



Australian Government Department of Health and Aged Care

Streamlining and expanding procedural programs to improve rural health

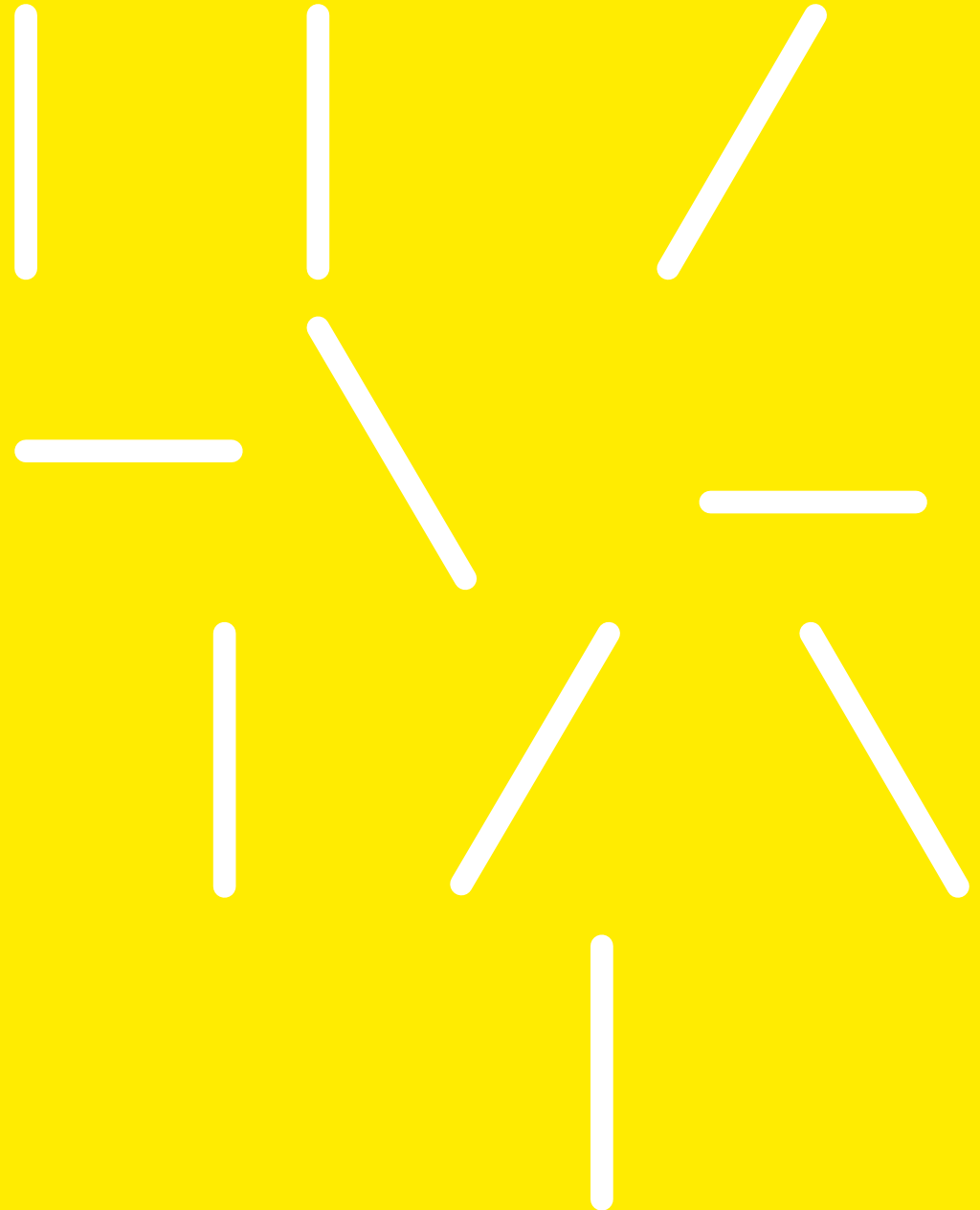
Consultation and design process to streamline and expand the Rural Procedural Grants Program and the Practice Incentives Program procedural GP payment

in association with



FINAL REPORT

26 April 2022





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by helping create better health services

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ABBREVIATIONS

ABBREVIATION	DEFINITION
ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AMC	Australian Medical Council
ARST	Advanced Rural Skills Training
AST	Advanced Specialised Training
CPD	Continuing Professional Development
Department, the	Australian Government Department of Health
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FARGP	Fellowship in Advanced Rural General Practice
GP	General Practitioner
GPPTSP	General Practitioner Procedural Training Support Program
HMA	Healthcare Management Advisors
KBC	Kristine Battye Consulting
MBA	Medical Board of Australia
MBS	Medical Benefits Schedule

ABBREVIATION	DEFINITION
MMM/MM	Modified Monash Model
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australian College of Physicians
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RFDS	Royal Flying Doctor Service
RPGP	Rural Procedural Grants Program
RPL	Recognition of prior learning
RRMA	Rural, Remote and Metropolitan Area
SMO	Senior Medical Officer
VR GP	Vocationally registered GP
WIP	Workforce incentive payment

EXECUTIVE SUMMARY

BACKGROUND AND CONTEXT

As part of the 2021–22 Budget, the Australian Government announced a consultation and design process to explore options for the expansion and streamlining of the Rural Procedural Grants Program (RPGP) and the Practice Incentives Program (PIP) Procedural GP Payments. Budget-related commentary on the process was included as part of expenditure announced for the Rural Health Strategy, which stated there was an allocation of:

‘\$0.3 million to develop a new model and streamline the Rural Procedural Grants Program and the Practice Incentives Program procedural GP payments into a new rural generalist GP support program for GPs with advanced skills (Department of Health, 2021)’

Healthcare Management Advisors (HMA) and Kristine Battye Consulting (KBC) were engaged to conduct the consultation and design process for a streamlined and enhanced program. This is the final report of that project, which explored the inclusion and prioritisation of a broader range of advanced skills in alignment with the National Rural Generalist Taskforce’s Advice to the National Rural Health Commissioner¹. The Taskforce’s Advice included recommendations around recognition of and support for advanced skills beyond procedural (obstetrics, surgery and anaesthetics) and emergency activities.

The project examined the scope for a broader range of advanced skills involving non-procedural clinical care such as mental health, paediatrics, palliative care, and Aboriginal and Torres Strait Islander health.

¹ National Rural Generalist Taskforce, Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway December 2018

The General Practice Training and Support Program (GPPTSP) was also considered for alignment with the RPGP and PIP Procedural GP Payment.

OBJECTIVES AND PROCESS

The project aimed to inform the Australian Government Department of Health (the Department) on how to incorporate the objectives of the existing programs and combine the most efficient and effective features of the two into a single administrative model, while also incorporating non-procedural advanced skills into the overall operations of the program.

This project comprised only the consultation and design process of the streamlined and enhanced program. Newly designed program arrangements – once the design principles are agreed, resourced and implemented – will see additional Rural Generalists and other rural GPs with a broader range of agreed advanced skills being better supported, resulting in improved access to specialised healthcare for rural communities. This project also considered the scope for rule changes that would enhance the program experience for participants.

The process for the project included:

- Desktop analysis of existing program documentation, administrative data on program activity, and policy and reports relevant to the design process (e.g. the National Rural Generalist Taskforce Advice)
- A range of consultation processes including:
 - peak and professional body feedback on two discussion papers
 - interviews with a small sample of GPs, consisting of:
 - (i) GPs in rural and remote areas accessing the existing RPGP, or

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- (ii) GPs who could be newly considered for eligibility based on their advanced skills in a range of potential in-scope areas (e.g. Aboriginal and Torres Strait Islander health).
 - Discussions with relevant internal stakeholders within the Department from Health Workforce and Primary Care Divisions, and
 - Extensive dialogue with staff from the two GP colleges contracted to administer the RPGP – Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP).

DESIGN CONSIDERATIONS

There were several design features and issues considered as part of the consultation process for the potential expansion and streamlining of the RPGP and PIP Procedural GP Payment.

Key design features for the RPGP consulted on included:

- Threshold qualifications for additional non-procedural advanced skill areas (i.e. advanced skills training recognised by GP colleges, and/or equivalent training and experience)
- Priorities and stakeholder preferences for inclusion of individual advanced skills verses a broader approach
- Requirements for nature of health service delivery (i.e. hospital, emergency and community-based service delivery).

Additional considerations for the RPGP included:

- Equity of access to continuing professional development (CPD)
 - for procedural and non-procedural advanced skills maintenance, and
 - between different employment models (e.g. Senior Medical Officers in Queensland, Royal Flying Doctors Service (RFDS), etc.)
- Additional loading for remote and very remote areas

- Banking or borrowing of incentives to support longer clinical placements or courses.

Key design considerations for the PIP Procedural GP Payment included:

- Appropriateness of the payment to incentivise GPs with non-procedural advanced skills
- Defining service delivery requirements for non-procedural advanced skills, and
- Appropriateness of expansion of the incentive.

A key consideration for the GPPTSP was its role as another mechanism for maintenance of skills and/or service delivery and whether it could be more directly linked to the RPGP and the PIP Procedural GP Payment.

Considerations for streamlining of the programs included:

- Appropriateness of streamlining programs with different purposes, and payment structures, and
- Impact of administrative streamlining on GP access to incentive payments and changes to program management processes that would be required.

SUMMARY OF EXPANSION AND STREAMLINING OPTIONS

The outcomes of the consultation process informed the specification of a range of expansion and streamlining options. A summary of these options is presented in Table ES1.

The costs of these options were estimated based on data gathered from the Department and GP colleges and workforce statistics. Estimates of the expansion costs needed to consider:

- the threshold qualification of advanced skills training likely to be recognised by one of the GP colleges
- an additional non-procedural component of the RPGP with equivalent funding to the current procedural component, and
- claim rates for current programs.

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An assessment of these options was undertaken against six evaluative criteria:

- Greater equity of access for rural and remote patients to advanced level care
- Greater incentive for GPs to undertake advanced skill CPD
- Greater incentive for GPs to deliver advanced skill care
- Administrative simplicity
- Promotion of the Rural Generalist, and

- Budgetary impact.

An overview of the options is presented in Table ES1, including a description, benefits and challenges, combined assessment score against the evaluation criteria for each option. Further detail on these options, is presented in Chapter 5.

Table ES1. Summary of expansion and streamlining options

DESIGN OPTION	DESCRIPTION	KEY BENEFITS AND CHALLENGES	ASSESSMENT SCORE ^(a)
A. RGP expansion options			
A1a. Narrow expansion	Addition of Aboriginal and Torres Strait Islander health and mental health	High priority advanced skills areas Limited expansion may have limited impact on access to services	1
A1b. Moderate expansion	Addition of Aboriginal and Torres Strait Islander health, mental health, paediatrics and palliative care	High priority advanced skills areas with broader community reach than A1a Challenges in appropriately defining nature of health service engagement for non-procedural areas	3
A1c. Broader expansion	All defined advanced skill areas supported by ACRRM AST and RACGP ARST curricula	Support for all Rural Generalists Challenges in appropriately defining nature of health service engagement for more non-procedural areas	2
A2a. Promotion of the Rural Generalist	Maintenance of current eligibility requirements and future alignment of the program with rural generalism (being provision of services across hospital, emergency and community settings). Access to CPD based on community need and GP interest	Flexibility of RGs to respond to community need for specific skills Uncertainty if this program will support additional GPs with non-procedural advanced skills due to service delivery requirements	1
A2b. Promotion of the Rural Generalist plus AMS, RFDS and MM-7 enhancement	As per Option A2a enhanced by the inclusion of GPs in employment models and/or regions that are currently have limited access (if any) to support for CPD	Flexibility of RGs to respond to community need for specific skills Additional support for rural and remote GPs who would otherwise not have access to CPD support Large expansion of eligible cohort with associated expansion in costs	-2

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DESIGN OPTION	DESCRIPTION	KEY BENEFITS AND CHALLENGES	ASSESSMENT SCORE ^(a)
B. PIP Procedural GP Payment expansion options			
B1. Matched skills-based expansion	Expansion of the program to provide an incentive payment for the delivery of non-procedural services supported through an RPGP expansion	Equivalent recognition and reward for the delivery of non-procedural advanced skills Service delivery will be very challenging to define without a mechanism such as MBS billing for other incentive payments	-1
B2. No change	No change to the program	Simplicity No additional incentive for non-procedural advanced service delivery	0
C. Streamlining options			
C1. No change	No change to either program	Simplicity and no additional cost Missed opportunity to align programs to better support Rural Generalists	0
C2. Administrative streamlining	Bring administration of the PIP Procedural GP Payment under the GP colleges	Monitoring of service delivery compliance may be more rigorous through colleges Significant administrative burden for the GP colleges	0
C3. Redirection of PIP Procedural GP Payment into RPGP pool	Redirection of the PIP Procedural GP Payment into an RPGP pool to potentially fund an expansion to support non-procedural advanced skill maintenance	Additional funding available to support a non-procedural expansion, with potentially limited impact on individual procedural and emergency GPs incentive to practice procedural and/or emergency skills Dissatisfaction from practices claiming PIP Procedural GP Payment	4
C4. A new Rural Generalist Support Program	A program designed to incentivise both ongoing skills maintenance and service delivery by Rural Generalists with advanced skills in procedural or non-procedural areas GP directed payment for more targeted incentivisation	Broader support for Rural Generalists Challenges in determining appropriate nature of health service engagement remain Dissonance between current program's support for 'proceduralists' versus new program for Rural Generalists	5

^(a) Assessment score is a combination of individual assessment criteria scores. Further detail on the assessment scores is provided in Section 5.6 ;, AST: Advanced Specialised Training; ARST: Advanced Rural Skills Training; MBS Medical Benefits Scheme.

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NEXT STEPS

The process for national recognition of rural generalist medicine as a speciality through the Medical Board of Australia is ongoing. Once this process has been completed, there may be a clearer direction and mechanisms in place for workforce incentive programs to support Rural Generalists.

This project explored several options for the RPGP and PIP Procedural GP Payment, including tiered expansion into priority areas, broader expansion, and matched practice incentive expansion. We have presented an analysis based on six key evaluative criteria. This will assist the Department in assessing the relative merits of these options and inform decisions about the most appropriate option for the expansion and streamlining of the RPGP and PIP Procedural GP Payment.

PART A: CONTEXT

1 INTRODUCTION

1.1 BACKGROUND OF PROJECT

As part of the 2021–22 Budget, the Government announced a consultation and design process to explore options for streamlining the Rural Procedural Grants Program (RPGP) and the Practice Incentives Program (PIP) Procedural GP Payment. Budget-related commentary on the process was included as part of expenditure announced for the Rural Health Strategy, which stated there was an allocation of:

‘\$0.3 million to develop a new model and streamline the Rural Procedural Grants Program and the Practice Incentives Program procedural GP payments into a new rural generalist GP support program for GPs with advanced skills (Department of Health, 2021)’

HMA/KBC were engaged to conduct the consultation and design process for a streamlined and enhanced program. This is the final report of that project, which examined the scope for a broader range of advanced skills involving non-procedural clinical care such as mental health, palliative care, and Aboriginal and Torres Strait Islander health.

The current programs provide financial assistance for eligible rural GPs and locums through two different mechanisms:

- (1) **The RPGP** offers **practitioner-based support** of continuing professional development (CPD) activities for GPs providing procedural (obstetrics, anaesthetics, surgery) or hospital-based emergency services, and
- (2) **The PIP Procedural GP Payment** gives **practice-based support** on a per procedural GP basis, with payment levels tiered according to service levels and rurality (geographic location of the practice).

It was envisaged that design of the new streamlined and expanded program developed by the project will ensure better alignment of these programs with the objectives of the National Rural Generalist Pathway. The aim of the National Pathway is to attract, develop and retain students and trainees into rural medicine training pathways, and ultimately to provide a wider range of medical services and improved health for rural and remote communities, including for Aboriginal and Torres Strait Islander people.

The project aligns with recommendations from the National Rural Generalist Taskforce’s Advice to the National Rural Health Commissioner on the Development of a National Rural Generalist Pathway, published in December 2018². This included several recommendations around recognition of advanced skills beyond procedural activities, including:

Recommendation 13: The Department of Health response to the Review of the Procedural Grants Program is broadened to include a Rural Generalist Additional Skills Program, which incorporates other Additional Skills beyond Surgery, Obstetrics, Emergency and Anaesthetics. [HMA/KBC emphasis]

The project also considered the relationship of the General Practitioner Procedural Training Support Program (GPPTSP) – which supports the development of advanced skills in anaesthetics and obstetrics – to the proposed new arrangements.

The project has also sought to inform the Department on how to incorporate the objectives of both existing programs and combine the most efficient and effective features of the two into a single administrative model, while also incorporating non-procedural advanced skills into the overall operations of the programs. The

² National Rural Generalist Taskforce, Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway December 2018

1 INTRODUCTION

project also examined the scope for rule changes that would enhance the program experience for participants.

This project comprised only the consultation and design process of a streamlined and enhanced program. Newly designed program arrangements – once the design principles are agreed, resourced and implemented – will require further consideration.

Once implemented, enabling additional Rural Generalists and other rural GPs to access support for a broader range of agreed advanced skills should result in improved access to healthcare for rural communities.

1.2 PROJECT PROCESSES

This document is the final report of the project. The report was informed by a range of processes, comprising:

- Desktop analysis of existing program documentation, administrative data on program activity, and policy and reports relevant to the design process (e.g. the National Rural Generalist Taskforce Advice)
- A range of consultation processes including:
 - peak and professional body feedback on two discussion papers
 - interviews with a small sample of GPs, consisting of:
 - (i) GPs in rural and remote areas accessing the existing RPPG, or
 - (ii) GPs who could be newly considered for eligibility based on their advanced skills in a range of potential in-scope areas (e.g. Aboriginal and Torres Strait Islander health)
 - Discussions with relevant internal stakeholders within the Department from Health Workforce and Primary Care Divisions, and
 - Extensive dialogue with staff from the two colleges contracted to administer the RPPG – Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP).

Findings from these processes are incorporated into the body of this report.

1.3 DOCUMENT STRUCTURE

The report is comprised of two parts and five chapters:

Part A: Context

- Chapter 1 (this chapter): provides background on why the project was initiated and the structure of the document
- Chapter 2: describes the project context including relevant policy settings and training pathways for advanced skill development for rural GPs; it also describes the current RPPG, PIP Procedural GP Payment and GPPTSP programs
- Chapter 3: describes the underlying dimensions of need for the programs, i.e. to support non-procedural skills maintenance and service delivery in the context of the RPPG and PIP Procedural GP Payment.

Part B: Design features and the way forward

- Chapter 4: presents proposed key design features in response to the project brief and discusses additional considerations that should inform final design considerations after conclusion of this project
- Chapter 5: identifies options for program expansion and estimated costs; it also includes an assessment framework to review options streamlining based on analysis of policy context, stakeholder feedback and cost modelling.

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SECTION A: PROJECT & DESIGN CONTEXT

2.1 UNDERLYING NEED FOR ADDITIONAL SUPPORT FOR CPD: PROCEDURAL GPs

Rural and remote communities are highly reliant on accessible and comprehensive primary healthcare services, particularly medical services provided by GPs. Rural GP procedural practice can include surgery, obstetrics, anaesthetics and/or emergency services. Procedural GPs play an important role in rural practice because rural areas have limited hospital-based resources and may not have a specialist available to provide these services that within a metropolitan area would require a specific referral-based speciality. As noted in the Procedural General Practitioner Payment Guidelines 2017, a rural or remote procedural GP provides

‘non-referred procedural services in a hospital theatre, maternity care setting or other appropriately equipped facility, which in urban areas would normally be a specific referral-based speciality.’³

These procedural GPs are sometimes referred to as Rural Generalists in recognition of their advanced-level skills in their field of procedural expertise.

Use and understanding of the term ‘Rural Generalist’ is still evolving. In 2018, the two colleges that establish and provide oversight for training standards for GPs

(ACRRM and the RACGP), agreed on a definition of a Rural Generalist. Known as the Collingrove Agreement, this consensus definition states that:

‘A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team’⁴.

Rural GPs require access to training opportunities, supervision and support to acquire and maintain the skills needed to practice safely and confidently in a rural community. While there have been several workforce incentive programs for procedural GPs to maintain and practice these procedural and/or emergency skills in rural and remote areas, there has not been the equivalent support for the delivery of advanced level non-procedural skills.

2.2 EMERGING PERSPECTIVES ON NON-PROCEDURAL SKILLS

The RACGP has previously highlighted concerns that the prioritisation of procedural skills over advanced non-procedural skills in policy approaches was a significant and pressing challenge for government.⁵ They proposed a shift in thinking towards greater recognition of GP advanced skills in the areas of aged care, palliative care, and internal medicine as the population ages and the burden of chronic disease increases.

³ Procedural General Practitioner Payment Guidelines 2017, Australian Government, Services Australia.

⁴ The Collingrove Agreement. 2018 Available at: <https://www.acrrm.org.au/rsrc/documents/misc/the-collingrove-agreement.pdf>

⁵ New approaches to integrated rural training for medical practitioners. 2014. National Rural Faculty, Royal Australian College of General Practitioners

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The National Rural Generalist Taskforce supported the recognition of a variety of advanced level skills by Rural Generalists. Recommendations to the National Rural Health Commissioner on development of the National Rural Generalist Pathway included support (through expansion of workforce incentive programs) for ongoing training in advanced level non-procedural skills. This recognised that

‘the current lack of such support is a disincentive for trainees to choose these critical areas of practice [non procedural] for supporting rural population health.’ (Australian Government. National Rural Health Commissioner, 2018)⁶

While greater recognition of these additional non-procedural skills for GPs practising in the rural and remote context has resulted in their inclusion in rural training pathways, there has not been an equivalent acknowledgement through policy incentives to support CPD.

2.3 POLICY CONTEXT

2.3.1 Background to rural GP incentive programs for additional procedural skills

In the early 2000s there was growing recognition of a decline in the provision of medical services to rural and remote communities. This was particularly noticeable in the numbers of rural proceduralists. The RPGP was initiated in 2004 as part of a suite of strategies to strengthen rural health services. The RPGP was aimed at increasing the numbers of rural GPs with procedural and emergency medicine skills to access educational activities relevant to their discipline. The purpose of this was to maintain their skill levels and support them to continue providing these services in their rural hospital, thereby enhancing the retention of these GPs in the community. The program was designed to address the cost barriers encountered by GPs in undertaking CPD – including the costs associated with course enrolment, travel, and locum cover.

⁶ National Rural Generalist Taskforce. Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway December 2018.

Initially the program supported the three procedural areas (obstetrics, anaesthetics, and surgery). It was subsequently expanded to provide support for GPs practicing emergency medicine in rural and remote settings.

More recently, recognition of the importance of emergency mental health services in rural and remote areas led to the inclusion of an additional component – emergency mental health.

Similarly, the PIP Rural Support Stream (through the PIP Procedural GP Payment) provides additional support for rural and remote GP practices that have procedural GPs providing obstetrics, anaesthetics and/or surgery services in their communities. These payments are in recognition of the additional financial burden that providing these services can place on general practices, such as the need for additional roster cover or loss of income due to procedural GPs delivering services at the local hospital.

2.3.2 Recognition of Rural Generalists

There has been a push over the past 20-plus years to formalise the training pathways of Rural Generalists.

The desire to create a critical mass of GPs with procedural expertise led to the development of specialist training pathways to produce GPs who can readily work in both hospital and community settings in rural and remote areas. The first of these Rural Generalist Pathways was founded in Queensland in 2007, followed by New South Wales in 2013. There are now pathways in place or in development in most states (See Section 2.4 for a more detailed description of training pathways for Rural Generalists).

In 2019 a commitment of \$62.2 million was made by the Government towards further development of a National Pathway to support dedicated Rural Generalist training and an application for professional recognition. The GP Colleges (ACRRM and RACGP), through the Rural Generalist Recognition Taskforce, submitted a joint application to the Medical Board of Australia (MBA) in December 2019 seeking formal recognition of Rural Generalist Medicine as a

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specialist field within general practice. Processes around responding to this submission were still underway at the time of finalising this report.

2.3.3 Broader primary care policy directions

Design principles for this project were also informed by the broader changes in health policy directions. This has influenced the suggested approach to target AS areas of interest.

There have been large changes to the structure and operation of Australia's health and social policy infrastructure over the last decade. Significant advances have included the creation of Primary Health Networks (PHNs), further investments in Closing the Gap to address the inequalities experienced by Aboriginal and Torres Strait Islander people, introduction of the National Disability Insurance Scheme, and continuing investment in mental health delivered through the primary healthcare system.

The Government recognises there is an ongoing need to strengthen and modernise Australia's primary healthcare system into the future. To facilitate that direction setting, the Minister for Health, the Hon Greg Hunt MP, announced the appointment of a team of experts in October 2019 to provide independent advice on the development of a Primary Health Care 10-Year Plan. A Consultation Draft of the Future focused primary health care: Australia's Primary Health Care 10-Year Plan 2022–2032 (the Plan) was released for public consultation and submissions could be lodged up until early November 2021.⁷

The final Plan was yet to be released at the time of finalising this report, but the Consultation Draft identifies a number of priority groups that can inform prioritisation of AS development:

- It identifies the priority of better healthcare for:

‘mental health; for older Australians; people with disability; people from culturally and linguistically diverse (CALD) backgrounds; lesbian, gay, bisexual, transgender and intersex (LGBTI) people; people in

socioeconomically disadvantaged circumstances; prevention and management of chronic conditions; and parents and children in the first 2,000 days.’

- It notes the importance of:

‘Closing the Gap to support quality person-centred, integrated care for Aboriginal and Torres Strait Islander people.’

- The Plan also notes that in the medium term (four to six years), consideration will be given to additional GP Service Incentive Payments and PIP payments to support quality bundles of care and improved outcomes for additional populations under voluntary registration arrangements, e.g.
 - ‘Parents and young children in the first 2,000 days of life
 - People with complex chronic conditions
 - People with disability, including people with intellectual disability
 - People with dementia
 - People needing palliative care’

There are several other significant proposed developments in the Plan that – if endorsed and implemented by a future government – have the potential to significantly alter the operational landscape for this project's in-scope program. These developments include proposals to:

- Introduce voluntary patient registration (VPR) with a person's usual general practice and nominate their usual doctor. VPR will provide a platform for general practice funding reform to incentivise quality person-centred primary healthcare. Over time, a greater proportion of funding for general practice will move to payments incentivising quality and outcomes.
- Evaluate the existing suite of funding supports for primary healthcare provision in rural settings.
- Continue and extend the Stronger Rural Health Strategy, drawing on the work of the National Rural Health Commissioner.

⁷ See relevant Australian Government Department of Health website page at:

<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/consultation-opens-on-draft-primary-health-care-10-year-plan>, accessed on 19 January 2021.

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- Trial the establishment of place-based rural delivery models in MM4–7 regions to support comprehensive primary healthcare teams in areas of market failure.
- Establish rural and remote health as a stream of work with each state and territory in regional and joint planning and collaborative commissioning approaches under the National Health Reform Agreement (NHRA).

2.4 TRAINING PATHWAYS FOR RURAL GENERALISTS

The design of supports for CPD need to link to training arrangements for GPs working in rural practice. Those arrangements are described in this section.

There are two recognised pathways for doctors training towards a rural generalist qualification, i.e. Fellowship of ACRRM (FACRRM) and the Fellowship of Advanced Rural General Practice (FARGP). See Figure 2.1. Both fellowships lead to Vocational Recognition and registration under the Specialist (General Practice) category with the Medical Board of Australia ⁸.

Figure 2.1: Australian General Practice Training Pathways for ACRRM and RACGP



¹There may be flexibility in the order in which training terms may be undertaken.

* Leading to specialist (general practice) registration.

** The FARGP is a specialist 12 month program for registrars wishing to specialise in rural general practice. The fourth year is optional.

⁸ General Practice Training in Australia - The Guide. 2020. Available at: [General Practice Training in Australia – The Guide | Australian Government Department of Health](#)

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There are several flexible pathways to meet the needs of individuals to achieve these qualifications through either GP college. The Regional Training Organisations have been responsible for the training of GPs through the Australian General Practice Training (AGPT) pathway. A process is currently underway to transfer responsibility for the AGPT program to the GP colleges following a transition period commencing from 2019 through to the beginning of Semester 1, 2023.

The FACRRM is a four-year program for Rural Generalists where training is embedded within a rural context. It is made up of three years of Core Generalist Training (CGT) and a minimum of 12 months of Advanced Specialised Training (AST).

The RACGP currently has a four-year program that candidates undertake for rural generalist training. The first three years covers the GP specialist training component and results in a Fellowship of RACGP (FRACGP). The fourth year, an Advanced Rural Skills Training (ARST) component, is required for candidates to specialise in rural general practice and results in an additional fellowship, the Fellowship in Advanced Rural General Practice⁹ (FARGP). The FARGP cannot be completed as a standalone qualification.

The RACGP is currently re-developing the FARGP to align with the requirements of a national rural generalist training framework. Following further updates to the curriculum, the FARGP will be re-branded as the RACGP's Rural Generalist Fellowship (FRACGP-RG).

2.5 ADVANCED SKILL RECOGNITION

2.5.1 Advanced skill qualified GPs

As mentioned above, the FACRRM and the FARGP include a minimum of 12 months of advanced skills training in at least one specific skill area. Both GP colleges have processes in place for recognition of prior learning (RPL) through

⁹ The Fellowship in Advanced Rural General Practice: Guidelines for general practice registrars and practising GPs. Available at: [FARGP-Guidelines-for-general-practice-registrars-and-practising-GP.pdf \(racgp.org.au\)](https://www.racgp.org.au/education/fargp-guidelines-for-general-practice-registrars-and-practising-gps.pdf)

¹⁰ Recognition of prior learning (RPL) checklist – Fellowship in Advanced Rural General Practice (FARGP) Available at:

alternative pathways for recognition of advanced skill training^{10,11}. Currently 1,045 GPs have completed an AST/ARST with one of the GP colleges (Table 2.1).

Table 2.1: Number of GPs with AST/ARST qualifications by advanced skill

Advanced Skill	ACRRM	RACGP	TOTAL
Surgery	14	16	30
Emergency Medicine	119	74	193
Child Health/Paediatrics	11	22	33
Obstetrics (6 or 12 months)	81	109	190
Anaesthetics	76	196	272
Aboriginal and Torres Strait Islander Health	25	90	115
Adult Internal Medicine	67	17	84
Mental Health	6	11	17
Small Town Rural General Practice	N/A	51	51
Remote Medicine	11	N/A	11
Palliative Care	-	4	4
Academic Practice	4	N/A	4
Population Health	13	N/A	13
Other*	N/A	28	28
TOTAL	427	618	1045

* 'Other' may include prospectively approved (by RACGP Rural Censor) advanced training programs in areas such as sexual health and population health. N/A indicates there is no specific AST/ARST offered by that college. There is no information on the specific breakdown of advanced skills included under 'other'; Source: ACRRM and RACGP.

These AST/ARST qualified GPs do not account for all rural GPs with procedural and/or emergency medicine skills who may have gained their qualifications and

<https://www.racgp.org.au/FSDEDEV/media/documents/Education/FARGP/RPL-Evidence-Checklist.pdf>

¹¹ Advanced Specialised Training: How to apply guide (ACRRM) – Recognition of prior learning pg. 9. Available at: <file:///C:/Users/peta.p/Downloads/ast-program-how-to-apply-guide.pdf>

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training prior to the introduction of these advanced skill components or through other mechanisms. This explains the difference in the numbers of rural GPs currently enrolled in the RPGP for procedural and emergency components compared to those who have completed formal advanced skill training through the GP colleges.

2.5.2 Credentialling of GPs with advanced skills

Undertaking an AST or ARST alone does not equate to the trainee being credentialled for a particular skill. Credentialling requires a separate process.

Credentialling is the formal process used to verify the qualifications, experience and professional standing of medical practitioners for the purpose of ascertaining their competence, performance and professional suitability to provide safe, high-quality healthcare services within a particular healthcare facility¹². Credentialling and defining the scope of practice for medical practitioners is a core responsibility of health service facilities. This occurs as part of the initial employment or engagement process and is managed by a health facility credentialling committee. Once this process has occurred, the GP is able to access financial support for relevant CPD activities, through the RPGP. Because of the current program scope, there is currently no equivalent process for credentialling of GPs practicing non-procedural advanced skills specified in the Rural Generalist fellowship curricula training frameworks.

2.5.3 Maintaining advanced skills

CPD is a professional obligation of all medical practitioners and is a registration requirement of the MBA. To meet this standard, Fellows of the RACGP and ACRRM must undertake CPD requirements established by their respective colleges.

¹² Credentialling health practitioners and defining their scope of clinical practice: a guide for managers and practitioners. 2015. Australian Commission on Safety and Quality in Healthcare. Available at: <https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialling-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf>

For all GPs practicing in obstetrics and gynaecology, general practice anaesthesia, diagnostic radiology, mental health or medical acupuncture, there are mandatory or recommended CPD activities required to maintain their specific skills in these fields. This is known as Maintenance of Professional Standards (MOPS) and is required for Fellows who have extended skills in procedural, mental health or emergency practice.

While GPs with advanced skills in other non-procedural areas are also required to undertake CPD requirements, there are no specified or mandated MOPS associated with these other advanced skill areas.

SECTION B: OVERVIEW OF THE PROGRAMS

2.6 RPGP MAJOR FEATURES

2.6.1 Program scope

The intention underlying the introduction of the RPGP was to support GPs in rural and remote areas to meet costs associated with attending relevant CPD. These costs may include course costs, locum relief and travel expenses.

The RPGP aims to 'improve rural and remote healthcare service delivery and workforce retention by supporting procedural General Practitioners (GPs) to undertake Continuing Professional Development (CPD) to maintain or enhance procedural skills.'¹³ This helps ensure that procedurally trained GPs are maintaining their skills and are up to date with current and new clinical practices. The outcome supported by this program is maintenance of procedural service

¹³ Australian Government Department of Health. Rural Procedural Grants Program Guidelines. 2021 Available at: [https://www1.health.gov.au/internet/main/publishing.nsf/Content/A46F25754A8D6B12CA257BF000209C09/\\$File/FINAL%20RPGP%20Management%20Guidelines%20March%202021.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/A46F25754A8D6B12CA257BF000209C09/$File/FINAL%20RPGP%20Management%20Guidelines%20March%202021.pdf)

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delivery capacity in rural and remote communities and ensuring safe and high-quality procedural and emergency services.

2.6.2 Program guidelines

Program guidelines specifying the eligibility and administrative arrangements for the RPGP are available on the Australian Government Department of Health website¹⁴. Key features of the Guidelines are summarised in this section.

The Guidelines state that RPGP has two components:

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

The support offered is up to \$20,000 per annum for the procedural component, and \$6,000 is available for emergency medicine CPD; an additional \$6,000 is available if emergency mental health services are also provided by the eligible GP¹⁴. This amounts to a maximum possible claim amount of \$32,000 per annum should a GP claim for the procedural component, the emergency medicine CPD component, and emergency mental health services.

For the purposes of participating in the RPGP program, applicants must meet the following eligibility criteria:

- Hold vocational recognition as a general practitioner (VR GP) or be enrolled in a Fellowship pathway with either ACRRM or RACGP
- The principal clinical practice is physically located in a Modified Monash Model (MM) category 3–7
- Hold unsupervised clinical privileges in an eligible discipline (surgery, anaesthetics and/or obstetrics or emergency medicine) at a nominated hospital located in MM3–7, and
- Participate in a regular roster or general on-call roster.

Further eligibility requirements for the emergency component of the RPGP include:

- Provide clinical care for emergencies in MM3–7, and
- Receive on-going training to maintain their skill level.

Rural locums may be deemed eligible for the RPGP while based in any geographic location, including urban areas, provided they meet all other eligibility criteria and undertake a minimum of 28 days locum work per financial year within MM3–7 locations.

2.6.3 Administration

Prior to 1 July 2020 ACRRM and RACGP were responsible for the administration of the RPGP, while Services Australia managed the payment of claims. Since that date ACRRM and RACGP have been responsible for both the program administration and claims payment. Those arrangements are specified in a service agreement.

Total funding (including GST) under the service agreements for the two-year period to 31 December 2021 was \$16,156,525 for each GP college (i.e. each college received just over \$8 m per annum). Under the agreements \$913,000 of the total funding provided to each college was assigned to program administration. This included support for establishment of payment systems and ongoing administration of the program.

The two colleges are tasked with the following program administrative tasks:

- assessing eligibility of the program for both participant and training activities
- maintaining a register of eligible GPs registered for the program
- processing eligible claims
- governance and administration activities (e.g. record keeping of claimants)
- communication activities such as publication of eligibility requirements

¹⁴ Australian Government Department of Health. Rural Procedural Grants Program Guidelines. 2021 Available at:

[https://www1.health.gov.au/internet/main/publishing.nsf/Content/A46F25754A8D6B12CA257BF000209C09/\\$File/FINAL%20RPGP%20Management%20Guidelines%20March%202021.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/A46F25754A8D6B12CA257BF000209C09/$File/FINAL%20RPGP%20Management%20Guidelines%20March%202021.pdf)

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- development of a fit-for-purpose payment system to deliver RPGP grant payments to eligible participants with administrative reporting capacity, and
- monitoring of program expenditure.

The GP Colleges must provide quarterly activity to the Department.

The ACRRM/RACGP Procedural Medicine Collaborative (PMC) is the advisory group for the RPGP. It provides guidance on program administration of the program. It comprises GP members nominated by the GP Colleges. The Department may attend the meetings as an invited guest. The PMC meets six-monthly to review program activity and examine any emerging eligibility and accreditation issues.

To lodge a claim under the RPGP a GP must lodge an initial registration that includes documentation indicating the applicant is currently an unsupervised provider of anaesthetic, obstetric, surgical and/or emergency medicine in a hospital or other appropriately equipped facility. Participants may only be registered with one college. After registering, participants can submit RPGP grant claims through the college they are registered with. Evidence of attendance or CPD activity is required to submit a claim.

2.6.4 Activity data

Program data presented in this chapter was sourced from the PMC meeting papers, RPGP quarterly reports for the Department of Health for each of the colleges, and Services Australia reports.

Aggregate claims data was reviewed for the past three financial years 2018–19, 2019–20 and 2020–21. Total annual claims in 2018–19 were \$17.058 million. There was a drop in annual claims in 2019–20 to a total of \$15.104 million likely due to the impact of COVID-19 on GPs' ability to access and set aside time for CPD. There was a small increase in total claims for 2020–21 to \$15.840 million. The addition of the Emergency Mental Health component contributed \$1.151 million

¹⁵ Rural Procedural Grants Program guidelines COVID-19 addendum, Dec 2021. Available at: https://www.health.gov.au/sites/default/files/documents/2022/01/rural-procedural-grants-program-guidelines-covid-19-addendum_0.pdf

in claims in its first year of availability. Fluctuation in payment trends for this year are due to the implementation of several program reforms, some permanent and others temporary. In 2020–2021 several changes to the eligibility of GPs and approved courses came into effect. As of 1 January 2021 program guidelines were updated to include only GPs who are vocationally registered or enrolled in a Fellowship pathway practicing in MM3–7 regions. As of 1 July 2020, previously ineligible online courses were allowed (reimbursed at \$1,000 per day for a maximum of 10 days) under a COVID-19 addendum to the RPGP guidelines¹⁵. This temporary measure is scheduled to cease 30 June 2022. Additionally, on 1 July 2020, a new allocation for GPs registered under the Emergency Medicine component was introduced, to support Emergency Mental Health CPD.

As claiming patterns in 2020–21 were impacted by the addition of a COVID-19 addendum to the guidelines allowing claims for online CPD, they may not be an accurate indicator of future expenditure beyond 30 June 2022. While these changes did not impact the average annual claim by GPs (which were similar to 2018–19 levels), there were still fewer GPs claiming in 2020–21 than in 2018–19, and more claims of lower amounts were paid.

While overall claim patterns have not changed significantly, there has been a shift in claiming patterns between colleges, particularly in response to increased uptake of online claims by members of one of the colleges.

2.7 PIP PROCEDURAL GP PAYMENT MAJOR FEATURES

2.7.1 Program scope

The PIP Procedural GP Payment is part of a broader Practice Incentives Program (PIP); this includes a number of payment streams designed to encourage GPs to provide services in particular areas of primary medical care need.

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The PIP Procedural GP Payment aims to encourage GPs in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services. Entitlement accrues to a practice rather than an individual GP (as occurs with RPPG).

2.7.2 Program guidelines

To apply for the PIP Procedural GP Payment stream, practices must first establish their eligibility to participate in PIP.

The PIP eligibility criteria require the practice to be registered for accreditation or accredited as a general practice against the RACGP Standards for general practices and maintain appropriate insurances. In addition to participating in the broader PIP program, a practice must also register for a specific PIP incentive payment. To be eligible for the PIP Procedural GP Payment, the practice must:

- have at least one procedural GP registered with the PIP for the entire reference period, providing one or more eligible procedural services
- meet the activity requirements for claiming the relevant payment tier, and
- be in a Rural, Remote and Metropolitan Area (RRMA) 3–7 location. (i.e. a different geographic classification to the RPPG).

PIP Procedural GP Payments are delivered under a tiered system depending on the level of service delivery by eligible procedural GPs in the practice (Table 2.2). GPs may only be eligible for one tier per six-month period, and tier payments are not cumulative. The support provides funding of up to \$17,000 per annum per procedural GP providing the highest level of service delivery (Tier 4) in both six-month periods. A loading for rurality based on RRMA classification is also applied based on the practice location, from 15% for RRMA 3 up to a maximum loading of 50% for RRMA 7¹⁶.

Table 2.2: PIP Procedural GP Payment tiered payment activity eligibility criteria

Tier	Activity required for payment
Tier 1 \$1,000 per procedural GP per 6-month reference period	A GP must provide at least one of the following procedural services in the six-month reference period: <ul style="list-style-type: none"> • obstetric delivery • general anaesthetic • major regional blocks • abdominal surgery • gynaecological surgery requiring general anaesthetic • endoscopy.
Tier 2 \$2,000 per procedural GP per 6-month reference period	A GP must both: <ul style="list-style-type: none"> • meet the Tier 1 requirements • provide afterhours procedural services on a regular or rostered basis – 15 hours per week on average, either on call or on a roster, throughout the entire six-month reference period, except for the first reference period when they apply.
Tier 3 \$5,000 per procedural GP per 6-month reference period	A GP must both: <ul style="list-style-type: none"> • meet the Tier 2 requirements • provide 25 or more eligible surgical, anaesthetic, or obstetric services in the six-month reference period.
Tier 4 \$8,500 per procedural GP per 6-month reference period	A GP must both: <ul style="list-style-type: none"> • meet the Tier 2 requirements • deliver 10 or more babies in the six-month reference period. <p>If a sole GP in a community delivers fewer than 10 babies, but meets the obstetric needs of the community, the practice may qualify for a Tier 4 payment.</p>

Source: PIP Procedural GP Payment guidelines¹⁵.

¹⁶ PIP Procedural GP Payment guidelines. 2017 Available at: <https://www.servicesaustralia.gov.au/organisations/health->

[professionals/services/medicare/practice-incentives-program/what-are-individual-incentives/procedural-general-practitioner-payment](https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program/what-are-individual-incentives/procedural-general-practitioner-payment)

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2.7.3 Administration

Applications for payments through the PIP incentives are administered through Services Australia on behalf of the Department of Health (i.e. not through the colleges).

Services Australia provides monthly data extracts for reporting services and manages an online administration system for the purposes of allowing practices to apply for PIP incentives, reviewing payments maintaining practices and provider details and receiving updates and information.

2.7.4 Activity data

PIP Procedural GP Payments totalled calculated expenditure of \$6.64 million for 2020 with an average GP FTE of 3.3 per practice. On average, practices claimed \$23,971 through the PIP Procedural GP Payment in 2021 (data not shown), however the median claim of \$17,000 is potentially more representative of the data due to a number of outliers at the higher end of the claim range.

The number of GPs claiming in each tier of activity level is given in Table 2.3.

Table 2.3: Number of GPs in each tier of the PIP Procedural GP Payment component, 2020

Time	Number of GPs			
	Tier 1	Tier 2	Tier 3	Tier 4
1 Jan – 30 Jun 2020	96	76	246	220
1 Jul – 31 Dec 2020	89	84	250	208
Change	-7	+8	+4	-12

Source: Services Australia

2.8 GP PROCEDURAL TRAINING SUPPORT PROGRAM (GPPTSP)

2.8.1 Program scope

The GPPTSP aims to improve access to obstetric and anaesthetic services for women living in rural and remote communities by supporting GPs practicing in MM3–7 regions to attain procedural skills in obstetrics or anaesthetics.

2.8.2 Program guidelines

This program provides up to \$40,000 to eligible VR GPs to gain either the Advanced Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), or a statement of satisfactory completion of Advanced Rural Skills Training in Anaesthesia through ACRRM¹⁷. To be eligible for funding through the GPPTSP, GPs must have a fellowship through either ACRRM or RACGP. They must also work in rural areas MM3–7 and source a training position to undertake advanced rural skills training in anaesthesia or obstetrics.

2.8.3 Administration

The GPPTSP is funded by the Department of Health and administered through ACRRM and RANZCOG. ACRRM manages the anaesthetics component of the GPPTSP and RANZCOG manages the obstetrics component.

ACRRM received \$454,000 in 2020–21 as part of the GPPTSP. It had scheduled payments for administration of the GPPTSP totalling \$2.001 million for the course of the funding services agreement from 30 January 2020 to 31 December 2023.

¹⁷ General Practitioner Procedural Training Support Program Anaesthetics. Application Guidelines 2021

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In 2020–21 RANZCOG received \$1 million in funding for distribution as part of the GPPTSP with a further \$95,000 for administration of the program.

2.8.4 Activity data

RANZCOG was allocated funding for up to 25 grants for the obstetrics component of the GPPTSP. ACRRM was allocated funding for up to 10 grants for the anaesthetic component (see **Error! Reference source not found.**).

Table 2.4: GPPTSP places by college / component, 2019 & 2020

College	2019			2020		
	ACRRM	RANZCOG	Total	ACRRM	RANZCOG	Total
Component	Anaesth.	Obstetric		Anaesth.	Obstetric	
Places available (n)	10	25	N/A	10	25	N/A
Applicants (n)	29	13	N/A	12	4	N/A
Successful applicants (n)	10	10	N/A	8	4	N/A
Funding committed*	\$400,000	\$400,000	\$800,000	\$320,000	\$160,000	\$480,000

*This allocates the total funding per place (\$40,000) into the year of award and assumes completion occurs. In actuality the colleges disburse funds differently. RANZCOG pays recipients \$20,000 on acceptance into the obstetrics program with the remainder paid upon completion. ACRRM pays recipients \$35,000 on securing an anaesthetic training post and \$5,000 on completion. Completion must occur within two years of commencement. Source of data: Department of Health reports from colleges for GPPTSP

3 EXPANDING SUPPORT TO NON-PROCEDURAL ADVANCED SKILLS: ASSESSING NEED

3.1 OVERVIEW OF PROCESS TO GAIN STAKEHOLDER VIEWS

The project team developed and distributed two discussion papers on the issues associated with streamlining and enhancing the CPD incentives programs. These were developed in conjunction with the GP colleges and then circulated to other relevant peak and professional bodies listed in Table 3.1.

Table 3.1: Peak bodies sent consultation paper 1

Peak bodies
Australian College for Emergency Medicine (ACEM)
Royal Australian College of Physicians (RACP)
Australian Paediatric Society (APS)
Australian and New Zealand Society for Geriatric Medicine (ANZSGM)
Australian and New Zealand Society of Palliative Medicine (ANZSPM)
Rural Doctors Association of Australia (RDAA)
Australian Medical Association (AMA)
Australia and New Zealand College of Anaesthetists (ANZCA)
Australian Indigenous Doctors Association (AIDA)
Royal Australian and New Zealand College of Psychiatrists (RANZCP)
General Practice Training Advisory Committee (GPTAC)
General Practice Supervisors of Australia (GPSA)
Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG)
General Practice Registrars of Australia (GPRA)
Procedural Medicine Collaborative (PMC)
Practice Incentives Program Advisory Group (PIPAG)

In addition, the project team undertook consultations with a small sample of individual GP providers in August 2021 to gain an understanding of the following:

- normative views of the field about the level of support required to strengthen the maintenance of non-procedural advanced skills and service delivery in rural and remote areas, and
- initial views of the field on a potential expansion and/or streamlining of the current programs (RPGP and PIP Procedural GP Payment) to support non-procedural advanced skills maintenance and service delivery in rural and remote areas.

Consultation included interviews with a total of 16 GPs: 7 rural GPs (with procedural and/or emergency advanced skills) currently accessing the RPGP, and 11 GPs with non-procedural advanced skills. One additional GP had both emergency and a non-procedural advanced skill.

We used these peak body and individual provider consultation processes to:

- better understand perspectives on underlying population level needs for different types of primary health service, and
- assess the implications for prospective GP workforce development and skills maintenance.

The insights gained from this consultation process, together with the findings from the desktop analysis presented in Chapter 2, informed our views about future program design options. Presented below are the design implications derived from the consultation analysis.

3 EXPANDING SUPPORT TO NON-PROCEDURAL ADVANCED SKILLS: ASSESSING NEED

3.2 DRIVERS OF NEED FOR CPD

3.2.1 Skills maintenance

There was general support from both peak/professional bodies as well as rural GPs for the need to support the ongoing maintenance of non-procedural advanced skills in rural and remote areas.

Design Implication: Rural GPs with non-procedural advanced skills require ongoing CPD for maintenance of their skills.

Design Implication: Rural GPs with non-procedural advanced skills face similar cost barriers to accessing CPD to their procedural and emergency skilled counterparts.

3.2.2 Service delivery

Many stakeholders highlighted the needs of rural and remote communities to access a broad range of primary medical services.

Key points in support of the delivery of advanced level non-procedural skills by GPs in rural and remote areas included:

- the importance of delivering services that are relevant to local needs of patients
- provision of advanced level services where specialist services were limited or unavailable, and
- cost effective treatment of patients.

Design Implication: There is a need for GPs to continue to deliver advanced level care in non-procedural fields in rural and remote communities, due to a lack of locally available specialist services.

3.2.3 Non-procedural advanced skills required

Peak and professional bodies were asked to provide a ranking of their top three additional advanced skill areas (from the current GP college advanced skill curriculum) that they considered were most relevant at a national level to promoting enhanced primary medical care in rural remote areas now.

Aboriginal and Torres Strait Islander health and mental health were most commonly noted in the top two priorities, followed by palliative care and paediatrics. Adult internal medicine was also noted by two stakeholders as an area of need.

Responses from GP interviews also aligned with the professional body responses, with the same four priority areas being identified. Five GPs provided their views on the priority areas. GPs provided rationales for their choice of priority advanced skills. Similar rationales were provided by peak bodies as well. In summary, these included:

- Increasing and/or unmet community need in the areas of mental health, paediatrics, palliative care.
- Difficult areas of primary medical care where a proportion of GPs could benefit from being able to apply additional skills, e.g. mental health.
- Importance of making progress on 'Closing the Gap' in Aboriginal and Torres Strait Islander health.

Design Implication: Mental health and Aboriginal and Torres Strait Islander health are seen by the field as areas of highest need for GPs with advanced non-procedural skills. This ranking was then followed by the next two priority areas identified in the consultation process as paediatrics and palliative care.

3.2.4 Recognition of non-procedural skills

In addition to the population level needs, and associated GP workforce skill level requirements discussed above, some peak body stakeholders highlighted the importance of recognising rural GPs with non-procedural advanced skills, to

3 EXPANDING SUPPORT TO NON-PROCEDURAL ADVANCED SKILLS: ASSESSING NEED

support the progression of embedding Rural Generalism as a workforce development principle.

Three of the 19 individual GPs identified the need for better recognition for GPs with non-procedural advanced skills.

Design Implication: There is currently limited recognition or support of rural and remote GPs with non-procedural advanced skills. Providing support for CPD in these areas will go some of the way to addressing the need for recognition and rewarding the practice of these skills.

3.3 SCOPE FOR PROGRAM EXPANSION AND STREAMLINING

3.3.1 RPGP

Peak and professional bodies were generally supportive of an expansion of the RPGP, however they considered that an expansion of the in-scope skills for the RPGP should not be at the cost of funding available for the current program.

Design Implication: Support for an expanded RPGP may be modest if expanded eligibility is not associated with an additional allocation of the program.

3.3.2 PIP Procedural GP Payment

There was no strong support for changes to the PIP Procedural GP Payment among stakeholders.

One peak body observed that there was already a disconnect between the skills that were currently supported by RPGP and the PIP Procedural GP Payment with no practice incentive available for GPs delivering emergency medicine.

Design Implication: The impact of the delivery of non-procedural advanced skills on a general practice is less clear than for procedural skills. There was not strong stakeholder support for the PIP Procedural GP Payment as being an appropriate mechanism to incentivise non-procedural advanced level services at a practice level (in contrast to the RPGP which was strongly supported as a mechanism to incentivise individual GPs to undertake ASTs and maintain those skills).

3.3.3 GPPTSP

Comments were invited regarding the GPPTSP in the context of the consultation and design process.

There was support from specialist colleges that the relevant colleges should administer their respective specialty training support program. There was also interest from one specialist college whose area is not currently supported by the GPPTSP for an expansion of the program to support training in their field.

Design Implication: Considering the GPPTSP in the context of the expansion and streamlining of the RPGP and PIP Procedural GP Payment may encourage the field to consider the expansion of this support to non-procedural advanced skills training.

Due to the significantly different aims of the GPPTSP and the potential to raise expectations of the field for expansion of this program in line with the RPGP and PIP Procedural GP Payment, the GPPTSP was not considered further in the consultation and design process.

PART B: DESIGN OPTIONS & THE WAY FORWARD

4 PROGRAM DESIGN FEATURES AND ADDITIONAL ISSUES

4.1 INTRODUCTION: RATIONALE FOR SEQUENCING OF DESIGN SPECIFICATIONS

Based on the scoping work presented in Part A, Chapters 2 to 3, we now present proposed design features that can:

- inform the enhancement of the RPGP and PIP Procedural GP Payment to better recognise non-procedural advanced skills, and
- guide decisions on potential streamlining of the administration of those two programs.

In developing the options for expanded programs we undertook a sequential analysis of the program possibilities; the project team initially considered choices related to ‘expansion’ of the RPGP. This then informed our approach to assessing expansion impacts on the PIP Procedural GP Payment.

The first round of consultations described in Chapter 3 found there were differing positions on the primary location (community or hospital) for delivery of non-procedural advanced skills and therefore the appropriateness of the PIP Procedural GP Payment as a mechanism to incentivise service delivery.

We consider the potential for program streamlining opportunities can only be determined after the scope of these two prior design areas – enhanced RGP scope and relationship of that expansion to PIP Procedural GP Payment – is established. The evolving policy context around recognition of Rural Generalism via the Australian Medical Council (AMC) and MBA processes should also inform considerations of approaches to streamlining in the medium term, beyond the streamlining and enhancement opportunities in the short term.

This chapter is presented in five sections.

- Section 4.2 focuses on design issues related to the RGP, specifically:

- features of the RGP that require attention prior to an expansion of the program scope to include non-procedural advanced skills
 - secondary issues related to RGP, and
 - additional issues related to the RGP raised through consultation that were beyond the project brief to address or respond to in detail
- Section 4.3 explores design issues associated with a potential expansion of the PIP Procedural GP Payment
 - Section 4.4 examines the possibility of streamlining the programs, and
 - Section 4.5 raises the idea of a new Rural Generalist Support Program.

4.2 RGP EXPANSION DESIGN ISSUES

4.2.1 Threshold qualification

Current state

To be eligible for the RGP at present, an applicant must have vocational recognition as a general practitioner (VR GP) or enrolment in a Fellowship pathway with either ACRRM or the RACGP. The recognition of other relevant training and experience (in obstetrics, anaesthetics, surgery and/or emergency medicine) is the responsibility of the employing hospitals for the procedural and emergency components of the RGP. For GP registrars to be eligible they must have pre-existing qualifications in one or more of the procedural components (such as the DRANZCOG for obstetrics) or complete a 12-month Advanced Specialised Training (AST) or Advanced Rural Skills Training (ARST) post in emergency medicine as confirmed by their college for the emergency component.

4 PROGRAM DESIGN FEATURES AND ADDITIONAL ISSUES

Design possibilities for expansion

As there is currently no clear pathway for hospitals to provide credentialing of non-procedural advanced skills, a mechanism to determine the appropriate threshold qualification to be eligible for a non-procedural component of the RPGP needs to be determined. Design possibilities for expansion include:

(1) Limit initial eligibility to GPs that have completed an AST/ARST as part of their fellowship training in a relevant non-procedural advanced skill

This could be an appropriate approach for the initial expansion of the program into non-procedural areas. The eligible cohort can be easily estimated through the number of GPs who have completed AST/ARST in the different non-procedural areas selected for inclusion.

(2) In addition to (1) above, recognise equivalent training

This approach proposes a mechanism, yet to be determined, to recognise equivalent training in a non-procedural area that would enable a GP to access the RPGP for non-procedural advanced skills CPD. Suggestions by stakeholders include recognised diplomas, e.g. Clinical Diploma in Palliative Medicine, Sydney Child Health Program. However, some concern was raised about a potential lack of clinical experience where courses did not include a component of clinical placement (i.e. the Sydney Child Health Program would not be considered equivalent to a Paediatric AST without additional clinical practice requirement). ACRRM and the RACGP advised the project team that the size of this cohort is difficult to estimate and would require further work to determine the potential number of eligible GPs. Enquiries with RACP confirm they do not hold data on the number of GPs undertaking the Clinical Diploma in Palliative Medicine through the RACP.

(3) Provide access to all Rural Generalists – FACRRM or FRACGP

Should a model be preferred where access to RPGP is not driven by individual advanced skills attainment and practice, access to all Rural Generalists could be considered. This recognises the additional training and/or skills and experience of Rural Generalists practicing in rural and remote areas. It could include not only those GPs who have gone through

the formal training for Rural Generalists and have a specific AST, but also those who have been grandfathered into these fellowships through recognition by the colleges of their skills and experience in rural and remote practice.

As noted in Chapter 2, there is currently an application underway to formally recognise Rural Generalist Medicine through the AMC and the MBA. A model providing access to CPD for all Rural Generalists may become clearer once this process has reached a conclusion.

Consultation feedback

While there was support for AST/ARST as the minimum qualification for eligibility to a non-procedural component of the RPGP, many stakeholders urged flexibility to include additional rural GPs providing advanced level services without a formal AST.

Many peak body stakeholders suggested that ACRRM and RACGP were best placed to determine the threshold qualification for the RPGP.

One stakeholder was not supportive of limiting initial eligibility to the AST/ARST and wanted to see recognition of equivalent training as part of an initial expansion. They did acknowledge that determining the number of GPs who would be eligible under recognition of equivalent training would be difficult to estimate.

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Key Finding 1: There was support for the ACRRM AST/FARGP ARST as the threshold qualifications for access to an expanded RPGP for non-procedural skills. However, many stakeholders also urged flexibility for those doctors who do not officially have an AST/ARST but are able to demonstrate advanced service provision. There was strong support for ACRRM and RACGP as the most appropriate bodies to make assessments on equivalent training.

Design suggestion #1: In the first instance of expanding the RPGP, completion of the AST/ARST curriculum as established by ACRRM and RACGP should be the threshold requirement for access to an expanded RPGP for non-procedural advanced skills CPD.

Design suggestion # 2: Processes should be put in place to estimate the number of rural and remote GPs who may seek recognition of equivalent training for non-procedural skills, so this group is not disadvantaged in their access to subsidised CPD through the RPGP in the longer term.

Design suggestion #3: ACRRM and RACGP are the appropriate bodies to determine recognition of equivalent training. In developing recognition standards, they should consult with the relevant specialist college and learned societies relevant to the advanced skill.

4.2.2 Additional skills

Current state

The RPGP supports CPD for procedural skills including obstetrics, anaesthetics and surgery and emergency medicine, including emergency mental health.

Design possibilities for expansion

- (1) **Expansion to include two additional non-procedural skills: Aboriginal and Torres Strait Islander health and mental health**

Support for Aboriginal and Torres Strait Islander health and mental health were seen by almost all stakeholders consulted through the project as the highest priorities for supporting expansion of access to the RPGP due to the continuing poor health outcomes experienced by Aboriginal and Torres Strait Islander peoples and the increasing need for mental health support in rural and remote regions. The alignment of these areas with Commonwealth health policy priorities also strengthens the support for the inclusion of these areas. Both areas were seen as complex and time-consuming areas of practice where support for GPs providing these services would be welcomed by the field.

- (2) **Expansion to include four additional non-procedural skills: Aboriginal and Torres Strait Islander health, mental health, paediatrics and palliative care**

In addition to Aboriginal and Torres Strait Islander health and mental health, the next most supported advanced skills areas were palliative care and paediatrics. These were also seen as areas of need for rural and remote areas. Greater provision of services in these areas at an advanced level would not only fill a gap in access to specialist services, but also enable enhanced management of patients in local settings, providing benefits for the patients as well as cost savings to the broader health system.

- (3) **Expansion to include all defined AST/ARST areas supported by the GP colleges**

The GP colleges suggested there was an argument for the inclusion of all areas in which the colleges supported formal advanced training options. The potential for significant budgetary implications along with less clear need for advanced skills beyond those listed in point (2) above, makes this a less attractive option.

- (4) **Broad access to CPD based on individual GP interest and community need**

Some stakeholders proposed a broader range of skills beyond those covered within the GP colleges' formal training options. Suggestions included geriatrics, dermatology, women's health and breast medicine. Beyond these skill sets, there was also some support for access to CPD across specialty areas where there was an underlying community need, for example, access to

4 PROGRAM DESIGN FEATURES AND ADDITIONAL ISSUES

palliative care CPD for Rural Generalists without an AST in palliative care, due to a locally ageing patient population with higher burden of disease.

Consultation feedback

Four respondents provided feedback on the minimum acceptable option for inclusion of non-procedural skills:

- Two stakeholder groups supported '[option] 2. Expansion to include four additional non-procedural skills: Aboriginal and Torres Strait Islander health, mental health, paediatrics and palliative care.'
- Two stakeholder groups supported a minimum option of '1. Expansion to include two additional non-procedural skills: Aboriginal and Torres Strait Islander health and mental health.' One of these groups also suggested the inclusion of paediatrics into this option.

While this limited expansion was considered a reasonable initial approach, some stakeholders were interested in seeing the inclusion of all advanced skills at some point in the future.

Key Finding 1:	Most stakeholders supported expansion of the RPPG to include non-procedural AST/ARST areas.
Key Finding 2:	Stakeholders agreed that Aboriginal and Torres Strait Islander health, mental health, paediatrics and palliative care were the areas most in need of support in rural and remote Australia.
Key Finding 3:	There was in principle acceptance of a stepwise approach to expansion of the RPPG with the recommendation that timelines for expansion of different skill areas be provided; furthermore, GPs who do not meet a future definition of a Rural Generalist should not be excluded from eligibility.

Design suggestion #4: The initial expansion of the RPPG should include four additional non-procedural areas: Aboriginal and Torres Strait Islander health, mental health, paediatrics and palliative care.

Design suggestion #5: In principle support for further expansion to additional non-procedural advanced skills (AST/ARST only) should be communicated to stakeholders with timeframes around additional processes to be undertaken prior to any further expansion.

4.2.3 Nature of health service engagement

Current state

The requirements of the current RPPG for GPs accessing the program is to have engagement with the health service and is primarily around unsupervised clinical privileges within a hospital. Those engagement rules are as follows:

- (1) **Procedural Component:** Unsupervised clinical privileges in an eligible discipline at a hospital, and participation in a regular¹⁸ or general on-call roster. GP locums must provide a minimum of 28 days locum work per financial year in an MM3–7 region.
- (2) **Emergency Component:** Unsupervised clinical privileges and experience and necessary skills to practice emergency medicine at a hospital located in MM3–7 and currently hold a position in emergency medicine at the facility nominated and participate in a regular roster or general on-call roster. To access the additional mental health component, provision of emergency mental health services must be part of their duties.

The guidelines do not include an explicit requirement that GPs are providing primary care to access the RPPG, although the Department has advised that it was assumed all participants were working in primary care practice.

¹⁸ Participation in a regular roster: GPs who work in rural hospitals are not always on an on-call roster because their hospital does not provide it. Instead the hospital may have a 24-hour roster. For the

purpose of this program, 'regular' is defined as providing the service at least once each month under normal circumstances.

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Design possibilities for expansion

Options for expansion that would align with the definition of the rural generalist role (i.e. providing services in the community, hospital and emergency) could be to require a GP seeking access to the RGP for non-procedural skills to be involved in the delivery of services within both a hospital and the community. This could include requirements for:

Part A: Engagement with hospitals

- (a) Non-procedural areas: an appointment to provide clinical services in the non-procedural specialist area at a hospital (recognising there may currently be limited positions of this type), and/or
- (b) Provision of emergency or procedural services: hold unsupervised clinical privileges in an eligible discipline (procedural or emergency) at a hospital, and
- (c) Participate in a regular or general on-call roster for either procedural or non-procedural activity.

AND

Part B: Engagement with community services

- a) A formal engagement with a specialist team in a non-procedural area. For example, participate in virtual case discussions, be part of a specialist-led hospital team, or be working within a recognised delegated or shared care model; and
- b) Deliver community-based services specific in the advanced skill area beyond the scope of a regular GP, e.g. delivery of outreach clinics in specialist advanced skill field, or dedicated clinic time for the advanced skill are within private practice equivalent to, say, 0.4 FTE.

Consultation feedback

Stakeholders raised concerns about the suggestion for GPs with non-procedural advanced skills to be involved in both community service delivery and hospital and/or emergency rosters. This was not considered by several stakeholders as possible or practical in many circumstances.

Some stakeholders acknowledged that currently eligible procedural GPs would not strictly meet the definition of a Rural Generalist. While changes to the eligibility for the current program are not currently being considered, they observed this should be considered in the context of alignment of the program with the National Rural Generalist Pathway.

Some stakeholders were supportive of the requirement for a GP with a non-procedural advanced skill having a formal connection with a relevant specialist team.

While stakeholders were supportive of the requirement to demonstrate advanced level service delivery for non-procedural areas, there was no support for a defined amount of service to underpin or quantify this level of engagement (e.g. a minimum specified FTE). All stakeholders who provided a response to this issue agreed that there should be an exemption for hospital-based service delivery for communities where there is no hospital.

However, having no local hospital or emergency service did not negate the community expectation for the local GP to provide emergency support. A case could be made for the support of emergency CPD for specific locations without emergency credentialing.

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Key Finding 4: Stakeholders did not see it as appropriate to have requirements on RPGP eligibility that specified certain levels of engagement with hospitals.

Key Finding 5: Stakeholders supported a requirement for GPs to demonstrate advanced skills specific service provision within the community but were not supportive of a defined proportion of FTE as a measure of this.

Key Finding 6: Stakeholders were supportive of exemptions to hospital-based service requirements in areas with no local hospital.

Design suggestion #6: A connection with a specialist team in the relevant non-procedural advanced skill should be a component of eligibility for an expanded RPGP in that advanced skill. Flexibility will be required around this connection to allow for individual GP and community circumstances. ACRRM and RACGP would be best placed to make determinations on appropriateness of an individual GP's connection to a specialist team. Guidance for interpretation of this aspect of the rules should be provided by the Department of Health in the program guidelines.

Design suggestion #7: Eligibility for GPs to access a non-procedural component of the RPGP should not include a requirement to provide services in a hospital or on an emergency roster at this stage. While the alignment of the RPGP with the National Rural Generalist Pathway remains an intention of the project, further work on the pathway needs to occur to ensure positions are available for GPs to be able to meet any future hospital and/or emergency service-based requirements.

4.2.4 Other considerations

Equity of access to support for CPD

Current state

There was evidence from the consultations that award entitlements within at least one jurisdiction gave access to support for CPD additional to that provided through the RPGP. For example, in that same jurisdiction GPs employed at one hospital where we undertook consultations were able to access support in the form of paid professional development leave and funding to pay for the CPD; because they were also able to apply for the RPGP, they were in effect sanctioned to 'double dip'.

This arrangement was more common in some states where Rural Generalists were likely to be employed in hospital settings. In the case of GPs in private practice there was less support available for CPD – rural workforce agencies provide a small amount of support for non-public sector medical practitioners to a maximum of \$3,000 per annum.

GPs are often working across hospital and community-based settings, which can lead to difficulties in determining which organisation should bear the costs of CPD and assessing who gains the benefits of ongoing CPD. As development of the National Rural Generalist Pathway progresses and there are more formally trained Rural Generalists, there will be growing expectations that GPs should have access to support for CPD, irrespective of the funding sources for the setting where they work, i.e. jurisdiction-funded, Commonwealth-funded, or a mixture of both.

Consultation feedback

Stakeholders were asked to consider if the RPGP, a Commonwealth funded program, should be providing support for CPD for GPs principally employed through jurisdiction funded hospitals, in the context of a limited pool of funding for CPD support.

There were mixed views on this issue, with one stakeholder suggesting a split in responsibility for CPD matched to FTE of the practitioner in each system.

Another stakeholder considered funding should not be provided where CPD support was available through a practitioner's current employment.

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Other stakeholders said they supported access to both the RPGP and any available state funding for CPD. This was due to there being uncertainty in availability of CPD across the varying employment models and the potential for some states to have responded to workforce issues differentially.

One stakeholder suggested a pooled funding arrangement between Commonwealth and State/Territory governments as a mechanism to provide equitable funding.

Key Finding 7: Stakeholders had differing views on the appropriateness of providing of RGP funding to GPs who receiving funding for CPD through jurisdiction managed hospitals. It was noted that access to jurisdiction-based CPD funding varies and is not universal across hospital-based GPs.

Loading for level of rurality

Current state

There is currently no provision in the RGP for a loading based on level of rurality. Within the PIP there is a rural loading recognising the difficulties of providing care, often with little professional support, in rural and remote areas. The PIP rural loading is higher for practices in more remote areas, in recognition of the added difficulties of providing medical care in these localities. The PIP rural loading is added to PIP practice payments. The rural loading is calculated by multiplying the practice's PIP payments by a percentage loading (detailed in Table 1 in the Rural Loading Guidelines). The rural loading varies with the remoteness of the practice and is based on the classification of the practice using RRMA (different to RGP which uses Modified Monash Model (MMM)).

Design possibilities

- (1) **Additional loading for MM6–7:** Remote areas were acknowledged as challenging places to deliver primary medical care and to access CPD due to additional travel time and costs. An additional loading could be applied to MM6–7 areas.
- (2) **Apply a tiered loading across MM4–7 to RGP:** the PIP Rural Loading Incentive is currently based on the Rural, Remote and Metropolitan Areas

(RRMA) Classification. It provides an additional 15% for RRMA 3, 20% for RRMA 4, 40% for RRMA 5, 25% for RRMA 6, and 50% for RRMA 7.

A tiered loading for RGP would be based on the MMM Classification system and starting at a base loading of 0% at MM3 and incrementally increase loading from MM4–7, up to a suggested maximum of, say, 50%.

Consultation feedback

Four out of the five stakeholders who provided a response to this issue indicated they would be supportive of rural loading. One stakeholder emphasised the need for this to be additional funding, not a redistribution of the current allocation.

One stakeholder group had a different position, favouring simplicity of the current payment structure over the introduction of a rural loading.

A loading based on the MMM classification was considered the most appropriate measure of indicator of rurality. One stakeholder proposed that the differences in cost to access CPD were largely associated with the travel component and conceded additional support for MM6–7 was worth considering.

Key Finding 8: Some stakeholders supported the introduction of a CPD rural loading for GPs in remote and very remote communities but acknowledged that many barriers affect all rural GPs; it is important not to complicate a system that is currently easily accessible.

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Design suggestion #8: A rural loading is not recommended at this stage as it would be an additional complication for the RPGP rules. Additionally, as RPGP is currently based on the location of practice (and not the residence of the GP), the rural loading could be allocated inappropriately, although this could be resolved by allocating rural loadings based on a GP's principal place of residence. A rural loading has the potential to add significant administrative burden to the program.

Design suggestion #9: The issue of a loading for level of rurality could be revisited in the context of any new Rural Generalist support program, should one be developed. An assessment of the level of additional costs incurred to access CPD by GPs residing in outer regional and remote areas requires additional investigation.

Banking or borrowing RPGP for extended CPD

Current state

RPGP payment limits are currently determined on an annual basis.

Design possibilities

- (1) **Allow borrowing and/or banking of RPGP entitlements:** The ability to borrow from the next year or to bank an individual's allocation from a previous year of an RPGP allocation could enable GPs to undertake longer CPD courses or clinical placements. Clinical placements were seen as one of the most useful ways to undertake CPD in non-procedural areas as it strengthens networks and clinical practice in the specialist field.
- (2) **Accumulation of up to 3 years of funding for CPD:** a longer accumulation of RPGP entitlements would need to be considered in the context of the GP's commitment to ongoing practice in the field to ensure that the CPD continues to benefit the local community. One suggestion was to include a minimum number of years in the one location to enable access to any such accumulation feature.

Consultation feedback

All four of the stakeholders providing a response to this issue indicated that accumulation of the RPGP would enable GPs to undertake longer term placements which would benefit their networks and enable a broad range of cases to be seen over an extended period.

While a mechanism to support longer CPD would be welcomed, two stakeholders indicated that funding for this was not the only barrier. Limited access to locums was also considered an issue in undertaking longer CPD.

Another stakeholder suggested the additional complexity could potentially hinder access to the program.

Stakeholder suggestions for a banking or borrowing mechanism included:

- An allocation of a higher number of days over a two- or three-year period
- Accrue unused RPGP over a period of two to three years, and
- An expiry date of notionally allocated funds of three years.

Key Finding 9: Stakeholders supported the potential for accumulation of RPGP funding over a longer period but suggested there are other barriers that prevent GPs from accessing longer term clinical placements.

Design Suggestion #10: Accumulation of the RPGP allowance across years is not currently recommended. The number of GPs likely to access a multi-year allocation is unknown and the impact on the budget would be uncertain. It would also add complexity to the program administrative arrangements.

Design Suggestion #11: In the case of a new Rural Generalist Support Program, the need for support for longer clinical placements should be revisited and a mechanism to access support for this developed.

4 PROGRAM DESIGN FEATURES AND ADDITIONAL ISSUES

4.3 PIP PROCEDURAL GP PAYMENT

4.3.1 Expansion considerations

Current state

The PIP Procedural GP Payment and the RPGP have broadly similar aims – to incentivise the provision of essential procedural skills in rural and remote areas. Currently the policy intent of the PIP Procedural GP Payment is largely in alignment with a focus on supporting procedural skills. However, the two programs differ in their support for emergency medicine with RPGP supporting ongoing service delivery in this area, while the PIP Procedural GP Payment currently does not specifically address incentives for this clinical role.

Design possibilities

- (1) **No change to PIP Procedural GP Payment:** The programs apply different approaches to incentivisation of delivery of advanced skills in rural and remote areas. The PIP Procedural GP Payment is perceived by many stakeholders as a form of compensation to practices for potentially lost earnings from procedural GPs being required to attend emergencies or the hospital to undertake procedures. There is an argument that there is less impost on a general practice of GPs delivering non-procedural advanced services as they are more predictable in nature (i.e. less likely to be driven by the need to deliver urgent care).
- (2) **Matched expansion of PIP Procedural GP Payment:** Notwithstanding some of the limitations discussed above, a case could be made that the incentivisation of advanced non-procedural skills is required to support practices to attract and retain GPs with advanced skills in areas of community need. Proposals for a PIP expansion (to match an RPGP expansion) could include the use of the payment to provide wrap-around services to support the ongoing practice of a GP with advanced specialist skills. For example, a practice could use the payment to assist in supporting a child health nurse in support of a GP with paediatric advanced skills.

Consultation feedback

The current rationale of the PIP Procedural GP Payment was confirmed by stakeholders, i.e. as a support for the practice for unplanned hospital attendances for procedural GPs and in some cases direct support of the procedural GPs, when passed on from the practice, as supplementary income.

The issue of appropriate remuneration for non-procedural advanced skills was raised by stakeholders. Two stakeholders suggested a PIP GP payment for non-procedural work could provide some compensation, in lieu of higher MBS advanced service delivery payments.

If the PIP Procedural GP Payment were to be extended to support non-procedural areas, stakeholders were supportive of it being used to provide extra practice-based support for delivery of the advanced skill and as remuneration for the practitioner:

Key Finding 10: Expanding the PIP program payments to allow for non-procedural services would represent a revision to the program objectives for this component of PIP. While the current program contributes to offsetting the costs of the practice around potential loss of income when procedural GPs are delivering services in a hospital, a non-procedural component could be used as supplement to practice remuneration to incentivise the recruitment and retention of GPs with non-procedural advanced skills.

Key Finding 11: Stakeholders suggested that PIP Procedural GP Payments could be used to enable the extended use of non-procedural skills through practice-based supports such as specialist nursing staff.

Key Finding 12: The issue of appropriate remuneration for delivery of non-procedural advanced skills may remain a barrier to incentivising practice of these skills in community settings.

Design Suggestion #12: Maintain current PIP Procedural GP Payment arrangements without adjustment for recognition of non-procedural advanced

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skills. While there is a case for including emergency and non-procedural advanced skill components within PIP, changes should be deferred until the broader directions for incentivising Rural Generalism are clarified via AMC and MBA processes currently underway.

4.4 STREAMLINING PROGRAMS

Current state

The RPKG is currently a practitioner-based payment for the support of CPD and is administered by ACRRM and RACGP. The PIP Procedural GP Payment is a practice-based payment administered through Services Australia as part of the broader program of practice incentives promoting quality and safety.

Consultation feedback

Stakeholders were asked to identify the risks and benefits of streamlining the RPKG and the PIP Procedural GP Payment.

Three of the stakeholders identified the differences in the purpose and payment structures of the programs as issues when considering a merger of the programs.

Concerns about a reduction in overall funding were raised by one stakeholder as a consideration.

Further to this, stakeholders were interested in ensuring that some part of the payments would continue to flow to the individual practitioners.

Only one stakeholder group was supportive of the streamlining of the programs, which they suggested could simplify program arrangements. They also suggested a significant proportion (85%) of the payment should be allocated to the individual GP.

Key Finding 13: There was not strong support from most stakeholders in the field for merging the administration of the two programs. Stakeholders highlighted that the underlying objectives of the PIP Procedural GP Payment and the RPKG are different.

Merging administration of these programs would confuse these policy objectives.

4.5 A NEW RURAL GENERALIST SUPPORT PROGRAM

Stakeholders were asked their views on the development of a Rural Generalist Support Program combining aspects of support for ongoing skills maintenance and service delivery in rural and remote areas. They provided varied views on this possibility. Suggestions for the new program included:

- a need to continue to provide two separate payments for both practitioners and practices
- a need to incentivise both skill advancement/maintenance and support skill utilisation
- ensuring continued support for those currently supported (individual GP or practice), and
- a requirement for additional funding so no GP or practice is financially worse off.

One stakeholder group suggested in the event of a new Rural Generalist Support Program consideration would be needed to giving support to those GPs not providing the full suite of services, as they were still providing a highly valued and critical contribution to continued service provision in many rural and remote communities.

Design Suggestion # 13: Maintain current RPKG and PIP Procedural GP Payment as separately administered programs at this stage. Consideration of merging of the two programs should be deferred until there is greater clarity around specific initiatives to develop more targeted program supports for the Rural Generalist workforce stream.

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

5.1 INTRODUCTION

The project developed options for program redesign to include non-procedural advanced skills, based on the key findings and design considerations presented in Chapter 4. Like the sequenced approach presented in that chapter, we now present a succession of options under three broad themes:

- expansion of the RPGP in the first instance (See Section 5.2 and Table 5.1)

THEN

- implications of a PIP Procedural GP Payment expansion (Section 5.3 and Table 5.2), and

THEN

- streamlining options (See Section 5.4 and **Error! Reference source not found.**).

Each option described in the tables includes commentary on the target group, recurrent costs, and issues associated with implementation, including nature of health service engagement.

In Section 5.5 we compare the options' strengths and weaknesses, judged against a set of evaluation criteria, e.g. administrative simplicity, and impacts of each option to undertake and deliver advanced skills in non-procedural areas.

5.2 RPGP EXPANSION OPTIONS

We present two main approaches to the expansion of the RPGP (see Table 5.1).

- an individual advanced skills-based approach, and
- a broader approach supporting the Rural Generalist model.

Within these approaches, several sub-options are presented that represent incremental expansions for additional areas of need, either through individual advanced skills support or support for specific employment models or regions where there are gaps in service and CPD support.

Table 5.1 includes the following information about the options:

- a brief option description
- threshold qualification and potential recognition of equivalent training, and
- nature of health service engagement

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

Table 5.1: RPGP expansion options

RPGP expansion options	Threshold qualification and recognition of equivalent training	Nature of health service engagement
INDIVIDUAL SKILLS BASED EXPANSION		
<p>A1a. Narrow expansion</p> <p>The following advanced skills would be recognised:</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander Health • Mental Health 	<p>The threshold qualification for advanced skills is an AST through ACRRM or ARST through RACGP.</p> <p>Current processes for recognition of prior learning (RPL) for AST/ARST through ACRRM and RACGP could be employed to include GPs with equivalent training and experience.</p> <p>Examples of equivalent training could include:</p>	<p>Aboriginal and Torres Strait Islander Health:</p> <ul style="list-style-type: none"> • Employed by ACCHOs or other AMSs in MM3–7, >6 months FTE • Statutory declaration by Board chair, nominated Indigenous board members, or service director (in the case of an AMS) that the GP delivers culturally appropriate services relevant to the locality <p>Mental Health:</p> <ul style="list-style-type: none"> • An appointment to provide clinical services at a recognised mental health facility in MM3–7. (e.g. inpatient unit, alcohol and drug rehabilitation unit, Headspace); or • If working solely in private practice, then a minimum of proportion MBS billing items in the financial year prior to the previous year dedicated to Mental Health services.
<p>A1b. Moderate expansion</p> <p>The following advanced skills would be recognised:</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander Health • Mental Health • Palliative Care • Paediatrics 	<ul style="list-style-type: none"> • Palliative Care: Clinical Diploma in Palliative Medicine offered by RACP • Paediatrics: Sydney Child Health Program and 6-month clinical placement/experience. • Aboriginal and Torres Strait Islander health: One year of FTE work in an AMS/ACCHO and supporting letter of culturally appropriate delivery of health services from a relevant ACCHO representative. • ACRRM and RACGP in collaboration with relevant specialist colleges should determine threshold for equivalent training. • ACRRM and RACGP should be responsible for the recognition of equivalent training for the purpose of accessing the RPGP. 	<p>Aboriginal and Torres Strait Islander Health and Mental Health: As above</p> <p>Palliative Care:</p> <ul style="list-style-type: none"> • Delivery of palliative care services in an aged care setting, hospital or hospice; and/or • Formal engagement with a specialist palliative care team; and • Home visits for the delivery of palliative care services. <p>Paediatrics:</p> <ul style="list-style-type: none"> • Delivery of community-based child health programs (e.g. outreach services such as school clinics, dedicated paediatrics clinic in private practice equivalent to 0.2 FTE); and/or • An appointment to provide clinical services for paediatrics at a hospital or outpatient clinic, with formal engagement with specialist paediatrics team.
<p>A1c. Broad expansion</p> <p>All defined advanced skill areas supported by ACRRM AST and RACGP ARST curricula</p>		<p>Aboriginal and Torres Strait Islander Health, Mental Health, Palliative Care, Paediatrics: As above</p> <p>Adult Internal Medicine, Population Health, Remote Medicine, Small Town Rural Practice, Academic Practice: Further scoping assessment for these specific fields would need to occur to determine appropriate nature of health service engagement requirement for each individually. ACRRM and RACGP in conjunction with any relevant specialist bodies would be best placed to consider engagement rules applying in these areas.</p>

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

RPGP expansion options	Threshold qualification and recognition of equivalent training	Nature of health service engagement
PROMOTION OF THE RURAL GENERALIST		
<p>A2a. Promotion of Rural Generalist</p> <p>Focus on the requirement to deliver advanced skills in both community and hospital settings (including emergency medicine)¹⁹ (reducing the emphasis on individual advanced skill areas)</p>	<p>Current credentialing requirements for enrolment into the program would be maintained, i.e. jurisdiction-based health services are responsible for the credentialing of the general practitioner through their employment processes. This model would allow for GPs that are credentialled for non-procedural advanced skills in the hospital setting (where such positions may be available currently or in the future) to be eligible if they were also providing emergency medicine services.</p>	<p>Hospital connection: Hold unsupervised clinical privileges in at least emergency medicine (and potentially other disciplines) at a nominated hospital in MM3–7 and participate in a regular roster or general on-call roster.</p> <p>Community connection: Evidence of delivery of services in the community through MBS billing in private practice (as evidenced through WIP eligibility).</p>
<p>A2b. Promotion of the Rural Generalist + AMS, RFDS and remote enhancement</p>	<p>Current credentialing requirements for enrolment into the program would be maintained. That is, hospitals are responsible for the credentialing of the general practitioner through their employment processes. Additional cohorts also recognised as eligible after a minimum of two years of service in their relevant employment or location:</p> <ul style="list-style-type: none"> • RFDS employed GPs • GPs in ACCHOs and other AMS in MM3–7 • GPs in MM6–7 	<p>Hospital connection: Hold unsupervised clinical privileges in at least emergency medicine (and potentially other disciplines) at a nominated hospital in MM3–7 and participate in a regular roster or general on-call roster.</p> <p>Community connection: Evidence of delivery of services in the community through MBS billing in private practice (as evidenced through WIP eligibility).</p> <p>Additional cohort (compared to option A2a): Requirement to deliver community-based services as required through employment with RDFS or AMS, or MBS billing in private practice in MM6–7 (similar to WIP). No requirement to deliver hospital-based services (because of their limited availability in these geographies) but will likely be providing ad hoc emergency care in the course of their service delivery.</p>

ACCHO: Aboriginal Community Controlled Health Organisation; WIP: Workforce Incentive Program

¹⁹ This expansion relies on an adherence to the definition of a Rural Generalist as defined in the Collingrove Agreement: ‘A Rural Generalist ... [provides] both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team’ [HMA emphasis]

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

5.3 PIP PROCEDURAL GP PAYMENT EXPANSION OPTIONS

In considering the expansion of the PIP Procedural GP Payment, we present two main options.

- Expand the payment (matched to the RPGP expansion) to include general practices supporting the delivery of non-procedural advanced skills, or
- No expansion.

Defining the specific health service delivery requirements for any expansion into service delivery of new advanced skills areas requires further consultation with stakeholders. It will be challenging to differentiate advanced service delivery from standard services delivered by a rural GP. This could be supported by the introduction of specific MBS items (reserved for eligible GPs) for delivery of advanced skills services to track the quantum of those services. This would enable a mechanism to provide a service delivery incentive payment, in a similar manner to the Workforce Incentive Payment (WIP).

Presented in Table 5.2 is a summary of options for expanding the PIP Procedural GP Payment to include non-procedural advanced skills matched to the expansion options for the RPGP.

Table 5.2: PIP Procedural GP Payment expansion options

PIP PROCEDURAL GP PAYMENT EXPANSION OPTIONS
MATCHED SKILL-BASED EXPANSION
B1a. Narrow expansion
<ul style="list-style-type: none"> • Aboriginal and Torres Strait Islander Health • Mental Health

²⁰ Recognition of equivalent training cohort is estimated to have 5-fold higher number of eligible GPs based on other AST to recognition of equivalent training estimates.

PIP PROCEDURAL GP PAYMENT EXPANSION OPTIONS

B1b. Moderate expansion

- 1a. As above
- Palliative Care
- Paediatrics

B1c. Broad expansion

1b. As above

All defined advanced skill areas supported by ACRRM AST and RACGP ARST curricula²⁰

NO EXPANSION

B2. No change to PIP Procedural GP Payment

5.4 STREAMLINING OPTIONS

There are three main options for the streamlining of the RPGP (Table 5.3):

- No change to the current administrative arrangements
- Combining the RPGP and PIP Procedural GP Payment under a single administration
- Redirecting PIP Procedural GP Payment into an expanded RPGP pool.

In addition to these options, a fourth approach could be considered: develop a new Rural Generalist Support Program. The estimated costs are additional costs associated with the streamlining option only. They do not include the cost of the existing RPGP or PIP payments.

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Table 5.3: Streamlining Options

Streamlining options	Description
C1. No change to administration of current programs	RPGP remains administered by the GP colleges PIP Procedural GP Payment remains administered by Services Australia
C2. Combine the RPGP and PIP Procedural GP Payment under the same administrative model	This option proposes ACRRM and RACGP would take responsibility for the administration of the PIP Procedural GP Payment along with the RPGP, which they currently administer. This would require the PIP Procedural GP Payment to align with the MMM geographical classification.
C3. Redirection of the PIP Procedural GP Payment into an expanded RPGP pool	This option proposes to redirect funding for the PIP Procedural GP Payment into the RPGP to support the expansion of the RPGP to include non-procedural advanced skills.
C4. Creation a new Rural Generalist Support Program Cost Sharing: Employment models used in relevant jurisdictions could be considered in any State or Territory / Commonwealth partnership in supporting this program	Combined program to support delivery of the National Rural Generalist Pathway, intended to support both CPD for and service delivery of advanced skills by GPs in rural and remote areas. Those eligible for the current RPGP program should remain eligible (at least for a certain period to enable any transition). All current and new Rural Generalists (FACRRM or FARGP) would be eligible for the program. Should a model similar to the WIP be employed, additional MBS item numbers

Streamlining options	Description
	for advanced service delivery by Rural Generalists would be a useful mechanism to determine eligibility for service delivery payments based on quantum of service delivery. Procedural and emergency GPs are paid through provision of services to a hospital; hence these services may not require additional service delivery incentive.

5.5 PROGRAM MERGER: ADDITIONAL COMMENTS

The RFQ for the project sought specific commentary on Option C3, Combine the RPGP and PIP Procedural GP Payment under the same administrative arrangements. The incentive programs in the rural workforce development space are numerous. There was some initial value in exploring this proposal because of the program rationalisation enabled by the option. However, more detailed analysis by the project team found several limitations reduced the attractiveness of this approach.

First, it is useful to contrast the program design rules. There are differences in:

- The target groups of the two programs:
 - RPGP is practitioner-based support and seeks to support procedural GPs by offsetting the costs of their CPD
 - PIP Procedural GP Payments are practice-based support and seek to encourage GP practices that include procedural GP expertise in recognition of the additional financial burden that providing these services can place on general practices, such as the need for additional roster cover or loss of income due to procedural GPs delivering services at the local hospital.
- The geographic rules:
 - RPGP is based on MMM classification
 - PIP Procedural GP Payments are based on RRMA classification, and

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

- The administrative arrangements:
 - RPGP is administered by the GP colleges
 - PIP Procedural GP Payment is administered via automated Services Australia processes for managing the overall PIP payments program.

It is technically feasible to merge the two programs together by rolling the current PIP payments into the RPGP program. This could involve maintaining the same practice-based incentives but with different geographic and administration arrangements (i.e. those of the RPGP). However, there are several short-term difficulties associated with this approach:

- Transferring administrative arrangements from Services Australia to the GP colleges would incur a relatively large one-off IT programming to ‘turn-off’ the system functionality, at an estimated cost of \$0.4 m.
- There would be a saving generated by transferring the PIP payments to eligibility being based on MM rather than RRMA, but this represents a significant number of entitlements ‘losers’, estimated at 454 practices.
- The payment administration processes – currently automated through Services Australia processes – would need to transfer to the two GP colleges, which would also have to set-up new payment processes. They would incur set-up costs in doing so (they have address and payment details for individual GPs, but not practices).
- The program rationalisation would require a willingness of the GP colleges to assume the administrative responsibility for the merged program, including some form of administrative checking of the practice-based entitlement of applicants. During consultations, the two Colleges said they were reluctant to assume that responsibility because of the need to create new administrative checking processes; they would expect extra remuneration for this further function.

These complexities would be best avoided if the longer-term objective in the CPD incentives area is Option C4, Creation of a new Rural Generalist Support Program (see Table 5.3 above).

5.6 OPTIONS COMPARISON

The pros and cons of the options presented can be examined by comparing them against six evaluative assessment criteria:

- Greater equity of access for rural and remote patients to advanced level care
- Greater incentive for GPs to undertake advance skill CPD
- Greater incentive for GPs to deliver advanced skill care
- Administrative simplicity
- Promotion of the Rural Generalist, and
- Budgetary impact.

The project team developed a scoring framework to assist with the assessment and comparison of options, based on the above criteria (see Table 5.4). It is important to note that the assessment has been completed for the AST/ARST cohort where relevant. An additional assessment would need to be completed to understand the impact of broader recognition of equivalent training for eligibility as this could have significant impact on the number of eligible GPs and would increase the budgetary impacts.

Table 5.4: Scoring framework for assessing program design and streamlining options

Criterion Score	Considerations for scoring option
Criterion 1: Greater equity of access for rural and remote patients to advanced level care	
<i>Assumption:</i> support for CPD for GPs with advanced skills will improve patient access	
Score = 0	no change relative to current arrangements
Score = 1	limited increase in number of GPs supported
Score = 2	moderate increase in number of GPs supported
Score = 3	large increase in number of GPs supported
Criterion 2: Greater incentive for GPs to undertake non-procedural advanced skill CPD	
<i>Assumption:</i> financial support is a key incentive for GPs to undertake CPD	
Score = 0	no change relative to current arrangements or uncertain change
Score = 1	limited increase in funding available for individual GPs with non-procedural advanced skills to undertake CPD
Score = 2	moderate increase in funding available for individual GPs with non-procedural advanced skills to undertake CPD

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

Criterion 3: Greater incentive for GPs to deliver non-procedural advanced skill care

Assumption: GPs are incentivised to deliver advanced skill services by individual support for CPD for RPGP or practice-based support for service delivery (PIP Procedural GP Payment)

Score = 0 no change relative to current arrangements

Score = 1 small increase in incentivisation of advanced skill service delivery

Score = 2 large increase in incentivisation of advanced skill delivery

Criterion 4: Administrative complexity

Assumption: additional program component (each extra skill) increases administrative complexity at the program level; combining two program objectives (service delivery and maintenance of skills) increases administrative complexity

Score = -2 significant administrative complexity

Score = -1 moderate administrative complexity

Score = 0 no change relative to current arrangements

Criterion 5: Promotion of Rural Generalism as a workforce principle

Assumption: the Rural Generalist workforce principle supports the delivery of advanced level primary, hospital and emergency care in rural and remote areas

Score = 0 no change relative to current arrangements

Score = 1 partial alignment to RG workforce principles

Score = 2 complete alignment to RG workforce principles

Criterion 6: Budgetary impact

Assumption: additional expenditure above the current program costs is considered a negative impact

Score = -3 significant additional cost (>50% above current program)

Score = -2 moderate additional cost (25-50% above current program)

Score = -1 limited additional cost (<25% above current program)

Score = 0 no change relative to current arrangements

Score = 1 cost saving

A comparison of the program design and streamlining options against the assessment criteria is provided in the following tables (See Tables 5.5 – 5.7).

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

Table 5.5: RPGP design options assessment

RPGP DESIGN OPTIONS	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promote rural generalism as a workforce principle	Criterion 6: budgetary impact	
Option A1a: Expansion to include Aboriginal and Torres Strait Islander Health and Mental Health	1	1	0	-1	1	-1	1
	Provides a small increase in specialist care in two areas of need. Minimal level of additional access for rural and remote communities. Minimal level of additional access for rural and remote communities due to limited number of AST/ARST qualified GPs.	The RPGP removes the cost barrier from undertaking CPD. This is equally relevant to non-procedural skills.	This will depend on the agreed eligible service delivery criteria for the additional advanced skills.	Further refinement of eligible health service engagement is required for each area. Once established, administration would be similar to the recent addition of emergency mental health. Recognition of equivalent training will require resourcing should this be included.	Rural generalism encompasses a broad range of procedural and non-procedural advanced level skills. This expansion is limited in its support of a range of non-procedural advanced skills. However, service delivery requirements will define if the hallmarks of a rural generalist (hospital, emergency and community service delivery) are all required.	Due to limited numbers of AST/ARST qualified GPs there is expected to be limited additional cost associated with this option.	
Option A1b: Expansion to include Aboriginal and Torres Strait Islander Health, Mental Health,	2	2	0	-1	1	-1	3
	Provides a small increase in specialist care in four key areas of need. Minimal	As per Option A1a plus additional non-procedural advanced skills supported.	As per Option A1a	As per Option A1a with the inclusion of two more advanced skill areas requiring	Rural generalism encompasses a broad range of procedural and non-	Due to limited numbers of AST/ARST qualified GPs there	This option is suggested should a smaller, well-defined

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RPGP DESIGN OPTIONS	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promote rural generalism as a workforce principle	Criterion 6: budgetary impact	
Palliative Care and Paediatrics	level of additional access for rural and remote communities due to limited number of AST/ARST qualified GPs.			additional refinement of eligibility and resourcing.	procedural advanced level skills. This expansion provides support for a range of priority non-procedural advanced skills. However service delivery requirements will define if the hallmarks of a rural generalist (hospital, emergency and community service delivery) are all required.	is expected to be limited additional cost associated with this option.	expansion with impact in clinical areas of need be preferred.
Option A1c: Expansion to include all GP college defined advanced skill areas	2 The recognition and support of ongoing skills maintenance for non-procedural advanced skills will provide communities with GPs capable of and willing to continue to deliver additional services locally where specialist availability is limited.	3 As per Option A1b plus additional non-procedural advanced skills supported.	0 As per Option A1a	-2 As per Option A1a with the inclusion of eight advanced skills in total. The additional four skills not included in the above options may be more challenging to determine appropriate nature of health service engagement. This will require	1 This option provides support for all advanced skills as defined by the GP colleges AST/ARST curricula. However service delivery requirements will define if the hallmarks of a rural generalist (hospital, emergency and community service	-2 Including all AST/ARST qualified GPs is expected to moderately increase the expenditure of the current program.	2

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RPGP DESIGN OPTIONS	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promote rural generalism as a workforce principle	Criterion 6: budgetary impact	
				additional resourcing to manage.	delivery) are all required.		
Option A2a: Expansion to include all required CPD; eligibility limited to currently eligible procedural and emergency GPs	0	0	0	-2	2	1	1
	It is not clear if additional support for currently supported Rural Generalists (proceduralists and emergency medicine GPs) will encourage delivery of additional non-procedural skills in rural and remote communities.	GPs already accessing the RPGP may have a limited opportunity to undertake additional CPD in areas outside procedural and emergency. Constraints on time rather than financial support may limit any additional CPD.	A program supporting broad CPD may have limited impact on the support for non-procedural advanced service delivery.	Inclusion of a broad range of advanced skills will be challenging to administer. Determining appropriate eligibility of CPD could be resource intensive.	This option supports the principle of Rural Generalists to participate in hospital, emergency and community service delivery.	This option is expected to provide cost savings due to a cohort of currently eligible GPs not meeting the definition of Rural Generalism.	
Option A2b: Expansion to include all required CPD; eligibility as per Option A2a with the addition of AMS GPs, RDFS and all MM6-7 GPs	0	1	0	-2	2	-3	-2
	As per Option A2a for the main cohort. The addition of the three extra categories of eligibility will see another 627 GPs supported with CPD who otherwise would not have access to it. The additional cohorts would have varying expertise in non-	As per Option A2a. Newly eligible GPs in the additional cohorts would have had no or limited access to support for CPD for non-procedural advanced skills. This would provide a financial incentive for GPs to undertake CPD in this area.	A program supporting broad CPD may have limited impact on the support for non-procedural advanced service delivery.	The inclusion of cohorts in addition to the expansion of CPD available as per Option A2a, will increase the complexity of administration of this program.	This option is supportive of the Rural Generalist while also acknowledging limitations to provide certain services for some GP cohorts that would not meet the definition of a Rural Generalist.	This option has the potential to significantly increase the expenditure of the current program due to the inclusion of additional cohorts.	While this option increases access to CPD for underserved GPs and populations, it is unclear if it would increase access to non-procedural advanced level care and comes

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RPGP DESIGN OPTIONS	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promote rural generalism as a workforce principle	Criterion 6: budgetary impact	
	procedural areas (with the exception of AMS GPs) so the direct impact on access to non-procedural expertise is uncertain.						at considerable expense.

Table 5.6: PIP Procedural GP Payment options assessment

PIP DESIGN OPTIONS	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promotion of workforce principle of rural generalist	Criterion 6: Budgetary impact	
Option B1: Matched skills-based expansion	1	0	1	-2	1	-2	-1
	PIP Procedural GP Payment incentivises service delivery through a practice-based payment. This may encourage practices to support the employment of GPs with non-procedural advanced skills.	Additional support for delivery of advanced non-procedural skills may provide some incentive for GPs with these skills to maintain their skills. Due to the practice-based nature of this payment the impact is likely minimal.	Due to the practice-based nature of the payment, it is likely to only have a small impact on an individual GP's intention to deliver non-procedural advanced skills.	Having additional skills streams under the PIP with potentially different service tiers and requirements would be complicated and challenging to administer and monitor appropriate claiming.	Matching support for service delivery of non-procedural skills with procedural skills would assist in broadening the definition of Rural Generalists beyond procedural services.	The impact on the budget is likely to be a moderate increase.	High complexity in determining a mechanism to measure service delivery and minimal direct incentivisation of GPs.

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PIP DESIGN OPTIONS	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promotion of workforce principle of rural generalist	Criterion 6: Budgetary impact	
Option B2: No change	0	0	0	0	0	0	0

Table 5.7: Streamlining options assessment

STREAMLINING	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promotion of workforce principle of rural generalist	Criterion 6: Budgetary impact	
Option C1: No change	0	0	0	0	0	0	0
Option C2: Streamlined administration (requiring transition to MM for practice payment)	0	1	1	-2	0	0	0
	Some practices newly included under the MM classification system would be able to provide support to attract and retain advanced skill GPs. Other practices may fall out of the eligible area; however this would likely have minimal impact on access due to these areas	A single administration system may encourage more GPs to claim for CPD support.	The common administration of the programs may encourage GPs with advanced skills to claim (as owners) or encourage their practices to claim a practice incentive payment aligned with their advanced skill.	Shifts administrative arrangements from an automated Services Australia process to a college-based administrative arrangement. This would enable some quality checking of claims. Managing both a practice and practitioner-based payment system may be complex.	No change relative to current arrangements.	Minimal budgetary impact expected.	Limited impact that generates additional outlays.

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STREAMLINING	ASSESSMENT CRITERION						OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promotion of workforce principle of rural generalist	Criterion 6: Budgetary impact	
	being marginal to metro regions.						
OPTION C3: Redirection of the PIP Procedural GP Payment into an expanded RPGP pool	0	2	0	0	1	1	4
	There is limited evidence to suggest that practice-based incentives are supporting access to procedural advanced skills. However, it is unclear if supporting non-procedural CPD will directly lead to better access for rural and remote patients.	There are financial barriers to maintaining non-procedural skills, which could be addressed with additional funding to support this CPD.	Minimal impact to the incentive to deliver non-procedural skills as there has not been support previously for this. Support for CPD will assist in GPs maintaining advanced skills to continue to provide service delivery.	Simplifies the administration by removing one component completely. Additional complexity will be as per the expansion option chosen for RPGP.	This would support a broader cohort of Rural Generalists with non-procedural skills. The extent of alignment with rural generalism will be determined by the nature of service engagement and eligibility requirements for the RPGP expansion.	Cost savings would be expected from this option.	Could redirect funding to supporting GPs with non-procedural advanced skills while having potentially minimal impact on service delivery.
OPTION C4: Creation of a new Rural Generalist Support Program	1	2	2	-1	2	-1	5
	Supporting rural generalism more broadly through both support for CPD and individual service delivery will increase access to non-procedural advanced care. The extent to which this increases access will depend on the	Increases incentive for non-procedural advanced skill CPD, where there was no support previously. Supporting non-procedural service delivery with a service delivery component targeted to the individual GP's activity levels	Support for service delivery targeted to an individual GP's activity level should incentivise non-procedural service delivery.	Depending on the eligibility and design of the program, along with any other supporting mechanisms to determine service delivery (e.g. MBS items for advanced level services), the complexity of the	Where a new program results in a more comprehensive and targeted support program for Rural Generalists there is potential for it to strongly promote the workforce principles of rural generalism.	The impact on the budget is likely to be minimal.	This option could enable a broader support program for rural generalists.

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STREAMLINING	ASSESSMENT CRITERION					OVERALL ASSESSMENT
	Criterion 1: Greater equity of access for rural and remote patients to non-procedural advanced level care	Criterion 2: Greater incentive for GPs to undertake NON-PROCEDURAL ADVANCED SKILL CPD	Criterion 3: Greater incentive for GPs to deliver NON-PROCEDURAL ADVANCED SKILL CARE	Criterion 4: Administrative complexity	Criterion 5: Promotion of workforce principle of rural generalist	
	final eligibility criteria. Limiting access to FARGP or FACRRM will limit the pool of additional expertise and access to it.	should also incentivise skills maintenance.		administration could change. Generally there should be administrative time and cost savings of having a service incentive and a CPD payment for the one group of GPs under one administration system. It is likely that this system would be duplicated by both GP colleges.	However, appropriate remuneration may still remain a challenge to enthusiastic uptake of a rural generalism. It will also be important to recognise the significance of the contribution of GPs with advanced skills who do not (or cannot) participate in all aspects of rural generalism (hospital, emergency and community service delivery).	

5 THE WAY FORWARD: OPTIONS FOR PROGRAM REDESIGN

5.7 SUMMARY AND CONCLUSION

This report has examined a range of issues around the consultation and design process for the expansion and streamlining of the RPGP and the PIP Procedural GP Payment. The aim of this process was to align with and support the ongoing development and recognition of the National Rural Generalist Pathway.

The views of stakeholders on the expansion of the RPGP program is predictably positive where there is no impact to the current program (i.e. where the program budget is expanded to support non-procedural skills). There was less clear support for the expansion of a practice incentive as a mechanism to promote non-procedural service delivery. This was in part due to the less well-defined criteria for service delivery for non-procedural advanced skills. Additionally, stakeholders questioned the appropriateness of the practice incentives for non-procedural service delivery and suggested better remuneration through alternative mechanisms such as increased MBS levels for advanced skill areas would be more appropriate.

This report describes the potential design elements of an expanded RPGP and impact on the PIP Procedural GP Payment. It shows that a stepwise expansion into priority areas with tight eligibility criteria could be a low-risk approach to expanding the RPGP. Expansion of a practice incentive for non-procedural service delivery requires further consideration to ensure auditable measures of service delivery are available and appropriate outcomes are targeted through this incentive. The streamlining of the programs may provide some administrative savings, however the benefit of undertaking such an activity without a broader policy impetus is currently uncertain.

The process for national recognition of rural generalist medicine as a speciality through the Medical Board of Australia is ongoing. Once this process has been completed, there may be a clearer direction and mechanisms in place for workforce incentive programs to support Rural Generalists.

The report explores several options for the RPGP and PIP Procedural GP Payment, including tiered expansion into priority areas, broader expansion, and matched practice incentive expansion. We have presented an analysis based on six key evaluative criteria, which will assist the Department in assessing the relative merits of these options to determine the most appropriate approach for the expansion and streamlining of the RPGP and PIP Procedural GP Payment.

6 APPENDICES

APPENDIX A PATHWAYS FOR RURAL GENERALISTS

Career pathways for Rural Generalists was a common theme that emerged from consultations carried out as part of this project. This issue is broader than CPD grants and/or service delivery incentives, but nonetheless an important consideration for the context of these programs. These considerations are not new, with many raised by stakeholders in the RACGP National Rural Faculty's 2014 report into 'New Approaches to integrated rural training for medical practitioners'²¹. For completeness, the following commentary is included.

Current state

Several GPs interviewed by the project team mentioned the lack of a clear career pathway for Rural Generalists with advanced skills. This is a particular issue for Rural Generalists with advanced skills in non-procedural areas where there are limited positions available for these GPs to practice their advanced skills in a hospital setting.

One GP also had concerns for the career pathways of Rural Generalists with procedural skills where specialist services have become available in their hospitals and Rural Generalists are no longer able to practice to the full scope of their skills and qualifications.

In some jurisdictions where there is strong support and reimbursement for Rural Generalists within the hospital system, there is an emerging trend for Rural Generalists to spend little to no time in general practice, which is contrary to the broad principles embedded in the Collingrove Agreement.

²¹<https://www.racgp.org.au/FSDEDEV/media/documents/Faculties/Rural/New-approaches-to-integrated-rural-training-for-medical-practitioners-final-report.pdf>

Being able to encourage the practice of procedural or non-procedural advanced level skills in rural and remote settings is highly dependent on the ability of GPs and trainees to see a clear and attractive career pathway where they are well supported to maximise the use of their broad skills.

The concerns raised about the career pathways for Rural Generalists in the context of consultation for this project provides some insight into the challenges facing the practitioners these programs hope to incentivise.

Consultation feedback: Barriers to rural generalism

Some stakeholders considered the different remuneration arrangements between GPs practicing in different settings was a barrier to rural generalism. Suggestions for addressing this were provided by some stakeholders, including the establishment of Rural Generalist positions and training which include part-time community practice and part-time hospital care, thereby avoiding the issue of better remuneration within the hospital system and the leakage of Rural Generalists away from community practice. Another stakeholder suggested State health departments should provide longer-term support for Rural Generalist positions within hospitals, potentially cofounded with the Commonwealth Government.

Some stakeholders suggested local issues played a role in the availability of positions for Rural Generalists in hospitals, with some hospitals management showing a lack of commitment to the model of rural generalism.

One stakeholder suggested that there had not been an alignment between the Commonwealth support for rural generalism and the implementation of this within the State/Territory health systems.