HealthConsult

Department of Health, Disability and Ageing

Evaluation of the Single Employer Model (SEM)

Early Report

28 August 2025

Contents

Abbreviations

ACCHO	Aboriginal Community-Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AMS	Aboriginal Medical Service
BRHS	Bairnsdale Regional Health Service
CWAATSICH	Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health
EBA	Enterprise Bargaining Agreement
ED	Emergency Department
EOI	Expression of Interest
FFS	Fee-For-Service
FSP	Fellowship Support Program
FTE	Full Time Equivalent
GH	Grampians Health
GP	General Practice
GPRA	General Practice Registrars Australia
GPSA	General Practice Supervision Australia
HETI	Health Education and Training Institute
HHS	Hospital and Health services
IP	Independent Pathway
KEQ	Key Evaluation Questions
LHD	Local Health Districts
LHN	Local Health Network
LIME	Leaders in Medical Education
MBS	Medicare Benefits Schedule
MBPH	Mildura Base Public Hospital
MLHD	Murrumbidgee Local Health District
MM	Monash Model
MoU	Memoranda of Understanding
MPN	Medicare Provider Numbers
NSW	New South Wales
NTCER	National Terms and Conditions for Employment of Registrars
PGY	Post-Graduate Year
PIP	Practice Incentive Program
QH	Queensland Health

QAIHC	Queensland Aboriginal and Islander Health Council
QLD	Queensland
RACE	Riverland Academy of Clinical Excellence
RACGP	Royal Australian College of General Practitioners
RCS	Rural Clinical School
RDAA	Rural Doctors Association of Australia
RG	Rural Generalist
RGPSA	Rural Generalist Program South Australia
RGTS	Rural Generalist Training Scheme
RMCLHN	Riverland Mallee Coorong Local Health Network
RSS	Rural Support Service
SA	South Australia
SEM	Single Employer Model
SWHHS	South West Hospital and Health Service
TAS	Tasmania
THS	Tasmanian Health Service
UCC	Urgent Care Clinics
VRGP	Victorian Rural Generalist Program
WIP	Workforce Incentive Program

Executive Summary

This Early Evaluation Report brings together initial findings from the evaluation of the National Single Employer Model (SEM) trials for General Practice (GP) and Rural Generalist (RG) registrars. This report precedes a full first interim report, due for release in February 2026 and is intended to provide early insights for policy makers, peak bodies, trial leads and SEM participants on the progress of the SEM trials.

This report covers the period from trial commencement to June 2025. As this is an early report and there is considerable variance in the trials' development and implementation, the evaluation questions have guided early inquiry and will be comprehensively answered over the course of the evaluation. Findings presented in this report should be interpreted in that context.

Introduction

This evaluation assesses the implementation of the SEM trials, their appropriateness as mechanisms to increase GP/RG training attractiveness and develop sustainable regional, rural and remote workforces, and their effectiveness in achieving key outcomes to date.

Evaluation approach

The evaluation commenced in February 2025 and will conclude in March 2028.

This report includes nine SEM trials across five jurisdictions: New South Wales, Queensland, South Australia (including Riverland Academy of Clinical Excellence (RACE)), Tasmania and Victoria.

This evaluation took a mixed methods approach, synthesising data from:

- **A document review** which informed comprehensive understanding of each trial
- **Interviews and focus groups** with 61 participants including trial leads, state health services, GP practice managers, GP supervisors, GP colleges, registrars and peak bodies
- **Trial data** to examine participant demographics and program characteristics.

The following limitations should be noted:

- Trial data was of variable quality and consistency
- A small number of participating registrars (n=8, all female) and general practices (supervisors and practice managers, n=12) were interviewed for this report.

The SEM trials

Participants in trials (registrars, health services, supervisors and practice managers) were supported through trial leads, administrative support, practice agreements, and guidance documents. Trial progress varied across jurisdictions, with some building on established foundations (e.g., New South Wales (NSW)) while others were early in implementation (i.e., commenced in 2025).

There are 122 registrars currently participating in the trials. Most are post-graduate year three to five, over half are female (n=59), and most obtained their degree from an Australian university (79%). Registrar College Fellowship training is approximately one third Royal Australian College of General Practitioners (RACGP) and two thirds Australian College of Rural and Remote Medicine (ACRRM).

Diverse trial models span different geographic locations, health service structures, and implementation approaches. Trials range in capacity from 15 to 80 participants; have different financial arrangements with primary care practices (e.g., percentage of Medicare Benefits Schedule (MBS) billings versus hours worked) and different levels of central coordination and responsibility where trials cover large geographic areas.

Stakeholder views on SEM trials

The section provides a summary of stakeholder views on the implementation of the SEM trials to date.

Registrars

- Valued the secure and consistent salary provided under the SEM arrangement.
- Considered the retention of earned benefits and access to leave entitlements when choosing SEM.
- Acknowledged that SEM removes billing pressures, allowing registrars to focus on clinical skill development (rather than billing) and allowing longer consultation times for more complex patients.
- Reported early issues with administration processes (e.g., timesheet approval, leave requests) and confusion around roles and responsibilities (i.e., who they reported to or go to with an issue).

General practice and training sites

- Interviewed practices were positive about the SEM trials to date. Workforce stability and financial risk reduction were highlighted as practice benefits.

- There was a positive view that SEM supported registrars to focus on clinical skill development.
- Some challenges were experienced with administrative processes with the single employer, such as managing registrar leave, invoicing and rostering.
- Practices also reported confusion around performance management responsibilities they held versus the single employer.
- Practices reported that they had established relationships with their local hospital/state health service through the SEM trial.

Colleges

- Held mixed views on whether SEM can improve GP/RG training attractiveness.
- Stakeholders expressed concerns on their late engagement in the overall SEM trial design, acknowledging they had been involved to various extents in jurisdiction-level trial design.
- Reported that systematic integration of SEM was difficult due to variation between the trials.

Findings

This section provides a summary of findings against the evaluation areas.

Implementation

Participants reported broad satisfaction with SEM arrangements, despite implementation challenges, largely related to uncertainty regarding roles and responsibilities and misaligned employment arrangements and conditions between GPs and state health services. Overall, stakeholders framed these as "teething issues", which for the most part were overcome through clear communication. Stakeholders held different views about the financial implications of SEM, although it is too early to assess how this may impact ongoing implementation and the uptake of SEM by registrars, practices and state health services.

Appropriateness

Stakeholders held mixed views on the SEM's appropriateness as a mechanism to achieve its policy objectives of increasing the attractiveness of GP/RG careers and building sustainable non-metropolitan workforces. Perceptions of appropriateness may be contingent on longer-term visions regarding what the SEM could achieve and may influence levels of engagement and investment where stakeholders are not aligned on the vision. Stakeholders across the trials highlighted that the SEM needs to align with changing GP and health system contexts in each jurisdiction as well as nationally.

Effectiveness

Most stakeholders considered it too early to comment or accurately assess whether SEM arrangements have improved the attractiveness of GP/RG training, primary care careers and training in regional, rural and remote locations. Registrar access to a secure salary, and their retention of earned benefits including leave were cited as key factors impacting their decision to undertake training on a SEM arrangement. While it is very early, six registrars have achieved fellowship through SEM. Early impacts were noted upon improved training quality and increases to patient access and continuity of care.

Considerations

Key considerations to support effective implementation:

- Streamline administrative processes around time sheets, leave approvals, etc, including reducing reliance on paper-based systems.
- Trial Leads should consider developing quick reference guides outlining key differences between SEM registrars and usual training arrangements.
- Clarify and clearly document roles and responsibilities of all parties (trial leads, Single Employer, training site managers and supervisors, registrars, GP colleges), including dedicated contacts for when issues arise.

1. Introduction

The Commonwealth Department of Disability, Health and Aging has engaged HealthConsult to undertake an evaluation of the National SEM trials from 2025-2028.

1.1. Project background

The SEM trials for GP and RG registrars aim to enhance the appeal of GP/RG training and sustainably expand workforces to increase access to comprehensive care, particularly in regional, rural, and remote areas.

The SEM trials were first launched in late 2020 by the Murrumbidgee Local Health District (MLHD) in NSW. A second trial followed in December 2022, implemented by South Australia's Riverland Mallee Coorong Local Health Network (RMCLHN).

The SEM trials enable registrars to maintain employment with a single entity throughout their training rotations. This model simplifies accrual of entitlements, offers fixed salaries independent of Medicare billings, and provides certainty around training and placement arrangements. A key priority of these trials is to build a local workforce in regional, rural, and remote areas, as well as other areas of identified workforce need.

The Australian Government has committed an additional $6.4 million to expand the SEM trials. This funding covers this national evaluation, and the introduction of a First Nations-led trial, which is intended to be led by the Aboriginal Community-Controlled Health Organisation (ACCHO) sector, complementing jurisdiction-led trials.

1.2. Evaluation overview

This evaluation commenced in February 2025 and will be completed by March 2028.

The evaluation's key aims are to:

- assess SEM trial appropriateness, implementation, effectiveness, financial impact, and impact on workforce retention in accordance with the Evaluation Framework.
- compare the different trial models and their features (e.g. place-based vs centrally led vs the First Nations-led trial) to identify key benefits, challenges, and stakeholder satisfaction.
- provide evidence-based recommendations to support continuous improvement, policy development, and future SEM rollout.

This report is the Early Evaluation Report and covers the period from trial commencement to June 2025. Note that as this is an early report and there is considerable variance in the trials'

development and implementation, the evaluation questions have guided early inquiry and will be comprehensively answered over the course of the evaluation and throughout remaining deliverables. Findings presented in this report should be interpreted in that context.

1.3. Structure of this report

This report provides a snapshot of trial progress to date and early findings.

The structure of this report is:

- **Chapter 1: Introduction** provides the background and context of the SEM trials, the evaluation purpose, and an overview of the report structure.
- **Chapter 2: Evaluation approach and methods** details the evaluation approach, including key evaluation questions and data sources informing this report.
- **Chapter 3: The SEM trials** describes the various SEM models implemented across jurisdictions, their key features, governance arrangements, and operational contexts.
- **Chapter 4: Implementation** analyses the delivery of the trials, examining trial features and progress, registrar and practice characteristics, registrar satisfaction, administrative arrangements, and implementation enablers and barriers.
- **Chapter 5: Appropriateness** presents findings on how appropriate the SEM trials are thus far for achieving their policy objectives over the long-term.
- **Chapter 6: Effectiveness** assesses outcomes related to training and career attractiveness in rural and remote areas, fellowship achievement, workforce retention, and early implications regarding training quality and patient access.
- **Chapter 7: Conclusions** summarises evaluation findings and provides evidence-based, early considerations for policy and program improvement.

The report includes three appendices: Appendix A contains the detailed Evaluation Framework with sub-questions, indicators, and data sources; Appendix B presents the program logic model; and Appendix C contains a description of each trial.

2. Evaluation approach

This chapter provides an overview of the evaluation approach including the guiding evaluation questions and the data sources which inform this report.

2.1. Evaluation questions

This early report contains findings related to the following key evaluation questions (KEQs):

- KEQ1: How appropriate is SEM as a mechanism to improve the attractiveness of GP/RG training and build a sustainable workforce in regional, rural and remote locations?
- KEQ2: How well have the trials been delivered?
- KEQ3: How effective were the trials in achieving the intended outcomes?
- KEQ4: What are the key learnings from the trials and future opportunities for SEM?

Sub-questions, indicators, and data sources for each KEQ are outlined in the Evaluation Framework presented in Appendix A.

2.2. Data sources and analysis

This report has been informed by a mixed methods approach, involving triangulation of data to corroborate findings.

2.2.1. Document review

A comprehensive review was conducted of key documents related to the SEM trials, including:

- Commonwealth and state/territory policy documents
- Trial proposals and implementation plans
- Memoranda of Understanding (MoUs) between the Commonwealth and jurisdictions
- Practice agreements between Single Employers and primary care practices
- Employment contracts and conditions for SEM registrars
- 19(2) Direction documents
- Other supplied documentation from trials.

The document review established the foundational understanding of each trial's objectives, design, and operational context.

2.2.2. Interviews and focus groups

16 interviews and eight focus groups were held between 22 April and 2 June 2025.

Stakeholders included:

- trial leads (n=15)
- state health services who employ SEM registrars (n=9)
- GP practice managers and/or supervisors of SEM registrars (n=12)
- SEM registrars (n=8)
- college representatives (n=13) from the RACGP and the ACRRM; and
- peak body representatives (n=4) from General Practice Registrars Australia (GPRA), General Practice Supervision Australia (GPSA), and the Rural Doctors Association of Australia (RDAA).

Participants are outlined in Table 1.

Table 1: Stakeholder interviews and focus groups

Stakeholder group	Number of focus groups/interviews	Number of participants
Trial leads	7	15
State health services	3	9
Colleges	4	13
Peak bodies	3	4
Registrars	2	8
Practice managers & GP supervisors	5	12
Total	**24**	**61**

2.2.3. Trial data

Trial data was collected from trial leads via a Trial Reporting spreadsheet (Table 2) provided by all trials. All data was analysed on a Department laptop, de-identified and aggregated for reporting purposes to ensure participant confidentiality and data security.

Table 2: SEM trial participant data collection requirements by category

Category	Data Fields
Participant Demographics	Full name, date of birth, gender, primary residence (state, suburb, country)
Medical Training Background	Post-Graduate Year (PGY), Australian/International Medical Graduate status, College Fellowship program (RACGP/ACRRM)
Trial Participation	Trial site, commencement date, expected duration, current leave status
Training Placements	Current GP practice placements, hospital placements (if any), training pathway, Advanced Skills Training
Administrative Details	Medicare Provider Numbers (MPNs) for each placement
Exit Information	Date of cessation (if applicable), reason for leaving trial

The trial data was subject to comprehensive analysis involving frequency counts and percentage calculations to examine participant demographics and program characteristics. However, several data quality limitations impacted the analysis. Data entry errors were identified across multiple variables, including gender, training pathway designation, and date of birth. Furthermore, inconsistencies in data collection and recording across individual trial sites compromised the reliability of comparative analyses between locations. As a result, data has mainly been presented aggregated across all trials.[1]

[1] The evaluation team will work with trial leads to improve data quality prior to the next report due in December 2025.

3. The SEM trials

This chapter provides an overview of how the SEM trials operate and details their progress to date. The SEM trials' program logic provides further information and is presented in Appendix B.

3.1. Trial administration and parameters

The Commonwealth Department oversees national policy for the SEM trials, with participation being voluntary for jurisdictions, primary care practices, and GP/RG trainees. Jurisdictional proposals to establish a trial must address unique local needs and contexts to receive Commonwealth approval and funding.

The trials primarily target Modified Monash Model (MM) 2-7 locations, based on the highest MM classification of each area over the previous five years. Jurisdictions can determine specific MM 2-7 regions for implementation, subject to Commonwealth approval, with all trials concluding by the end of 2028.

In jurisdiction-led trials, the state or territory functions as the Single Employer. A direction under subsection 19(2) of the Health Insurance Act (SEM s19(2) Direction), arranged by the Department, enables registrars to bill Medicare for services in private general practices despite their state/territory employment. This direction specifies eligible MBS items, covering non-referred clinical attendance and procedural skills performed by the registrar in approved primary care settings. The direction modifies funding flows rather than providing additional funding and prevents "double dipping" of services already funded under the National Health Reform Agreement.

When a state/territory entity acts as the Single Employer, a Memorandum of Understanding (MoU) is established between the Commonwealth and the state health service, outlining roles, responsibilities, and operational arrangements. These MoUs specify parameters including the maximum number of registrars (up to 80 per jurisdiction at any time) and service provision details.

Eligible registrars include any GP/RG trainee formally enrolled in a fellowship program meeting the requirements of ACRRM or RACGP, though individual trials may have additional criteria, such as being enrolled in the state's rural generalist training pathway (refer to Appendix C).

Voluntary participation remains essential for both registrars and primary care practices in all SEM trials.

3.2. Overview of the SEM trials

As of May 2025, SEM trials are operating across five jurisdictions in Australia and have progressed through varying stages of implementation. The trials demonstrate diverse approaches to implementing the SEM.

3.2.1. NSW

The NSW SEM trial evolved from the original Murrumbidgee Local Health District (MLHD) model that commenced in late 2020, as the first Commonwealth-supported SEM trial. In early 2024, NSW expanded to a broader implementation across eight Local Health Districts (LHDs) organised into two collaborative trials:

- **Collaborative Trial One:** Murrumbidgee, Western NSW, Southern NSW, Illawarra Shoalhaven, and Far West LHDs
- **Collaborative Trial Two:** Hunter New England, Northern NSW, and Mid-North Coast LHDs

The NSW trials support up to 80 registrars on an RG training pathway across the eight participating LHDs. A small number of registrars from the original MLHD trial achieved fellowship in October 2023 and have remained in the area, representing early positive retention outcomes.

3.2.2. Queensland

Queensland adopted a staged implementation approach:

- **Proof-of-Concept Trial:** Commenced in early 2024 with a cohort of seven registrars across three Hospital and Health services (HHSs): Darling Downs, Central Queensland, and Townsville
- **Pilot Trial:** Began in 2025, in three regions (Northern including Cairns and Hinterland, Townsville, Mackay, North West, and Torres and Cape; Central including Central West, Sunshine Coast, Wide Bay, Central Queensland, and Metro North; and Southern including South West, Darling Downs, West Moreton, Gold Coast, and Metro South) based on learnings from the proof-of-concept phase

Each region will have up to a maximum of 20 registrars. The Queensland model is particularly focused on very rural and remote areas (MM 4-7).

3.2.3. RACE

The RACE SEM Trial has been operating since late 2022 through the Riverland Mallee Coorong Local Health Network (RMCLHN). This trial predates the broader South Australian approach and functions as a distinct initiative focusing on a single Local Health Network (LHN) region. The RACE model emphasises close integration between hospital and community settings, with a strategic

approach to participant selection focused on long-term retention in the region. The RACE model also includes pre-vocational doctors (i.e., prior to commencing GP/RG training).

3.2.4. South Australia

South Australia's Regional SEM trial launched in February 2025 as a broad initiative covering five regional Local Health Networks (Barossa Hills Fleurieu, Eyre & Far North, Flinders & Upper North, Yorke & Northern, and Limestone Coast). The trial is coordinated by the Rural Support Service (RSS) on behalf of the participating LHNs, building on the existing Rural Generalist Program South Australia (RGPSA) framework. With capacity for up to 60 participants, this trial leverages established rural workforce networks to create a coordinated statewide approach focused on MM 2-7 locations.

3.2.5. Tasmania

Tasmania's statewide SEM trial commenced in mid-2023, supported by an $8 million commitment from the Australian Government in the October 2022-23 budget as part of the Primary Care Pilot Program and a $5 million contribution from the Tasmanian Government. The trial is available to all MM 2-7 locations across the state. Tasmania has a 20-headcount maximum in their SEM trial.

3.2.6. Victoria

Victoria launched its SEM trial in February 2025 with a focused approach through three hospitals: Bairnsdale Regional Health Service (BRHS), Grampians Health (GH) and Mildura Base Public Hospital (MBPH). The Victorian trial is smaller in scale (15 full time equivalent (FTE) positions) and shorter in duration (two years) compared to other jurisdiction-led trials, reflecting Victoria's intent to evaluate effectiveness before considering broader implementation.

3.2.7. First Nations-led trial

The First Nations-led trial commenced planning in 2024. Led by the Queensland Aboriginal and Islander Health Council (QAIHC), this trial represents a significant departure from jurisdiction-led models by positioning ACCHOs as the Single Employer.

The trial is initially focused on Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited (CWAATSICH) with plans for other primary care practices to host registrars. This community-controlled approach emphasises cultural safety, self-determination, and integrated mentorship from Elders and community leaders.

3.2.8. Upcoming progress

The ACT has expressed interest in hosting a trial and Western Australia's trial proposal was approved by the Commonwealth in August 2025. The Northern Territory (NT) government has independently commissioned a SEM-like trial for post-fellowship GPs/RGs in the Big Rivers region. Any future SEM or SEM like-models in the NT would be considered based on the learnings of the Big Rivers model and the fit for the NT context.

All Commonwealth supported trials are scheduled to conclude by the end of 2028, with the evaluation informing future policy decisions.

4. Implementation

This chapter presents early evaluation findings related to **KEQ2: How well have the trials been delivered?**

To do so it outlines key features of the trials, SEM registrars, and participating primary care practices. It also examines satisfaction with the SEM, and the administrative arrangements and processes central to implementation. The chapter concludes by discussing factors which have enabled, or at times posed challenges to successful implementation.

4.1. Trial features

Each SEM trial has distinct design features and operational approaches. Table 3 provides a comparison of key features across the current trials. Further details on each Trial are provided in Appendix C.

Table 3: Key features of SEM trials

Jurisdiction	Trial lead	Single employer	Focus	Maximum positions[2]	Contract length	Financial arrangement[3]
NSW	NSW Rural Health Division	LHD	RG	80 FTE	1-4 years	Practices retain 100% MBS billings, LHDs invoice for registrar time (hours)
TAS	Tasmanian Department of Health	Tasmanian Health Service (THS)	RG/GP	20 (headcount)	Fixed-term 12-month contracts for up to 4 years	MBS billing split - THS invoices 50% of billings
QLD	QLD Office of Rural and Remote Health	HHS	RG/GP	60 FTE (20 per region)	1-4 years	Practices reimburse HHS for registrar salaries per National Terms and Conditions for Employment of Registrars (NTCER)
VIC	Victorian RG Program	BRHS, GH, MBPH	RG	15 FTE	2 years (2025-2027)	MBS billing split - Practices keep

[2] These are trial imposed limits (as every jurisdiction can have up to 80 FTE under the 19(2) at any one time)

[3] This relates to the financial arrangement between employer and primary care practices.

Jurisdiction	Trial lead	Single employer	Focus	Maximum positions[2]	Contract length	Financial arrangement[3]
						$100/half day session + 50% remaining
SA	RSS	LHNs	RG/GP	60 FTE	1-4 years	MBS billing split - LHNs invoice agreed % of billings
RMCLHN 'RACE'	Riverland Mallee Coorong LHN	RMCLHN	RG	20 FTE	Up to 5 years[4]	RMOs: Practices keep $300/session + 50/50 split of Medicare billings Registrars: 50/50 split of registrar billings
First Nations	QAIHC	CWAATSICH	RG/GP	Not specified (demand-driven)	Flexible arrangements	To be confirmed

While all trials maintain the core SEM concept of a Single Employer throughout different training rotations, there are notable differences in implementation approaches, which has been driven by different underpinning intents and philosophies of the trial.

The trials differ primarily in their:

- implementation scale (from 15 to 80 positions)
- geographical coverage (statewide vs. targeted regions)
- practice selection approach (open eligibility vs. strategic selection)
- financial arrangements with practices
- level of local/place-based control over operations
- training structure - some trials incorporate split time between hospital and GP practice as a core feature (notably RACE and Queensland).

Most trials are focused specifically on RG training and are affiliated with jurisdiction-based rural generalist pathways. The NSW, Queensland, and South Australia trials operate at larger scales (60-80 positions), while Victoria has taken a more limited approach (15 FTE) for their initial trial. Several trials have integrated hospital-based training components alongside GP placements, reflecting different approaches to comprehensive RG preparation.

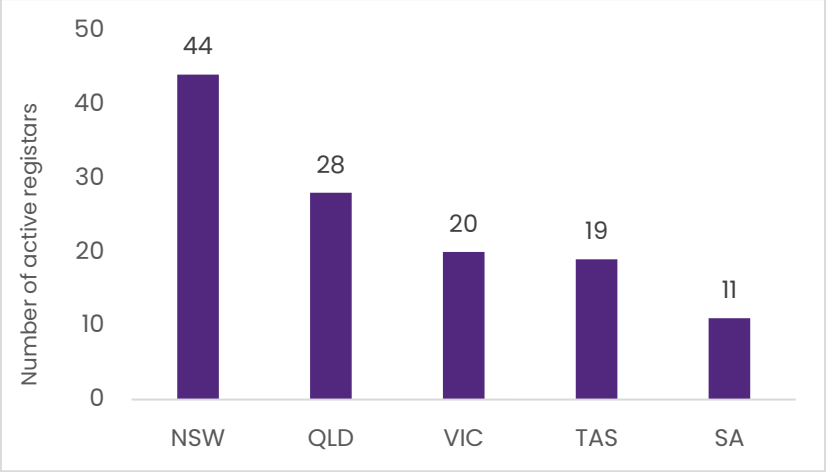
[4] Including pre-vocational training

4.2. SEM registrars

Given the limitations identified in the data (see section 2.2.3), where data is presented below, to ensure transparency, the total number of participants included in the analysis is identified as "n=".

Across all trials, 122 registrars are currently undertaking GP/RG training through a SEM arrangement. The participants are spread over the trials, with NSW having the largest trials with 44 participants in their two trials, with SA the smallest with 11 participants across the RACE and broader SA trials (Figure 1).

Figure 1: Number of registrars by trial site (n=122)

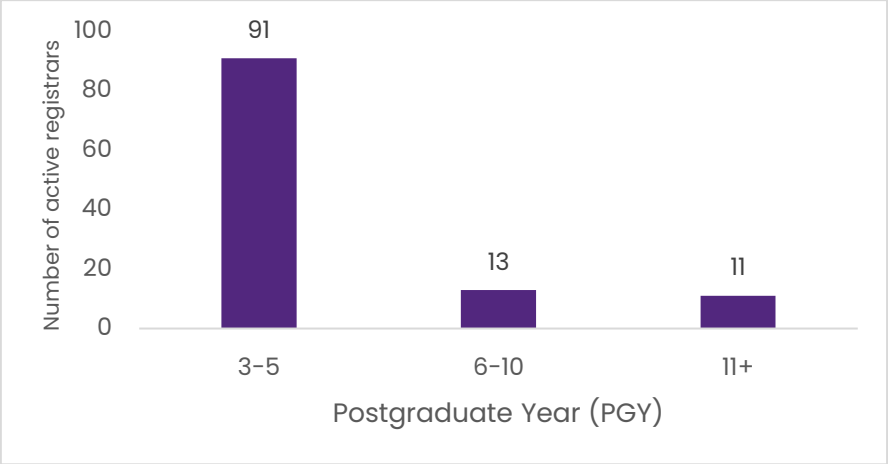


Source: Developed by HealthConsult using SEM trial data March 2025

Most participants are PGY three to five (n=91) (Figure 2).[5]

[5] This should be interpreted with caution as some trial sites reported only up PGY4+. Similarly, another trial site reported only up to PGY10+. This means that both PGY3-5 and PGY 6-10 may be over reported and include registrars with additional years' experience.

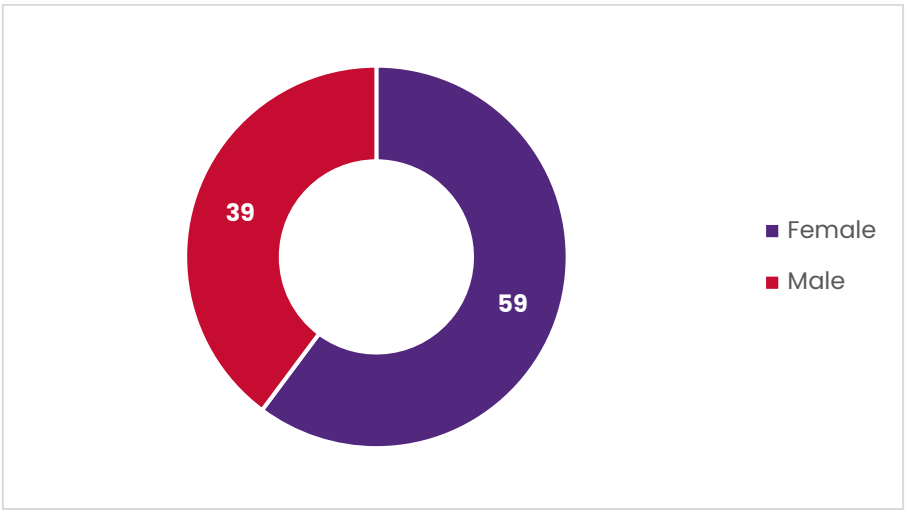
Figure 2: Post-graduate year (n=122)



Source: Developed by HealthConsult using SEM trial data March 2025

Most registrars identify as female (53%, n=64). This however should be interpreted with caution, as 24 records did not include a gender, with 19 entering an incorrect response. Where gender was specified, no participants recorded a response that identified a gender other than male or female (Figure 3).

Figure 3: Gender (n=98*)

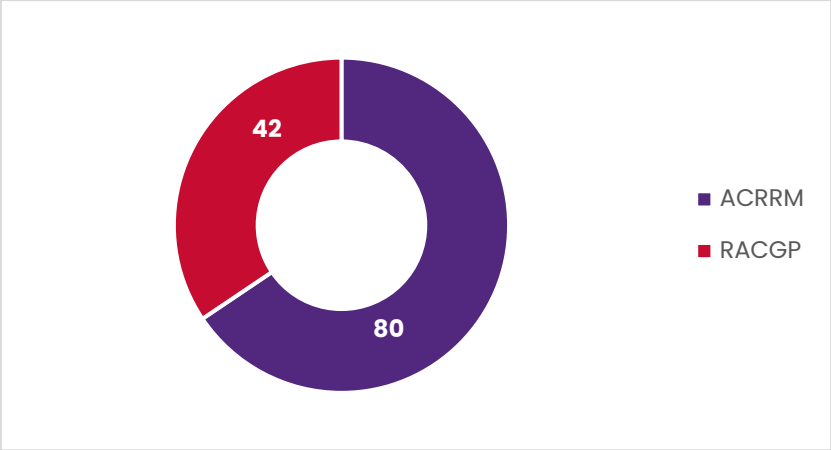


* 24 participants excluded, as no gender identified

Source: Developed by HealthConsult using SEM trial data March 2025

Registrar College Fellowship training is approximately one third RACGP and two thirds ACRRM (Figure 4).

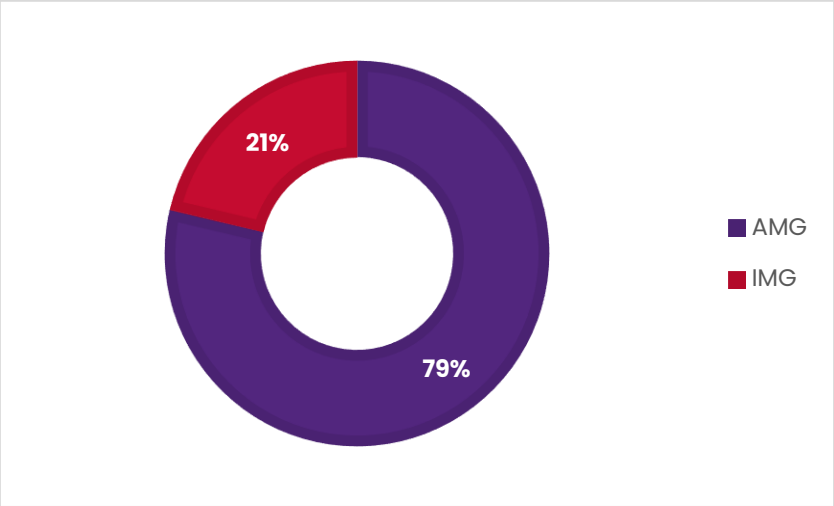
Figure 4: GP training college (n=122)



Source: Developed by HealthConsult using SEM trial data March 2025

Most SEM registrars obtained their medical degree from an Australian university (Australian Medical Graduate, AMG), with only 21% (n=26) of registrars reporting that they obtained their degree at an international institution (International Medical Graduate, IMG) (Figure 5).

Figure 5: Origin of medical degree (n=122)



Source: Developed by HealthConsult using SEM trial data March 2025

In total, 31 SEM registrars ceased the training program during this reporting period. These numbers are not included in the above analysis. Data for participants that ceased the program has not been consistently reported, and as such meaningful analysis is limited. A qualitative analysis of reported reasons for cessation includes:

- Resigned as individual relocated
- Resigned from SEM but continued training under a fee-for-service model
- Completed training and obtained Fellowship.

4.3. Eligible primary care practices

The SEM trials have 270 primary care practices across Australia listed on the 19(2) direction and therefore eligible to host a SEM registrar (not all of these practices will currently have a SEM registrar). The distribution of practices varies significantly by jurisdiction and remoteness classification. Table 4 shows the breakdown of participating practices by Modified MM classification for each trial.

Table 4: Eligible practices by jurisdiction and MM classification

State/Territory	MM 2	MM 3	MM4	MM 5	MM 6	MM 7	Total Practices
NSW	1	27	18	29	-	-	**75**
QLD	-	-	11	11	2	-	**24**
RACE	-	1	-	6	-	-	**7**
SA	1	13	6	23	9	4	**56**
TAS	23	7	-	14	6	2	**52**
VIC	2	17	19	17	1	-	**56**
Total	**27**	**65**	**54**	**100**	**18**	**6**	**270**

Source: Jurisdiction 19(2) directions

4.4. Satisfaction with SEM arrangements

Early consultation showed broad satisfaction with SEM arrangements despite some implementation challenges. When asked whether they would recommend SEM, most registrars agreed, citing leave entitlements (see 6.1.3) and now streamlined processes, after earlier administrative challenges in some jurisdictions (see 4.5), as reasons for recommending SEM.

> *I would recommend SEM; there are five of us in our region and we're happy (Registrar).*

> *I would recommend it, particularly for those starting in GP. I think the benefits are having that continuation on from your hospital years and carrying on leave entitlements (Registrar).*

Some registrars provided feedback that implementation challenges and excessive administrative burdens placed upon them in addition to their workload had negatively impacted their experience and level of satisfaction.

> *Unfortunately, I can't recommend SEM the way I am experiencing it. That might be region specific. I was really excited to join the program, but there's been some implementation issues. (Registrar)*

One practice manager highlighted that the SEM registrars' employment contract was linked to their willingness to stay and their satisfaction in the practice, which also meant that the clinic had a more consistent workforce.

> *We've had our SEM doctors happy to stay because they've obviously got that contract. We're happy to keep them for their whole term and it's nice to not have so many registrars rotate through the clinic like we previously had. (Practice manager)*

Some stakeholders noted that registrar satisfaction may decrease as they progress through later years of training if satisfaction is contingent upon perceived earnings (see 4.6.2)

> *The satisfaction from my point of view is great, I'm very happy with how it's gone. The satisfaction from the junior doctor registrars' point of view is 50/50. For one it's working perfectly, he's a first year who's doing his first rotation through GP. For the other SEM registrar it's less satisfying, he's already done some GP time and might be earning less. (State health service)*

Registrars themselves acknowledged that the SEM could result in lower potential earnings in their later years of GP training (see 4.6.2), however this did not appear to be a major factor shaping their satisfaction with SEM employment arrangements. It is worth noting that registrars choosing to move to fee-for-service arrangements represent a valid pathway to complete their training and should not be seen as shortcoming of SEM.

4.5. Administrative arrangements and processes

Early feedback from all stakeholder groups emphasised several administrative issues which posed early challenges to implementing the SEM. These were largely related to:

- Uncertainty regarding roles and responsibilities; and
- Misalignment between GP and state health service employment arrangements and conditions.

Overall, stakeholders framed these as "teething issues", which for the most part have been overcome, particularly through clarification and clear communication (see 4.6.1).

4.5.1. Understanding roles and responsibilities

Several stakeholders mentioned early confusion regarding delineations of responsibility for single employers, practice managers and training site supervisors. Registrars spoke of challenges navigating administrative issues in contexts where their practice and the health service also appeared unsure of the bounds of their exact responsibility to the registrar and how they should therefore assist when issues arose. This particularly related to issues when

employment conditions differed from their contractual agreement, or there were changes to the arrangement that they would like to make.

> *It's new and there's this big gap we don't know who pays the overtime? Who does the scheduling? What happens if you're not happy with your hours? I signed a contract that was nine to five on Monday, Tuesday, and Wednesday. And I'm doing eight until six on those days, as well as overnight and weekends. That was never discussed with me when I signed the contract because I signed it through the hospital and then the GP practice said I must do these hours. (Registrar)*

Peak body representatives emphasised that they had received feedback from registrars and training site supervisors indicating confusion about who was responsible for the registrar and who they should go to for assistance with employment-related administration. They also reported feedback that there was overall confusion regarding who was responsible for interfacing with the registrar around particular issues, including in cases where performance management was required.

> *There's been concern from registrars, they're questioning, "who's our boss and how should things be coordinated?" We need to focus on how we make that seamless, minimise touchpoints for a registrar. Having to apply for leave from three people would be a nightmare. How do we consider the registrars' experience and reduce miscommunication? (Peak body representative)*

One registrar noted a lack of a clear accountability structure between their employer and their GP practice site. When facing issues like being overbooked, the registrar felt that they had no designated manager to address their concerns, and that neither the hospital nor the practice was taking responsibility for solving problems.

> *If I have an issue, like for example my GP practice overbooks me and I run over time, it's hard to sort out because every time I bring it up, I get ping ponged between the hospital and GP practice because I don't have a manager. (Registrar)*

Responsibility for performance management and improvement

While most state health services, practice managers and supervisors hadn't experienced performance-related issues amongst their registrars, some noted their confusion about the extent to which they were expected to monitor registrars' performance and work hours. Two practice managers suggested that oversight of timesheets and other documentation may help mitigate any confusion regarding hours worked.

> *The SEM doctor we've got now is only entitled to half an hour lunch break, but she's blocked off for the whole hour, so I don't know what she does for that other half hour. I don't know if it's my responsibility to have that conversation because I don't see what*

she's documenting. Seeing the time sheets would be beneficial and I just think communication is the key, working together as both parties because SEM's a great model. (Practice manager)

The confusion around roles and responsibilities was also noted when one practice manager raised concern about a future trainee's performance. As the registrar would not technically be their employee, the practice manager felt burdened by the thought of additional performance management tasks adding to their workload.

We've got another SEM doctor starting next semester. The health service was quite honest and said they've had some difficulties with his performance, so we need to flag with them any issues. I've got 35 staff that I manage, so to then have to pay special attention to someone that they know has already got issues and keep on top of that as well - when they don't really conform to our policies and procedures that we enforce as an employer, that's going to be tricky. I'm nervous about having him here. (Practice manager)

While it was not highly prevalent, such apprehension indicates that the SEM could impact the level of responsibility taken by practice managers and training site supervisors to enable strong performance, as they may see this as the role of the Single Employer, despite them providing the GP training environment.

4.5.2. System misalignment

All stakeholder groups noted implementation issues relating to misalignment between state health services and GP practices' employment policies and procedures. These included:

- invoicing and timesheets
- leave processes and public holidays; and
- rostering and fatigue management.

Registrars noted challenges related to navigating two separate employment arrangements, managing what they perceived at times as different employers, different systems, and different expectations despite their contractual obligations.

Invoicing and timesheets

Payments and timesheet processes were, for the most part, considered inefficient. In more than one jurisdiction registrars were required to complete paper timesheets, which often had to be manually signed off by the training site. This was seen as time consuming and out-of-date, leading to additional time required for administrative duties and delayed invoicing and payment cycles.

> *Our invoicing process is a bit of a challenge at times. The trainees work their set hours in the GP practices, and they fill out a paper form with their hours, which is so outdated. It's signed by the GP practice, it's signed by the trainee, and they e-mail it to the state health service, who within the month should be issuing invoices to the practice for the hours worked as well as the on costs and Super. That should be happening monthly. It's not. It's held up because it's paper and it's relying on the trainee to record the hours. (Trial lead)*

Additionally, a lack of dedicated administrative support was noted, meaning that pay-related issues could take longer to address. Registrars found a lack of administrative support challenging.

> *There is hardly anyone working in SEM admin. I write paper time sheets and scan and e-mail them, but there's been quite a lot of issues. I have been paid every fortnight, but some others have not been. It has been a lot of back and forth between me, the practice and the SEM team about how it was all meant to happen. (Registrar)*

Some practice managers noted that a lack of dedicated administrative support within the Single Employer meant that at times invoicing was held up, with implications for the practice's cash flow. One practice manager noted that this issue has largely been resolved through clear communication and ongoing discussion.

> *There was a bit of difficulty with payments. We were doing our figures and sending off our spreadsheets and it was taking our state health service quite some time to come back to us with invoicing. We were holding a lot of money in our bank account, which was affecting our cash flow. But that has improved since having regular discussions with them. (Practice manager)*

Practice managers noted that it was important that the Single Employer built their understandings of how private practice financially operates, to avoid lengthy payment times which could negatively impact practices.

Leave and public holidays

Stakeholders mentioned that processes involved with applying for leave were also time consuming and often required multiple touchpoints for approval, causing some challenges.

> *We work in partnership with the GP practices, so any leave needs to be firstly approved from the GP practice, then it's approved by our medical director of health services. (Trial lead)*

Some health services noted that at times registrars had forgotten to formally request leave through appropriate channels and had only communicated with their GP practice.

Often the registrar will forget they're still employed by SA health, so will forget to tell us. They do forget the employer is somewhere in the background. So sometimes this communication gets missed, but it's just a process issue and nothing major has happened. Most of the issues were early on and have been ironed out. (Trial lead)

Some stakeholders noted that the differences between leave provisions for a SEM registrar and a non-SEM registrar were not always clear, indicating further clarification may be necessary to ensure understanding.

It's difficult because I don't understand the study leave because non-SEM registrars don't get paid study leave. I don't understand it. So, it's very hard to manage requests. (Practice manager)

In some jurisdictions the public holidays observed by state health services or regionally and GP practices differed. This led to confusion regarding whether SEM registrars should be working on those days. For example, in one Aboriginal Medical Service the sensitivities around the date of Australia Day were acknowledged, meaning that the public holiday on the 26th of January could be swapped for a different date; however, this was not aligned to the registrar's contract with their Single Employer.

Implementation will likely be strengthened through explicit communication about requirements, to avoid confusion and ensure clarity about employment, leave and public holiday expectations.

Rostering and fatigue management

Across all trials, SEM contracts specify minimum hours between shifts, and a maximum number of hours and consecutive days which can be worked, to appropriately manage registrar fatigue, which can otherwise impact wellbeing as well as performance and patient care.

Issues emerged when health service and GP rostering systems did not align and there was no oversight of registrar work hours. For instance, some trial leads and health services noted instances where registrars were on call at the hospital overnight yet rostered to work in practice the next morning, particularly where one roster cycle would end or begin. For the most part these were resolved through communication with practices.

Sometimes the practices miss the 8-day maximum, and usually they recognise this was an error due to rosters running over etc. (State health service)

Training site supervisors noted challenges in ensuring registrars' rosters were coordinated between the hospital and the practice to ensure they weren't coming into the practice after night shifts or long weekends. Some registrars also noted rostering conflicts and commented that this led to additional administrative burdens when they needed to contact the health service or practice to amend overlap and ensure appropriate breaks between shifts.

It's difficult not knowing when I'm working and then having to clear up discrepancies (Registrar)

While some stakeholders emphasised that the SEM could lead to more effective implementation of fatigue management policies, this was only the case when the Single Employer was clearly able to have oversight of both rosters, requiring advance notice from the practice. However, fatigue management is an issue for all trainees and is not SEM specific.

Most trainees are working across multiple sites and that can be complex to roster, but then that also means someone has oversight. One of our health services has said that it's great to now have oversight over their roster and when and where registrars are working. Previously they would have three different contracts. Now there's oversight of safe working hours. (Trial lead)

Unfortunately, some health services only discovered overtime and fatigue management issues after the fact, when they were examining recorded hours worked. One health service commented that the practice may have been expecting too much from the registrar, noting that this was ineffective for successful model implementation.

We've had some general practices that have not gone into it in the right spirit. Day one, they wanted the registrar to do overtime and they were on call that night. So, we jumped in the car to sit down with them face to face and say - "This is not what this is about. This is about training GPs for longevity. You flogging them for the first six months is not helping anyone." (State health service)

To address these issues, one peak body suggested that practices also require advance notice of the health service roster, so that they can ensure that an additional staff member is available should fatigue management rules need to be applied.

RGs may have been on call, and they are due at the GP practice at nine in the morning. They're expected in the practice even if they have had to had to deliver a baby at 2am. It's difficult because the community needs the GP in the morning, and it's hard for the practice to cover. There needs to be funding to cover another GP anyway the next day in clinic. You need the registrar to know what their roster is from the hospital on time, so that they can alert their GP. There needs to be some maturity in the system so that these standards are applicable in GPs. (Peak body representative)

Overall, issues relating to system misalignment were given due attention by most stakeholders, indicating their willingness to improve implementation and ensure appropriate and fair employment conditions aligned to contractual obligations.

4.6. Factors impacting implementation

When asked about what has either enabled or posed challenges to successful implementation, stakeholders noted:

- Communication, clarity and strong relationships (enabler); and
- Perceived financial implications (both enabler and challenge)

4.6.1. Communication, clarity and relationships

When referencing early 'teething issues', many stakeholders emphasised that these had been overcome through strong communication and clarification, particularly between GP practices and the Single Employer. For instance, in Victoria, the trial lead noted that they received feedback from health services that communication with primary care providers has strengthened, which has been helpful for resolving early implementation issues. Similar enabling impacts of strong communication were noted across Tasmania, NSW, and Queensland.

> *The communication and rapport we have been building with GP practice managers, the state health services, the colleges, has worked well to bring everyone working together closely on the same page. Our SEM program has run as smoothly as it could have, we've used our communication to sort things out. (Trial lead)*

Early stakeholder involvement and communications

Most representatives from colleges emphasised that they should have been brought into discussions about SEM earlier, and that their ongoing engagement should be prioritised given their central role in GP/RG training and promoting SEM arrangements.

> *We need proper consultation with consideration in mind that this is a training program that the colleges are delivering. (College representative)*

One college representative suggested deeper engagement with the Leaders in Medical Education network, and with cultural advisors at colleges could maximise possible touchpoints with trainees and lead to more effective recruitment of SEM trainees.

Another college representative noted that because they weren't brought into discussions about SEM when it was being designed at each jurisdictional level, they couldn't have input into each trial's design and support them adhering to educational standards and requirements.

> *We weren't consulted as applications came through and policy settings were developed, which was a bone of contention for us, because we ended up with so many different models. It's very difficult to integrate in a systematic way into training because there's so much variation… the concept of innovation and trials meant that jurisdictions let a thousand flowers bloom without checking in with the colleges. There was an*

understanding that it would have to meet standards but there was no real operational input into what sorts of parameters around the trials would assist or hinder that. (College representative)

Similarly, peak body representatives highlighted that implementation may have been smoother if they had been involved earlier in model establishment, so that they could provide design support regarding adherence to upcoming changes in overarching employment conditions and standards.

Further guiding documents

When issues relating to unclear roles and responsibilities and system misalignment emerged in Queensland, one health service clarified appropriate implementation by drafting a work instruction clarifying processes:

We drafted a work instruction for SEM about what this looks like, what the rules of engagement are. We gave that to the practices so they can see how the registrars should be structured, what their entitlements are, we specified that and how it applies in the SEM context, just to try to ensure some ground rules so that when questions arise we can say well, this is the framework that we're wanting to be aiming for. (State health service)

GP training site supervisors across the trials noted that, from their perspective, implementation would be further supported by the provision of practical guiding documents outlining the key information required to help navigate dual systems.

I think to improve things you should simplify the system with practical tools instead of using flowery language – for example you could create a practical comparison tool about Enterprise Bargaining Agreements (EBAs) with simple comparisons between private/public entitlements. (GP supervisor)

Colleges also suggested that further guidance could be provided, including to registrars, specifying roles and responsibilities. One college representative noted that such guidance would likely require coordination between all stakeholder groups aside from registrars, which may be challenging but should provide a solid foundation for further implementation.

We need clarity over roles and responsibilities and clear communication of those roles and responsibilities, with the audience being registrars both current and future, but also for practices, so they feel fully informed and sure about existing responsibilities. This coordinating between the States and the Commonwealth, the two colleges, the lead agencies and individual practices will be inherently challenging. But I think it's necessary for clarity of understanding as to what this is, what it is not, and within that, who's

responsible for what? Then we're all operating with clear common understanding. (College representative)

At the national level, the Commonwealth introduced regular Communities of Practice for trial leads and set up a SEM SharePoint site to encourage resource sharing. These initiatives were intended to help stakeholders access up-to-date guidance, share practical insights about what was working and not working, and collaboratively address challenges – strengthening the SEM network and promoting a more consistent approach.

The Commonwealth also developed the Jurisdiction-led Trial Parameters and Principles document[6] (May 2025), which sets out the guidelines for operating the jurisdiction-led SEM trials.

Consistent and available point of contact

Across the trials, the importance of a point of contact was highlighted as crucial for successful implementation, particularly for practice managers, supervisors and registrars.

It's important to provide a clear contact for information and issues including administrative, financial, and training. (GP supervisor)

When discussing challenges in early implementation, some stakeholders noted that it had been hard to solve problems where there didn't seem to be a dedicated person assisting with SEM administration amongst the trial lead organisation and/or at the health service.

Early on it was hard to figure out who to go to. Communication in the early days was a bit lacking, but there seems to be a main person to contact now, which has helped. (Practice manager)

One registrar in NSW noted substantial improvement and streamlined processes despite initial challenges. They attributed such improvement to having a single point of contact for all SEM related issues.

Relationship building and strengthening across system

Across the trials, views were mixed as to whether the SEM had contributed to strengthened relationships. Yet strong relationships, particularly between primary care practices and health services were cited as essential for successful implementation.

In Queensland in particular, relationships between health services and GP practices were seen as having been strengthened through the SEM. The SEM has contributed to knowledge-sharing which may have positive implications for better operations across different parts of the health system.

[6] Single Employer Model (SEM) jurisdiction-led trial Principles and Parameters | health.gov.au

> *It's worked well, to take GP colleagues a bit more into the hospital. I've appointed a principal GP as my deputy, so it's been great for my recruitment as well. Now everybody essentially works across both places and has more knowledge of work within both systems. It's strengthened our relationship in many ways. It's meant they understand what we do a bit more, and we understand a bit more about what they do and how they work. (State health service)*

Because implementation requires working together productively, these relationships were strengthened with purpose, and staff across both primary care and health services have built understandings of how they each operate and can productively work together.

4.6.2. Perceived financial implications

Trial leads and health services

Across the board, trial leads understood the SEM as a model with some funding shortfalls, at least in its early stages, though they expressed optimism that investments would pay off later should registrars stay in rural and regional areas and alleviate workforce shortages.

Health services also emphasised that SEM arrangements were costly, though some were able to offset cost through reduced locum usage and employing registrars on sessional rates, as opposed to private practice rates. One state health service explained that, while this was helping to offset costs, they were still required to pay supervision hours for junior registrars.

> *I think it's slightly easier if you've got Emergency Department (EDs) to place people into, to be able to help minimise the cost, or I suppose other areas where you can employ them directly in the hospital. (State health service)*

Some stakeholders expressed caution around health services' concentration on offsetting cost. It was noted that this could contribute to losing sight of the SEM's aims as a training and employment model and have implications for the overall workforce mix within health services (see 5.2).

> *It has been brought to the forefront of my executives' mind the comparatively low cost of a registrar. I do worry that because we're now getting an increased medical workforce, they're seeing junior doctors as part of a workforce solution when it's not what it was intended to do. We must be careful that we're not using registrars to fill gaps on the roster, and make sure we're providing them appropriate training, education and supervision. Sometimes the executive level doesn't necessarily see that you can dilute the pool down too much. (State health service)*

The SEM trials may benefit from ongoing consideration of how state health services may be perceiving and taking steps to mitigate financial implications. It is important to ensure that quality training continues to be provided and prioritised.

Registrars

All stakeholder groups noted the potential for registrars to earn less money via a SEM arrangement than if they were billing in private practice, particularly in their later years of training. Financial implications were cited by several trial leads and health services as reasons for withdrawal from their SEM arrangement. However, registrars choosing a fee-for-service arrangement does not diminish the value of SEM, and fellowship rates while on SEM are not the primary success metric for the trials.

> *We had one trainee leave the program because they could earn more money in that fee-for-service model. (Trial lead)*

In Victoria, trial leads have invested effort into communicating the financial implications of SEM arrangements, including webinars explaining projected differences in earnings. Victorian trial leads also asked practices to track what registrars could have been paid under the National Terms and Conditions for the Employment of Registrars (NTCER)[7] and compare this with what they were paid under SEM. This comparison is conducted alongside registrars, so they are aware of any difference.

> *There's the risk that the trainee would be billing at a slower rate under the SEM, and this gives the practice an opportunity to sit down and talk to them about it. (Trial lead)*

Some health services reported challenges attracting and recruiting registrars due to considerable differences in projected earnings. Detailed cost data is currently being collected and analysed, with findings indicating that rates may vary substantially depending on a range of influencing factors.

> *We were unable to even get close to what the practice was providing. It became a financial decision at the end. They're like, "I'm not stupid. I'm not going to take a $100,000 pay cut." (State health service)*

Registrars considered the financial implications of SEM arrangements, but this was not always their primary consideration (see 6.1.3).

General practices and supervision

Overall, practice managers and supervisors commented that SEM arrangements were working positively for them financially, as the fixed costs of SEM registrars were reducing uncertainty more than for than a non-SEM registrar.

[7] NTCER-v2024-01-20250129.pdf

> *It lowers risk for practices; the pay is a fixed percentage each month. If you're employing a registrar, you're on the hook for anything that comes your way. The SEM is a better sell for prospective employers. (Practice manager)*

There was, however, some concern that SEM registrars may not be incentivised to see and bill the same number of patients as non-SEM registrars (see section 6.3.1), and there were some other financial implications for practices reported. One supervisor was able to compare their SEM registrar to the year before they were on SEM as they were already working at the practice. They noted that the practice was slightly worse off as the registrar was no longer billing the hospital for obstetric services and ED services, and they also earned less in the second year. From their perspective, the investment is advantageous to practices only if registrars are retained.

> *If registrars stay, it's worth the cost to the practice, but if they don't, there's significant supervision and financial cost. (GP supervisor)*

Both GP practices and supervisors provided feedback that additional funding was required to appropriately cover supervision costs. While in some trials, such as RACE, supervision is funded through on call payments or GP agreements, this is not uniform, and many stakeholders highlighted that funding is not compensating required supervision.

> *We need better recognition and financial support for time spent on supervision. (GP supervisor)*

Peak body representatives also highlighted that further funding should be provided for supervision, in acknowledgement of their additional responsibility and workload.

> *Supervisors get income for up to three hours of education a week. That's it. But they are still 100% responsible for the safety of that registrar and their patients. (Peak body representative)*

While the importance of funding for supervisors was highlighted, stakeholders also acknowledged that this issue is not related only to SEM arrangements, however the SEM could provide a mechanism for addressing this issue.

5. Appropriateness

This chapter will present evaluation findings related to KEQ1: **How appropriate is SEM as a mechanism to improve the attractiveness of GP/RG training and build a sustainable workforce in regional, rural and remote locations?**

It provides an overview of stakeholder views as to whether the SEM is appropriate for addressing its policy objectives. It then explores how views and associated levels of engagement are contingent on longer-term investment in the SEM, and how each SEM needs to align with changing GP and health system contexts in their respective jurisdictions as well as federally.

5.1. Achievement of policy intent

Overall, stakeholders' views varied on the extent to which SEM is appropriate for achieving its aims to:

- increase the attractiveness of GP/RG training and primary care careers
- build a sustainable workforce in regional, rural and remote areas.

While for the most part, the SEM was seen as attractive due to its leave provisions and secure salary (see 6.1.3), most stakeholders considered it too early to comment on whether the model was appropriate for increasing GP/RG training and primary care career attractiveness (see 6.1).

Stakeholders' views on the SEM's appropriateness for building sustainable workforces in regional, rural and remote areas were also divergent. It was noted that, on its own, the SEM was unlikely to be a meaningful long-term solution. However, when implemented in ways which also promote workforce sustainability, with a focus on long-term careers and registrar retention in community, the SEM could offer an appropriate mechanism for achieving this aim.

5.2. Long-term investment

Stakeholder understandings of appropriateness can be related to their levels of investment in the SEM. Strong investment in achieving the SEM's aims across all stakeholder groups is important for successful implementation.

> *Jurisdictions involved need to all be supportive of the program intent. That can influence how it is supported. (College representative)*

Because the SEM requires collaboration between multiple levels of government, private primary care, GP training colleges, and public health services, stakeholders noted some challenges in

aligning divergent shorter-term fragmented interests with shared longer-term goals across the broader health system.

> *Some people without an understanding of the health space, see it as a burden and a deficit for the health services when we're going through crises. We need to save 3 million over the next few years. While we understand what the benefits of SEM are to the population, there are still some political agendas, that state services should not cover primary care, which is the role and responsibility of the Commonwealth. It is difficult at the end of the day. I don't see what we do as so black and white, but it needs collaboration. (Trial lead)*

The appropriateness of the SEM to achieve its intent hinged upon the extent to which stakeholders viewed it as either a short-term employment structure or saw its potential for providing sustainable, long-term workforces and building health service capabilities. Where the SEM was seen as having more long-term potential stakeholders seemed more invested in making best use of it to wrap-around and integrate registrars in community, maximising opportunities for retention.

> *One big win is when someone buys a house in the area, gets married in the area. The SEM model as funding doesn't necessarily do that, it's about the wrap-around model, and how to integrate them in the local community, and the jurisdictions are doing that to different extents. This is something SEM can do, but also that any state government can do, it doesn't have to be through the SEM. (Peak body representative)*

The RACE model has been developed to be a place-based, longitudinal approach to building and retaining the workforce. The model allows trainees the opportunity to be embedded in local hospitals and general practices from internship to Fellowship. It aims to improve connections across primary and tertiary care, enabling registrars to be more effective due to existing relationships, improved continuity of care and reduced workforce transience.

In NSW the SEM was recognised as a near-term workforce solution for rural and remote areas. Strategic recruitment placed registrars in specific areas in immediate need of GPs to support health service demand.

Such a focus on health service workforce shortages may impact the appropriateness of the SEM for building sustainable GP workforces if the intent is understood as retaining registrars within hospitals rather than as GPs in practices. This could contribute to losing focus on SEM's primary function, which is to facilitate registrar training.

> *It needs to be focused on GP training not so hospitals can prop up failing rosters. We need to make that clear and keep focus on getting people into GP training. (State health service)*

Trial leads also noted the importance of maintaining a consistent message that SEM is a training solution, not about health service workforces.

Given the importance of long-term investment in the SEM from all stakeholder groups, ongoing communication alongside strategic activities to advance a shared, long-term vision may be required. This could take the form of community of practice workshops or further supporting information for practices, colleges and health services emphasising the long-term aims of the SEM and why their investment in these is important and valuable.

5.3. A changing GP landscape

Across the trials, several stakeholders noted that the SEMs ongoing appropriateness will depend upon how it aligns with and complements ongoing and upcoming system-level changes.

Alignment with changing policy contexts

The Australian Government's recent announcement of expanded bulk billing incentives and the Bulk Billing Practice Incentive Program (2025-26 budget) was brought up as likely to impact whether practices would participate in SEM arrangements, given their financial position would differ in such a situation. One trial lead reported that it was difficult to recruit practices with higher bulk billing rates.

There was so much getting told "No I don't think this is going to work for us, we're primarily a bulk billing practice." (Trial lead)

The expansions of Urgent Care Clinics (UCCs) announced in recent Strengthening Medicare budget measures were also noted as changing the context around SEM, with some stakeholders noting that it may have recruitment and workforce supply implications should UCCs provide lucrative employment offerings.

> *It will be interesting to see whether there will be greater pressure to recruit registrars, because a lot are getting hours in the UCCs, so recruitment might become harder because of the announced expansion of UCCs. (Practice manager)*

Some stakeholders noted that other jurisdictional policies and incentives for GP registrars and practices were at times either conflicting with or duplicating the aims of the SEM, decreasing its appropriateness and increasing its redundancy. For example, the Victorian Government's GP grant program[8] and Queensland's GP trainee incentive scheme.[9] College representatives highlighted the variance between jurisdictions and trials, emphasising that some trials seemed

[8] General Practitioners (GP) grant program | health.vic.gov.au

[9] GP trainee incentive scheme | health.qld.gov.au

more appropriate for advancing the SEM's policy aims within their jurisdictional context, and others were less aligned.

> *It's difficult to talk about SEM as though it's the same everywhere when it's not. The opportunities, perceived benefits, and compromises that people make moving to a SEM are different, even within some jurisdictions, let alone across jurisdictions. We're in this awkward policy space where we talk about SEM as though its uniform and it's not. It leads to quite a bit of cross purpose when we talk about policies and reform, where people think everything is like the one example that they've seen when it's not. (College representative)*

Thorough scoping of Australian and jurisdictional policies which intersect with the aims of the SEM may support ensuring the trials are both aligned to current and upcoming policy changes and beneficial to advancing their objectives within shifting contexts and health systems.

> *The… [$30,000 GP Training Incentive Payments[10]] election commitment puts up a policy that opposes the SEM. It's tricky when they release information like this. I would like there to be consistency. The SEM has just started, and it already feels like there is something that could derail it. We put so much time and resources into getting this and it's too soon to know if it will be successful or not. This new initiative comes in before that, so it undercuts SEM. It should have been either or. They could have put that money into SEM which is run off the smell of an oily rag. (Trial lead)*

Flexibility to adapt to changing skill and career requirements

While stakeholders recognised the importance of alignment to changing policies, the SEM was highlighted as providing potential, particularly through the RG pathway, for registrars to have the required skills to flexibly adapt to the changing nature of GP/RG work. When considering its appropriateness, peak bodies and some trial leads emphasised that the SEM could align well with new employment models likely required due to system changes and individual employment preferences.

> *Is it an attraction piece or is it a workforce piece for retention? It gets a bit messy making blanket statements around attraction. You're looking at an RG registrar, someone that's maybe interested in wanting to do research, working a few days in women's health, doing something else. Theres a change in the hours GPs want to work, there's the concept of a portfolio career. It's a factor that needs to be noted. Not sure if we're in a position where we can say that SEM to date has been an attraction and retention winner. (Peak body representative)*

[10] GP Training Incentive Payments | health.gov.au

When reflecting on their long-term goals for SEM registrars, some trial leads spoke positively of the diverse skills and capabilities which registrars would likely have upon completion, linking these to improved health service capacity and offerings in rural and remote areas.

> *I think we can see that we're going to have multi-skilled consultants come out it, and that's a service for our community… We've also been able to provide specialties that people previously would have had to go to a metro area to receive. SEM has been the impetus to build additional, needed services in the region. (Trial lead)*

Overall, it was emphasised that to be an appropriate mechanism to achieve its policy intent the SEM itself needs to remain flexible and complement systemic and workforce changes.

> *You need to lean into all the system changes happening around SEM because it's really exciting. SEM started 3-4 years ago, and the world has moved on. (Peak body representative)*

6. Effectiveness

This chapter will present early evaluation findings related to **KEQ3: How effective were the trials in achieving the intended outcomes?**

It explores views on whether SEM has increased the attractiveness of GP/RG training, careers in primary care and placements in regional, rural and remote locations, including whether attractiveness is shaped by registrars' leave provision and the retention of earned benefits. This chapter also examines the SEM's role in fellowship achievement and consideration of post-fellowship pathways and employment. The SEM's possible impacts upon registrar training as well as increased patient access are also explored.

6.1. Improved attractiveness of GP/RG training

6.1.1. GP/RG training and primary care careers

Stakeholders' views were mixed on whether the SEM has increased the attractiveness of GP/RG training and primary care careers. While many noted that it was too early in implementation to know the model's effectiveness, some believed that the SEM had influenced trainees' decisions to undertake GP.

> *Have heard from a few people where SEM has been the right thing, the thing that tipped them over to GP, where they have come from a different training pathway and were not happy and now don't need to start from scratch. So, it's attracting people to want to do GP in my experience. (Practice manager)*

However, most stakeholders held the view that thus far the SEM was not responsible for attracting trainees to primary care careers, as those who had taken up a SEM place to date had already decided to undertake GP or RG training.

> *It hasn't made a huge difference - it's purely a different employment model; it's not making the career more attractive. (GP supervisor)*

6.1.2. Training in regional, rural and remote areas

Overall, the SEM was not considered the sole determinant of someone's decision to work in regional, rural and remote areas. Most stakeholders that thought that the SEM had increased the attractiveness of regional, rural and remote training spoke of it as a contributing factor, alongside other incentives and pull factors.

> *I think it's having an influence on trainees moving rural. I don't think it's the sole reason why they're going, but one of the contributing factors. There are other things; the GP Colleges have incentivised locations, we've got caps that are forcing registrar distribution across our regions. We're running initiatives to try and encourage people to go rurally. It's just one other tool in the toolbox that sweetens the deal to go rural. I don't think it would be attributed solely to SEM. (College representative)*

Several stakeholders mentioned that for many who grew up outside metropolitan areas, registrar attraction to employment in regional, rural and remote areas was often related to returning home, or returning to a familiar lifestyle associated with living outside cities. It was noted that the SEM could support relocation as it enables registrars to keep earned entitlements.

> *Registrars born and/or raised in rural areas have mentioned that SEM has been a pathway to help them return back and be able to carry over their entitlements. (Trial lead)*

While the SEM was not seen as the primary factor in attracting trainees to regional, rural or remote locations, some stakeholders noted that the model gives trainees another option and some additional flexibility, wherein they can trial working rurally to see if it works for them, while still retaining their earned benefits through a trial period.

> *It provides a way for doctors to try rural practice without jumping off a cliff. It's exciting for them to have more options and potential. (GP supervisor)*

One college representative also noted that the SEM arrangement may be attractive for registrars currently training in rural generalism but who have longer-term aspirations to work in hospitals, so that they do not lose the entitlements they have accrued in hospital settings.

> *We suspect there's a cohort who are training in rural generalism, who see their long-term career in hospital medicine, and that they chose SEM because it's a way of protecting their leave and entitlements while they do short-term work in community GP. So, they use it as a tool to protect state-based benefits. (College representative)*

Across all jurisdictions, stakeholders noted that the majority of their registrars did not originate from metropolitan areas. The NSW trial lead estimated that around half of their SEM registrars grew up in a regional or rural area. Reasons for relocation to train were not primarily related to the SEM itself but to a myriad of other personal factors.

> *People who are moving to these places are doing it for a specific reason, whether that's family, whether that's the lifestyle, the community, or things like that. (Trial lead)*

Most registrars thought that the SEM itself had not made them more likely to stay in a regional or rural area, as they were intending to stay regardless, due to social, employment, and family ties.

My family are all situated in the regional area, so I'm quite comfortable here. I've got a good practice with good people around, so I would have stayed regional anyway. (Registrar)

6.1.3. Employment benefits

The provision and retention of earned employment benefits alongside a consistent and secure salary was consistently brought up across all stakeholder groups as key to the attractiveness of the SEM. In particular, paid parental leave was cited as very important.

I think that that the SEM is beneficial to those who are on the edge of choosing GP with that financial or parental responsibility. Those people are moving into it when they might not have otherwise. (College representative)

It was recognised that the SEM effectively removes barriers to GP/RG training associated with the lack of leave entitlements.

It's an option that removes one of the disadvantages people had of moving out of the hospital system. We're keeping things at a level playing field. So as an option for those it suits it's a no brainer. (College representative)

While most interviewees believed that the leave provisions and secure salary were attractive, this attractiveness was seen to lessen as registrars progressed to their final years, when their potential earnings as a non-SEM registrar could be more likely to increase.

My major attraction was the leave, to get all the leave types which was very difficult as a registrar just in the clinic. I'm not too sure whether the other registrars have felt the same, but I've noticed the overall payment is quite a bit less. When I went on this program, I was well aware of that, but leave was a major attraction. (Registrar)

All consulted SEM registrars were female, so at this early stage it is not possible to indicate whether parental leave provisions would also be a key consideration amongst males. Consulted registrars continually highlighted that the SEM promoted gender equity. Registrars were often happy that the arrangement could facilitate their beginning a family, which was prioritised even where registrars had the view that they would be earning less overall.

SEM makes conditions fairer for female GPs. It makes it reasonable to do this job and have a family. (Registrar)

Some stakeholders also noted that there may be features of the SEM's attractiveness understandable through a gendered lens, primarily due to its provision of paid parental leave.

The SEM makes it attractive in evening the playing the field for women. Overall, it's much easier for men to move around, they don't have to worry about maternity leave. It's very good for women, and they're supportive of it. (Practice manager)

I think the ones that we have are predominantly female and they're happy in the SEM because of the level of security. The males are probably more so chasing a little bit more of that dollar. (State health service)

Colleges and peak bodies raised that upcoming changes in GP and RG training and employment conditions and the broader applicability of leave types within General Practice may influence the SEM's attractiveness.

Some of the conditions it was trying to address, the context of that is changing. If you are on the Australian GP Training (AGPT) program from next year you will have access to base rate parity from semester one, to exam and study leave and parental leave, this changes the context for SEM. What are the benefits of being on a SEM vs not when there's a more even playing field conditions wise? (Peak body representative)

Consideration of how the SEM will intersect with imminent changes to broader leave and earned benefit policies will likely be important for decreasing the likelihood that these key features of its attractiveness become redundant.

6.2. Fellowship and post-fellowship employment

The SEM has supported registrars to achieve fellowship. Since trial commencement, at least six registrars have fellowed. Stakeholders noted that fellowship was supported through registrars having time to focus on their studies, enabled through the provision of study leave, and reduced pressure to see patients due to registrars' consistent salary.

One has become a fellow. He mentioned that the SEM program lifted the pressure that he had to go through during exams. He was able to actually focus on the exam to achieve the fellowship, rather than focus on the number of patients he needs to see. (Trial lead)

One NSW health service noted that most of their doctors continued to work in the rural and remote areas that they trained in once they achieved fellowship.

We've had doctors who have gone on to fellow and who have stayed in the region, which is fantastic. They have stayed in the towns in which they put a spent majority of their time training, which are smaller towns. (State health service)

Across the trials stakeholders noted that, for the model to be successful in building sustainable workforces, it was important to strategically plan for employment models and objectives post-fellowship. In Queensland, the trials leads are beginning to develop appropriate post-fellowship employment models beyond 2028. One GP supervisor did note that the structure of the SEM in

Queensland meant that registrars were less likely to form strong social and family ties in their area of employment.

> *Queensland Health provides accommodation if they're working at least 50% of the time in the hospital. We're only three hours from Brisbane, and they work 8 days straight a fortnight, with six days off. I don't think any of the registrars will stay in regional areas as they all have partners in Brisbane. They need family connections to encourage them to stay. (GP supervisor)*

Practice managers raised some concerns about a lack of viable career paths for some advanced skills training areas post-fellowship, noting that, while hospital-based skills (e.g. anaesthetics, obstetrics, ED) have employment options, skills like paediatrics, palliative care, and mental health are less financially viable in GP settings due to Medicare limitations for extended consultations.

Several peak body representatives and some trial leads emphasised that the end goals for SEM registrars should be to work as GPs or RGs within private practice, not employed under a SEM arrangement. This was seen as important for keeping doctors in GP/RG professions, rather than working within hospitals after they fellow.

> *What are the end points, the goals of the graduates? Our goal is for none of them to be on SEM when they graduate. I think graduates on SEM at the end is a poor indication of success. Part of the job is to train them to be in private practice. Because otherwise they would all want salaried roles in hospitals, rather than in private practice. We need to look past the narrowed salary model. (Trial lead)*

Some registrars reported they would consider remaining on a SEM arrangement post-fellowship, however they noted that they would continue to assess the benefits against their potential earnings in the broader contexts of their individual goals.

> *I feel like there's a decent chance I would stay on SEM post-fellowship. Once I come back from this maternity leave, I will be reflecting on my feelings. It will depend on billing and earning capacity. (Registrar)*

6.3. Other outcomes

Early indications of effectiveness have emerged in relation to the SEM's possible impact on registrar training, and improvements to patient healthcare access.

6.3.1. Training impacts

Across the trials, most stakeholders either thought it was too early to comment on whether the SEM was impacting registrars' training experience, or they thought there wasn't a large impact.

I'd argue that the training experience is largely the same. (College representative)

Several stakeholders noted that the SEM itself, as an employment structure, was not intrinsically linked to altered training. However, it was noted that the SEM can provide registrars more opportunities for diverse training experiences, though it requires the health service or trial lead to focus on education to maximise the opportunities provided through study leave provisions and reduced billing pressure. The SEM's perceived reduction in billing pressure was viewed positively where it facilitated quality training opportunities and allowed registrars to pursue their interests.

There are some models that put a huge emphasis on education and training as an attractor. One trial in particular layer enormous amounts of extra support that were never there without a SEM. That's not to cast aspersions on the great supervision experiences before. But this trial really does pull out all the stops with lots of mentoring, lots of engagement, lots of teaching, sheltered time with senior medical and clinical leaders, lots of support. That's brilliant. That's a trainee's dream to have that opportunity. But it's not standardised across all the trials at the moment. (College representative)

One health service reported that their SEM arrangement has enabled a partnership with a practice to enable them to run a skin excision clinic out of that practice, which will have a training focus and make use of the SEM registrars. It was noted that this should, over time, effectively shift these procedures from the hospital to the GP environment, reducing health service workforce strain.

Acknowledging there's less pressure on the registrars to bill, the practice recruited a skin cancer specialist GP with a background in teaching, so we will run a skin excision clinic that is public health supported using the SEM registrars. (State health service)

Trial leads, practice managers and registrars also noted that the SEM arrangement could facilitate additional training opportunities which could help the registrar meet the specific needs of the communities in which they were working.

The trainee and the Aboriginal Medical Service (AMS) were happy that they could take the time to learn about the different cultural sensitivities with our patients, the trainees also appreciated that their AMS sent them to cultural immersion training. (Trial lead)

Because there is less pressure on them to focus on billing, SEM registrars appreciated that they were able to centre developing their clinical and advanced skills, citing this as one of the key benefits of being on a SEM arrangement.

I'm interested in mental health specialisation and with SEM there's a better hourly rate for longer consultations. (Registrar)

Several supervisors and practice managers commented that this had flow on impacts on patient access for certain types of consultations, because registrars were able to see more complex patients which require longer consultation times. Registrars also commented on the importance of access to longer consultation times where needed.

> *I don't have to tell someone who has told me that they've tried to get mental health help in the past and they've been let down each time, who has just told me they're suicidal that "I'm sorry, but we're about to pass 19 minutes and I need to kick you out". They have trauma and that comes into our consult every time, and so there's a lot more needing to look after them and see what else is going on than just a script. And having to let go of that interest for financial reasons is a major disadvantage to my community. (Registrar)*

There were some concerns raised by practice managers that, due to the SEM, registrars may not be learning to bill appropriately and see a profitable number of patients.

> *I feel we're setting them up to fail. We're setting them up to be used to those 20-minute, 40-minute appointments. They're not getting used to how to do things in 15 minutes and rebook or cover one item and see someone in two weeks to tackle those next problems. (Practice manager)*

One practice manager commented that this effectively meant that the SEM arrangement was enabling registrars to centre their medical practice instead of their business practice. While this had implications for practice managers, in essence it was seen as neither positive nor negative.

> *Some come in wanting to run a business and make money and others just want to practice medicine, and SEM is good for the latter. (Practice manager)*

For the most part, these concerns were related to registrars not being as comprehensively trained and practised in billing within private practice.

> *I think it impacts, but it's small. It's about ease. When a GP registrar starts there is so much to learn. Billing is a whole new learning curve. On SEM there's no incentive to embark on that. (GP supervisor)*

Consideration of how billing capabilities can be centred within training approaches in SEM arrangements may address these concerns.

6.3.2. Patient access

While most stakeholders thought it was too early to comment, some stakeholders reported increased patient access due to the SEM. Some practices that couldn't previously host trainees due to costs or lack of attraction factors were now able to do so. Practice managers and supervisors noted significant positive impacts.

Patient access has improved massively. While before it was limited by registrar availability, the capacity to be seen is now limited by beds as opposed to doctor numbers. Doctors have seen their waitlists reduce. We've gone from five or six doctors to about twelve now in the clinic, so you'll actually get an appointment with a good doctor, it's made it amazing. (GP supervisor)

Continuity of care

Some practice managers, supervisors and health services also noted promising indicators of enhanced continuity of care. One trial lead reflected that registrar commitment to building relationships in the community stood in contrast to fragmented care experiences provided by rotating locum GPs.

I heard from one of the GP practice owners that the SEM trial has helped the continuity of care in the community. Some patients are now actually able to see the same doctors. He also said that from his perspective the SEM registrars are keen to make a reputation for themselves in the practice, in comparison to a locum rotating GP they are more engaged in continuity of care. (Trial lead)

Some stakeholders also commented that, due to their registrars working across both the health service and GP, the same registrars had been able to follow up with patients post hospital discharge within GP.

7. Conclusions and recommendations

This early report has provided a snapshot of the National SEM trials and their implementation to date. This chapter summarises early findings and discusses opportunities for SEM implementation enhancement.

7.1. Summary of findings

The SEM trials have attracted diverse participants, including registrars from various training pathways and backgrounds, with 122 registrars currently undertaking GP/RG training on a SEM contract.

The trials differ in their design and have progressed through variable stages of implementation. All prioritise MM 2-7 locations, with particular emphasis on more remote areas in some trials such as Queensland's focus on MM 4-7. The trials have engaged a range of practice types, including private GP practices, community health services, and ACCHOs. The First Nations ACCHO-led trial represents a unique approach, focusing specifically on building capacity in Aboriginal and Torres Strait Islander health through a community-controlled employment model. This trial emphasises cultural alignment and immersion alongside clinical training.

Overall, interview participants were satisfied with SEM arrangements. Implementation challenges included uncertainty regarding roles and responsibilities and misalignment between GP and health services employment arrangements and conditions. These issues were largely overcome through clear communication, which enabled successful implementation. Different stakeholder groups' perceptions of the financial implications of SEM participation impacted implementation, and both enabled and hindered progress at various times. For example, whether state health services saw the benefits of building a future GP/RG workforce in the region and willing to invest in the salary costs versus using SEM registrars to fill hospital rosters. Although it is too early to draw conclusions about how this has impacted the uptake of SEM by registrars and general practices.

The SEM's appropriateness for advancing its policy objectives was found to depend on whether stakeholders invested in its long-term potential. Evaluation findings also indicated the importance of alignment with changing policy contexts, health system needs and individual career aspirations.

Overall, views were divergent on the SEM's effectiveness in increasing training, career, and location-based attractiveness, however access to a secure salary, and the retention of earned benefits were key factors impacting registrar attraction. In longer-standing trials, some

registrars have achieved fellowship. Early impacts of SEM arrangements are also evident in improved training quality and increases to patient access.

7.2. Considerations for improvement

Given the early stage of the evaluation, considerations focus on process improvements to support effective implementation.

- Streamline administrative processes around time sheets, leave approvals, etc, including reducing reliance on paper-based systems.
- Trial Leads should consider developing simple quick reference guides outlining key differences between SEM registrars and usual training arrangements (for example, leave provisions, contracted hours, etc.)
- Clarify, clearly document and communicate roles and responsibilities of all parties (trial leads, Single Employer, training site managers and supervisors, registrars, GP colleges), including dedicated, available key contacts for GP practices and registrars for when issues arise.

The evaluation itself will focus on improving trial data quality and consistency through template refinements (e.g., drop down fields, data validation rules) and working with trial leads directly.

Appendix A Evaluation Framework

Table 5: Evaluation Framework

KEQs		
Sub-question	**Indicators**	**Data sources/collection**
KEQ1: How appropriate is SEM as a mechanism to improve the attractiveness of GP/RG training and build a sustainable workforce in regional, rural and remote locations?		

1.1 To what extent is the SEM arrangement and trials appropriate to implementing the policy intent of the SEM trials?	• Extent to which SEM is an appropriate approach to increase attractiveness of GP/RG training and primary care careers
	• Extent to which SEM is an appropriate approach to build a sustainable workforce in regional, rural and remote areas
	• Extent to which the SEM aligns with other Commonwealth and state workforce policy and program priorities and objectives
	• Extent to which SEM registrars' employment agreements comply with state and Commonwealth employment legislation
		• Interviews/focus groups with:
		  ○ Trial leads
		  ○ Department of Disability Health and Aging
		  ○ State health departments
		  ○ RWAs
		  ○ Colleges
		  ○ PHNs
		  ○ Peak bodies
		• Case studies

KEQ2: How well have the trials been delivered?		
2.1 How have the trials been delivered and what are the key features of the trials?	• Description of trial activities, including leadership, governance, collaboration, selection processes for trial sites and registrars, negotiation of practice agreements, financial and billing arrangements, key objectives.	• Document review (including practice agreements, MoUs, proposals, contracts)

KEQs			

		• Number and characteristics of:
		  ○ Participating practices (E.g. MM, private/ corporate/ ACCHO, size (FTE equivalent), hospital role)
		  ○ Participating registrars - Rural background, University, participation in Rural Clinical School (RCS) (and location) PGY, college and training pathway, IMG, AST, gender, age
		• Distribution of SEM registrars by MM
			• Interviews/focus groups with Trial leads
			• Case studies
			• Trial data reporting template

2.2	How appropriate were the administrative arrangements and processes for management, accountability and transparency purposes for state health services and participating GPs/ ACCHOs/ other training sites?
	Did they add any administrative costs or system changes for participating General Practices/other training sites?
		• Description of administrative arrangements and processes and how these were developed including:
		  ○ MOUs between Commonwealth and States/Territory or Commonwealth and First Nations Trial Single Employer
		  ○ MOUs between States/Territory Health Departments and state health services
		  ○ MoU/practice agreement between Single Employer and General Practice/other training sites
		  ○ Employment arrangement between Single Employer and registrar (e.g. adoption of same EBA as hospital-based registrars)
		• Additional resources (personnel, systems, funding) required for administration of the program
		• Stakeholders' views of appropriateness of administrative arrangements and processes, and opportunities/ mechanisms for review
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ Peak bodies
			• Case studies
			• Document analysis (including practice agreements, MoUs, proposals, contracts)

KEQs			
		• Stakeholders' satisfaction with SEM arrangement, including their ability to manage risks (inc. financial), administrative burden • GP supervisors' satisfaction with support from Single Employer to supervise registrar	

2.3	To what extent has SEM impacted on registrar training?	• Description of training placements and pathway (e.g. diversity of experiences)
		• Registrars' exposure to rural and regional healthcare, especially in community settings and across different socioeconomic and cultural groups
		• Registrars' ability to adhere to and meet GP training requirements set by the colleges
		• Registrars' confidence in their regional and rural skills to work in their local service settings
		• Registrars' perceptions of the extent that training is flexible and meets individual interests/training needs
		• Colleges' perceptions of the extent of SEM's impact on quality of training for registrars
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ State health departments
			  ○ Peak bodies
			  ○ Colleges
			• Case studies
			• Surveys of registrars

2.4	To what extent are GP/RG registrars satisfied with SEM arrangements?	• Registrars' awareness of, or satisfaction with workplace conditions including:
		  ○ Mechanisms for dispute resolution
		  ○ Mechanisms for fatigue disclosure
		  ○ Management of fatigue
		  ○ Their wellbeing
		  ○ Line of reporting and supervision
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ Peak bodies
			• Case studies
			• Survey of registrars

KEQs			
		○ Salary ○ Entitlements and benefits (e.g. leave) • Reasons SEM registrars continue or discontinue SEM	
2.5	To what extent do SEM participants remain on SEM for the duration of training?	• Number (%) of participants continuing under SEM contract until completion or fellowship • Number (%) of registrars withdrawing from SEM, and reasons for withdrawal	• Case studies • Survey of registrars • Trial data reporting template
2.6	To what extent does supervision, training and support of a SEM registrar differ to supervision of a non-SEM registrar for GP supervisors?	• Perspectives on differences and similarities in supervision/ training/supports between SEM and non-SEM registrars	• Interviews/focus groups with: ○ Trial leads ○ Peak bodies ○ Colleges • Case studies
2.7	What are the financial impacts of delivering the trials for the Commonwealth, State and Territory health departments, state health services, and primary care practices (e.g. General Practices, ACCHOs, other training sites) and registrars? What other funding sources/resources have been invested? How does this compare to usual arrangements?	• Total Commonwealth funding and support provided for SEM trials • Total funding and support provided by state governments, state health services, General Practices/other training sites • Estimated indirect costs of delivering SEM incurred by state governments, state health services, General Practices/other training sites • Use and cost of locums to fill workforce gaps, including MBS benefits paid to identified locums, pre and post SEM • Funding and indirect costs of training registrars and meeting workforce needs without SEM arrangement	• Interviews/focus groups with: ○ Trial leads ○ State health departments • Case studies • Document review • MBS Billing data

KEQs			
		• Perceived difference of cost/earnings of SEM versus non-SEM registrars to participating training sites (E.g. GP Practices, ACCHOs)	

2.8	What has helped or hindered the implementation of SEM? (E.g. system-level factors, practice-level factors, college/training pathway, individual registrar-level factors, community-level factors)? Is this different for different trials, e.g. First Nations trial, jurisdiction-led, different SEM approaches?	• List and description of factors that have affected implementation of SEM	• Interviews/focus groups with:
			  ○ Department of Disability, Health and Aging
			  ○ Trial leads
			  ○ State health departments
			  ○ Peak bodies
			  ○ Colleges
			  ○ RWAs
			  ○ PHNs
			• Case studies
			• Document review

KEQ3: How effective were the trials in achieving the intended outcomes?			

3.1	To what extent have the trials improved the attractiveness of GP/RG training and training in regional, rural and remote regions?	• Change in number of GP/RG registrars commencing in training programs (AGPT, Fellowship Support Program (FSP), Rural Generalist Training Scheme (RGTS), Independent Pathway (IP)), and proportion of training placements filled, by jurisdiction, rural and remote[11]	• Training data
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ State health departments
			  ○ Colleges
			• Case studies

[11] Subject to data availability at the region-level

KEQs			
	To what extent is this attributable to SEM?	• Stakeholder views on whether SEM has attracted registrars committed to rural primary care training in the SEM region • Reported attraction factors among registrars (SEM and non-SEM) training in regional, rural and remote regions • Description of other factors impacting attractiveness of GP/RG training (e.g. policy, changes to state EBAs, RG recognition)	• Surveys of registrars
3.2	Have the trials been effective in maintaining employment benefits for registrars? What employment benefits are accessed? Are there any differences between trial models?	• Description and length of employment agreements, available to registrars and implications • Registrars' utilisation of benefits/entitlements, and barriers to accessing	• Document review (trial design documents, EBAs etc) • Interviews/focus groups with Trial leads • Case studies • Survey of registrars

3.3	To what extent have the trials supported registrars to achieve GP/RG fellowship?	• % of SEM registrars that fellow
		• Comparison of number of GP/RG registrars fellowing before and since SEM availability in region[12]
		• Reasons why SEM registrars do not achieve GP/RG fellowship
			• Trial data reporting template
			• Training data
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ State health departments
			  ○ Colleges
			• Case studies

[12] Granularity of data at a regional level will not be available, and will need triangulation with qualitative data

KEQs			
			• Survey of registrars

3.4	How effective were the trials in retaining SEM registrars in the region or other regional, rural or remote locations post-fellowship?	• Number and percentage of registrars retained as a GP/RG in region (district or town) at 1-and 2- years post-fellowship, compared to pre-trial
		• SEM registrars' intent to stay regional/rural post-training
		• Extent of registrar/fellow reporting connection with health and medical system in region
		• Reasons given by SEM registrars for intent to stay/leave region post-fellowship
		• Number and location of SEM registrars who left region for other rural/remote region post-fellowship and reasons for moving
			• MBS billing data
			• Survey of registrars
			• Case studies
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ State health departments

3.5	To what extent are SEM registrars satisfied with their post-fellowship employment?	• Description of post-fellowship employment (appointment, specialty, location, employment arrangement, skills utilisation, satisfaction)	• Case studies

3.6	To what extent have the trials increased linkages between health system, Single Employers and training sites	• Number of registrars with training placements split fractionally between hospital and private practice (split rosters)
		• Description of trial design processes (e.g. codesign) and ongoing governance arrangements (e.g. composition of governance committee, Terms of Reference, meeting frequency)
		• Changes in perceptions, understanding and relationships with GP and primary care among hospital-based staff
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ State health departments
			• Case studies
			• Document review (MoUs, contracts, proposals, practice agreements)

KEQs			

3.7	To what extent have the trials impacted access to healthcare services in trial regions?	• Change in primary care GP services per capita in trial regions (MBS Billing)
		• Capacity of primary care practices (e.g. GP practices, ACCHOs) to deliver services and meet community needs, pre and since SEM
			• MBS billing data
			• Interviews/focus groups with:
			  ○ Trial leads
			  ○ State health departments
			  ○ PHNs
			  ○ RWAs
			• Case studies

KEQ4: What are the key learnings from the trials and future opportunities for SEM?			

4.1	What are the key lessons learnt? What has impacted on the success of the trials? Is this different for different trials, e.g. First Nations trial, jurisdiction-led, different SEM approaches, training pathways (AGPT, FSP, IP, RGTS, Remote Vocational Training Scheme (RVTS))	• List and description of learnings about SEM for GP/RG training, e.g.:
		  ○ Explore growth of Rural Generalism
		  ○ Explore rural pathways from medical school to fellowship
		  ○ Opportunities for GPs/RGs to work to full scope of practice / use advanced skill (procedural and cognitive) within service system
		• List and description of factors that have impacted success of trials
			• Interviews/focus groups with:
			  ○ Department of Disability, Health and Aging
			  ○ Trial leads
			  ○ State health departments
			  ○ Peak bodies
			  ○ Colleges
			  ○ RWAs
			  ○ PHNs
			• Case studies

4.2	How has SEM enabled innovative training and employment arrangements?	• Description of innovative training and employment arrangements (e.g. blended supervision, fractional post-fellowship appointments)	• Interviews/focus groups with Trial leads • Case studies • Document review

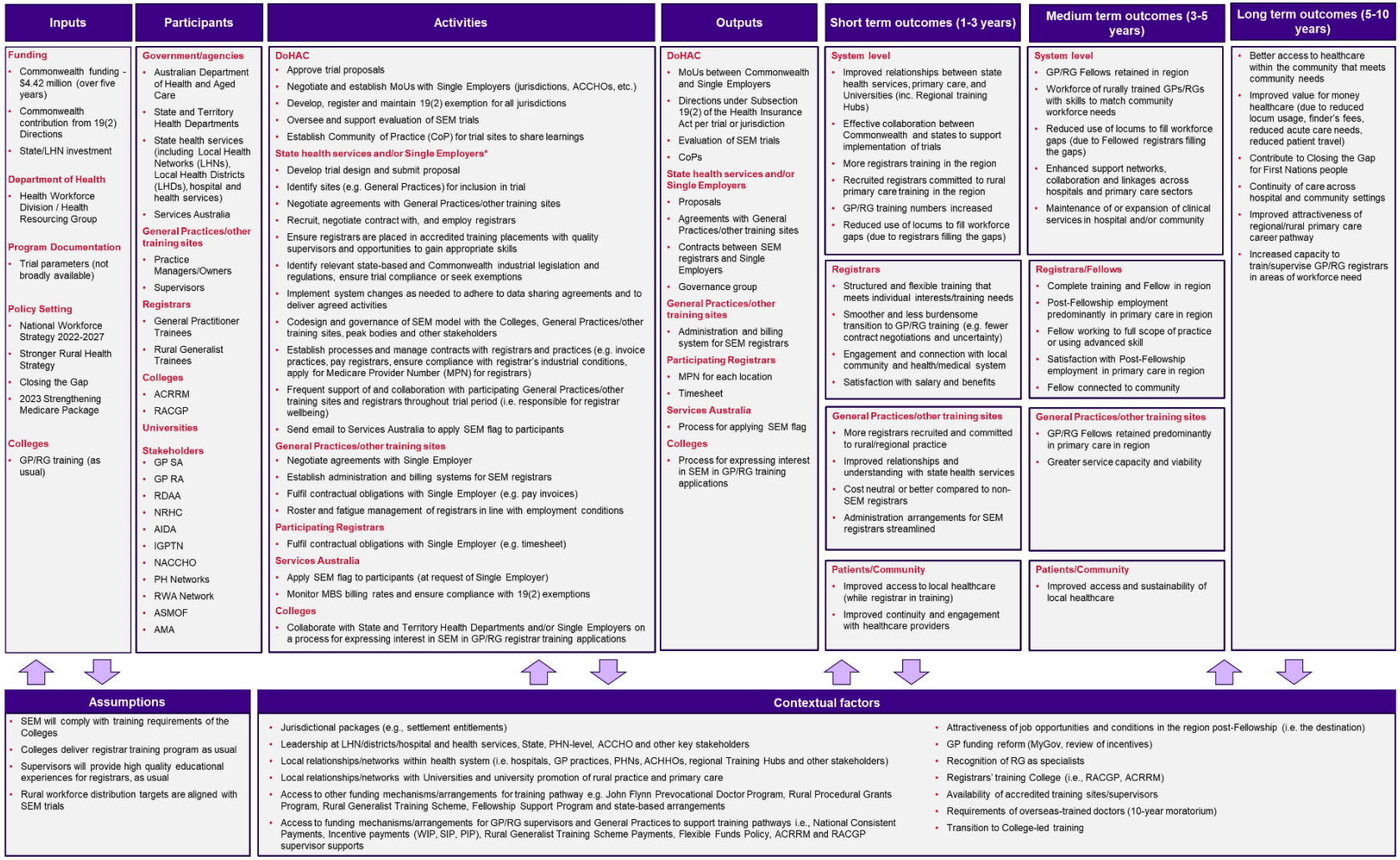
KEQs			

4.3	Are there any unintended consequences of the trials, including on registrar learning, income incentives and role of the colleges, training sites and non-participating primary healthcare practices?	Description of unintended impacts. Example issues to explore:
		• Fellowed registrars' confidence in Medicare Billing
		• Earnings post-fellowship (under fee-for-service (FFS) arrangement) for SEM compared to non-SEM registrars
		• Comparison of SEM and non-SEM registrar billing rates
		• Description of impacts on non-SEM practices – positive and negative
		• Description of impacts on non-SEM registrars – positive and negative
			• Interviews/focus groups with:
			  ○ Department of Disability, Health and Aging
			  ○ Trial leads
			  ○ State health departments
			  ○ Peak bodies
			  ○ Colleges
			  ○ RWAs
			  ○ PHNs
			• Case studies
			• MBS billing data

4.4	What are the opportunities for improvement of SEM for GP/RG training?	List and description of opportunities for the future of SEM for GP/RG training	• Interviews/focus groups with:
			  ○ Department of Disability, Health and Aging
			  ○ Trial leads
			  ○ State health departments
			  ○ Peak bodies
			  ○ Colleges
			  ○ RWAs
			  ○ PHNs
			• Case studies

KEQs		
4.5	What would be the benefits, risks and impacts of continuing the trials for registrars, the Commonwealth, state health departments, state health services and the community?	Triangulation of findings to earlier measures. Indicators and data sources will be determined once the evaluation is underway and the key findings are identified.

Appendix B Logic model



Appendix C Trial descriptions

The following tables provide a detailed overview of SEM trial operating across Australia.

C.1. NSW

Feature	Description
Trial Period	February 2024 - December 2028
Trial Lead	NSW Rural Health Division
Single Employer	Eight LHDs across two collaborative trials: • Collaborative Trial One: Murrumbidgee, Western NSW, Southern NSW, Illawarra Shoalhaven, Far West • Collaborative Trial Two: Hunter New England, Northern NSW, Mid-North Coast
Maximum Positions	80 trainees using Section 19(2) exemptions at any one time
Contract Length	1-4 years depending on stage of training
Participating Practices	Over 60 practices across MM 3-7 locations
Focus	RG (must be enrolled in Health Education and Training Institute (HETI) RG Medical Training Program)
Registrar Selection	Must also be in HETI RG Medical Training Program
Training Site Selection	Eligible GP practices
Financial Arrangement	Practices assign all gross billings to themselves. LHDs invoice practices for trainee hours at award rates plus superannuation and oncosts. Practices pay only for patient-related work, not educational time
Key Features	Registrars contracted through specific LHDs with employment under LHD awards; GP practices operate as extensions of hospital system rather than standalone employers; Placement flexibility allowing registrars to work outside their primary LHD area through inter-LHD negotiations; Mixed training model with both GP-based placements and hospital-only placements; Collaborative operational management between multiple LHDs; Preferential recruitment targeting undersubscribed regions; Built on Murrumbidgee LHD pilot learnings since 2021

C.2. Queensland

Feature	Description
Trial Period	Proof-of-Concept: Semester 1, 2024; Pilot trials: Semester 1, 2025 - 2028
Trial Lead	Queensland Health Office of Rural and Remote Health
Single Employer	Three regions (Hospital and Health Service clusters): **Northern Region:** Active: Townsville HHS, Cairns & Hinterland HHS, Northwest HHS; In-scope: Mackay HHS, Torres & Cape HHS; **Central Region:** Active: Central QLD HHS, Sunshine Coast HHS; In-scope: Metro North HHS, Wide Bay HHS, Central West HHS; **Southern Region:** Active: Darling Downs HHS, Southwest HHS; In-scope: West Moreton HHS, Gold Coast HHS, Metro South HHS
Maximum Positions	20 FTE per region; State government funding: 2025: 9 FTE; 2026: 15 FTE; 2027: 24 FTE; 2028: 30 FTE
Contract Length	1-4 years
Participating Practices	24 practices focusing on MM4-7 locations
Focus	RG or GP
Registrar Selection	Registrars with commitment to work rurally in primary care and Advanced Skills Training required by the region
Training Site Selection	Strategic selection of MM4-7 primary care practices (can include MM2-3 hospitals to cover fellowship requirements). Practices must demonstrate capability to deliver SEM and established relationship with respective HHS
Financial Arrangement	Primary care providers reimburse HHS for registrar salaries in line with NTCER. HHS receives Queensland Health (QH) funding contribution towards salary costs for primary care component only. Practices retain teaching/supervision payments, Practice Incentive Payments (PIP) and Workforce Incentive Payment (WIP) payments
Key Features	Proof-of-concept approach before full rollout; Focus on very rural and remote areas; Emphasis on local HHS control and relationships; Annual Expression of Interest process for practice selection; Shared performance management between HHS and practices; Flexibility for registrars to move between SEM practices; Maintained QH indemnity and Workcover coverage

C.3. RACE

Feature	Description
Trial Period	Commenced late 2022 to 2028
Trial Lead	RMCLHN

Feature	Description
Single Employer	RMCLHN
Maximum Positions	20 trainees at any one time using Section 19(2) exemptions
Contract Length	Up to 5 years[13]
Participating Practices	8 practices across MM 3-7 locations (1 MM3, 7 MM5)
Focus	RG
Registrar Selection	Those with commitment to regional and rural areas. Trainees must be enrolled in RACE and ACRRM/RACGP training programs by PGY3
Training Site Selection	GP college accredited practices in MM 2-7. Practice allocation self-determined by registrar in collaboration with lead site and practice, based on built relationships during training programs, registrar area of interest and clinic specialties offered.
Financial Arrangement	RMOs: Practices keep $300/session + 50/50 split of Medicare billings Registrars: 50/50 split of registrar billings
Key Features	5-year employment security from internship through registrar training; Longitudinal integrated community training starting day one of internship; Transition from hospital-centric to community-centric RG development; Build dedicated rural workforce through early community integration; Provide a range of Advanced Skills Training positions; Focused on supporting registrars to achieve full rural generalist qualifications.

C.4.SA

Feature	Description
Trial Period	February 2025 - December 2028
Trial Lead	Rural Support Service (RSS) on behalf of five regional LHNs
Single Employer	Five regional Local Health Networks: Barossa Hills Fleurieu LHN; Eyre & Far North LHN; Flinders & Upper North LHN; Yorke & Northern LHN; Limestone Coast LHN
Maximum Positions	60 trainees using Section 19(2) exemptions at any one time
Contract Length	1-4 years depending on stage of training

[13] Including pre-vocational training

Feature	Description
Participating Practices	Estimated 42 practices by 2028 across MM 2-7 locations (planned growth: 16 to 26 to 35 to 42 sites)
Focus	Rural Generalist or GP - must be linked to RGPSA
Registrar Selection	Must be enrolled in ACRRM, RACGP training programs. RSS/RGCU manages distribution using equity principles
Training Site Selection	Eligible GP practices
Financial Arrangement	MBS billing split - LHNs invoice agreed % of billings
Key Features	Centralised RSS coordination across five regional LHNs with standardised documentation and contracts; Mixed training model - some LHNs mandate hospital component while others focus solely on GP placements; LHN autonomy in determining trainee capacity based on financial and supervisory resources; Centralised Expression of Interest (EOI) recruitment process with LHN-specific selection and college coordination; Standard 3-4 year contracts under SA Health EBA; Monthly working parties for ongoing coordination and stakeholder engagement; Built on existing Riverland trial experience with statewide expansion

C.5. Tasmania

Feature	Description
Trial Period	July 2023 to December 2028
Trial Lead	Tasmanian Department of Health
Single Employer	Tasmanian Health Service (THS)
Maximum Positions	20 headcount trainees
Contract Length	Fixed-term 12-month contracts up to 4 years
Participating Practices	Multiple GP college accredited practices across MM 2-7, including: MM 2: Bellerive, Claremont, Exeter, Hobart; MM 3: Burnie, Devonport, Ulverstone, Wynyard; MM 5: Campbell Town, Cygnet, Dover, Geeveston; MM 6: Bicheno, Queenstown, Rosebery; MM 7: Currie (King Island), Whitemark (Flinders Island)
Focus	RG or GP
Registrar Selection	Must be enrolled in ACRRM or RACGP training programs. THS coordinates placements and manages distribution

Feature	Description
Training Site Selection	Eligible GP practices
Financial Arrangement	THS invoices practices 50% of MBS billings
Key Features	THS Single Employer across three regions with the Tasmanian Department of Health handling administration and practice arrangements; Fixed-term 12-month contracts with expression of interest process for continuation; 50/50 revenue split between THS and practices; Unique supervision and training funding including courses and scholarships; Capital infrastructure scheme to upgrade GP practice training capacity; Mixed hospital and GP practice placements under same contract; Strategic focus on MM3 and MM5 areas with 35% in ACCHOs; Headcount cap limitation (20 positions maximum regardless of FTE)

C.6. Victoria

Feature	Description
Trial Period	February 2025 - February 2027 (2 years)
Trial Lead	Victorian Rural Generalist Program (VRGP)(Department of Health, Victoria)
Single Employer	Three hospitals: BRHS (Gippsland); GH (Grampians); MBPH (Loddon Mallee)
Maximum Positions	15 FTE (22 registrars as of February 2025)
Contract Length	2 years (2025-2027); Victorian Public Health Sector Doctors in Training Enterprise Agreement 2022-2026
Participating Practices	56 practices signed up to Section 19(2) exemption.
Focus	Exclusively RG (selection from VRGP)
Registrar Selection	Rural Generalist registrars on a recognised RACGP or ACRRM training pathway, enrolled in VRGP and entering a GP placement in 2025 or 2026. Selected by BRHS, GH and MBPH. Selection criteria prioritised for intention to live and work in the region of the employing health service.
Training Site Selection	Eligible primary care providers. 6 practices (MM3 – MM5) hosting SEM trainees as at February 2026
Financial Arrangement	Practice retains first $100 gross billings per half-day clinic session plus 50% of remaining gross billings
Key Features	Limited trial to three hospitals for two years; no-disadvantage guarantee for participating hospitals, general practices and trainees; central coordination with local implementation

C.7. First Nations (ACCHO)

Feature	Description
Trial Period	Engagement phase: March 2025; Implementation: TBC
Trial Lead	Queensland Aboriginal and Torres Strait Islander Health Council
Single Employer	ACCHOs (primarily Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health)
Maximum Positions	Not specified (demand-driven based on ACCHO capacity and registrar interest)
Contract Length	Flexible employment arrangements: Contractor, fixed-term, or permanent employee positions. Duration aligned with RACGP/ACRRM training requirements
Participating Practices	Collaborating Health Services: Acacia Country Practice; South West Hospital and Health Service (SWHHS); Royal Flying Doctor Service Queensland (RFDS QLD)
Focus	RG or GP with strong emphasis on First Nations health and cultural competency
Registrar Selection	Community-led recruitment ensuring cultural alignment. Screening based on commitment to rural practice, interest in First Nations health, and willingness to engage in cultural safety training
Training Site Selection	Eligible GP practices
Financial Arrangement	To be confirmed
Key Features	First SEM trial in ACCHO setting with community-controlled workforce planning; Cultural safety induction and immersion components for registrars; Mentorship from Elders and cultural guidance; Four training partners with MOUs and Terms of Reference; Community-controlled approach to sustainable healthcare delivery in First Nations communities