program? Is this balance cost-effective?

#### ***Consequences***

9. What are the broader consequences of the program for the health care system, especially the recruitment and retention of procedural GPs to rural and remote areas?

#### ***Other matters***

10. Is there information available on the number of Procedural GPs in rural and remote areas of Australia (include those that are part of the TRRPGP Program and those that are not)?
11. Can ACRRM and RACGP provide access to recent Procedural GP surveys? In what form is this information?
12. What type of information was sought through these surveys?
13. Given the information sources from the Procedural GP survey what form of consultation with Procedural GPs as part of this project would be most appropriate (e.g. a short online survey or telephone focus groups, other options)?

## *Section B*

### Discussion questions (all other stakeholders)

#### **Effectiveness**

1. Who has accessed the training grant: numbers, characteristics (age, gender, location)?
2. What proportion is this of the target group?
3. What types of training programs have been undertaken?
4. Have there been any specific trends over the life of the program (e.g. use of the program by a particular group or rural location)?
5. Is the program well known, understood and easy to apply for?
6. What are the barriers to accessing the program (e.g., availability of locums)?

#### **Appropriateness**

7. Is the training relevant and useful?
8. Is the training time long enough?
9. Is the grant sufficient? What if it were reduced?
10. Are grant payments timely?
11. Does the program target all rural and remote procedural GPs and GPs practicing emergency medicine? Are there are exclusions? And why?

#### **Efficiency**

12. Is the program administratively efficient for ACRRM, RACGP, DoHA and Medicare Australia? (e.g. are their roles clear and appropriate, and the processes efficient?)
13. How much funding is spent on grant payments and how much is spent on the administration of the program? Is this balance cost-effective?
14. Are the training grants good value for money? (i.e. do grants maximise the amount of training that GPs receive?)

#### **Consequences**

15. What are the benefits and/or disadvantages of the program for procedural GPs, their patients and the communities in which they live?
16. What is the impact of administration of the program on ACRRM, RACGP and the DoHA?
17. What are the broader consequences of the program for the health care system, especially the recruitment and retention of procedural GPs to rural and remote areas?

18. To what extent are program benefits offset by costs elsewhere?
19. How far do the benefits of the program replace other benefits? (i.e. to what extent does the program substitute for benefits which would otherwise have occurred)

***Opportunities for improvement***

20. Could the program objectives be better achieved through alternative means?
21. Is the TRRPGP Program effective? How could the effectiveness of the program be improved?
22. Does the efficiency of the program need to be improved? If so, how could the efficiency of the program be improved?

***Other matters***

23. What data do you collect on the TRRPGP Program?
24. Could this data be available to us for use in the program review?

## *Appendix B*

# Stakeholder Consultation

Those stakeholders consulted to inform this evaluation are identified in Table B.1 below.

Table B.1

**STAKEHOLDERS CONSULTED**

Representative	Organisation
Mr Barny Lee	Department of Health and Ageing (DoHA)
Ms Fiona Mommsen	DoHA
Ms Sally Robinson	DoHA
Ms Lauren O'Connor	Medicare Australia
Dr Bruce Chater	Australian College of Rural and Remote Medicine (ACRRM)
Ms Marita Cowie	ACRRM
Ms Helen Crew	ACRRM
Ms Di Wyatt	ACRRM
Mr Richard Lawrance	Royal Australian College of General Practitioners (RACGP)
Ms Pauline Curtis	RACGP
Mr Steve Sant	Rural Doctors Association of Australia (RDAA)
<b>TRRPGP Collaboration</b>	
Dr Bruce Chater	ACRRM
Dr Chris Mitchell	RACGP
Dr Geoffrey Thomas	ACRRM
Dr Stephen Holmes (by phone)	ACRRM
Dr John Quayle	ACRRM
Ms Pauline Curtis	RACGP
Ms Di Schaefer	RACGP
Ms Marita Cowie	ACRRM

Note: Consultations were undertaken over the period 10 March 2008 to 28 March 2008.

## Appendix C

### References

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