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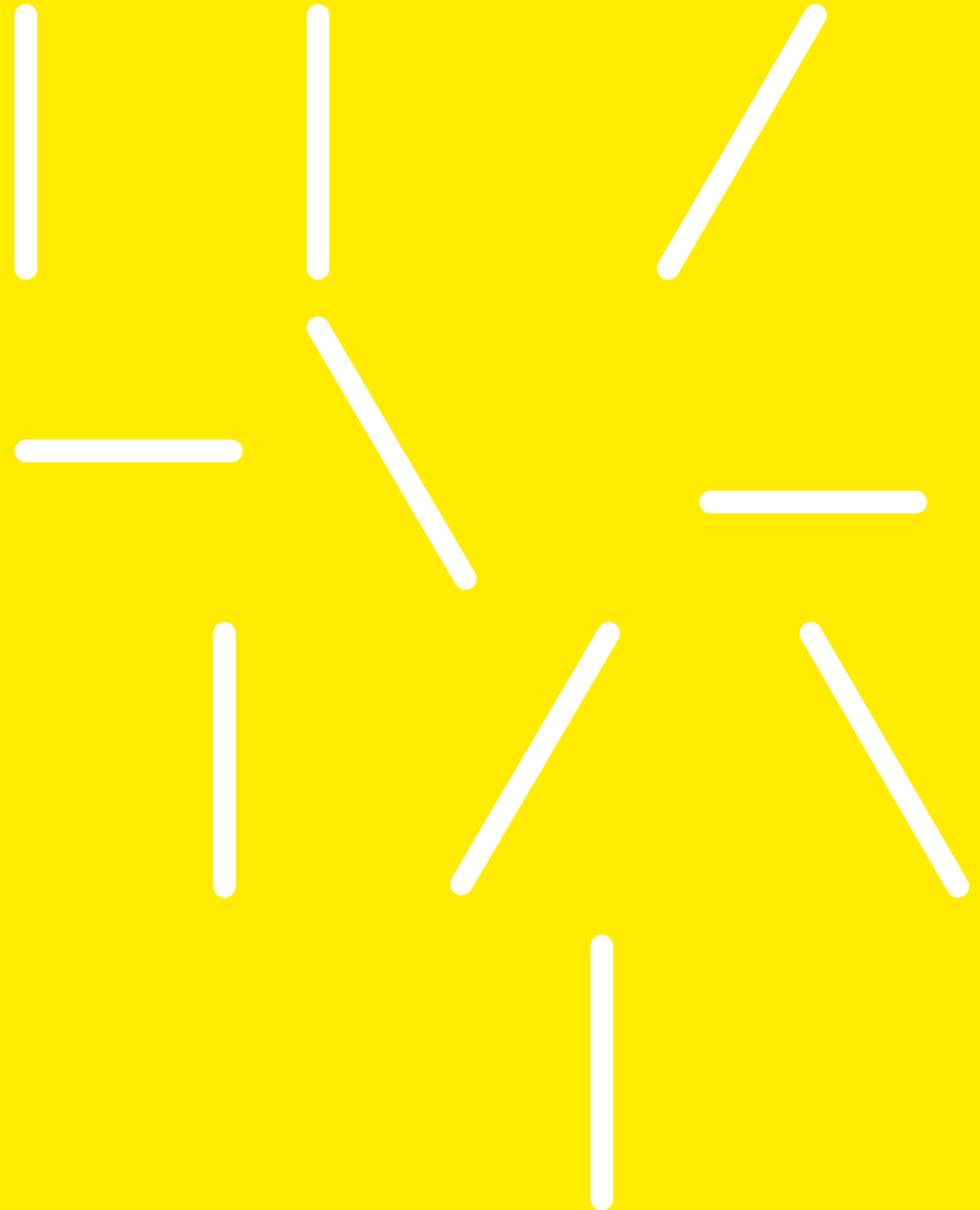
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**Evaluation of the COAG  
Section 19(2) Exemptions  
Initiative – Improving Access  
to Primary Care in Rural and  
Remote Areas**

FINAL REPORT

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14 OCTOBER 2021





## OUR VISION

*To positively impact people's lives by helping create better health services*

## OUR MISSION

*To use our management consulting skills to provide expert advice and support to health funders, service providers and users*

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# ABBREVIATIONS

ABBREVIATION	Definition	ABBREVIATION	Definition
ACCHO	Aboriginal Community Controlled Health Organisation	NACCHO	National Aboriginal Community Controlled Health Organisation
AHPRA	Australian Health Practitioner Regulation Agency	NGO	Non-government organisation
COAG	Council of Australian Governments	PHN	Primary Health Network
Department, the	Australian Government Department of Health	PHO	Principal House Officer
ED	Emergency department	PMS	Computer based patient management system, e.g. Medical Director
GIRS	Geographic Index of Relative Supply	RDAA	Rural Doctors Association of Australia
GP	General Practitioner	RFDS	Royal Flying Doctor Service
HMA	Healthcare Management Advisors	RFQ	Request for Quotation
IAHP	Indigenous Australians' Health Program	RG	Rural generalist
Initiative, the	Section 19(2) COAG Exemptions Initiative (other references to S 19 (2) exemptions refer to non-COAG exemptions)	RHOF	Rural Health Outreach Fund
LHN	Local Health Network	RVTS	Remote Vocational Training Scheme
MBS	Medical Benefits Schedule	RWA	Rural Workforce Agency
MMM	Modified Monash Model of geographical location	S19(2)	Section 19(2) Exemptions Initiative
MOU	Memorandum of Understanding	SOP	Standard operating procedure
MPS	Multipurpose Health Service	VMO	Visiting medical officers
MSOAP	Medical Specialist Outreach Assistance Program	VRG	Virtual Rural Generalist program in NSW
		WACHS	Western Australian Country Health Service

# EXECUTIVE SUMMARY

## BACKGROUND TO THE EVALUATION

Section 19(2) of the *Health Insurance Act, 1973* precludes state and territory health services claiming Medical Benefits for non-admitted, non-privately referred services delivered in hospitals, multipurpose services and community clinics. However, in 2006–2007 the Council of Australian Governments (COAG) introduced the *Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas Initiative* (the Initiative) with the objectives of:

- (1) improving access to primary care for people living in rural and remote areas
- (2) supporting participating sites to attract and retain a relevant primary healthcare workforce, and
- (3) assisting with the sustainability of rural hospitals.

The Initiative recognises that many people living in rural and remote areas throughout Australia face difficulties in gaining access to appropriate health professionals and healthcare services in their community.

In December 2020 there were 118 sites across four jurisdictions (New South Wales, Queensland, Western Australia and the Northern Territory) listed as participating in the Initiative. Two further jurisdictions are not fully engaged:

- South Australia continues to have a Memorandum of Understanding (MOU) with the Commonwealth but has yet to submit any site applications, and
- Victoria has finalised an MOU but there were no operational sites at the time this report was completed.

Medical Benefits Schedule (MBS) rebates received by sites under the Initiative in 2019–20 totalled \$13.6 m.

## Evaluation requirement and approach

The MOU between the Commonwealth and participating jurisdictions states that the Commonwealth will:

*‘Conduct an evaluation of the Initiative by 30 June 2020, in consultation with participating states and territories.’*

The existing MOUs were varied by the Commonwealth in September 2020, extending the Initiative operation to 31 December 2021.

The Australian Government Department of Health (the Department) engaged consultants from Healthcare Management Advisors (HMA) to:

*‘undertake a robust review of the COAG Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas (the Initiative) – to determine how the Initiative achieves its objectives’*

## Evaluation objectives and method

The aim of the evaluation, as specified in the project brief, was to determine the extent to which the Initiative was appropriate, effective, efficient and of quality and value.

To undertake the review, the following eight project stages were undertaken:

**Stage 1: Project planning:** defined the project scope, clarified roles and responsibilities and formulated a detailed project management plan.

**Stage 2: Situation analysis:** developed a summary of current Initiative arrangements and issues for exploration during the evaluation.

**Stage 3: Evaluation plan:** the plan finalised the evaluation questions, specified data sources and data collection protocols, and designed collection tools.

## EXECUTIVE SUMMARY

**Stage 4: Data collection:** HMA collected a range of qualitative and quantitative data via surveys and interviews conducted with relevant stakeholders. We sought insights into the effectiveness of the Initiative from a range of stakeholder perspectives.

**Stage 5: Case studies:** we conducted a series of 10 case studies. These provided an in-depth understanding of how well sites were able to meet the objectives of the Initiative and identified barriers to the future success of the Initiative.

**Stage 7: Information synthesis:** the project team triangulated from the previous stages and undertook an evaluative assessment of the Initiative's performance.

**Stage 8: A final report was prepared** incorporating all key findings from the evaluation and options to improve the Initiative for the future. A draft of the final report was circulated to four participating jurisdictions and three engaged jurisdictions not actively participating. The final report incorporates feedback from that process, including jurisdiction responses to the options suggested for program refinement,

This document is the final report of the evaluation.

## CONTEXT: OVERVIEW OF THE INITIATIVE

The MOUs specify the rules for operation of the Initiative, including:

- Approval to participate, services that are eligible to be claimed, and rules for the reinvestment of MBS rebated revenue
- Consultation required with other providers to gain approval as a participating site
- Provider eligibility requirements based on geographic location – Modified Monash Model (MMM) categories 5 to 7
- Eligible services for reinvestment of MBS funds claimed by providers
- Requirements for a site Operational Plan, and
- Reporting arrangements for participating sites.

The wider context for the Initiative influences what happens 'on the ground' at individual participating sites, including:

- Doctor remuneration arrangements and rural and remote health services, which vary by jurisdiction
- Other Section 19(2) exemption arrangements that operate in rural and remote areas
- The rural policy context, especially in relation to workforce training and financial incentives to attract and retain the health workforce outside metropolitan areas,
- The broader health and human services context that affects local planning for primary health service delivery, including further Commonwealth programs that improve access to primary healthcare, including Primary Health Networks, Indigenous Australians' Health Program, and the Rural Health Outreach Fund, and
- Broader developments in the health and human delivery in the areas of the National Disability Insurance Scheme, the Royal Commission into Aged Care, and pilots funded under the new *National Health Reform Agreement 2020–2025*.

### Patterns of service delivery under the Initiative

Although the program website lists 118 participating sites, only 92 of those sites were paid MBS revenue in 2019–20.

New South Wales and Queensland have the most participating sites, having 36 and 39 active sites respectively in 2019–20, representing 81% of the 92 active sites. Western Australia had 11 active sites (12% of the total) and Northern Territory had 6 active sites (7% of the total).

The jurisdictions had quite different geographic profiles of where their active sites were located. New South Wales and Queensland sites were more likely to be in MMM Category 5. Northern Territory sites were either in MMM Category 6 or 7. All Western Australian active sites were in MMM Category 7.

In 2019–20 the 92 active sites that received MBS rebates had a median rebate of \$56,081. There were significant variations in the median payments across jurisdictions, ranging from a low of \$34,134 in New South Wales to a high of \$217,050 in the Northern Territory.

In 2019–20 eight sites generated over \$600,000 in revenue each (ranging from \$0.600 million (Fitzroy Crossing) to \$1.043 million (Derby)).



## EXECUTIVE SUMMARY

- these eight sites accounted for revenue of \$6.3 million under the Initiative, more than 45% of total funds generated, and
- three of these sites were in WA, four in Queensland and one in NT.

The mean revenue for the other 85 sites with under \$0.6 million in revenue was \$85,702 in 2019–20.

## EVALUATION FINDINGS

The evaluation team formed the following overall assessment of the Initiative.

### Program design and administration

Our examination of the program's design and administration found that there was strong support for the single eligibility criterion that public health services must be based in areas 5 to 7 of the Modified Monash Model geographical classification. There was also support for: review mechanisms for sites that are no longer eligible under this criterion; clearer program objectives; and greater transparency in program operations, including publication of MOUs and formalised and regular engagement of site service providers with local stakeholders.

HMA considered that changes are needed to site reporting processes to make a clearer link between the operational plan, models of care and reinvestment. We suggest Operational Plans should be refreshed at least once within each MOU cycle.

### Appropriateness

Consideration of the Initiative's appropriateness observed that funding contributions to different sites resulting from the Initiative can be internally inequitable – larger sites with more salaried doctors have a greater ability to undertake MBS billing.

This characteristic highlights a program impact that emerges from its inherent design; MBS revenues of a site are not directly linked to underlying health needs of a community.

There is limited capacity to address this program characteristic – the foundation of the Initiative is primarily a top-up funding stream that enables access to MBS billing.

Communities and health service providers need to access other funding sources to address local healthcare needs in a more targeted way, including programs administered or commissioned by Primary Health Networks (PHNs), Rural Workforce Agencies (RWAs), the National Disability Insurance Scheme (NDIS), aged care funding, and locally based services delivered by local providers such as local government and local health networks (LHNs).

### Effectiveness

With respect to effectiveness in meeting overall objectives, we found that the Initiative influenced access to urgent medical care and after-hours services at a large proportion of participating sites. It has also contributed to increased availability of primary care services in many locations. Much of the MBS revenue reinvestment was allocated to medical officer remuneration to support and/or provide acute hospital emergency services.

Nationally MBS revenues under the Initiative represented in the order of 6% of modelled salaries and wages of participating sites, suggesting that the Initiative is, on average, a reasonably significant contributor to overall revenue of these sites. This proportion varied significantly by both site and jurisdiction.

Although the revenues provided under the Initiative are reasonably significant, the evaluation observed that the program is not a guarantee of an individual health service's long-term viability. Historical service delivery arrangements, industrial arrangements, gradual population decline in rural areas, and the sudden resignation of a key manager or clinician can all interact to threaten the sustainability of health services and compromise the models of clinical care available to some small communities.

## THE WAY FORWARD: OPTIONS FOR PROGRAM REFINEMENT

The findings from the evaluation suggest that changes to the current arrangements should be considered to ensure implementation of the Initiative:

- is responsive to the context in which it is operating,



## EXECUTIVE SUMMARY

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- is transparent about how it is being administered at Commonwealth, jurisdiction and site levels, and
- allows for potential benefits from the Initiative to be maximised.

Areas of improvement that we consider should be examined include:

- Clearer principles and objectives to guide the development and implementation of the Initiative in jurisdictions at sites (*Option 1*)
- Revised program governance arrangements (*Option 2*) that expand formalised and required engagement via:
  - *Option 2 (a)*: sub-regional (site level) governance committees, including stakeholders not currently specified in the MOU, such as RWA representatives and local community members, and
  - *Option 2 (b)*: Commonwealth/jurisdiction bi-lateral governance committees (one for each participating jurisdiction)
- Establishing mechanisms to maximise benefit to communities through collaborative planning and co-investment by exploring the relationship with other Commonwealth and jurisdiction program investments in the town and its surrounding community (*Option 3*), and
- Administrative refinement to program processes (including formalised jurisdiction-level reporting on reinvestment and a mid-cycle review process for all plans) (*Option 4*).

The report summarises jurisdiction responses to each of these options.

During stakeholder discussions for the evaluation there was some support for larger changes to funding arrangements for small health services in rural and remote areas. These options for funding redesign included:

- Pooling of funds at a sub-regional level using revenues from the Initiative together with other relevant programs including RWAs, PHNs, NDIS, aged care, local government and LHNs, and
- Place based planning and service development.

These options were beyond the scope of this evaluation, which was to focus on the effectiveness, design rules and appropriateness of the Initiative.

## NEXT STEPS

The evaluation report will inform development of the next MOUs with jurisdictions.

# PART A

# CONTEXT

# 1 BACKGROUND

## 1.1 INITIATIVE CONTEXT

Section 19(2) of the *Health Insurance Act, 1973* precludes state and territory health services claiming Medical Benefits for non-admitted, non-privately referred services delivered in hospitals, multipurpose services and community clinics. However, in 2006–2007 the Council of Australian Governments (COAG) introduced the *Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas* (the Initiative) with the objectives of:

- (1) improving access to primary care for people living in rural and remote areas
- (2) supporting participating sites to attract and retain a relevant primary healthcare workforce, and
- (3) assisting with the sustainability of the rural hospitals.

The Initiative recognises that many people living in rural and remote areas throughout Australia face difficulties in gaining access to appropriate health professionals and healthcare services in their community.

In December 2020 there were 118 sites across four jurisdictions (New South Wales, Queensland, Western Australia and the Northern Territory) listed as participating in the Initiative [1]. Medical Benefits Schedule (MBS) rebates received by jurisdictions under the Initiative in 2019–20 totalled \$13.716 m.<sup>1</sup>

<sup>1</sup> Unpublished data provided by the Department

## 1.2 REQUIREMENT FOR EVALUATION

The Memorandum of Understanding (MOU) between the Commonwealth and participating jurisdictions states that the Commonwealth will:

*‘Conduct an evaluation of the Initiative by 30 June 2020, in consultation with participating states and territories’*

The existing MOUs were varied by the Commonwealth in September 2020, extending the Initiative’s operation to 31 December 2021.

The Australian Government Department of Health (the Department) engaged Healthcare Management Advisors (HMA) to

*‘undertake a robust review of the COAG Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas (the Initiative) – to determine how the Initiative achieves its objectives’*

## 1.3 EVALUATION OBJECTIVES

The aim of the evaluation, as specified in the project brief, was to determine whether the Initiative is appropriate, effective, efficient and of quality and value. Our assessment has been informed by examining the Initiative’s performance against the following key evaluation questions:

# 1 BACKGROUND

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- What effects has the COAG Section 19(2) Initiative had on approved eligible sites?
- Have COAG Section 19(2) exemptions improved access to primary healthcare services?
- Are current COAG Section 19(2) Initiative eligibility criteria appropriate to achieve the Initiative's objectives?
- Are current administrative arrangements and processes appropriate for management, accountability and transparency purposes?
- Does the COAG Section 19(2) Initiative continue to meet the need to improve access to primary care in rural and remote areas?

## 1.4 DOCUMENT PURPOSE & STRUCTURE

This document is the final evaluation report. The report was finalised based on feedback from jurisdictions on a draft version circulated in mid-August 2021.

The report is comprised of two parts and five chapters:

### **Part A: Context**

- Chapter 1 (this chapter): background on the evaluation
- Chapter 2: overview of the Initiative, including the operational context by jurisdiction and other service delivery arrangements that impact on Initiative sites
- Chapter 3: the evaluation framework applied to assess the Initiative impact

### **Part B: Evaluation Findings & Next Steps**

- Chapter 4: our evaluation observations and findings
- Chapter 5: the way forward– options for program development based on the evaluation findings. The final report includes a summary of jurisdiction's observations on each option.

Additional background on the scope of the Initiative and relevant data that supported the evaluation analysis is given in the Appendices ( see Chapter 6).

## 2 OVERVIEW OF THE INITIATIVE

In this chapter we describe the design characteristics of the Initiative and broad patterns of delivery (see Section A). In Section B we describe the wider context for Initiative operations that influence what happens ‘on the ground’ at individual participating sites, including:

- Doctor remuneration arrangements
- Other Section 19(2) exemption arrangements that operate in rural and remote areas
- The rural policy context, especially in relation to workforce training and financial incentives to attract and retain the health workforce outside metropolitan areas, and
- The broader health and human services context that affects local planning for primary health service delivery, including:
  - further Commonwealth programs that improve access to primary healthcare, including Primary Health Networks, Indigenous Australians’ Health Program, and the Rural Health Outreach Fund, and
  - broader developments in the health and human service delivery in the areas of the National Disability Insurance Scheme, the Royal Commission into Aged Care, and pilots funded under the new *National Health Reform Agreement 2020–2025*.

### SECTION A: MAIN FEATURES

#### 2.1 MOUs – OPERATIONAL PHASES AND JURISDICTION COVERAGE

Implementation of the Initiative is underpinned by an MOU between the Commonwealth of Australia and the participating jurisdiction. The Initiative has had

three iterations, each over an approximate four-year period. The first MOU covered the period 2006–2010; the second covered the period 2010–2015.

The current MOU initially covered the period 2016–2020; the Commonwealth extended the MOU until December 2021 to align with finalisation of this evaluation. The MOUs for the current arrangements contain a single eligibility criterion – an eligible public health site must be located in areas 5 to 7 of the Modified Monash Model (MMM) geographical classification scheme.

The number of participating sites has gradually increased and currently there are 118 approved eligible sites across four jurisdictions – New South Wales, Queensland, Western Australia, and the Northern Territory. Two further jurisdictions are not fully engaged:

- South Australia continues to have an MOU with the Commonwealth but has yet to submit any site applications, and
- Victoria has recently finalised an MOU but there were no operational sites at the time this report was completed.

#### 2.2 INITIATIVE OBJECTIVES

The full objectives of the Initiative are specified in Part 6 of the MOUs, Clause 6.1. This states the Initiative supports rural and remote hospitals in small communities:

‘by increasing access to Commonwealth funding and ensuring that states and territories **increase support for primary health care in these areas.**’

The MOU adds that:

‘it recognises that there are challenges in **attracting and retaining adequate primary health care providers in rural and remote areas ...**’

The Initiative therefore:

## 2 OVERVIEW OF THE INITIATIVE

‘... aims to **achieve a net gain in primary health care services** in these areas.’

Operation of the Initiative has ongoing recognition at COAG level. Clause G22 of the National Health Reform Agreement Business Rules (Schedule G) observes that: sites approved to participate in the Initiative ‘may bulk bill the Medicare Benefits Schedule for eligible persons requiring primary health services who present to approved facilities.’ [2]

### 2.3 PRINCIPLES

Clause 7 of the MOU with each jurisdiction specifies principles to guide its development and operation:

‘All Australians should have equitable access to appropriate and quality health care throughout their lifetime, regardless of their place of residence within Australia.’

Australians in rural and remote communities face particular challenges when it comes to accessing appropriate health care, and it is the responsibility of all Australian governments to seek to address these challenges.

The health and medical workforce is a finite and valuable resource and its members’ involvement and support is crucial to the continued success of the Initiative.

Funding accessed through the Initiative should not be used for any purpose that undermines the viability or profitability of existing, privately operated health services, including existing general practices.

Implementation of the Initiative should take place as transparently as possible, while ensuring that agreed data collection and reporting requirements remain straightforward and uses existing processes where possible.<sup>2</sup>

It is noteworthy that the fourth of these principles – avoiding undermining local private sector viability – must be demonstrated in applications for an exemption. The MOU Schedule A Definitions explicitly state that ‘primary care practitioners may choose to be represented by a representative (sic) in negotiations.’

### 2.4 PROGRAM RULES

The MOUs specify the rules for target locations, consultations required to obtain approval to participate, services that are eligible to be claimed, and rules for the reinvestment of MBS rebated revenue. The rules state the following:

- *Consultation with other providers:* representatives of the proposed site obtain support for the Initiative operating in a locality from other local primary health care providers (including general practitioners), the Royal Flying Doctor Service (RFDS) and Aboriginal Health Services (AHS).
- *Provider eligibility:* a medical practitioner or health professional delivering health services at an exempt site and wishing to access payments under the MBS must have met the registration requirements of the *Health Insurance Act, 1973*.
- *Eligible services:* MBS funds claimed by providers are used to ensure increased primary health services – and funds derived from the Initiative for a site are to be returned to that site, in accordance with the Operational Plan.
- *Operational Plan:* the Plan must specify, *inter alia*: the site operational model (service types to be billed to Medicare); names of primary care practitioners billing Medicare; and the breakdown of proposed Medicare expenditure for reinvestment at the site. At least 70% of MBS rebated funds must be invested in new services and improvements (expenditure on administration and incentive payments is capped at 30% of rebated funds). The service types that can be

<sup>2</sup> See the New South Wales MOU. [18]



## 2 OVERVIEW OF THE INITIATIVE

implemented with the additional funds are, for example, additional health professionals, professional development, and equipment.

- *Reporting:* Clause 8.2 of the MOU requires jurisdictions to report on the Initiative at each site for the preceding financial year by 31 August each year.

### 2.5 STANDARD OPERATING PROCEDURES

The Primary Health Care Governance and Implementation Section, Primary Care Division, has a suite of Standard Operating Procedures (SOPs) to inform Department processes for managing the program. This document re-states much of the MOU contents but has additional processes and guidance on:

- assessing applications lodged by jurisdictions and protocols for communication of decisions back to jurisdictions and updating the website list of approved sites
- assessing annual reports lodged by jurisdictions, and
- records management for applications and annual reports. [3]

The SOPs articulate how delegations work to give effect to approving the exemption of individual sites under the Initiative:

‘The delegation is granted by the Health Minister acting under subsection 131(1) of the *Health Insurance Act, 1973*, in the ‘Instrument of Delegation’ to specific positions within the department.

The Assistant Secretary of the MBS Policy and Specialist Services Branch, Medical Benefits Division has delegation under this Instrument to approve exemptions under the Initiative. Exemptions are granted through Directions for the Initiative.’ [3]

## 2.6 PATTERNS OF DELIVERY

### 2.6.1 Initiative participation

Although the program website lists 118 participating sites, only 92 of those sites were paid MBS revenue in 2019–20. Table 2.1 shows the number of those active sites by jurisdiction and categorises their MMM ratings.

**Table 2.1:** MMM score for active Initiative sites (paid MBS revenue), 2019–20 <sup>3</sup>

MMM SCORE	NSW	QLD	WA	NT	TOTAL	MMM SCORE %
4		2			2	2
5	33	17			50	54
6	3	11		3	17	18
7		9	11	3	23	25
<b>Total</b>	<b>36</b>	<b>39</b>	<b>11</b>	<b>6</b>	<b>92</b>	<b>100</b>
<i>Jurisdiction share of total %</i>	39	42	12	7	100	

Source: Unpublished Department data – MBS payments data

The table shows that: New South Wales and Queensland had the most participating sites, having 36 and 39 active sites respectively in 2019–20, representing 81% of the 92 active sites. Western Australia had 11 active sites (12% of the total) and Northern Territory had 6 active sites (7% of the total).

<sup>3</sup> Only sites that received an MBS rebate in 2019–20 have been included

## 2 OVERVIEW OF THE INITIATIVE

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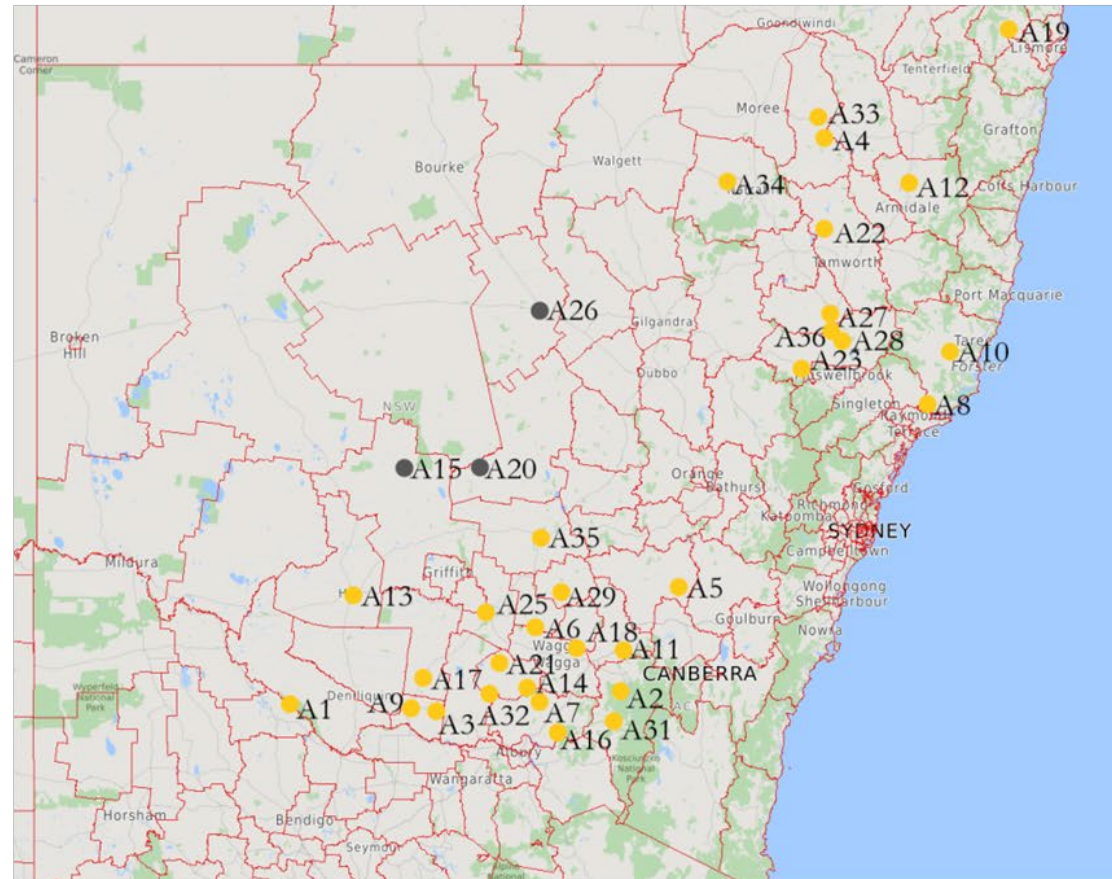
The jurisdictions had quite different geographic profiles of where their active sites were located. New South Wales and Queensland sites were more likely to be in MMM Category 5. Northern Territory sites were either in MMM Category 6 or 7. All Western Australian active sites were in MMM Category 7.

The location of Initiative sites that received MBS revenue under the Initiative are shown in Figure 2.1 to Figure 2.4.

## 2 OVERVIEW OF THE INITIATIVE

**Figure 2.1:** Location of NSW Initiative sites receiving MBS revenue, 2019–20

Jurisdiction: NSW			
Site	Tag	Site	Tag
Baham MPS	A1	Kyogle MPS	A19
Badlow MPS	A2	Lake Cargelligo Hospital and HS	A20
Berrigan HS	A3	Lockhart Hospital and HS	A21
Bingara MPS	A4	Manilla MPS	A22
Boorowa MPS	A5	Merriwa MPS	A23
Coolamon MPS	A6	Murrumbidgee-Harden Hospital and HS	A24
Culcairn MPS	A7	Narrandera HS	A25
Dungog Community Hospital	A8	Nyngan Multi-Purpose Service	A26
Finley HS	A9	Quindi HS	A27
Gloucester Soldiers Memorial Hospital and CHC	A10	Scots Hospital and CHC	A28
Gundagai MPS	A11	Temora HS	A29
Guyra MPS	A12	Tocumwal HS	A30
Hay Hospital	A13	Tumbarumba MPS	A31
Henty MPS	A14	Urana MPS	A32
Hillston Hospital and HS	A15	Wanialda MPS	A33
Holbrook Hospital	A16	Wee Waa Hospital and CHC	A34
Jerilderie Hospital and HS	A17	West Wyalong Hospital	A35
Junee MPS	A18	Wilson Memorial Hospital Murrurundi and Murrurundi CHC	A36



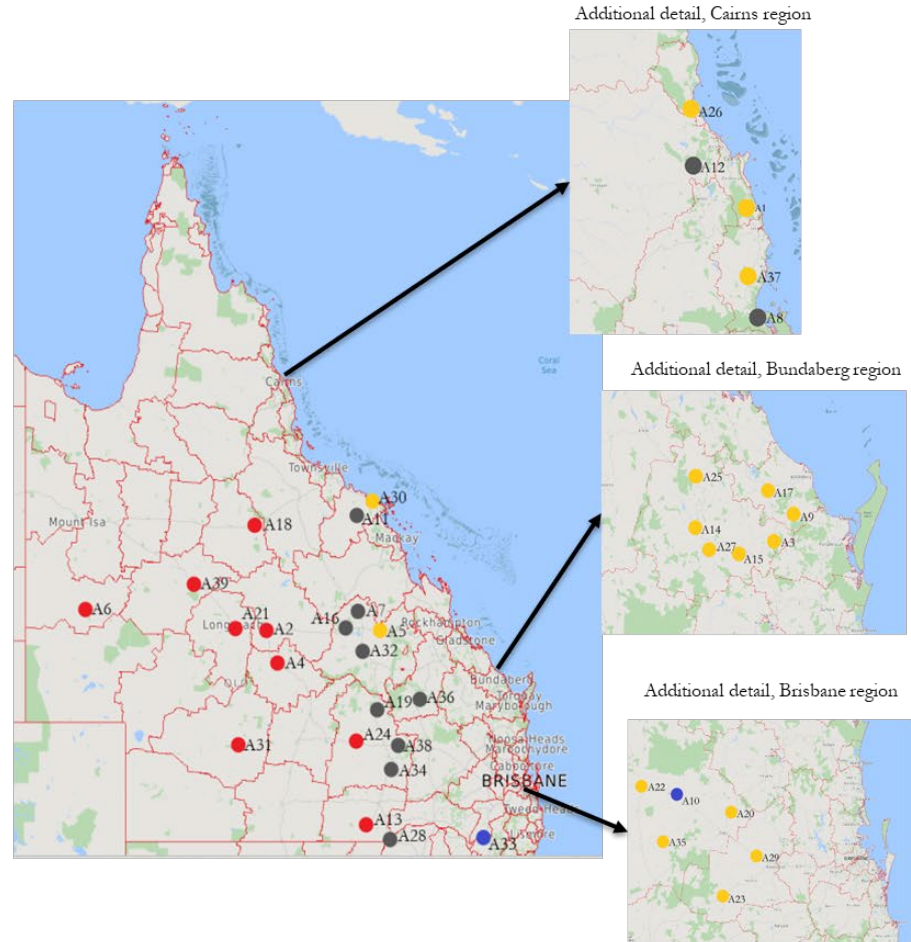
**Legend**

- = COAG s19(2) Exemptions Initiative sites (MMM 5)
- = COAG s19(2) Exemptions Initiative sites (MMM 6)

## 2 OVERVIEW OF THE INITIATIVE

**Figure 2.2:** Location of Queensland Initiative sites receiving MBS revenue, 2019–20

Jurisdiction: Queensland			
Site	Tag	Site	Tag
Babinda Hospital	A1	Longreach Hospital	A21
Barcaldine MPS	A2	Miles HS	A22
Biggenden MPS	A3	Millmerran MPS	A23
Blackall Hospital	A4	Mitchell Hospital	A24
Blackwater MPS	A5	Monto HS	A25
Boulia PHC	A6	Mossman MPS	A26
Capella OC	A7	Mundubbera HS	A27
Cardwell CH	A8	Mungindi MPS	A28
Childers MPS	A9	Oakey HS	A29
Chinchilla HS	A10	Proserpine Hospital and CHC	A30
Collinsville Hospital	A11	Quilpie MPS	A31
Dimbulah PHC	A12	Springsure MPS	A32
Dirranbandi MPS	A13	Stanthorpe Hospital	A33
Eidsvold HS	A14	Surat Hospital	A34
Gayndah Hospital	A15	Tara Hospital	A35
Gemfields OC	A16	Taroom Hospital	A36
Gin Gin Hospital	A17	Tully Hospital	A37
Hughenden HC	A18	Wallumbilla HS	A38
Injune HS	A19	Winton MPS	A39
Jandowee HS	A20		

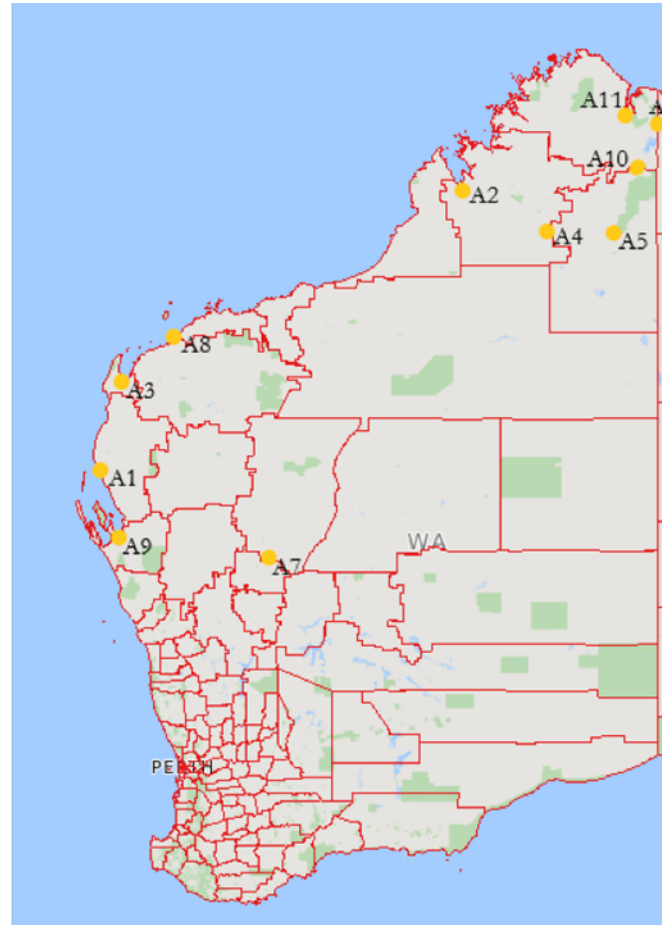


- Legend
- = COAG s19(2) Exemptions Initiative sites (MMM 4)
  - = COAG s19(2) Exemptions Initiative sites (MMM 5)
  - = COAG s19(2) Exemptions Initiative sites (MMM 6)
  - = COAG s19(2) Exemptions Initiative sites (MMM 7)

## 2 OVERVIEW OF THE INITIATIVE

**Figure 2.3:** Location of Western Australia Initiative sites receiving MBS revenue, 2019–20

Jurisdiction: Western Australia			
Site	Tag	Site	Tag
Carnarvon Hospital	A1	Meekatharra Hospital	A7
Derby Hospital	A2	Onslow Hospital	A8
Exmouth HS	A3	Shark Bay Nursing Post	A9
Fitzroy Crossing HS	A4	Warmun HC	A10
Halls Creek Hospital	A5	Wyndham District Hospital	A11
Kununurra District Hospital	A6		



Legend

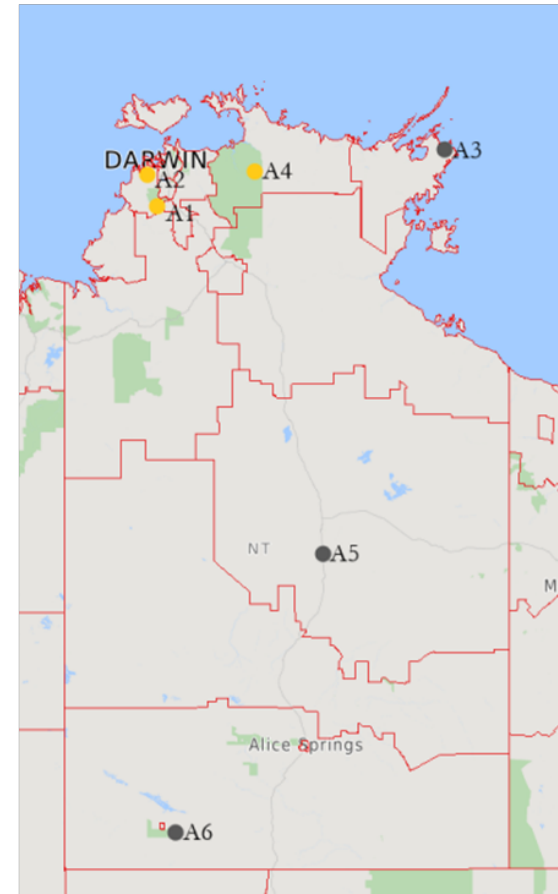
● = COAG s19(2) Exemptions Initiative sites (MMM 7)



## 2 OVERVIEW OF THE INITIATIVE

**Figure 2.4:** Location of Northern Territory Initiative sites receiving MBS revenue, 2019–20

Jurisdiction: Northern Territory			
Site	Tag	Site	Tag
Adelaide River HC	A1	Jabiru CHC	A4
Batchelor HC	A2	Tennant Creek Hospital	A5
Gove District Hospital	A3	Yulara HS	A6



Legend

- = COAG s19(2) Exemptions Initiative sites (MMM 6)
- = COAG s19(2) Exemptions Initiative sites (MMM 7)



## 2 OVERVIEW OF THE INITIATIVE

### 2.6.2 MBS claims

In 2019–20 the 92 active sites received MBS rebates totalling \$13.6 m. They had a median rebate of \$56,081 (see Table 2.2).

**Table 2.2:** Median size of MBS rebate by jurisdiction, 2019–20

	NSW	QLD	WA	NT	TOTAL
Median MBS rebate paid	\$34,134	\$55,366	\$217,050	\$213,314	\$56,081
No. of billing services	36	39	11	6	92
Min. payment	\$76	\$8,024	\$17,606	\$104,665	\$76
Max. payment	\$303,368	\$968,524	\$1,042,564	\$893,877	\$1,042,564

Source: MBS Data Extract, 2019–20, prepared for HMA Evaluation

Table 2.2 shows there were significant variations in the median payments across jurisdictions, ranging from a low of \$34,134 in New South Wales to a high of \$217,050 in Western Australia.

## SECTION B: BROADER CONTEXT

### 2.7 IMPACT OF DOCTOR REMUNERATION ARRANGEMENTS ON MBS BILLING

The nature and legal structure of the rural health service system in which the Initiative operates differ for each jurisdiction and within jurisdictions. Of particular importance are the remuneration arrangements for doctors. These arrangements

significantly affect the operations of the Initiative, particularly how MBS revenue is raised and reinvested.

**Queensland:** in rural and remote Queensland, Local Health Networks (LHNs) known as Hospital and Health Services (HHSs) employ doctors to staff local hospitals to provide acute, inpatient, outpatient and emergency care. Doctors in small rural hospitals are now predominantly employed as Senior Medical Officers (SMO) (largely replacing the Medical Superintendent and Medical Officer Right to Private Practice arrangement). A right of private practice assignment model generally operates in non-metropolitan hospitals, whereby an allowance is paid to the SMO and all private practice revenue is paid to HHS. [4] Under the *Medical Officers' (Queensland Health) Certified Agreement (No. 5) 2018* [5] SMOs receive a loading applied to the base salary where they are billing MBS revenue, historically set at 25% of salary.

**New South Wales:** private GPs provide community based and hospital care remunerated under a Medicare fee-for-service model for office-based care. Remuneration is under the terms of the *New South Wales Rural Doctors Association (RDA) Settlement Package*. [6] This establishes payment rates for medical services provided by GP Visiting Medical Officers (VMOs) at 125 small hospitals in rural NSW, specified in the Package. These payment rates are only available to RDA (NSW) members and are substantially higher than the Medicare rebates otherwise payable. The package ensures that GP VMOs providing on-call and after-hours services in areas with minimal specialist backup are remunerated appropriately for the services they provide. The VMO services to the local hospital may include procedural and inpatient services, emergency care triage categories 1–3, and on-call services (dependent on their credentialing and scope of practice).

In small towns, some GPs and general practices provide community based medical care only, and do not provide VMO services to the local hospital.

**Western Australia:** remuneration arrangements are guided by the terms of the *WA Health System Medical Practitioners AMA Industrial Agreement 2016*. [7] WACHS salaried doctors are under arrangement A of the industrial agreement and have relinquished rights to private practice earnings in exchange for a substantially higher pay rate.

In the southern half of Western Australia, the general practice and hospital service model in rural communities has similarities to New South Wales, i.e. GPs providing

## 2 OVERVIEW OF THE INITIATIVE

VMO services to the local hospital. There are two locally based Aboriginal Community Controlled Health Organisations (ACCHOs) in the southern part of the state, South West Aboriginal Medical Service (based in Bunbury) which provides services in the South West, and Great Southern Aboriginal Health Services that operates in the Great Southern region.

In the northern half of the state, the predominant remuneration and employment model is salaried medical officers employed by the Western Australian Country Health Service (WACHS). Under the terms of the WA Award, salaried medical officers at WACHS facilities can elect to retain up to 25% of the practitioner's salary from nett earnings from private practice within the hospital.<sup>4</sup> Private general practice is very limited across the remote communities of northern Western Australia. ACCHOs operate in many communities in the Kimberley, the Pilbara, and Geraldton.

**Northern Territory:** medical staff in the participating sites are employed by NT Health Services under the *Medical Officers Northern Territory Public Sector 2018–21 Enterprise Agreement Territory Award*. [8] Under the award, medical officers are eligible to receive 50% of the MBS revenue they bill as remuneration, capped at a maximum of \$100,000 per annum.<sup>5</sup>

### 2.8 NURSING AND ALLIED HEALTH WORKFORCE

Across rural and remote Australia, nurses are employed in acute care settings and community health services by LHNs. ACCHOs employ primary care and specialist nurses, e.g. Diabetes Nurses, Child and Maternal Health Nurses. Increasingly, non-government organisations (NGOs) employ nurses to provide specialist nursing services (e.g. chronic disease care, mental health), usually under a commissioning arrangement with Primary Health Networks.

<sup>4</sup> See Clause 29 of the Award

<sup>5</sup> See Clauses 21.9 to 21.12 of the Award

Similarly, allied health professionals are employed by LHNs, ACCHOs and NGOs. While availability of private allied health practices is more limited in rural and remote areas, private providers often deliver services to smaller communities from a regional hub or across a rural cluster of towns.

### 2.9 OTHER SECTION 19(2) EXEMPTIONS IN RURAL COMMUNITIES

Interviews with Department of Health staff in the Indigenous Health Division, and the Rural Access and Health Training Branches of Health Workforce Division identified five Directions for Section 19(2) exemptions under the *Health Insurance Act*, in addition to the COAG Section 19(2) Exemptions Initiative. These comprised:

- The Aboriginal Community Controlled Health Services Section 19(2) Direction managed by the Indigenous Health Division
- The Queensland State Government (Indigenous Health) Section 19(2) Direction<sup>6</sup> managed by the Indigenous Health Division
- The Northern Territory State Government (Indigenous Health) Direction<sup>7</sup> managed by the Indigenous Health Division
- The Murrumbidgee Local Health District Direction, managed by Health Workforce Training, and
- The Remote Vocational Training Scheme Direction, managed by Health Workforce Training.

It is important to understand the breadth of Section 19(2) exemptions in place, their specificity, the rural and remote communities in which they operate and the potential intersection with the COAG Section 19(2) Initiative. We provide an

<sup>6</sup> This exemption was previously known as the Remote Medical Benefits Scheme (RMBS)

<sup>7</sup> Also previously known as the RMBS

## 2 OVERVIEW OF THE INITIATIVE

overview below. The services where these arrangements apply are listed, by jurisdiction, in Appendix B.

### The Aboriginal Community Controlled Health Services Direction

This Direction allows Medicare benefits to be payable for professional services provided by ACCHOs in respect of:

- Non-referred professional services provided by salaried medical practitioners, participating midwives and participating practice nurses, and
- Referred professional services provided by salaried allied health, dental health professionals, optometrists, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal Health Workers.

There are 123 organisations identified in the accompanying Schedule in all states and territories.

ACCHOs operate on a resident or visiting basis in some of the listed COAG Section 19(2) exempt sites in New South Wales, Western Australia, Queensland and Northern Territory. At these sites, the ACCHO may provide medical, allied health and/or nursing services. Some also offer dental services, which may be under an arrangement with an LHN, university dental school, or philanthropic organisation. ACCHOs are increasingly reliant on Medicare income to support and expand their service offerings.

### The Queensland State Government (Indigenous Health) Direction

This Direction allows Medicare benefits to be payable in respect of:

- Non-referred professional services provided by salaried medical practitioners, participating midwives and participating nurse practitioners
- Referred professional services provided by salaried allied health and dental health professionals, optometrists, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal health workers.

The Direction applies to staff employed by the Queensland State Government for services provided in an Aboriginal and Torres Strait Islander community and/or clinic in 55 specified communities or employed by the RFDS in Queensland.

### The Northern Territory

This Direction applies to staff employed by the Northern Territory Government and provided in an Aboriginal and Torres Strait Islander community and/or clinic in 66 specified communities. The Direction allows Medicare benefits to be payable in respect of:

- Non-referred professional services provided by salaried medical practitioners, participating midwives and participating nurse practitioners, and
- Referred professional services provided by salaried allied health and dental health professionals, optometrists, Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal health workers.

### Murrumbidgee Local Health District Direction

This Direction has been made to enable new partnerships between the Murrumbidgee Local Health District (LHD) and specified private general practices to trial innovative employment arrangements for rural medical generalist trainees. The purpose of the single employer model is to provide continuity of working conditions for rural generalists during training. By having access to the 'single employer' Direction, the LHD can employ rural generalist registrars as they move between hospital training (Post Graduate Year (PGY) 1, 2 and their Advanced Skills Training) and their GP training. The Direction is specific to the Murrumbidgee LHD and six identified GP training practices in the MMM 4 locations of Cootamundra, Young and Deniliquin and the MMM 5 locations of Temora, Gundagai and Narrandera. This Direction is enabling the Murrumbidgee Rural Generalist Training Pathway.

The Direction specifies that:

- the professional services are provided in a specified general practice
- the patient is not receiving an episode of hospital treatment, and
- the service is provided by a participating rural generalist trainee who is centrally employed by the Murrumbidgee LHD for the provision of primary and acute care and is registered in the rural generalist's innovative employment model trial within the Murrumbidgee region.

This Direction was issued on 19 October 2020 and has effect until 31 December 2024.

## 2 OVERVIEW OF THE INITIATIVE

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### Remote Vocational Training Scheme Direction

The Remote Vocational Training Scheme (RVTS) Extended Targeted Recruitment Pilot Direction 2021 directs Medicare benefits for professional services provided by participating remote general practice trainees who are:

- Formally enrolled in the RVTS and training towards GP Fellowship with the Royal Australian College for General Practitioners or the Australian College of Rural and Remote Medicine,
- Employed with a salary in one of the RVTS extended targeted-recruitment training posts for appropriate primary care attendance, and
- Registered with the RVTS Extended Targeted Recruitment Pilot.

While the Direction indicates that sites will be in a rural and remote practice location in MMM 4–7, the currently approved sites are in MMM 5, 6 and 7 and in Tasmania (Smithton), Victoria (Robinvale), New South Wales (Cobar, Lake Cargelligo), Queensland (Clermont, Mt Isa, Badu Island), South Australia (Streaky Bay, Cleve, Kimba, Elliston, Cowell) and Western Australia (Fitzroy Crossing).

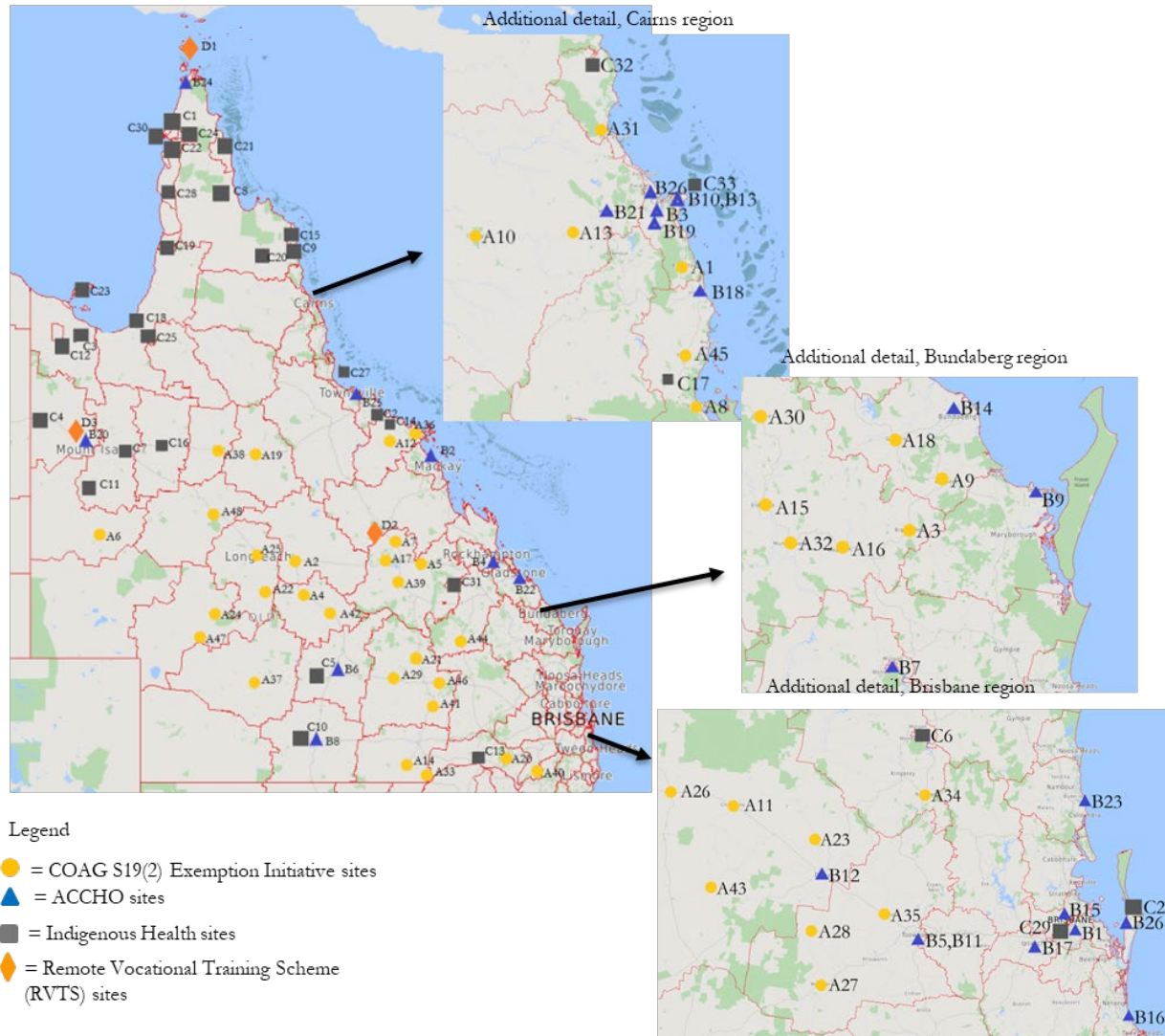
The Direction commenced 21 January 2021 and has effect until 31 December 2021.

### Summary comment

An examination of individual sites operating under these various arrangements highlights that many services are in close proximity to each other. This will often enhance local availability to Commonwealth funded primary care services beyond the services receiving MBS revenue under the COAG Section 19(2) Exemptions Initiative. This service proximity is illustrated by Figure 2.5 which maps sites that are operating under different Section 19 directions in one jurisdiction (we have used Queensland as an example to illustrate the geographic diffusion of the different Section 19 exemption arrangements (see next page)).

## 2 OVERVIEW OF THE INITIATIVE

**Figure 2.5:** Location of Queensland Initiative sites compared to location of sites operating under various other Section 19(2) Exemptions Directions (ACCHO, Indigenous Health and RVTS)





## 2 OVERVIEW OF THE INITIATIVE

### 2.10 RURAL POLICY CONTEXT

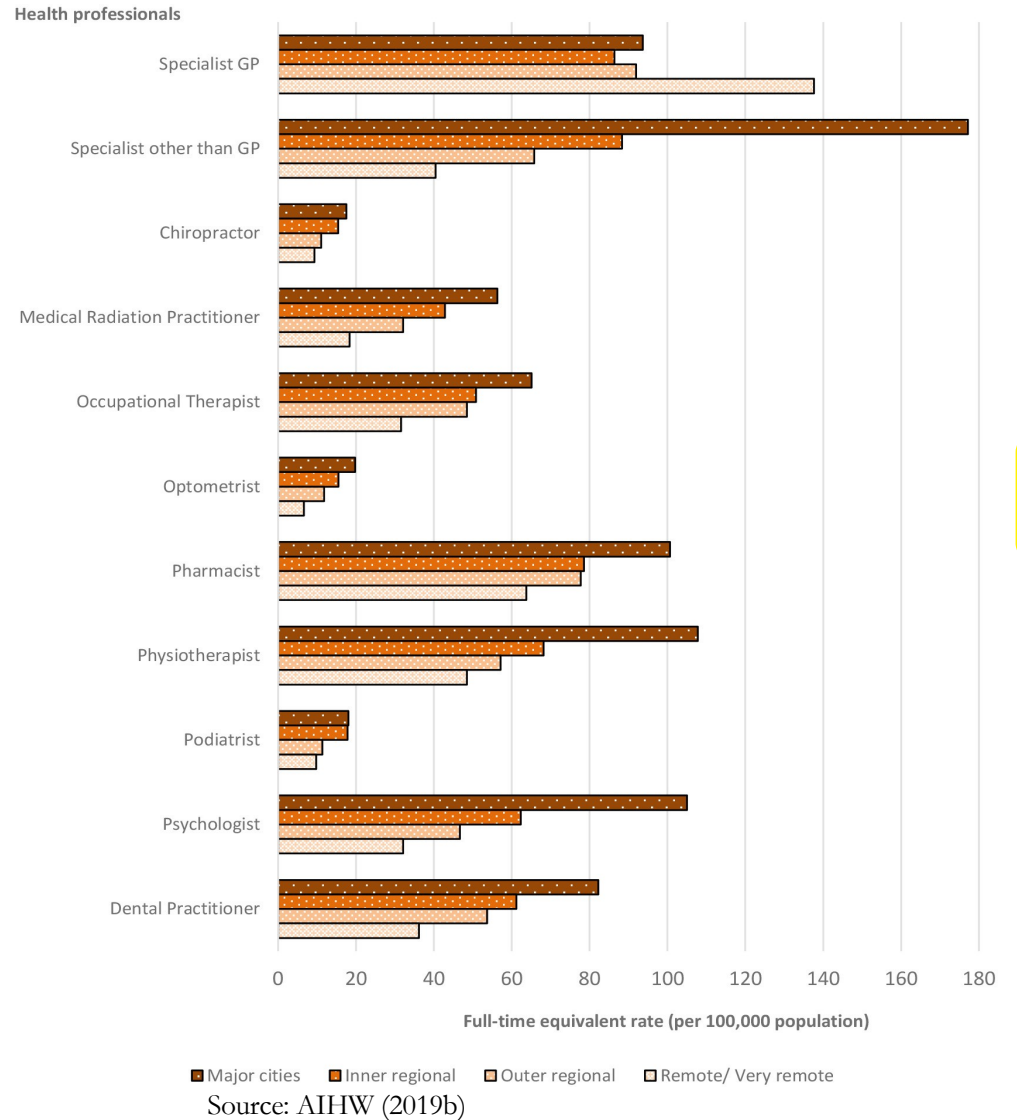
#### 2.10.1 Health workforce supply

The Australian Government has introduced a range of policies to address health workforce shortages. Supply strategies have included recruitment of internationally trained medical graduates (IMGs) and other health professionals; doubling the number of medical school places in 2006; and, in response to the Review of Higher Education (Bradley Review) [9], uncapping university training places for nursing and allied health students.

Nationally, there were 410.4 FTE doctors per 100,000 residents in 2017 compared with 382.1 FTE per 100,000 in 2013. In 2017, the nursing and midwifery workforce totalled 284,120 FTE or 1,154.9 FTE per 100,000 residents, which was similar to the 2013 levels on a per population basis. However, the supply of allied health practitioners registered with the Australian Health Practitioner Regulation Agency (AHPRA) increased in the period 2013 to 2017 from 98,545 FTE (426.1 FTE per 100,000 residents) to 114,606 FTE (465.8 FTE per 100,000. [10])

Despite the overall increase in Australia’s health workforce supply since then, maldistribution persists and does not mirror the health needs of the population [11]. The geographic distribution of Australia’s health workforce is summarised in Figure 2.6.

**Figure 2.6:** Employed AHPRA registered health professionals – full-time equivalent rate, by Australian Standard Geographical Classification remoteness area (2017)

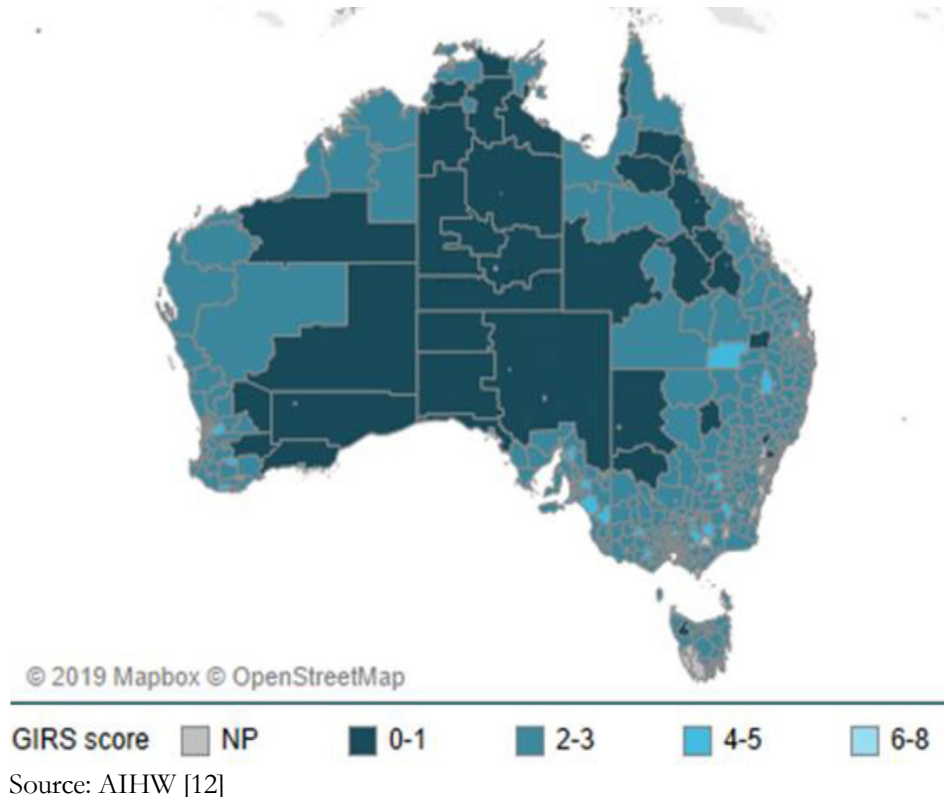




## 2 OVERVIEW OF THE INITIATIVE

While the specialist-GP FTE rate (per 100,000 population) is relatively higher in remote and very remote areas, this figure does not reflect population dispersion nor residents' ability to access services. The Geographic Index of Relative Supply (GIRS) adjusts the known workforce supply for land size, population dispersion and proximity of the population to relevant service locations. GIRS scores range from 0 to 8. Areas with lower GIRS scores are more likely to face workforce supply challenges than those with higher scores. Figure 2.7 illustrates that relative to major cities, remote and very remote areas of Australia face substantially higher GP workforce supply challenges.

**Figure 2.7:** GIRS index scores, Specialist General Practitioners by Statistical Area (SA2) (2014)



### 2.10.2 Initiatives supporting attraction, recruitment and retention

Since the introduction of the Initiative in 2006, there has been a range of Commonwealth policies and programs introduced or reconfigured to better respond to rural workforce shortage and maldistribution. In addition, there is now evidence of the positive impact on long rural clinical immersions during medical training for the rural medical workforce [13].

In addition to strategies to grow the workforce supply, other policies to attract, retain and re-distribute the health workforce to rural and remote areas have focused on workforce training, professional development and financial incentives. These programs are detailed in Appendix C. The extent to which the Initiative contributes to workforce supply and retention needs to be considered in context of these other policy initiatives, some of which are now demonstrating positive outcomes.

### 2.11 IMPROVING ACCESS TO PRIMARY HEALTHCARE

In addition to Medicare, the Australian Government predominantly invests in the support of primary healthcare through Primary Health Networks (PHNs) and ACCHOs.

#### Primary Health Networks (PHNs)

The PHNs are a key Australian Government initiative designed to improve access to primary healthcare, and integration of service delivery within a regional network. There are 31 PHNs across Australia, superseding the previous Medicare Local initiative in 2015. The PHNs commission a range of primary healthcare services informed by their Health Needs Assessment. While the nature and scope of commissioned services differ between PHNs, they target chronic disease prevention and management, mental health, drug and alcohol, aged care, palliative care, Aboriginal and Torres Strait Islander health and After Hours. In contrast to Medicare Locals, PHNs commission services from local, regional or national

## 2 OVERVIEW OF THE INITIATIVE

providers, rather than directly employing health professionals to deliver primary healthcare.

### Indigenous Australians' Health Program (IAHP)

In July 2014, the Australian Government established the IAHP, consolidating four existing funding streams specific to Aboriginal and Torres Strait Islander people. The funding streams were primary healthcare; child and maternal health programs; Stronger Futures in the Northern Territory (Health); and programs covered by the Aboriginal and Torres Strait Islander Chronic Disease Fund. The purpose of the IAHP is to provide Aboriginal and Torres Strait Islander people with access to effective, high quality, comprehensive, culturally appropriate primary healthcare delivered through the national ACCHO sector.

### The Rural Health Outreach Fund

The Rural Health Outreach Fund (RHOF) aims to improve access to medical specialists, GPs, allied and other health providers in rural, regional and remote areas of Australia. The RHOF, introduced in 2011, consolidated the activities of five existing outreach programs:

- Medical Specialist Outreach Assistance Program (MSOAP)
- MSOAP – Maternity Services
- MSOAP – Ophthalmology
- National Rural and Remote Health Program; and
- Rural Women's GP Service Program.

There are four health priorities under the RHOF: maternity and paediatric health, eye health, mental health and support for chronic disease management. Rural Workforce Agencies (RWAs) manage the RHOF in each jurisdiction other than Queensland – where it is managed by Check-Up.

### Intersection with the Section 19(2) Initiative

Over the last decade the Australian Government has increased investment in primary healthcare services through the PHNs, the IAHP and the RHOF. In July 2020, the Australian Government introduced a new funding model for the IAHP

which combines **capitation and activity** and includes adjustments for cost of delivering services (**remoteness**) and **health needs** of locations.

## 2.12 WIDER HEALTH AND HUMAN SERVICES CONTEXT

The introduction of the National Disability Insurance Scheme highlighted the market failure and known challenges to attracting and retaining allied health workforce in rural and remote areas. Private providers and NGOs are developing business models to extend disability support services into rural areas.

The recent report by the National Rural Health Commissioner [14] highlights the issue of fragmented funding models impacting on development of attractive allied health positions and has put forward recommendations for establishment of allied health *Service-Learning Consortia* to improve allied health workforce supply and distribution through integrated training and service delivery using fund blending models.

Implementation of the Royal Commission into Aged Care recommendations will have implications for rural service development and workforce development particularly for nursing and allied health. Many of the Section 19(2) sites are Multipurpose Health Services (MPS) which include service delivery capability in the areas of community care and residential aged care. Furthermore, many NGOs and private allied health providers have developed business models that work across disability, aged care and primary healthcare in rural and regional areas.

The new *National Health Reform Agreement 2020–2025* was signed off by all Australian governments in May 2020. Through this agreement, the Australian Government contributes funds to the states and territories for public hospital services. This includes services delivered through emergency departments, hospitals and community health settings.

The long-term reforms outlined in the 2020–2025 agreement will examine how well the different components of the health system interact. The reforms will give local health services the flexibility to try new solutions to address system barriers and

## 2 OVERVIEW OF THE INITIATIVE

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improve service delivery to ensure health services best suit the needs of their local community. The six reforms focus on:

- Empowering people through health literacy – person-centred health information and support will empower people to manage their own health and engage effectively with health services
- Prevention and wellbeing – to reduce the burden of long-term chronic conditions and improve people’s quality of life
- Paying for value and outcomes – enabling new and flexible ways for governments to pay for health services
- Joint planning and funding at a local level – improving the way health services are planned and delivered at the local level
- Enhanced health data – integrating data to support better health outcomes and save lives, and
- Nationally cohesive health technology assessment – improving health technology decisions will deliver safe, effective and affordable care.

There is scope for sites funded under the Initiative to consider the emergent reforms in relation to joint planning at a local level and flexibility in paying for health services.

## 3 EVALUATION APPROACH

This chapter presents HMA's approach to evaluating the Initiative, which included defining the program logic and specifying the evaluation areas for examination. We include details of our approach to:

- Stakeholder consultations
- MBS data analysis
- The conduct of case studies, and
- A survey of Initiative participating sites.

### 3.1 SPECIFYING THE PROGRAM LOGIC AND EVALUATION AREAS

The evaluation questions specified in the Request for Quotation (RFQ) are detailed at Appendix A.

A program logic articulates the reasoning driving the program and highlights the linkages between the different service delivery components. It describes the linkages between the following:

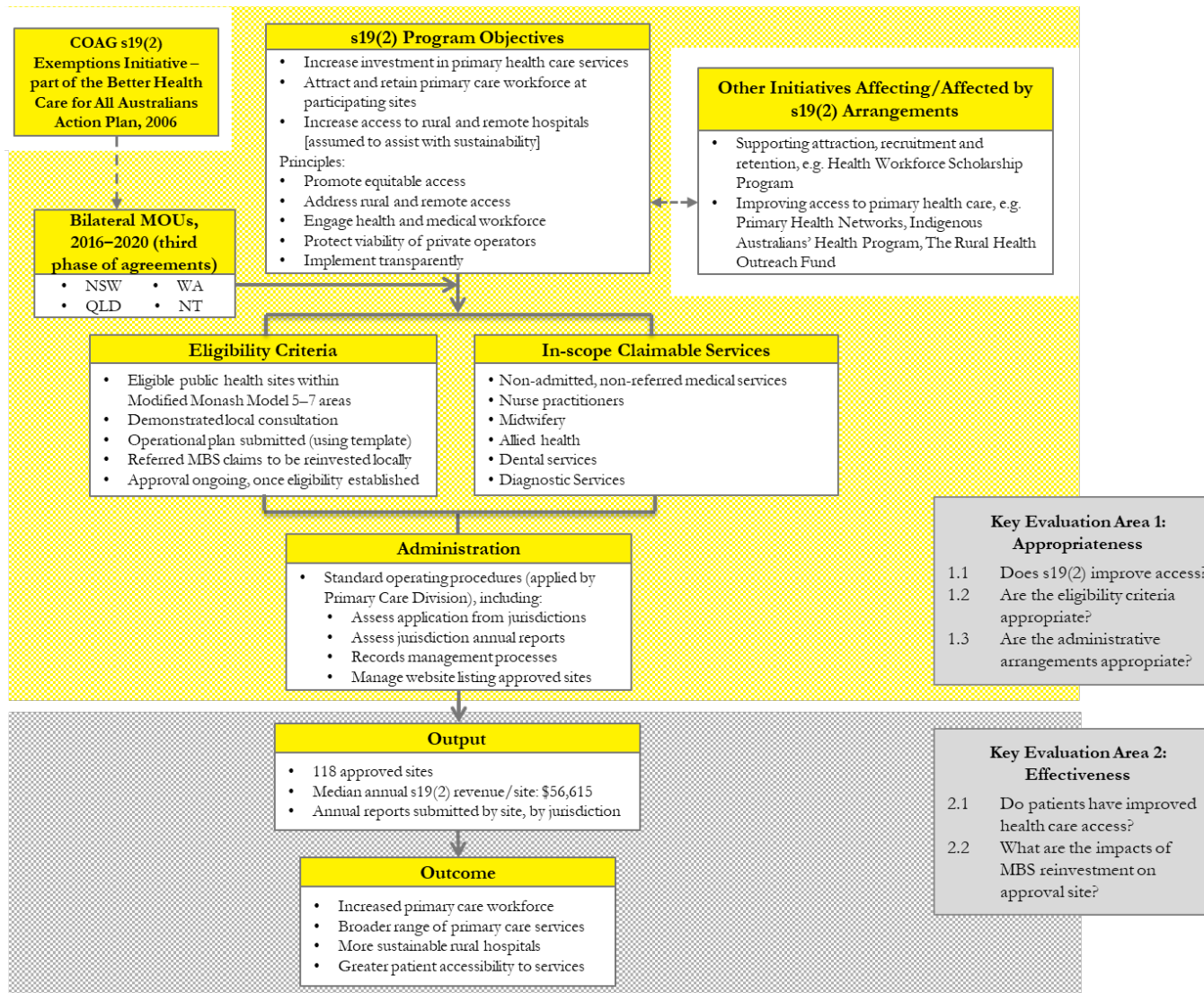
- 1) **Objectives** of the program or service, which can include consideration of policy, strategy and structure of the program and governing arrangements (the why)
- 2) **Inputs** including financial, staff and equipment (the what and the who)
- 3) **Process** (the how)
- 4) **Outputs**, which can be quantifiable measures

- 5) **Outcomes**, short-, medium- and long-term outcomes expected to result from the program or services.

The program logic relationships for the Initiative are illustrated in Figure 3.1 on the next page, together with a summary of the relationship to the key evaluation areas.

### 3 EVALUATION APPROACH

**Figure 3.1:** Program logic for the Initiative with overlaying evaluation areas



## 3 EVALUATION APPROACH

### 3.2 EVALUATION METHOD

The review comprised the following eight project stages:

**Stage 1 – Project planning:** (December 2020) We defined the project scope, clarified roles and responsibilities and formulated a detailed project management plan.

**Stage 2 – Situation analysis:** (February 2021) A summary of current Section 19(2) arrangements, policy, and issues for exploration during the evaluation was developed through a review of documentation.

**Stage 3 – Evaluation plan:** (February 2021) Based on findings from the situation analysis, we developed a detailed evaluation plan as follows:

- drafted detailed evaluation questions
- determined data sources and data collection protocols
- designed data collection tools
- described the approach to data analysis, and
- outlined reporting arrangements

**Stage 4 – Data collection:** (February 2021 – early June 2021) HMA collected a range of qualitative and quantitative data via surveys and interviews conducted with relevant stakeholders. This included the following:

- *consultations* with
  - internal Department of Health stakeholders
  - all jurisdictions (both participating and non-participating)
  - rural workforce agencies
  - 7 PHNs with case study sites

A full list of those stakeholders consulted by 24 May 2021 is at Appendix D.

- *analysis of MBS claims data* for participating sites for the period 2016 to 2019, and
- *submissions* on the operation of the Initiative from
  - the Rural Doctors Association of Australia (RDAA) and its affiliates, and

- National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates.

- a *survey of all 92 participating sites* that lodged an MBS claim under the Initiative in 2019–20 that sought the views of facility managers on the effectiveness of the Initiative.

**Stage 5 – Case studies:** (April to May 2021) HMA investigated the impact of the Initiative on different communities by conducting a series of 10 case studies at selected sites. These case studies sought an in-depth understanding of how well sites were able to meet the objectives of the Initiative and identify barriers to future success of the Initiative. Sites were selected based on considerations of the size of the community, level of remoteness, and the presence or absence of ACCHOs and/or private general practice.

**Stage 6 – Data analysis:** (early to late June 2021) HMA examined the information collected in Stages 2 to 5, including:

- annual reports from participating sites
- standard operating procedures
- medical benefits schedule data relevant to the Initiative operations
- survey results
- interview feedback
- case study information, and
- other relevant data gathered throughout the evaluation.

**Stage 7 – Information synthesis:** (June 2021) The project team triangulated findings from the previous stages and formed evaluative judgements of Initiative performance against the evaluation questions specified in Attachment A. This enabled an assessment of the extent to which the Initiative is appropriate, effective, efficient and of quality and value.

**Stage 8 – Preparation of the final report (this document):** (June to July 2021) The draft report will be circulated to jurisdictions for comment. The report will incorporate all key findings from the evaluation and include options to improve the Initiative for the future.



## 3 EVALUATION APPROACH

### 3.3 SPECIFIC DATA COLLECTION PROCESSES: ADDITIONAL INFORMATION

#### 3.3.1 MBS data analysis

With support from the Department's Medical Benefits Division, HMA obtained MBS data relating to sites participating in the Initiative. The objective for the data analysis was to summarise the characteristics of the MBS claims mix, focusing on the last full financial year of the current MOU. The analysis examined the claims by aggregating individual MBS items (volume of item claims and monetary value of claims) into meaningful categories related to the Initiative implementation. These categories were:

- Non-admitted, non-referred services by GPs, separately identifying as discrete separate sub-categories, enhanced primary care (EPC) items and after-hours item claim volumes
- Non-admitted, non-referred services by specialists
- Midwifery
- Allied health
- Psychology
- Occupational therapy
- Speech therapy
- Podiatry
- Social Work
- Other
- Dental services
- Diagnostic imaging services.

Appendix E details the MBS item categorisation that informed the analysis in this report.

#### 3.3.2 Case studies

The case studies involved on-the-ground site visits to 10 Initiative sites in four jurisdictions (NSW, QLD, WA and NT). At each case study site, we conducted interviews with:

- senior management representatives of the LHN responsible for the participating case study health service
- the facility manager
- site revenue clerks
- representatives of the LHN revenue management teams
- senior medical doctors at the facility
- facility clinicians providing primary care service, and
- local GPs and representative of ACCHOs, where present and available.

The evaluation analysis drew on more detailed information on each case study site made available from the Department:

- Operational plans, and
- Annual reports, including reinvestment plans for each year of the current MOU.

The case study sites were selected to emphasise the breadth of service delivery arrangements and contexts within which the Initiative operates, including their geographic location (jurisdiction and MMM level), presence of a private GP practice, proximity to an ACCHO, and size of MBS claim.

The contextual characteristics of the 10 case study sites and the rationale for their inclusion in the evaluation is shown in Table 3.1.

### 3 EVALUATION APPROACH

**Table 3.1:** COAG S19(2) Exemptions Initiative evaluation case study sites – summary of contextual features

Jurisdiction	Case study site name / MBS Claim – \$m (2019/20)	Nearest large town	LGA population	MMM score	No. of private GP clinics in town	Most proximate ACCHO	Rationale for inclusion as a case study
NSW (39% of total active services – 36 services)	<b>Nyngan MPS</b> Claim: \$0.050 m	Dubbo (165 km)	2,621	6	2 (none located in Nyngan MPS)	Bourke Aboriginal Health Service (205 km) & Brewarrina AHS (209 km)	Assess role of S19(2) in an MPS (pooled funding); far west NSW
	<b>Quirindi Health Service</b> Claim: \$0.030 m	Tamworth (64 km)	7,893	5	3 (one in Quirindi Health Service)	Walhallow Aboriginal Corporation	Outer Hunter New England service; recently joined the Initiative
	<b>Temora Health Service</b> Claim: \$0.300 m	Cootamundra (54 km)	6,274	5	2 (none located in Temora Health Service)	Riverina Medical & Dental Aboriginal Corporation (Wagga Wagga 85 km)	One of two sites in NSW with larger MBS billings; part of Murrumbidgee S19(2) Exemption
QLD (42% of funded services – 39 services)	<b>Longreach Hospital</b> Claim: \$0.258 m	Rockhampton (687 km)	3,530	7	1 (not located in Longreach Hospital)	Not applicable	Applies a ‘one practice model’ across the hospital and GP service (all GPs employed as SMOs)
	<b>Proserpine Hospital</b> Claim: \$0.969 m	Airlie Beach (30 km)	17,000	5	2 (none located in hospital)	Not applicable	Assess impact of S19(2) in North Queensland tourist town. Large MBS annual claim (\$1 m+); recently joined the Initiative (2018)
	<b>Tully Hospital</b> Claim: \$0.660 m	Cairns (141 km)	29,689	5	2 (not located in Tully Hospital)	Mamu Health Service (Tully)	Assess impact of S19(2) in a small coastal town with a proximate ACCHO
WA (12% of funded services – 11 services)	<b>Kununurra WACHS</b> Claim: \$0.200 m	Darwin (828 km)	7,317	7	1 (located in Kununurra DH)	Ord Valley Aboriginal Health Service (in town)	Enabled exploration of S19(2) service within a network of AMSs (Kimberley AMS Council).
	<b>Meekatharra WACHS</b> Claim: \$0.070 m	Geraldton (536 km)	1,008	7	1 (located in Meekatharra Hospital)	Ngangganawili Aboriginal Health Service (187 km in Wiluna)	Site previously with larger MBS billings compared to WA average; recent change to service delivery arrangements has reduced billings; MMM 7 site with an ED.
NT (7 % of funded services – 6 services)	<b>Tennant Creek Hospital</b> Claim: \$0.890 m	Alice Springs (506 km)	7,392	7	Nil	Anyinginyi Health Aboriginal Corporation (in Tennant Creek)	A large NT services; will enable exploration of S19(2) service with local AMS
	<b>Jabiru Community Health Centre</b> Claim: \$0.200 m	Darwin (255 km)	6,902	6	Nil	Red Lily Health Board; scheduled to assume control of Jabiru Clinic in 2022	Enabled exploration of S19(2) service in a primary care clinic

### 3 EVALUATION APPROACH

While undertaking the case studies, the evaluation team obtained more detailed information on several other Initiative sites, typically because they were close by geographically. Additional sites that we make some reference to in the evaluation findings include Gundagai MPS and Babinda MPS.

#### 3.3.3 Survey of participating sites

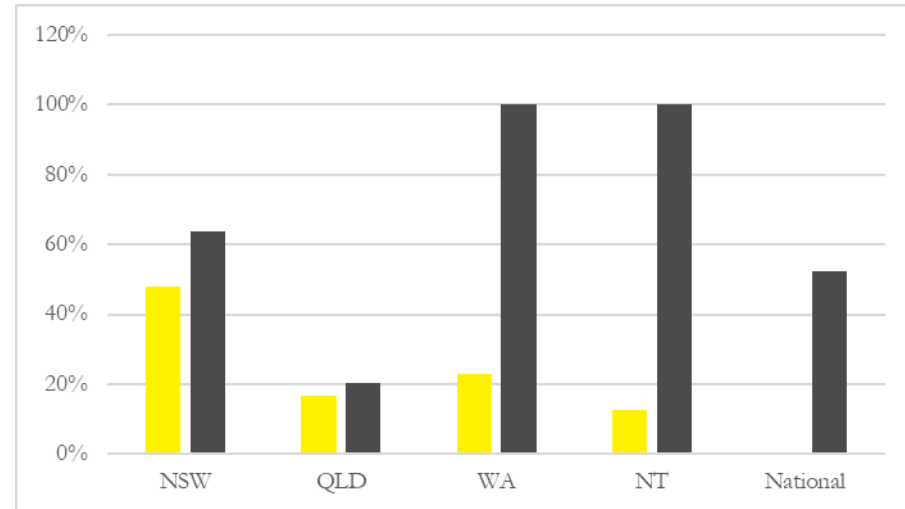
As part of the evaluation process, HMA asked facility managers at each Initiative site to complete a brief survey about their experience with the operations of the Initiative. Some of the main themes explored in the survey were:

- effectiveness of the Initiative in meeting the MOU objectives
- barriers to MBS revenue generation encountered by participating sites
- how the MBS revenue was reinvested at the site over the period of the 2016–20 MOU, and
- the full time equivalent (FTE) staffing levels at the site on 30 June 2020 (including management, administration, clinical and non-direct care staff, e.g. cleaners, catering).

The survey was open for completion from 25 May 2021 to 16 June 2021.

The evaluation team received responses from 48 of the 92 sites that claimed revenue under the Initiative in 2019–20, a response rate of 52%. The response rate by jurisdiction is given in Figure 3.2, which ranged from a low of 20% in Queensland to a high of 100% in WA and the NT (NSW had a response rate of 60%).

**Figure 3.2:** Survey of participating sites - response rate by jurisdiction (black, n=92) and jurisdictional makeup of survey respondents (yellow, n=48)



# PART B

# EVALUATION FINDINGS & WAY FORWARD

## 4 EVALUATION FINDINGS

In this chapter we provide our evaluation observations and findings. The evaluation analysis addresses the key evaluation questions specified in the project RFQ and incorporates three broad areas of examination: effectiveness, program administration, and appropriateness.

### SECTION A: EFFECTIVENESS ASSESSMENT

Our evaluative assessment of the Initiative's effectiveness examined the impact of the program on the objectives specified in the MOU – increasing access to primary care, access to a relevant healthcare workforce, and development of sustainable health services. We examine the Initiative's achievement in each area in this section.

#### 4.1 ACCESS TO PRIMARY CARE

At an aggregate MBS claims level, the MBS payments for doctor-related MBS billings by participating sites had a total value of \$13.6 m in 2019–20. Table 4.1 (see next page) shows the largest categories of MBS billing were for primary medical care delivered by doctors via commonly billed time-based items:

- Non-referred attendances (including items 3, 23, 36 and 44) – \$6.7 m in payments (49.0 % of the total) with a median payment of \$19,955 per service, and
- After-hours non-referred attendances (including items 5000, 5020, 5040 and 5060) – \$3.6 m in payments (26.3% of the total) with a median payment of \$19,515 per service.

Review of operational plans at case study sites shows the bulk of these consultations were for urgent and/or emergency medical care.

Table 4.1 indicates that much smaller proportions of payments were for:

- care related to assessment, including disease management, and items for other primary care professionals such as nurse practitioners, and allied health professionals – \$0.5 m (4.1% per cent of the total); median payment per service was \$0 (72 of the 92 sites had no claims for these items), and
- 'other items' (including pathology, diagnostics, obstetrics) – \$2.7 m of the total; median payment per service was \$4,503.

Analysis of this mix of MBS categories showed a high degree of variability. For example, there was:

- greater use of the after-hours items in NSW (60.1% of jurisdiction claims), but less use of the assessment and other professional items (0.6% of jurisdiction claims)
- WA sites made the least use of the after-hours items (13% of jurisdiction claims)
- the most extensive use of assessment and other professional items was in the NT (9.3% of jurisdiction claims), and
- billing for some specialist items was typically 'lumpy' across jurisdictions, e.g. diagnostic imaging billing occurred at seven WA sites, which represented 95.4% of the \$0.840 m claimed for these items across all jurisdictions.

Jurisdiction-based summaries of MBS benefits paid under the Initiative are at Appendix F.

## 4 EVALUATION FINDINGS

**Table 4.1:** National MBS benefits paid by aggregated MBS categories of all participating sites, 2019–20 (n=92)

MBS Aggregated Categories	Total claims for all sites \$m	Percent of total for all sites	Mean claims per site (\$)	Median claims, per site (\$)	Range of values, all sites (min and max)	No. of sites with zero claims in a category
<b>1. Non-referred Attendance (sub-total) – commonly billed items</b> (e.g., 3, 23, 36, 44)	<b>\$6.7 m</b>	<b>49.0%</b>	<b>\$72,343</b>	<b>\$19,955</b>	<b>\$0–\$565,240</b>	<b>1</b>
<b>2. After-hours Non-referred Attendance (sub-total)</b>	<b>\$3.6 m</b>	<b>26.3%</b>	<b>\$39,015</b>	<b>\$19,515</b>	<b>\$0–\$295,586</b>	<b>11</b>
<b>3. Assessment related items, including disease management and other primary care professionals (sub-total)</b>	<b>\$0.5 m</b>	<b>4.1%</b>	<b>\$1,193</b>	<b>\$0</b>	<b>\$0–\$64,616</b>	
<i>3a. A14 (Health Assessments)</i>	<i>\$0.1 m</i>	<i>1.1%</i>	<i>\$1,742</i>	<i>\$0</i>	<i>\$0–\$54,745</i>	<i>72</i>
<i>3b. A15 (GP care plans)</i>	<i>\$0.2 m</i>	<i>1.5%</i>	<i>\$2,374</i>	<i>\$0</i>	<i>\$0–\$46,368</i>	<i>68</i>
<i>3c. A20 (GP mental health treatment)</i>	<i>\$0.060 m</i>	<i>0.3%</i>	<i>\$730</i>	<i>\$0</i>	<i>\$0–\$7,838</i>	<i>49</i>
<i>3d. Nurse Practitioner</i>	<i>\$0.1 m</i>	<i>1.0%</i>	<i>\$1,597</i>	<i>\$0</i>	<i>\$0–\$64,616</i>	<i>71</i>
<i>3e. Practice Nurse</i>	<i>\$0.03 m</i>	<i>0.2%</i>	<i>\$488</i>	<i>\$0</i>	<i>\$0–\$13,740</i>	<i>78</i>
<i>3f. Allied Health</i>	<i>\$0.004 m</i>	<i>0.0%</i>	<i>\$225</i>	<i>\$0</i>	<i>\$0–\$2,744</i>	<i>87</i>
<b>4. Other MBS items (sub-total)</b>	<b>\$2.7 m</b>	<b>20.5%</b>	<b>\$4,503</b>	<b>\$0</b>	<b>\$0–\$416,619</b>	
<i>4a. Anaesthetics</i>	<i>\$0.004 m</i>	<i>0.0%</i>	<i>\$226</i>	<i>\$0</i>	<i>\$0–\$1,462</i>	<i>79</i>
<i>4b. Pathology</i>	<i>\$0.05 m</i>	<i>0.4%</i>	<i>\$704</i>	<i>\$0</i>	<i>\$0–\$10,065</i>	<i>47</i>
<i>4c. Diagnostic Imaging</i>	<i>\$0.8 m</i>	<i>6.2%</i>	<i>\$9,318</i>	<i>\$0</i>	<i>\$0–\$416,619</i>	<i>79</i>
<i>4d. Operations</i>	<i>\$0.5 m</i>	<i>3.7%</i>	<i>\$5,615</i>	<i>\$2,022</i>	<i>\$0–\$63,635</i>	<i>4</i>
<i>4e. Obstetrics</i>	<i>\$0.1 m</i>	<i>1.1%</i>	<i>\$1,775</i>	<i>\$0</i>	<i>\$0–\$43,103</i>	<i>59</i>
<i>4f. Specialist Services</i>	<i>\$0.1 m</i>	<i>0.8%</i>	<i>\$1,424</i>	<i>\$0</i>	<i>\$0–\$45,950</i>	<i>82</i>
<i>4g. Other MBS items (sub-total)</i>	<i>\$1.1 m</i>	<i>8.3%</i>	<i>\$12,456</i>	<i>\$4,864</i>	<i>\$0–\$102,187</i>	<i>3</i>
<b>Total</b>	<b>\$13.6 m</b>	<b>100%</b>	<b>\$147,542</b>	<b>\$54,615</b>	<b>\$76–\$1,042,564</b>	<b>0</b>

Source: MBS Data Extract, 2019–20, prepared for HMA Evaluation.

Definitions for MBS item numbers included in each aggregated category are given in Appendix E.

## 4 EVALUATION FINDINGS

The MBS claims data give an indication of the level of resource input for primary care-related services provided by the Initiative to participating sites. However, assessing whether the Initiative can be considered to have ‘improved access to primary care’ is problematic from an evaluation perspective for the following reasons:

- First, there is no baseline information available on service delivery arrangements at each site prior to Initiative implementation
- Furthermore, most current staff are not familiar with what services were in place under prior arrangements some time ago (up to 14 years ago at many sites).

Importantly – because of the implications for designing future Initiative agreements – the evaluation team considered that the current MOU objective is too broadly specified. There would be greater clarity around the Initiative’s impacts if accessibility were considered from two perspectives that can be compared to an objective standard. We suggest the following measures could be considered:

- (1) **Has the Initiative ensured access to urgent and/or emergency medical care?** Typically, in a small rural town (MMM 5 or higher), available medical care should include access to a medical practitioner on call or available via telehealth during daytime hours (see for example [15]), and
- (2) **Has the Initiative ensured access to integrated, comprehensive primary care?** Such services should include provision of general practitioner care in association with nursing and allied health practitioners to deliver care management plans, chronic disease management, community-based mental healthcare, maternal and child health, women’s health, family planning, and support for lifestyle management. The overall objective of integrated services should be to promote health and wellbeing, assist people to rehabilitate and recover, and to support people to live at home. [16]

The evaluation case study analysis enabled a better understanding of the relative mix of these two different forms of primary care accessibility, as defined above. In Table 4.2 (see next page) we compare the levels of engagement in emergency care and integrated primary care at the 10 case study sites. It is noteworthy from this assessment that:

- **The Initiative’s funding at eight of the 10 case study sites had increased access to urgent/emergency care** by ensuring these arrangements were sustainable over the medium term (greater than 12 months). At those eight sites the arrangements typically involved doctors living in the town and providing 24-hour cover via on-call arrangements. At one site (Proserpine) the emergency care model introduced as a direct result of the Initiative was more extensive (see Case Study Box #1 on page 30).
- **The Initiative was less effective in supporting access to integrated, comprehensive primary healthcare.** In six of the case study towns (Nyngan, Quirindi, Tennant Creek, Jabiru, Kununurra and Meekatharra) the hospital/clinic based medical care focussed urgent / emergency medical care. There were several reasons for this:
  - the hospital-based nature of the service (e.g., use of patient management systems (PMS)) was primarily for MBS billing functions, not patient recall and ongoing clinical management, and
  - there were limited referral pathways to other locally based primary care clinicians for ongoing management beyond the acute presentation. This lack of referral was not surprising because at several of these case study sites there were limited numbers of nurse practitioners and/or allied health practitioners available to support non-acute needs.



## 4 EVALUATION FINDINGS

**Table 4.2:** Evaluation case study sites – local characteristics of access to primary care

Measure of Access to Primary Care	Queensland			New South Wales			Northern Territory		Western Australia	
	Tully	Longreach	Proserpine	Temora	Nyngan	Quirindi	Tennant Ck	Jabiru	Kununurra	Meekatharra
The Initiative claims: 2019–20	\$0.660 m	\$0.258 m	\$1.300 m	\$0.300 m	\$0.050 m	\$0.040 m	\$0.600 m	\$0.200 m	\$0.200 m	\$0.070 m
The Initiative contribution to urgent / emergency care in hospital, e.g. treatment of Categories 4 and 5 ED presentations	Score 3 The Initiative added capacity to hospital – 1 SMO and nurse; enabling rotation to Aboriginal community health service	Score 3 The Initiative added to the number of doctors at the health service	Score 3 The Initiative funded 3 additional principal house officer (PHO or doctor) FTE, plus full-time reception / admin staff	Score 1 S19(2) has a minimal impact. There was already a viable private practice providing VMO services	Score 0 Virtual Rural Generalist (VRG) program, with only 1 week in 6 on-site face-to-face; not making major difference to emergency care availability	Score 0 Private practice and Health One; not making major difference to urgent/ emergency care availability	Score 3 The Initiative ensured funding of 24 hours ED service	Score 3 The Initiative ensured access to a GP within hours and on-call after hours	Score 2 The Initiative supports better management of Categories 4 & 5; private practice had limited capacity to deal with walk-ins due to workforce shortage	Score 2 Private practice in town; patients sometimes choose to present to ED rather than private practice
The Initiative contributed to Integrated comprehensive primary healthcare (e.g. chronic disease management, lifestyle management, mental health, child health)	Score 2 GP clinic in hospital and nurse hours. However, limited capacity to deliver integrated, comprehensive care	Score 2 GP outreach to more remote communities but this service is at risk due to Queensland Health budget constraints	Score 3 PHOs funded by the Initiative undertook 6-month rotations in private GP practices, in addition to 6 months in ED	Score 1 There was already a viable private practice providing VMO services.	Score 0 Goal to have nurse practitioner and Aboriginal health workers	Score 0 Developmental model of care at this stage with intention around care navigation and workforce development	Score 0 Service focused on urgent care for triage categories 4/5, because of high demand and no private practice	Score 1 Service is mainly focused on urgent care, but GP based at site seeks to provide coordinated care (subject to demand constraints)	Score 1 Podiatrist (private provider) and antenatal outreach nurse provide some broader primary care services	Score 1 Visiting midwife 2 days per month. Ultrasound equipment purchased for practice, saving travel to Geraldton

Legend: **Evaluative Assessment Colour Code:** S19(2) Initiative – evaluator observations on impact of the Initiative at each of the case study sites in relation to access to primary care:

0: No impact/ Developmental	1: Marginal impact	2: Important contribution	3: Significant contribution
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## 4 EVALUATION FINDINGS

### CASE STUDY BOX #1

#### Proserpine Hospital: using the Initiative to improve access to emergency care

Proserpine Hospital is a 33-bed facility that has day surgery capacity and a community health centre. The immediate town has a population of 3,500 people but the hospital is the major source of acute care, including emergency care, for a regional population of 34,000 people, including the large coastal tourist town of Airlie Beach (10,000 people) 30 km to the east, and multiple tourist resorts in the nearby Whitsunday Islands. There are two private practices in Proserpine with 6 FTE GPs. These GP services were closed on weekends and did not provide services after hours or on weekends. Prior to the Initiative commencement at the site, after-hours emergency care for the Whitsunday catchment was available from Proserpine Hospital's 2 FTE Principal House Officers (PHOs). These positions struggled to deal with the volume of after-hours presentations.

Proserpine Hospital (MMM 5) was approved as a participating site under the Initiative in 2017. In 2019–20 the health service received MBS revenues of \$0.969 million. **The relatively high level of MBS billing for an Initiative site was enabled by the employment of a further four PHO positions. This extra clinical staffing allowed the introduction of a 24-hour, seven days per week emergency department (ED). The clinical ED staff are further supported by 2.2 FTE of administrative staff who provide a reception service, assess Medicare eligibility, collect patient billing details, and lodge authorised claims.** The PHOs are employed as GP registrars and during their training rotation at Proserpine are required to allocate half their clinical time to care in the ED and the remaining half to working in a Proserpine private general practice. The site now has little difficulty attracting registrars to staff the ED because the site, in addition to giving access to training in private general practice, is accredited as a registrar training facility with the Australian College of Emergency Medicine and the Royal Australasian and New Zealand College of Obstetricians and Gynaecologists.

A further nurse position is funded under the Initiative. This role leads multidisciplinary clinics for wound care, chronic disease and palliative care.

Normative assessment of the Initiative impact on access to primary care services from the evaluation survey of site managers supported the insights provided by the case studies and MBS data analysis (see Table 4.3). Across sites responding to the survey:

- 98% of managers considered that their local community had adequate access to urgent medical care, and
- 65% of managers considered they had adequate access to integrated comprehensive primary care (defined in the survey as GP services plus all other primary health workers and equipment required to address the holistic primary care needs of patients). There was some variation in this response rate by jurisdiction with a low of 43% (n=23) in NSW and a high of 100% in WA (n=11).

**Table 4.3:** Assessment of adequacy of local service availability at Initiative sites. % 'Yes'/'No' for urgent medical care & integrated comprehensive primary care

Assessment of local service adequacy	Yes	No	n
<b>Adequacy of local urgent medical care (i.e., category 4 and 5 presentations in the ED)</b>			
All responses (NSW, QLD, WA, NT)	98%	2%	47
<b>Adequacy of integrated comprehensive primary care (i.e., GP services plus all other primary health workers and equipment required to address the holistic primary care needs of patients)</b>			
All responses (NSW, QLD, WA, NT)	65%	35%	48
<i>NSW responses</i>	43%	57%	23
<i>QLD responses</i>	63%	38%	8
<i>WA responses</i>	100%	0%	11
<i>NT responses</i>	83%	17%	6

Source: evaluation survey of Initiative site managers, question 8

Facility managers were asked whether the Initiative was an effective way of increasing investment in primary healthcare services. Across all sites 50% of respondents (n=46) either 'agreed' or 'strongly agreed' with this assessment. The variation in this response rate by jurisdiction is shown in Table 4.4.

## 4 EVALUATION FINDINGS

**Table 4.4:** Assessment of the Initiative as an effective way to increase investment in primary care services

Effectiveness of the Initiative in...	Disagree /strongly disagree	Neither agree nor disagree	Agree / strongly agree	n
<b>Increasing investment in primary care services?</b>				
All responses (NSW, QLD, WA, NT)	35%	15%	50%	46
<i>NSW responses</i>	17%	9%	74%	23
<i>QLD responses</i>	14%	29%	57%	7
<i>WA responses</i>	100%	0%	0%	11
<i>NT responses</i>	17%	50%	34%	6

Source: evaluation survey of Initiative site managers, question 9

### Access to primary care: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

- Finding 1:** Analysis of MBS claims, case study site observations and the survey of participating sites found that the Initiative has improved access to urgent/emergency medical care and after-hours services at many participating sites.
- Finding 2:** Case study observations and survey results were consistent with MBS claims data patterns in suggesting that the Initiative has less impact on enhancing access to integrated, comprehensive primary care services. It is acknowledged there may be some health service funded referrals, call-back and coordination not reflected in the MBS claims data.
- Finding 3:** Observations from the case study sites suggest the availability of integrated primary care services is dependent on access to a range of primary care services which, depending on the location, may include private general practice and/ or Aboriginal Medical Services to provide a core foundation for other primary care services. However,

it is difficult to build a broader profile of primary care services in a smaller community where core general practice capability (e.g., Nyngan) or the service profile of an Aboriginal Medical Service is limited (e.g. Tennant Creek, where the ACCHO did not provide pre- or post-natal services).

### 4.2 ACCESS TO RELEVANT HEALTHCARE WORKFORCE

The extent to which the Initiative contributes to recruitment and retention of the healthcare workforce differs between jurisdictions. Our analysis of the Initiative workforce impacts was informed by how the Initiative funds were reinvested, based on an examination of the annual reports for the case study sites (Table 4.5, see next page).

## 4 EVALUATION FINDINGS

**Table 4.5:** How Initiative funds were reinvested at case study sites, 2019–20

Service	Total Initiative funds	Breakdown of reinvestment of Initiative funds <sup>(a)</sup>																					
		Administration		Personnel										Other									
				Doctors		Telehealth Services		Nurses		Data Entry/ Other		Allied Health Professionals		Professional Development		Staff Training		Equipment		Locum cover			
		\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%		
Temora NSW	141,642	45,590	32	0	0	0	0	0	0	0	0	0	0	9,065	6	0	0	0	0	76,987	54	10,000	7
Quirindi NSW	14,272	14,272	100	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nyngan NSW	46,413	13,924	30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10,940	24	21,549	46	
Kununurra WA	271,547	97,458	36	0	0	0	0	47,321	17	33,680	12	90,904	33	0	0	2,185	1	0	0	0	0	0	0
Meekatharra WA <sup>(b)</sup>	0	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a	0	n/a
Jabiru NT	204,525	10,983	5	102,263	50	0	0	0	0	0	0	0	0	13,001	6	0	0	0	0	4,650	2	73,629	36
Tenant Creek NT	1,205,841	0	0	555,762	46	173,565	14	240,132	20	0	0	236,382	20	0	0	0	0	0	0	0	0	0	0
Tully QLD	639,293	133,295	21	379,499	59	0	0	126,500	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Longreach QLD	274,674	86,403	31	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	188,271	69
Proserpine QLD	1,157,700	217,671	19	826,462	71	0	0	106,890	9	0	0	0	0	2,727	0	0	0	0	0	3,950	0	0	0
<b>Total:</b>	<b>3,955,908</b>	<b>619,596</b>	<b>16</b>	<b>1,863,985</b>	<b>47</b>	<b>173,565</b>	<b>4</b>	<b>520,842</b>	<b>13</b>	<b>33,680</b>	<b>1</b>	<b>336,351</b>	<b>9</b>	<b>15,728</b>	<b>0</b>	<b>2,185</b>	<b>0</b>	<b>96,527</b>	<b>2</b>	<b>293,449</b>	<b>7</b>		

(a) Percentages are a proportion of MBS funding (second column)

(b) Meekatharra annual report contained nil data on reinvestment, due to changed model of care arrangements, including attracting a GP to the town to deliver private practice GP services and on-call emergency services of the hospital.

Source: Initiative Annual Reports, 2019–20

## 4 EVALUATION FINDINGS

The case study analysis indicated that in the Northern Territory and Queensland, the majority of revenue (53% of funds available for reinvestment) were allocated to medical officer salaries including Senior Medical Officers (SMOs), junior doctors and medical locums. This was not surprising based on the award arrangements that operate in those jurisdictions, partially linking hospital doctor salaries to MBS billing (see Section 2.7).

In NSW, the GP VMO arrangements operate whereby GPs are contracted to provide services to the hospital rather than being directly employed by the LHN. The use of these arrangements is reflected in the high allocation of funds to locum cover at Temora and Nyngan.<sup>8</sup> Similar arrangements applied at the Longreach case study.

Analysis of the case study experiences indicated that the Initiative investment in allied health and nursing was limited. Investment in allied health occurred at three case study sites and accounted for 10% of total case study revenue reinvested. At similarly low levels was investment in nursing, which accounted for 13% of overall revenue reinvestment, but at only four case study sites. There was negligible investment in professional development and staff training across the case study sites (under 2% of reinvested Initiative funds).

An illustration of how reinvestment of Initiative funds was used to support the development of a healthcare workforce relevant to local needs is provided by Gundagai MPS (see the Case Study Box #2).

### CASE STUDY BOX #2

#### **Gundagai MPS: using the Initiative to improve access to a broader primary care workforce**

Gundagai is in the Riverina of NSW and situated within the Murrumbidgee LHD. The township and surrounds have a population of 1,925. Gundagai has an MPS (30 bed facility with 12 hospital care beds and 18 residential aged care facility beds) and one private general practice providing community based primary care, emergency care and inpatient care. The practice has a registrar in the hospital during the day with the GP fellows on-call to support the registrar at the hospital where required. The doctors are remunerated for VMO services under the NSW RDA Settlement package.

The practice has a patient load of approximately 3,000 Standardised Whole Patient Equivalent (SWPE) but requires a minimum of five doctors to manage a sustainable on-call roster for the town and manage workload balance to retain GPs and Registrars. However, Medicare revenue from this patient base is insufficient to support 5 FTE GPs (8 headcount) and general practice running costs.

To support the sustainability of primary care and secondary care services in the community and build service delivery capacity, the Medical Centre has negotiated an agreement with the Murrumbidgee LHD to guarantee 24/7 coverage to Gundagai MPS by payment of a fixed amount of revenue generated through the Initiative. The practice has used the Initiative revenue to contribute to employment of a Nurse Practitioner (1 FTE) and mental health nurse (0.6 FTE) within the practice supporting the development of an in-house multidisciplinary team, increased capacity for GP care planning and enhanced primary care, improved continuity of care, and further contributing to practice sustainability through Medicare generation.

<sup>8</sup> Locum cover was high at Jabiru in 2019–20 due to delays in recruiting a permanent SMO, who – by the time of the case study visit – was working at the clinic.

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Investment in equipment to support service delivery predominantly occurred at NSW case study sites but was negligible overall. The case study sites attributed equipment as a suitable way of allocating funds at NSW because of the generally lower average levels of funds at these sites (e.g. \$46,413 funds available at Nyngan). Where average funds were lower, there was less incentive to invest in workforce and so greater propensity to invest in equipment.

Allocation of Initiative reinvestment funds to administration represented 16% across the 10 case study sites overall but varied considerably by individual site.

Running in parallel with the Initiative has been increased interest in development of rural medical training models. Rural Generalist (RG) training has been in place in Queensland for nearly 15 years and is being explored in NSW, the Northern Territory and WA. A key feature of the Queensland and Northern Territory model is the employment of the RG by the LHN (as a single employer) along their training pathway. Consultations with SMOs identified some reservations about the training model due to its perceived greater emphasis on development of hospital-based skills, rather than developing expertise in general practice. However, one Initiative site has developed models where RG trainees alternate their time in hospital and local general practices to develop expertise in primary care as well as consolidating their specific advanced skill in the hospital (Proserpine).

In NSW, the Murrumbidgee LHD has progressed a separate S19(2) Exemption to trial a single employment model for RG training. Under this arrangement, the RG trainee is based in general practice, where the majority of their work occurs, and in-reaches to the hospital to provide acute care and advanced care/ procedural services. There is continuing interest in exploring this model to develop an appropriately skilled medical workforce with skills to work across primary and secondary care, as well as enabling structural reform for rural workforce development.

In the survey of Initiative sites, facility managers were asked to assess whether the Initiative was an effective way of contributing to the attraction of the primary care workforce. Across all sites 32% of respondents (n=46) either 'agreed' or 'strongly agreed' with this assessment. The variation in this response rate by jurisdiction is shown in Table 4.6.

**Table 4.6:** Assessment of the Initiative as an effective way to contribute to the attraction and retention of the primary care workforce

Effectiveness of the Initiative in...	Disagree /strongly disagree	Neither agree nor disagree	Agree / strongly agree	n
<b>Contributing to the attraction and retention of the primary care workforce?</b>				
All responses (NSW, QLD, WA, NT)	38%	30%	32%	47
<i>NSW responses</i>	26%	35%	39%	23
<i>QLD responses</i>	14%	29%	57%	7
<i>WA responses</i>	100%	0%	0%	11
<i>NT responses</i>	33%	50%	17%	6

Source: evaluation survey of Initiative site managers, question 9

### Access to relevant healthcare workforce: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 4:** The highest proportion of case study site Initiative reinvestment at a national level was allocated to supporting medical officer salaries and locum costs (47%). That overall reinvestment pattern was dominated by Queensland and Northern Territory where the model of engagement of the medical workforce to provide acute hospital emergency services was a key driver of that observed pattern. No reinvestment in doctors' salaries was recorded at the NSW and WA case study sites.

**Finding 5:** In sites where the quantum of revenue generated by MBS billings was relatively low, the Initiative arrangements were less likely to support employment of more staff.



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**Finding 6:** Case study consultations identified a reluctance by some site managers to employ staff under permanent contracts due to uncertainty of revenue under the Initiative (the four-year duration of an MOU does not appear to remove this uncertainty). In Queensland, this legal requirement could be avoided by employing some medical staff on short term, 12-month contracts.

**Finding 7:** Case study consultations found that the Initiative has been used to support employment of junior doctors in hospitals as a component of Rural Generalist training in Queensland. A separate S19(2) exemption (not formally part of the Initiative) is trialling a single employer model to support RG training in NSW, with a focus on GP exposure and in-reach to hospitals. Consultations with peak body stakeholders, including RWAs, found a strong interest in further exploration of these more flexible employment arrangements.

### 4.3 DEVELOPMENT OF SUSTAINABLE HEALTH SERVICES

The third objective of the Initiative is to assist with the sustainability of rural health services. The evaluation assessed performance against this objective from several perspectives:

- Contribution of the Initiative to overall service budgets
- Normative assessment of facility managers about the importance of the Initiative, based on survey responses, and
- Role of the Initiative in facilitating maintenance of core services.

<sup>9</sup> The benchmark average used for this analysis was \$90,654 (2019–20 prices). The salaries and wages average for the benchmark service included salary oncosts (e.g. superannuation, long service leave). It did not include costs of medical staff because the benchmark service used VMOs to deliver medical services. The effect of this

We examine the evidence for each of these perspectives in turn.

#### 4.3.1 **Relative contribution of Initiative revenues to service budgets**

A comprehensive analysis of the relative size of Initiative revenues to the overall budgets of services would require examination of the profit and loss statements for each site. Such an analysis would require an assessment of financial report comparability across sites (e.g. approaches to treatment of depreciation and salary on-costs), information on processes for the allocation of LHN overheads to individual sites, adjustments to accounts to ensure cross-site comparability, and extensive data collection processes from all sites via the Chief Financial Officer of the LHN.

None of these processes were practical within the scope of this evaluation. We therefore developed a proxy measure of each service's budget, based on modelling assumptions, which we then compared to site Initiative revenues. Our approach involved the following steps:

- Obtaining details of the estimated FTE at each site from the survey of participating sites
- Calculating a benchmark estimated average salary for a comparable small rural health service (based on financial data for health services available to HMA). This average was based on a typical small rural health service with a mix of nursing, allied health, non-direct care (including cleaners and catering staff), administrative and management staff. The benchmark service used VMOs to deliver medical services, and these estimates were excluded from salary costs within the benchmark.<sup>9</sup>

exclusion will be to reduce the modelled salaries and wages bill in small rural health services in jurisdictions / regions that typically employ doctors (i.e. northern WA, NT and QLD). Partially offsetting this effect will be the inclusion of doctor FTEs in the survey responses for these locations.

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- Applying the benchmark salary to the reported FTE contained in survey responses to derive a ‘modelled budget’ of salaries and wages for each respondent health service, and
- Comparing the relative size of the Initiative MBS revenues to the modelled budget, expressed as a percentage.

The results of that analysis at a jurisdiction level are summarised in Table 4.7 (see next page) and indicate the following:

- At a national level, the MBS revenues represented in the order of 6% of modelled salaries and wages of survey respondent sites, suggesting the Initiative is, on average, a reasonably significant contributor to overall revenue of participating services
- There are variations across jurisdictions in this measure with MBS revenues as a proportion of modelled salaries and wages ranging from a low of 3% across all respondent sites in NSW, to a high of 8% across all respondent sites in NT (the same measure was 6% in WA and 7% in Queensland).

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**Table 4.7:** MBS revenues as a percentage of modelled salaries and wages for Initiative survey respondent sites

JURISDICTION	SURVEY RESPONSE NUMBERS (N)	MODELLED SALARIES AND WAGES (S&W) BUDGET (TOTAL)	AGGREGATE INITIATIVE MBS REVENUE, BASED ON INDIVIDUAL SITE RECEIPTS (2019–20) FOR RESPONDENT SITES	MBS REVENUE AS % OF MODELLED SALARIES & WAGES BUDGET, AT A JURISDICTION LEVEL	MBS REVENUES AS A % OF MODELLED S&W BUDGET – RANGE OF VALUES WITHIN JURISDICTION	
					Smallest % for a respondent site within the jurisdiction	Largest % for a respondent site within the jurisdiction
NSW	21	\$59.628 m	\$1.608 m	3%	0%	7%
QLD	7	\$24.317 m	\$1.472 m	6%	0%	80% <sup>(a)</sup>
WA	11	\$61.654 m	\$4.1 m	7%	1%	82% <sup>(b)</sup>
NT	5	\$15.728 m	\$1.188 m	8%	4%	38%
<b>Total/measure for all respondent sites</b>	<b>44</b>	<b>\$161.327</b>	<b>\$8.368 m</b>	<b>6%</b>	<b>0%</b>	<b>82%</b>
<i>Other site aggregations</i>						
<i>- Respondent sites in northern WA, NT and QLD</i>	22	\$98.272 m	\$6.690 m	8%	0%	82%
<i>- Respondent sites in southern WA and NSW</i>	22	\$62.148 m	\$1.679 m	3%	0%	7%

Note: the benchmark average salary used to calculate the modelled salaries and wages budget (benchmark\* FTE) was \$90,654 (2019–20 prices)

(a) Service with a very low reported FTE (1.7)

(b) Service with a very low reported FTE (0.4)

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### 4.3.2 Importance of the Initiative to sustainability: normative assessment

In the survey of Initiative sites, facility managers were asked to assess whether the Initiative was an effective way of assisting to support the sustainability of the health service [at this location]. Across all sites 50% of respondents (n=48) either 'agreed' or 'strongly agreed' with this assessment. The variation in this response rate by jurisdiction is shown in Table 4.8.

**Table 4.8:** Assessment of the Initiative as an effective way to support the sustainability of health services

Effectiveness of the Initiative in...	Disagree /strongly disagree	Neither agree nor disagree	Agree / strongly agree	n
<b>Assisting to support the sustainability of the health service [at this location]</b>				
All responses (NSW, QLD, WA, NT)	29%	13%	58%	48
<i>NSW responses</i>	13%	9%	78%	23
<i>QLD responses</i>	0%	25%	75%	8
<i>WA responses</i>	100%	0%	0%	11
<i>NT responses</i>	0%	33%	67%	6

Source: evaluation survey of Initiative site managers, question 9

The reason for the lesser level of support in WA is unclear, given the financial modelling suggests that revenue received under the Initiative is higher on average than in both NSW and Queensland.

### 4.3.3 Role of the Initiative in facilitating maintenance of core services

Assessments of the contribution of the Initiative to health service sustainability should be considered in the context of the assessment of the first program objective – enhanced access to primary care. In Section 4.1 we noted the Initiative has clearly improved access to emergency medical care and after-hours services at many participating sites. The availability of financial resources underpins that service

delivery development, evidence that the Initiative has contributed to delivery of these core services. However, it should be emphasised that access to the Initiative – and its associated support for primary care service development, access to greater levels of relevant healthcare workforce, and increased financial support – is not a guarantee of long-term health service viability. Historical service delivery arrangements, industrial arrangements and gradual population decline can all interact to threaten the sustainability of health services and compromise the models of care available to some small communities. The interaction of these various challenges is illustrated by our case study of the Nyngan MPS in north-western NSW (see Case Study Box #3 below).

#### CASE STUDY BOX #3

##### **Nyngan MPS: contribution of the Initiative to sustainable health services is dependent on medical workforce capacity and the underlying service model**

Nyngan MPS provides acute care, inpatient care, emergency care and residential aged care in the 36-bed facility. The Bogan Medical Centre is owned and operated by the Bogan Shire Council and usually has two locum GPs in the clinic, but they do not provide medical coverage to the MPS. There is one privately owned solo general practice; the GP previously worked as a VMO to the MPS, but that service has since ceased. In response, Western NSW LHD applied the Virtual Rural Generalist Service to provide telehealth medical support to the Nyngan MPS for emergency and inpatient care with a GP on-site one week in six. As a result of the limited medical presence physically, revenue generated through the Initiative is curtailed. Medicare revenue was \$46,413 (2019–20) and \$29,980 (2018–19). The funds generated were reinvested in locum support (\$21,000 each year), administration (\$14,000 and \$8,000 in each respective financial year) and equipment (\$11,000 in 2019–20).

The fragility of primary care services in Nyngan has a severe impact on access to care for the Nyngan MPS residents. Under the MPS model, funding for primary care services to residents is intended to be met through Medicare, as in other residential aged care facilities. However, in Nyngan the residents do not have access to potential benefits of Medicare such as private allied health services supported through GP care plans, Pharmaceutical Benefits Scheme

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scripts or medication reviews by consultant pharmacists. Furthermore, as the Nyngan MPS operates under the NSW patient information system, there is no information technology support at the service to develop and record care plans or put in place care management systems for management of chronic and complex conditions.

We return to the issue of access to health services in outer rural and remote settings in our commentary on appropriateness of the Initiative in Section D of this chapter.

### Development of sustainable health services: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 8:** At a national level, the MBS revenues enabled by the Initiative represented in the order of 6% of modelled salaries and wages of survey respondent sites, suggesting that the Initiative is, on average, a reasonably significant contributor to overall revenue of participating services. This indicator of Initiative revenue contribution varied by jurisdiction with, for example, a lower level of 3% in NSW surveyed sites and a higher level of 8% in NT surveyed sites. WA noted the materiality of Initiative revenue was low relative to that health service's total revenue.

**Finding 9:** Two thirds of respondents to the evaluation Initiative site survey from NSW, Qld and NT (n=42) saw the program as a way of supporting the sustainability of health services at the location where they worked. 100% of the WA responses (n=11) disagreed with this view, indicating their position the Initiative did not contribute to supporting the sustainability of the health service.

**Finding 10:** The availability of financial resources under the Initiative underpinned service delivery development at many case study sites through reinvestment of funds to support primary care service development and access to greater levels of relevant healthcare workforce.

**Finding 11:** Visits to case study sites highlighted that access to the Initiative is not a guarantee of an individual health service's long-term viability. Historical service delivery arrangements, industrial arrangements, gradual population decline, and the sudden resignation of a key manager or clinician can all interact to threaten the sustainability of health services and compromise the models of clinical care available to some small communities.

## SECTION B: PROGRAM DESIGN & ADMINISTRATION

The evaluation brief specified that there should be an examination of the program's design and administration. In this evaluation area, the team examined the Initiative's eligibility criteria, administrative arrangements, including the MOU principles and objectives, required processes for stakeholder engagement and reporting, and Department of Health administrative arrangements.

### 4.4 INITIATIVE ELIGIBILITY CRITERION: APPROPRIATENESS

There was strong support for the single eligibility criterion for the Initiative – public health services based in areas 5 to 7 of the MMM geographical classification scheme – during project consultations with jurisdiction representatives, LHN management, PHNs, and RWAs. This program rule was considered a straightforward way of designating services within scope and was easy to administer. More importantly, stakeholders uniformly considered that services in this classification faced site-specific challenges in responding to primary care needs and recruiting appropriately skilled professionals.

The MMM is updated approximately every five years following the Australian Bureau of Statistics national census. If an exempted site becomes ineligible due to

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changes in the MMM classification of the site, the Commonwealth will provide 18 months' notice that the site will be phased out of the Initiative (see Clause 6.4 of the MOU).

During consultations, the evaluators became aware of several hospitals that are subject to these MOU provisions, i.e. Stanthorpe Hospital and Chinchilla Hospital in the Darling Downs HHS and Scone Hospital in the Hunter New England LHD.

### CASE STUDY BOX #4

#### **Stanthorpe Hospital: the need for a review process when site eligibility changes**

Stanthorpe Hospital was granted an exemption under the Initiative in 2014 when the key eligibility criteria required a community to be <7,000 and in a District of Workforce Shortage. With the introduction of the MMM 5–7 criteria, communities with populations above 5,000 people no longer satisfy that requirement. In 2020, the annual review of the MMM classification determined that Stanthorpe was an MMM 4 (rather than a MMM 5) and the Medical Director was advised that the site was no longer eligible and would have to cease MBS billing by 1 January 2022. While the Medical Director requested the Department to reconsider this determination, the event highlighted the absence of a review or appeal mechanism in the current MOU.

Since 2014, funds generated through the Initiative have been predominantly reinvested to support rural medical workforce development. MBS funds of \$0.471 m are currently invested in delivery of after-hours emergency care at Stanthorpe Hospital and to support the delivery of complex mental health, paediatric and general outpatient clinics. The Initiative currently supports 2.2 FTE RG trainees with the Darling Downs HHS supporting an additional 2 FTE positions. These positions add capacity within the hospital enabling a sustainable roster, internal staffing relief and support for community-based general practice by providing after-hours care and facilitating joint appointments of medical staff. This additional workforce capacity is supporting a training and service model to Texas and Inglewood, two MMM 5 communities without full-time medical coverage.

Withdrawal of MBS funds provided under the Initiative has the potential to significantly reduce access to primary care to the sub-regional population supported by Stanthorpe Hospital and reduce workforce development training opportunities.

The current MOU contains no review mechanism to assess the impacts of removing a site's entitlement to participate in the Initiative. This example supports a case for a review process for sites that no longer meet the eligibility criteria. Such factors could include: evidence that the Initiative has directly and measurably met the objectives of the program; local clinicians and stakeholders provide written support for continuation; and evidence of state or territory commitment to maintain and / or expand their contribution to the service.

The innovative workforce development models developed at Stanthorpe Hospital, based on use of RG trainees funded through the Initiative, suggests an alternative approach to dealing with Stanthorpe Hospital's ineligibility based on the changed population levels of the town; a future funding stream that could potentially be accessed is PHN support for innovative workforce models using RGs. This would avoid modifying the underlying population eligibility rule of the Initiative, which has strong stakeholder support.

#### **Initiative eligibility criteria: Summary assessment**

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 12:** Development of a new MOU should consider introduction of mechanisms for dealing with the underlying service development needs of sites that no longer comply with the MMM 5 to 7 eligibility criterion. This could include PHN support for innovative RG models.



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### 4.5 SUITABILITY OF CURRENT ADMINISTRATIVE ARRANGEMENTS

#### 4.5.1 Principles: Value and contribution

Clause 7 of the MOU with each jurisdiction specifies principles to guide its development and operation. We listed those principles in Chapter 2, Section 2.3.

It is noteworthy that the fourth of these principles – avoiding undermining local private sector viability – must be demonstrated in applications for an exemption. The MOU Schedule A Definitions explicitly state that ‘primary care practitioners may choose to be represented by a representative (sic) in negotiations.’

However, all the other principles operate as general statements and do not explicitly link to the Initiative objectives via either the application rules or reporting statements. Furthermore, it was not clear to the evaluators that these other principles had informed jurisdictional approaches to Initiative implementation.

#### MOU Principles: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 13:** The current MOU principles have minimal impact on the Initiative’s operations. However, they do provide a useful statement of the context explaining why the Initiative was introduced in 2008 and continues to operate. It may be better that these general statements are rephrased as a ‘preamble’ in a redrafted MOU. The current statement relating to engagement with primary care practitioners has ongoing importance in informing applications and consultation processes once participation of a site is approved; it should be retained in the operational arrangements of the MOU.

#### 4.5.2 Site engagement of stakeholders

The guidelines indicate that sites should engage with local stakeholders for the purpose of operational planning as a component of the application process. The application requires signed endorsement by local GPs, hospital doctors, ACCHOs, and the RFDS that may be materially affected by the Initiative, together with other stakeholders including the PHN, local government and community representative.

The evaluation has found variation between jurisdictions and within jurisdictions in relation to the extent to which the LHNs engage with communities, local service providers and PHNs for application, operational planning and reinvestment purposes. In the most part, the sites/LHNs reported that they had not re-submitted an operational plan since their initial application for an exemption, the majority of which preceded the current MOU.

There was a spectrum of engagement with local stakeholders for reinvestment decision-making. At the high engagement end of the spectrum, the Murrumbidgee LHD has established S19(2) Initiative committees in each site (see Case Study Box #5). Similarly in Kununurra, an Advisory Committee inclusive of the Senior Medical Officer, Boab Health, and Wunan Health meet quarterly with recommendations for reinvestment signed off by the WACHS Regional Director.

In Queensland case study sites, reinvestment decisions were predominantly internal to the HHS.

At the low engagement end, one site retrospectively determines revenue allocation after meeting medical staffing costs.

Across sites, engagement with RWAs to identify workforce priorities and workforce development opportunities was very limited or absent. Similarly, there was limited formal engagement with PHNs to utilise their health needs assessment for reinvestment considerations, or alignment of reinvestment with PHN commissioning opportunities. PHNs and RWA consultations identified opportunities to better maximise benefits derived from the Initiative through collaborative planning and leveraging available funds and programs.

External stakeholders identified concerns with transparency of the program. Stakeholders indicated difficulty in obtaining a copy of the MOU between the Commonwealth and Queensland, whereas the MOUs between the Commonwealth,

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NSW and WA are available on the internet. Issues were also raised about apparent absence of a review of operational plans on a regular cycle (e.g., at the commencement of each MOU) or mechanism to trigger the review of the eligibility of a site where local service status changed.

Case study participants currently applying for exemptions in Western NSW indicated difficulty in finding publicly accessible information (e.g., fact sheets) about the Initiative on Commonwealth and NSW Health websites. This hindered discussion with external stakeholders and state employees who were concerned about the legitimacy of billing Medicare in public hospitals or by employed staff.

### CASE STUDY BOX #5

#### **Murrumbidgee LHD: Good practice site engagement, governance and reinvestment to improve access to primary care**

##### **Context**

The Murrumbidgee LHD (MLHD) has 22 facilities that hold an Initiative Exemption, of which 11 are an MPS and 11 are hospitals. Medical services in these facilities are predominantly provided by GP VMOs. MLHD operates the Remote Medical Consultation Service (RMCS) to support clinicians in outlying hospitals by prescribing medical treatments, providing first aid advice and identifying when further care is required. Sometimes hospitals in outlying areas are not staffed by doctors all the time. In such instances the RMCS allows clinicians (usually nursing staff) to seek advice on appropriate treatment options and have patients assessed via phone or video link to avoid admitting or transporting patients long distances unnecessarily. The MLHD currently has a contract with Rural and Remote Medical Services (RARMS) to provide telehealth support to rural facilities for category 4 and 5 presentations when there is not a doctor on-call to the hospital.

The Manager of Revenue Performance & Improvement sits in the Finance and Performance section of the MLHD and has the responsibility of managing the

Initiative across all rural facilities. This position supports each site in the application and operational planning process and convenes bi-monthly meetings of the local Initiative committee to review implementation issues and plan for reinvestment of funds. The Manager also supports sites to develop, implement and review Medicare claiming processes and works with the practices and LHD Medical Administration to arrange VMO contracts, streamline applications for provider numbers for VMOs and GP registrars, provide information packs for new doctors including consent to opt into the Initiative and opt into gap cover arrangements. The Manager shares ideas about reinvestment opportunities across sites and prepares site level revenue and expenditure reports that are visible to local stakeholders. The Manager works strategically with the Ministry of Health to provide information about the Initiative and value of reinvestment to communities.

**Governance:** the local Initiative committee includes representation from the Health Service Manager; the Revenue Clerk; the Manager, Revenue Performance and Innovation, MLHD; GP(s) practice principals; the Local Health Advisory Committee representative; and local government.

Priorities for reinvestment identified by the local Initiative committee are assessed by the Cluster Manager for the area and, where supported, progressed to the MLHD Executive Committee for approval. The Executive Committee includes the Director of Medical Services; the Director Clinical Operations; and the Manager of Finance.

**Reinvestment:** funds are reinvested across a variety of areas to improve access to primary healthcare and/or support health workforce recruitment and retention. These include:

- **Workforce recruitment and retention:** contribution to locum backfill for Practice Principals; contribution to agency fees to recruit doctors to Narrandera to experience rural health (including allocation for travel and accommodation); Quack Quest – online video and international recruitment strategy – recruitment strategy for GPs to Temora; and local student scholarships.
- **Workforce development to address service gaps:** training for a local GP in pain management and equipment for ultrasound guided injections. This training

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will enable local access to pain management services and the trained GP will provide training to other GPs to increase capacity across the region.

- **Workforce for delivery primary healthcare:** Nurse Practitioner (Gundagai Medical Centre); Mental health nurse (Gundagai Medical Centre); short-term allocation of hours for a trauma counsellor to work from the Temora Medical Centre.

This case study provides an example of benefits of local governance to inform reinvestment strategies responsive to local service needs and value of embedding management of the Initiative within the Executive structure of the LHN.

### Engagement with stakeholders: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 14:** Two jurisdictions do not publish their MOUs publicly. This is not ideal. The Initiative arrangements can impact on the operations of private providers and ACCHOs and therefore transparency about the arrangements that apply is needed. Further, the local community should be aware of the health service delivery arrangements that operate in their town.

**Finding 15:** Responsibility for final sign-off of reinvestment decisions generally sat with either facility or LHN senior management. Case study observations found that the level of engagement with stakeholders to inform reinvestment varied between jurisdictions. There were sites with greater emphasis on stakeholder engagement (e.g. via an implementation committee that met bi-monthly and included community and GP representatives) that made recommendations for reinvestment although final sign-off remained with the LHN.

**Finding 16:** Greater transparency about funds available for reinvestment in a town could be enhanced by insights of other stakeholders about underlying health needs in their community. In addition to GPs and

community members, this could include RWA, PHN, local ACCHO or State Affiliate representation.

**Finding 17:** The evaluation team observed examples of innovation which had occurred because of LHNs engaging with a broader range of stakeholders around Initiative implementation plans. One LHN developed links with universities, general practice training providers and larger regional hospitals to progress junior doctor training across hospitals and general practice. Some locations used the Initiative to extend GP services to smaller MMM 5–7 communities beyond their immediate town, e.g. Stanthorpe, Longreach, Tully.

### 4.5.3 Reporting arrangements

Review of the current reporting template and case site reports demonstrate that reporting arrangements are transactional and predominantly focused on quantum of Medicare funds generated, number of patients serviced and how funds have been spent.

#### Reporting arrangements: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusion:

**Finding 18:** Annual site reporting is not linked to an updated operational plan, nor does it require an assessment of impact of funds reinvestment.

### 4.5.4 Sub-regional and jurisdiction governance

External stakeholders (RWAs, PHNs, RDAA and NACCHO) consistently identified the need for stronger governance of the program at a jurisdiction and local level. The key areas of concern were in relation to clearer guidelines and transparency in identification of sites, approval processes and appeal mechanisms. There was also concern about transparency with respect to sites approved under the Initiative, whether the site is implementing the Initiative and, if so, the quantum of

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revenue generated, and transparency of decision-making for reinvestment. The apparent absence of a review of operational plans on a regular cycle (e.g. at the commencement of each MOU) was raised, as well the lack of a mechanism to trigger the review of the eligibility of a site where local service status changed.

NACCHO's written submission to the evaluation indicated there was inadequate consultation with the sector at the local ACCHO level and with their jurisdiction affiliates in relation to new applications, ongoing implementation of the Initiative and reinvestment. RDAA raised concerns around the governance of reinvestment, highlighting the risk of funding generated through the Initiative being re-directed to the bottom line of public hospital bodies rather than used to increase access to primary care services as intended. While it was acknowledged that the Initiative is an excellent mechanism to use when there is market failure in community based general practice and other primary care models, it should be directed to supporting the jurisdictions to develop integrated models of care. This was re-iterated by several PHNs. Furthermore, PHNs have capability in developing primary healthcare models of care and patient information system support that the hospitals could draw upon.

### CASE STUDY BOX # 6

#### **An example of LHN and PHN cooperation across the regional primary care sector**

**The South West HHS in Queensland operates nine general practices in communities where there is no private practice. It has partnered with Western Queensland PHN to establish the Health Care Home model of care in these practices, using their practice support team to develop practice systems, patient recall, staff training, data cleansing and data extraction for quality improvement and monitoring key health indicators.**

Under the current MOU, the jurisdiction submits an operational plan to the Commonwealth for sites where an exemption is being sought under the Initiative. In Queensland, under the first MOU (2006), all applications were presented to a Reference Group for consideration and sign-off. The Reference Group comprised representatives from Queensland Aboriginal and Islander Health Council, Queensland Division of General Practice (now Check-Up), Health Workforce

Queensland and Rural Doctors Association Queensland. External stakeholders considered this mechanism for coordination had greater transparency around the application and approval stage as well as providing a point of contact for local stakeholders to raise concerns if there were issues in implementation of the Initiative.

Broadening governance at a jurisdiction level to include representatives from the ACCHO sector, RWA, rural PHNs and Rural Doctors Association presents opportunity to identify, explore and leverage innovations and other funding sources that have relevance to the intent of the Initiative at a jurisdiction or regional level.

Under the current MOU, it is the intent that revenue is reinvested at the site (according to plans set out in the Operational Plan) and overseen by a local governance group. As outlined immediately above and in earlier sections, there is considerable variability between and within jurisdiction in local governance processes. There were a number of external stakeholders who identified opportunities to use a S19(2) exemption to support system change (e.g. the Murrumbidgee single employer model for Rural Generalist trainees employed by the LHD and based in general practice) or address structural issues particularly at a sub-regional level, e.g. the 4Ts model. This was seen to have potential for greater benefit particularly where the quantum of investment required per site was relatively modest, or where smaller communities did not have a doctor (but had primary care needs) and could not derive financial benefit from an exemption.

### CASE STUDY BOX # 7

#### **The 4Ts: Applying sub-regional planning to develop a sub-regional response**

There is no existing model of care in NSW that comprehensively supports both primary care and hospital-based needs in small rural communities. The Western NSW LHD recognised that the sustainability of both primary and acute care services in some towns requires the pooling of resources and integrating care across both federal and state jurisdictions, as well as needing support for innovative new models of recruitment and retention.



## 4 EVALUATION FINDINGS

The 4Ts project builds on proof-of-concept work completed in collaboration with the Rural Doctors Network (RDN) and the Western NSW Primary Health Network (WNSW PHN).

The 4Ts is a single employer model operating in Tullamore, Trundle, Trangie and Tottenham. Each site was granted approval to participate in the Initiative in October 2020. Each community has an MPS, ED and general practice (co-located on-site), and is supported by the Virtual Rural Generalist Service. The LHD employs two local doctors (working part time in Trundle and Trangie) and rotating locums under the VRG Service. VRG coverage supports the ED and MPS on the days the GPs are not in the community and after hours. At each site, practice management/ administration and nursing staff work across the 'general practice', ED and MPS. There is a shared patient information system across the four sites, i.e. Prac Soft and Best Practice. Therefore, each site has systems in place for primary care and chronic disease management, with capability for data interrogation by Pen CS for quality improvement purposes and Medicare billing. The MPS residents have access to Medicare, PBS and care planning.

This one-employer model seeks to integrate multidisciplinary care across primary and acute care services in small rural communities. It differs to other single-employer models in that it includes nursing and administrative staff as well the GPs. It is anticipated that pooled resourcing will sustain more comprehensive health services in communities than may otherwise have been the case. While Western NSW LHD is placed as the single employer across these towns, the project does not assume that the LHD should be the single employer if this model were to be translated more broadly across other communities at some future time.

**This example demonstrates the potential benefit that can be realised through collaborative planning and resourcing across primary and secondary care settings at a sub-regional level.**

### CASE STUDY BOX # 8

#### Potential model – using S19(2) Directions to invest in integration

A structural challenge in the primary healthcare system is that under the fee-for-service model, GPs are not paid for integrated service development activities.

The Murrumbidgee PHN has established a *Winter Strategy* to reduce *Potentially Preventable Hospitalisations*. Twenty practices have signed up to the Strategy. Under the strategy, a practice nurse manages a review of the most vulnerable patients across the practices and develops a preventative care plan for identified patients. These patients are placed on a risk register. If the patient presents to ED, there is a warm handover back to GP with the intent to reduce hospitalisations. Each practice is paid \$8,000 p.a. to participate in the strategy. Investment of S19(2) Initiative revenues was identified as a potential mechanism to support system change at a town/ sub-regional level, with funds contributing to a care navigator position, or community pharmacist to do medication reviews and prioritise care for the most vulnerable and keep people out of hospital.

A sub-regional governance group that includes representation from the LHN, PHN, RWA, local ACCHO and local government enables access to relevant health and workforce needs assessment to inform prioritisation and planning, provides the foundation for collaborative resourcing to maximise the potential benefit of the Initiative, can identify changes within the service system that may need to be considered in relation to the operation of the Initiative (e.g. new private practice that may wish to establish, nuanced negotiation of Medicare items to be claimed) and provide transparency to local, sub-regional and regional stakeholders internal and external to the LHN for planning and implementation of the Initiative.

#### Sub-regional and jurisdiction governance: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 19:** Consideration should be given to broader representation of stakeholders in governance of the Initiative to provide transparency and to facilitate opportunities to leverage resources from other program funding streams and identify innovations to maximise benefit from the Initiative.

## 4 EVALUATION FINDINGS

### 4.6 DEPARTMENT OF HEALTH ADMINISTRATION

The Primary Care Policy Section, in the Primary Health and Palliative Care Branch of the Department of Health, manages the COAG S19(2) Exemptions Initiative. Standard Operating Procedures (SOPs) have been developed to assist staff manage the Initiative.

In reviewing the SOP, the evaluators found that it provides clear directions for the application assessment, approval and management of the program. However, the annual report assessment is focused on MBS claims at each site and compliance checks. The evaluation team noted that it is difficult for the program management team to determine total MBS expenditure by states and territories based on current information provided. This aligns with findings of the evaluation that current reporting requirements do not provide transparency around reinvestment of revenue, the extent to which investment aligns with operational plans or evidence that can inform an assessment of impact of the Initiative.

#### Department of Health administration: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 20:** The current reporting mechanisms of the Initiative focus on levels of MBS revenue generation. Appreciation of the models of care and closer examination of reinvestment processes at each site would enhance understanding of underlying drivers for the MBS billing.

## SECTION C: EFFICIENCY OF CURRENT ARRANGEMENTS

### 4.7 MBS BILLING – SITE & LHN PROCESSES

At each case study site, we interviewed representatives of the administrative teams and relevant managers to understand the process flows within health services for

managing patients presenting for primary care. At most sites (eight of the 10 case studies) the main service provided under the Initiative was urgent / emergency care. The process map (at Figure 4.1 (see next page)) shows typical steps in the management of these patients and the associated documentation and billing processes for one jurisdiction (in this case Kununurra, WA). This shows that the processes involved were cumbersome and complex and data entry was duplicative because information was required in both electronic and paper-based systems. The administrative detail and processes can vary slightly for health services in other jurisdictions but generally still involve complex IT interfaces and duplicative data entry.

Across jurisdictions administration staff may be required to:

- collect patient details (name, address, age)
- assess Medicare eligibility (particularly important at some sites with large numbers of tourists passing through town) and record the Medicare number
- transfer case details from the hospital patient administration system and ED clinical management system (where treating doctors recorded their notes about the nature of their clinical intervention) into the Medicare billing system
- allocate an MBS item number, and
- depending on local protocols, submit the claim directly to Services Australia or the LHN billing team, for verification and lodgement.

Medicare billing processes were not optimised at all sites. There was scope to increase the number of items claimed at some, but not all, sites, due to:

- doctors having limited knowledge of MBS. This was especially the case for junior doctors who were often more focused on developing their clinical skills, rather than conforming with administrative requirements
- missed opportunities to bill for extra items within a consult because they were:
  - too busy in ED
  - had limited interest or incentive to bill where they were already paid under state awards or VMO arrangements
  - delays in obtaining provider numbers for locums and junior doctors
  - turnover of locums not familiar with local MBS billing processes, and
  - no administrative support in after-hours periods.



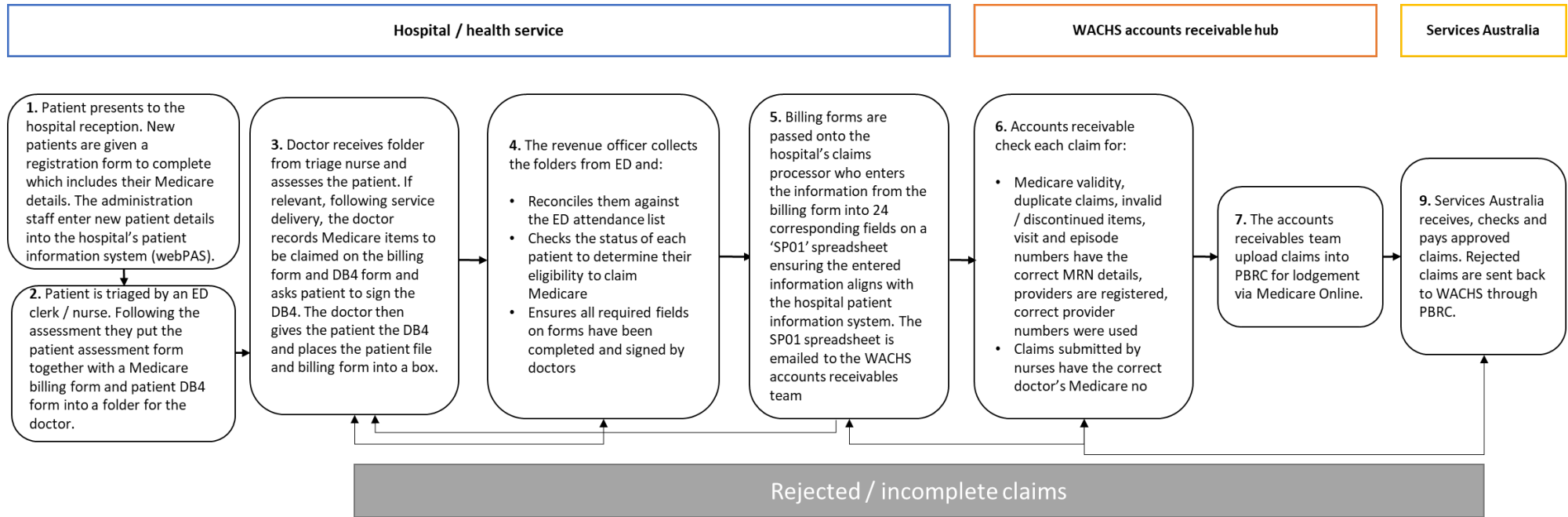
## 4 EVALUATION FINDINGS

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- resistance by hospital staff and other stakeholders concerned that billing Medicare was double dipping
- limited sharing of information between LHNs within some jurisdictions (NSW and Queensland) to develop improved administrative processes, i.e. each site has developed their own approach to collecting data and checking claim veracity
- variation between sites in requesting/requiring patients to sign bulk bill claims forms (DB4); the requirement to sign had been waived due to COVID-19 but it was unclear how long this would continue, and
- variation between sites in requiring doctors to complete the DB4. There were instances where the revenue clerk completed the form based on the ED record, while in other locations the revenue clerk checked the ED record and added additional items that the doctor may have missed and asked the doctor to check and sign.

## 4 EVALUATION FINDINGS

**Figure 4.1:** Processes required to lodge an MBS claim under the Initiative, as applied at Kununurra Hospital, Western Australia



Source: Kununurra Hospital case study

The case study analysis identified relatively large levels of administrative staff associated with the Initiative, ranging from 0.5 FTE to 2.2 FTE per site. The administrative staff, in addition to supporting the claims management processes, would assist with reception duties and patient flow management (e.g. queuing in the waiting room).

The NT health services sought to deal with the administrative complexity by providing support to all service delivery sites operating a S19(2) exemption. Each health service (Top End and Central Australia) had a billing support team that trained new doctors and revenue clerks in MBS billing processes, reviewed claims and lodged them on behalf of the site and ensured that all new doctors received

their prescriber numbers from Services Australia in a timely manner. These arrangements in the NT reflected:

- the large numbers of sites in that jurisdiction operating a S19(2) exemption (including both Initiative and RMBS exemption sites), and
- the revenue realised from the previous year was treated as a budget line item that facility managers were accountable for reaching the following financial year. Facility managers received a monthly performance report on their site's revenue billing performance under the Initiative compared to a revenue target.

A similar central billing team functioned at WACHS, based in Bunbury.

## 4 EVALUATION FINDINGS

The PMS software supporting the lodgement of MBS claims varied between health services but included Medical Director (Queensland and Central Australia HS, Northern Territory), Communicare / River Medical (Queensland), and PCIS (Top End HS Northern Territory). In contrast, the NSW sites use the hospital based electronic medical record patient management module and the NSW Health Power Billing and Revenue Collection system to lodge MBS claims.

The evaluation team undertook a sample survey (n=8) in two jurisdictions of the reasons that some sites listed on the Department as participating had not billed in the previous financial year (2019–20). These reasons included: variation in the local model of care (n=2) e.g. where the GP had changed their preference for where they consulted with patients (from the hospital to private practice); the status of the facility had changed from a hospital to a community health service (n=1); delivery arrangements at the hospital had changed to a contracted provider from outside the town (n=6); and the non-reporting of revenue was a data extraction error by the LHN in the data submitted to the Department (n=1).

### MBS billing arrangements: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 21:** Observations at case study sites found that processes used by Initiative sites to lodge a legally compliant MBS claim were extensive and contribute to explaining the high levels of site-level administration costs. Site revenue officers must reconcile emergency department attendance lists against records in the hospital patient administration system and manually – in all jurisdictions except NSW – re-enter the data in a separate MBS patient management / billing system (PMS). High turnover of hospital doctors due to routine training rotations means constant attention is required to ensure new doctors have a site-specific provider number issued by Services Australia. The extensive provision of urgent and emergency care – involving large numbers of patient walk-ups that haven't previously attended the hospital – produced large data entry volumes relating to patient personal details (name, address, gender, date of birth,

Medicare number) which must be accurately recorded in the PMS to avoid claims rejection.

**Finding 22:** PMSs used in general practice settings were standard at Initiative sites in NT and Queensland, but this situation is not common in non-Initiative health services within those jurisdictions. As result, LHNs and/ or sites running the Initiative invest additional effort to ensure doctors experienced in using hospital-based patient administration systems are also familiar with the accurate use of PMSs. (NSW has an IT software package for MBS billing processes which is unique to that jurisdiction and leads to less administrative effort for ensuring MBS claims integrity).

## SECTION D: APPROPRIATENESS

An evaluative assessment of appropriateness examines the underlying need for a program. In this part of the evaluation analysis we examine issues about the relationship between the access to MBS funding enabled by the Initiative Directions and the underlying needs for health services in rural and remote geographic areas.

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### 4.8 MBS CLAIM LEVELS NOT LINKED TO UNDERLYING POPULATION NEED

Overall revenue derived from the Initiative was \$13.6 m in 2019–20 across the 92 billing sites in that financial year. However, there was a wide variation in the quantum of Medicare billing generated by different sites.

In 2019–20 eight sites generated over \$600,000 in revenue each (ranging from \$0.600 million (Fitzroy Crossing) to \$1.043 million (Derby)).

- these eight sites accounted for revenue of \$6.3 million under the Initiative, more than 45% of total funds generated, and
- three of these sites were in WA, four in Queensland and one in NT.

The mean revenue for the other 85 sites with under \$0.6 million in revenue was \$85,702 in 2019–20, a relatively low level of MBS top-up funding:

## 4 EVALUATION FINDINGS

- in NSW, the maximum amount of revenue generated by a site within the state was \$0.303 million; five sites in the state generated less than \$10,000 (ranging from \$76 to \$7,036).

This analysis highlights that revenue generating capacity under the Initiative is typically linked to the number of salaried doctors at a site, especially where there are larger emergency departments – as in the bigger MMM 5 to 7 towns in WA, NT and Queensland.

The models of care that operate within the context of the GP VMO arrangements (as in NSW) generate relatively less MBS revenue for their sites under the Initiative, because the doctors are not salaried and operating extended hours or 24-hour emergency departments (as in Queensland and the Northern Territory).

An underpinning principle guiding the development and operation of the Initiative (as set out in the MOU) is that:

*All Australians should have equitable access to appropriate and quality health care, throughout their lifetime, regardless of their place of residence within Australia.*

However, the nature of the Initiative is that its design elements (i.e. approval to access the MBS) does not enable a direct link between MBS revenue generation and the underlying primary care needs of a community. This lack of linkage occurs because revenue generation under the Initiative is mainly reliant on the availability of medical practitioners with provider numbers, with the quantum of MBS revenue generated dependent on volume of services provided. Therefore, small remote communities without regular access to a medical practitioner will have very limited revenue generated but are likely to have high primary healthcare needs.

### Link of Initiative to underlying population need: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 23:** Funding contributions to different sites resulting from the Initiative can be internally inequitable within the program arrangements – larger sites with more salaried doctors have a greater ability to undertake MBS billing. This characteristic highlights a program design characteristic of the Initiative; MBS revenues of a site are not directly linked to underlying health needs of a community. There is limited capacity to address this program characteristic – the foundation of the Initiative is primarily as a top-up to funding, enabled by access to MBS billing. Communities and health service providers need to access other funding sources to address local healthcare needs in a more targeted way, including programs administered or commissioned by PHNs, RWAs, aged care funding, and locally based service delivered by local providers such as local government and LHNs.

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## 4.9 ONGOING BARRIERS TO CARE

The concept of access to healthcare can be described as the potential ease with which consumers can obtain healthcare. Access in a healthcare context is a complex and multidimensional concept. Disaggregation of the concept into a range of dimensions is outlined in Table 4.9. This more granular description allows policy makers and health service organisations to identify key questions to be addressed in the planning and delivery of services to ensure optimal access to healthcare for Australians living in regional, rural and remote areas.

## 4 EVALUATION FINDINGS

**Table 4.9:** Defining access to healthcare – key concepts

ACCESS DIMENSIONS	DEFINITIONS	
	Health system characteristics	Population characteristics
Availability	Volume and type of services	Volume and type of service the population needs
Geography	Proximity of providers to consumers	Ease with which the population can transcend this space
Affordability	Direct and indirect costs of securing healthcare	Consumers' ability to meet the direct and indirect costs of healthcare
Accommodation	Manner in which the supply resources are organised	Consumers' ability to contact, gain entry to and navigate the health system
Timeliness	Time until healthcare can be provided	Urgency of the need for healthcare
Acceptability	Providers' attitudes and beliefs about health and personal characteristics of consumers (e.g. age, gender, ethnicity, religion)	Consumers' attitudes and beliefs about health and personal and practice characteristics of providers
Awareness	Communication of health and health systems information to consumers	Consumers' understanding of their health needs and knowledge of how to have these needs met

See: Helping policy makers address rural health access problems [17]

To summarise the underlying issues of access we encountered through our case studies, we compared the experience of the 10 case study sites against these access dimensions. Our observations about the frequency that these access dimensions are a problem at Initiative sites is summarised in Table 4.10 on the next page.

## 4 EVALUATION FINDINGS

**Table 4.10:** Evaluator assessment of ongoing health service accessibility issues in case study sites

Dimension	Continuing Issues in MMM 5 to 7 localities Observed at Case Study Sites	Frequency – Issue Identified as a Problem at Case Study Sites (at a sub-regional level)
Availability	All communities in MMM 5–7 and the Northern Territory are automatically classified as a Distribution Priority Area (DPA) for general practitioner services	All sites [access to GPs is an ongoing problem, despite the DPA rules]
	Patients encounter delays in accessing GP appointments and some doctors have closed books. Manifests as high Category 4 and 5 presentations to EDs or exacerbation of problems and increased potentially preventable hospitalisations	Some sites [1 to 4 case study sites]
	GPs have high caseloads due to higher clinical need in rural and remote communities	All sites
	Small populations in towns and there is a threshold below which communities cannot support a full-time doctor (under private practice arrangements), i.e. practice viability, coupled with unsustainable on-call requirements and/or recruitment and retention challenges	Some sites [1 to 4 case study sites]
	The number of allied health professionals is low and insufficient workload/ patient numbers to justify full-time salaried positions or viable private practice	Some sites [1 to 4 case study sites]
	High caseload and challenging work environments lead to burnout, high turnover – impacting on continuity of care	Some sites [1 to 4 case study sites]
	Difficulty in recruiting and retaining practice nurses, Aboriginal Health Workers, allied health professionals and administration staff	Some sites [1 to 4 case study sites]
Geography	For small communities without a local GP – distance to travel to access medical care remains problematic	Many sites [5 to 10 case study sites]
	Extensive travel to regional centres and capital cities is required to access specialist care and specialised services	Many sites [5 to 10 case study sites]
Affordability	Lower socioeconomic status and reduced capacity to pay for private GP and allied health services	Some sites [1 to 4 case study sites]
	Patient capacity to pay for travel to access care is compromised	Many sites [5 to 10 case study sites]
	Patient transport subsidies cover specialist medical services but not allied health	All sites
Accommodation	As a result of availability challenges, service provision and referral pathways are inconsistent	Some sites [1 to 4 case study sites]
	Demand management and/or resource management strategies, referral criteria impede access to care, e.g. pregnant Indigenous women in Tennant Creek struggle to access vitamins to support quality ante-natal care	Some sites [1 to 4 case study sites]
	Siloed funding (directed to service provider organisations) limits multidisciplinary primary healthcare model of care (inclusive of GP)	All sites
	Communities receive an array of services funded by State and Commonwealth governments (directly or via commissioning arrangements) creating a complex, often uncoordinated and fragmented care environment.	All sites
Timeliness	Patient access is impacted by availability – delay in accessing care locally	Some sites [1 to 4 case study sites]
	Outreach/ visiting services can be infrequent or there is often extended time between visits	Many sites [5 to 10 case study sites]
Awareness	Poor health literacy leads to lower utilisation of services or delays in seeking healthcare	Many sites [5 to 10 sites]
	Patchiness of service provision – ‘don’t know when service will be in town’	Some sites [1 to 4 case study sites]

Legend: Evaluative Assessment Colour Code: impact of the Initiative on accessibility dimensions (as specified in Table 4.9) at each of the case study sites

All sites	Many sites [5 to 10 sites]	Some sites [1 to 4 sites]
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## 4 EVALUATION FINDINGS

### CASE STUDY BOX # 9

#### Primary care in Tully: barriers to access care are multi-dimensional

Tully is located two hours' drive south of Cairns and two hours north of Townsville. It has a population of approximately 3,000 people. Mission Beach is about 25 kilometres from Tully and has a population of about 4,000. Innisfail is the main service centre for the Cassowary Coast Shire with a population of 10,000.

There is one private general practice in Tully. The Tully Medical Centre has two full-time fellows (one of which is the practice principal) and currently four GP registrars. However, this staffing level fluctuates, depending on the number of registrars allocated by the Regional Training Provider. The practice principal also services the residential aged care facility in Tully. The Medical Centre is heavily booked with a waiting time of six to eight weeks to see the practice principal and about two to three weeks for appointments with other doctors.

There is one private practice at Mission Beach managed by a small corporate provider. One GP works in this practice (0.6 FTE) and has closed books.

Mamu Aboriginal Health Service is based in Innisfail and provides outreach services to Tully, Babinda and Ravenshoe. A GP services the Tully community one day per week. However, Mamu is experiencing difficulties recruiting doctors.

Tully Hospital is staffed by eight doctors. This includes three permanent SMO appointments, four PHOs (two rotating from Cairns Hospital and two rotating from Innisfail Hospital) and one SMO (temporary appointment) funded through Initiative revenue. Tully Hospital is currently funded for nine acute care beds but can operate up to 20 beds (if funded).

In addition to the ED, Tully Hospital operates a GP clinic with booked appointments (18 per day) three days per week and two afternoons. One SMO is rostered onto the GP clinic each day with the roster shared between three resident doctors. There is a two-week waiting list.

Tully Hospital ED sees about 40 to 50 patients per day when there is no GP clinic. When the clinic operates, ED sees about 22 patients (including after-hours presentations). The shortage of GPs in the community, low socio-economic

status of the area, and farm workers who cannot access medical services during the day, results in high use of the hospital clinic and ED.

#### Key challenges impacting on patient access to care for the Tully and Mission Beach communities

- **Affordability:** (1) private practice is not financially viable on bulk billing and patients are charged a private fee. The rural BB item number (10991) is only for Health Care cardholders and under 16-year-olds. The rebate is \$9 and even when added to standard item 23, it is about \$35 less than the private fee. (2) Patients have variable capacity to pay, which puts pressure on ED

- **Timeliness:** (1) there is a six to eight week wait for appointment with GP fellow at private practice, two weeks for GP registrars; two-week wait at Tully GP clinic; and the solo practice at Mission Beach has closed books

- **Systems to support quality primary healthcare:** while Tully Hospital GP Clinic has River Medical – (Communicare) in place, systems have not yet been operationalised to support health assessments and care plans. This is a focus of future work.

**The Tully Case Study highlights the ongoing challenges of building medical workforce capacity.** For private practice this includes the viability of the practice where it has fluctuating GP registrar numbers. This impacts on revenue and forward planning and difficulties attracting GP registrars where the practice is competing with Queensland Health medical awards, i.e. registrars take a pay drop when they leave the hospital setting (they now have a financial incentive to pursue the RG pathway). A similar issue is faced by Mamu Aboriginal Health Service.

Tully Hospital is seeking to become a GP/RG training practice but will need to become accredited under the Royal Australian College of General Practitioners (RACGP) standards. Currently there is very limited practice management capability within the HHS to support accreditation. However, consideration could be given to shared GP training positions between the hospital and Tully Medical Practice.

## 4 EVALUATION FINDINGS

When considered in the context of the access dimensions summarised above, the Initiative is not designed to address many of the factors continuing to impede access to primary healthcare at participating sites. Importantly, the Initiative cannot be expected to be sufficiently nuanced to address this range of access issues; this is because the Initiative is essentially designed to facilitate access to a funding stream (the MBS program), supported by some broad principles about how the accessed funds should be reinvested. The nature of this policy instrument design means the Initiative cannot be expected to solve the large variability in access issues that are experienced by different rural and remote communities; each of these communities has a unique combination of access issues.

We suspect the \$13.6 million of annual MBS top-up funding provided under the Initiative is relatively low when compared to the underlying health needs of the communities where the participating sites operate. But it would be misleading to not consider the extensive range of other services that are funded in these rural and remote areas; these include services funded or commissioned by RWAs, PHNs, NDIS, and locally available community support services delivered by LHNs and local government.

### Ongoing barriers to care: Summary assessment

Based on the analysis presented above, the evaluation team reached the following conclusions:

**Finding 24:** The Initiative program design – with its reliance on MBS billing to determine the level of top-up revenue to a site – does not vary resourcing according to a range of other underlying access problems encountered by communities residing in outer rural and remote areas; the mix of these problems is highly variable by site and relates to service availability of primary care services other than emergency care, geographic proximity to services, affordability, system navigation by patients, cultural acceptability, and health literacy.

**Finding 25:** It was beyond the scope of the project to assess levels of funding under the Initiative relative to the underlying health needs of the community where they operate. Such an analysis would require access to an extensive range of additional data sets. Comprehensive analysis of underlying needs assessment within a health service catchment would have to examine, *inter alia*: rates of chronic disease, complex conditions and avoidable hospital admissions, and access to non-medical primary healthcare, including services funded or commissioned by RWAs, PHNs, NDIS, and locally available community support services.

**Finding 26:** Although there are limitations on the capacity of the Initiative to address ongoing structural problems contributing to the underlying health needs of outer rural and remote communities, caution must be exercised. We are not advocating an unpicking of the current arrangements without certainty that better funding mechanisms could be implemented. A unilateral withdrawal of the current funding would have a harmful impact on access to primary healthcare services in locations currently receiving funding under the Initiative.

## SECTION E: OVERALL EVALUATION ASSESSMENT

Based on the detailed assessment provided above, the evaluation team formed the following overall assessment of the Initiative operations and its impacts presented below.

### Effectiveness

With respect to effectiveness in meeting overall objectives, we found that the Initiative improved access to urgent medical care and after-hours services at a large proportion of participating sites. It has also contributed to increased availability of primary care services in many locations. Much of the MBS revenue reinvestment was allocated to medical officer remuneration to support acute hospital emergency services.

## 4 EVALUATION FINDINGS

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Nationally MBS revenues under the Initiative represented in the order of 6% of modelled salaries and wages of participating sites, suggesting that the Initiative is, on average, a reasonably significant contributor to overall revenue of these sites. This proportion varied significantly by both site and jurisdiction.

Although the revenues provided under the Initiative are reasonably significant, the evaluation observed that the program is not a guarantee of an individual health service's long-term viability. Historical service delivery arrangements, industrial arrangements, gradual population decline in rural areas, and the sudden resignation of a key manager or clinician can all interact to threaten the sustainability of health services and compromise the models of clinical care available to some small communities.

### Program design and administration

Our examination of the program's design and administration found that there was strong support for the single eligibility criterion that public health services must be based in areas 5 to 7 of the Modified Monash Model geographical classification. There was also support for review mechanisms for sites that are no longer eligible under this criterion; clearer program objectives; and greater transparency in program operations, including publication of MOUs and formalised and regular engagement of site service providers with local stakeholders.

HMA considered that changes are needed to site reporting processes to make a clearer link between the operational plan, models of care and reinvestment. We suggest Operational Plans should be refreshed at least once within each MOU cycle.

### Appropriateness

Consideration of the Initiative's appropriateness observed that funding contributions to different sites resulting from the Initiative can be internally inequitable – larger sites with more salaried doctors have a greater ability to undertake MBS billing. This characteristic highlights a program impact that emerges from its inherent design; MBS revenues of a site are not directly linked to underlying health needs of a community. There is limited capacity to address this program characteristic – the foundation of the Initiative is primarily as a top-up to funding, enabled by access to MBS billing. Communities and health service providers need to access other funding sources to address local healthcare needs in a more targeted

way, including programs administered or commissioned by PHNs, RWAs, the NDIS and locally based service delivered by local providers such as local government and LHNs.

## 5 THE WAY FORWARD: OPTIONS FOR PROGRAM REFINEMENT

The findings from the evaluation suggest that changes to the current arrangements should be considered to ensure implementation of the Initiative:

- is responsive to the context in which it is operating
- is transparent about how it is being administered at Commonwealth, jurisdiction and site levels, and
- allows for potential benefits from the Initiative to be maximised.

In this chapter we outline a continuum of options.

### 5.1 OVERVIEW OF OPTIONS

The Initiative currently operates in four jurisdictions with differing industrial arrangements to engage their medical workforce. Capacity for revenue generation at a site level is largely dependent on medical workforce availability and associated local service delivery models.

There is variation in governance and administration of the Initiative between jurisdictions, as well as between LHNs within jurisdictions. External stakeholders identified the need for greater transparency in all aspects of the Initiative from application and operational planning to reinvestment decisions, facilitated by establishing a cycle of planning and review.

While the Initiative presents a revenue stream to local health services, the median quantum of MBS available for reinvestment available at a community level is relatively modest in the majority of sites. Partnering with local, regional or state-level agencies offers opportunities for joint planning, resource allocation and investment to maximise benefit derived from the Initiative.

Areas of improvement that we consider should be examined include:

- Clearer principles and objectives to guide the development and implementation of the Initiative in the jurisdictions (*Option 1*)

- Revised program governance arrangements (*Option 2*) that expand formalised and required engagement via:
  - *Option 2 (a)*: sub-regional (site level) governance committees, including stakeholders not currently specified in the MOU, such as RWA representatives and local community members, and
  - *Option 2 (b)*: a Commonwealth/jurisdiction bi-lateral governance committee (one for each participating jurisdiction)
- Establishing mechanisms to maximise benefit to communities through collaborative planning and co-investment by exploring the relationship with other Commonwealth and jurisdiction program investments in the town and its surrounding community (*Option 3*), and
- Administrative refinement to program processes (including formalised jurisdiction-level reporting on reinvestment and a mid-cycle review process for all plans) (*Option 4*).

These options have been designed to facilitate subsequent negotiation of the new MOU between the Commonwealth and jurisdictions. Parties will be able to explore priorities to progress program enhancement, but the structuring of the options allows for areas of debate/sticking points to be isolated so a consensus view can be more easily identified.

During stakeholder discussions for the evaluation, there was some support for larger changes to funding arrangements for small health services in rural and remote areas. These options for funding redesign raised included:

- Pooling of funds at a sub-regional level using revenues from the Initiative together with other relevant programs including RWAs, PHNs, NDIS, local government and LHNs, and
- Place based planning and service development.

## 5 THE WAY FORWARD: OPTIONS FOR PROGRAM REFINEMENT

These options were beyond the scope of this evaluation, which was to focus on the effectiveness, program rules and appropriateness of the Initiative.

After the detailed description of each option below we include a summary of the jurisdiction feedback on that option.

### **OPTION 1: ADMINISTRATIVE REFINEMENT OF THE INITIATIVE**

**Option scope and rationale:** the principles and objectives of the Initiative should be revised to provide greater clarity to guide the jurisdictions and service providers about their approach to implementation and reinvestment.

We suggest the following current principles be rephrased as a preamble for a future MOU, to provide a statement about the context for the Initiative and explaining why it was introduced in 2008 and continues to operate:

*The overarching purpose of the Initiative is to facilitate access to an additional funding stream from the Medical Benefits Schedule that can be applied to improve access to primary health care in response to identified local priorities*

- *Priorities for reinvestment in primary health care should be informed by local health and workforce needs assessment*
- *The Initiative seeks to promote the development of a local health workforce skilled to work in rural and remote communities*
- *Actions implemented under the Initiative should ensure the nexus between acute and primary health care delivery is strengthened at a local level*
- *Health professionals are a valuable and finite resource in rural and remote areas and need to be clinically capable of working in and across both settings*
- *Funding accessed through the Initiative should not undermine the viability and profitability of existing, privately operated health services including existing general practices.*

In addition, we recommend revised objectives for the MOU to provide greater clarity about the focus of the Initiative at a site level and inform reinvestment

decisions. Therefore, each site should be required to identify one or more priority objectives through their Operational Plan, including:

- *promote the provision of urgent medical care where access to this care is limited*
- *expand the availability of comprehensive team based primary care in rural and remote communities*
- *promote and support recruitment, training and development, and retention of a flexible health workforce to provide for models of care tailored to rural and remote populations and service environments*
- *assist in supporting the sustainability of rural and remote health services, and / or*
- *respond to identified primary care needs of the community.*

#### **BENEFITS OF OPTION 1**

- Provides clear direction that the development of primary healthcare and the primary healthcare workforce is the primary purpose of the Initiative
- Enables flexibility to target the Initiative in response to local context
- Focuses sustainability on rural health services rather than hospitals alone, recognising the interconnection of primary and secondary care in rural and remote areas

**Jurisdiction feedback on the option:** subject to further editing and refinement, there was overall support for this option from all jurisdictions, apart from WA. The latter jurisdiction requested additional consultation on the overall strategic intent of the Initiative.

### **OPTION 2: REVISE PROGRAM GOVERNANCE ARRANGEMENTS**

There are two sub-options within Option 2.

Option 2(a): sub-regional governance committees and local implementation committees.

**Option scope and rationale:** there should be revision to local governance of the program to further progress the intent of the Initiative and enable access to relevant



## 5 THE WAY FORWARD: OPTIONS FOR PROGRAM REFINEMENT

health and workforce needs assessment data to inform prioritisation and planning. This approach could also inform the foundation for collaborative planning to maximise the potential benefit of the Initiative (Option 3).

To facilitate this enhanced governance, we suggest a requirement for all sites to implement an organised structure of sub-regional stakeholders proximate to a site with representation from:

- LHD executive
- PHN executive
- RWA executive
- Aboriginal Community Controlled sector (where relevant)
- Local Government, and
- A community representative.

This sub-regional governance group would have responsibility to assess:

- site applications before submission
- develop and review operational plans
- approve reinvestment
- review the effectiveness of models of care developed under the Initiative where sites may no longer meet eligibility criteria (e.g. Stanthorpe Hospital situation) or where local stakeholders seek a revision to a site exemption
- review reports prior to submission to the jurisdiction.

The sub-regional governance committee should meet at least six monthly, with secretariat support provided by the LHN.

At a site level a local governance group should be formed with representation from the following:

- Health service facility manager
- Revenue clerk
- Participating GPs/ SMOs
- Community representative
- Other local health services (private providers, ACCHO)

The sub-regional governance group should have responsibility for overseeing local implementation, identifying and addressing operational issues, monitoring potential impact on local private, ACCHO and NGO services, and identifying local priorities for new investment. The local governance group should meet on a quarterly basis.

### BENEFITS OF OPTION 2(A)

The composition of the sub-regional and local governance group will enhance:

- Access to and input from local health and workforce needs assessments (PHN and RWAs) for evidence to inform reinvestment
- Identification and alignment with other programs, initiatives and funding opportunities that can be leveraged at site, sub-regional and regional level in conjunction with Initiative reinvestment to strengthen health service delivery, new models of care, and workforce development strategies that should be pursued
- Provision of local advice to jurisdiction and Commonwealth Departments to inform decisions in relation to changes in eligibility of sites
- Early identification of changes within the service system that may need to be considered in relation to the operation of the Initiative, e.g. a new private practice that may wish to establish, negotiation of items that can be claimed
- Provide transparency to local, sub-regional and regional stakeholders internal and external to the LHN for planning and implementation of the Initiative

**Jurisdiction feedback on the option:** there was not strong support for this option from any jurisdiction. The general view was that this option added a layer of governance that did not allow for consultative arrangements already in place at a health service level and/ or required under existing jurisdiction governance arrangements.

Option 2(b): a Commonwealth/jurisdiction bi-lateral governance committee should be established (one for each participating jurisdiction)

**Option scope and rationale:** the purpose of the Commonwealth/jurisdiction bi-lateral governance committee is to ensure both levels of government are informed of:



## 5 THE WAY FORWARD: OPTIONS FOR PROGRAM REFINEMENT

- Any changes in broader health policies that may impact on the operation of the Initiative
- Jurisdictions can inform the Commonwealth of changes in the status of participating sites that may affect:
  - Their eligibility and processes to deal with future transition (e.g. provides a process for managing cases like Stanthorpe Hospital)
  - The level of claims made at a site, e.g. resignation of a doctor
  - Changes in site governance arrangements
  - New proposals to enhance local level service integration, particularly those that require links across funding programs from the Commonwealth and jurisdictions.

The jurisdiction governance committee should meet at least once within each financial year of the MOU operation, ideally around the middle of the year, to progress consideration of new applications.

### BENEFITS OF OPTION 2(B)

The bi-lateral governance committees will ensure:

- continuity of information flow about the impact of the Initiative between levels of government over the life of the MOU
- Provide a mechanism to:
  - Better understand the rationale about new applications for participation by sites and the underlying model of care that is proposed for implementation
  - Review the ongoing status of sites that are no longer eligible and formulate a transition plan
  - Review reinvestment activities at a site level
  - Review the effectiveness of template tools and how they support the MOU implementation, including the form for new sites and the annual reporting template

**Jurisdiction feedback on the option:** jurisdictions support this option in principle but would seek to negotiate the precise role of a bi-lateral governance committee.

### OPTION 3: USE SUB-REGIONAL GOVERNANCE COMMITTEES AS A COORDINATION MECHANISM

**Option scope and rationale:** this option would expand the role of the sub-regional governance committees proposed in Option 2(a). Under Option 3 these committees would be tasked with identifying primary healthcare and workforce development priorities at the sub-regional level. This option would provide a mechanism to identify potential program resources available through the PHN, RWA, LHN that can be complemented by Initiative reinvestment to maximise reach or benefit.

PHN program resources within scope of the coordination activities could include:

- AOD services
- after-hours arrangements
- mental health programs, and
- chronic disease programs.

The RWA program resources considered by the sub-regional governance committee could include the Rural Health Outreach Fund and other Outreach programs.

In addition, the sub-regional governance committee could be empowered to develop sub-regional workforce training and development strategies where the Initiative contributes to and complements investments by RWAs, Universities, University Departments of Rural Health, and LHNs.

The workforce development role of the sub-regional governance committee could be expanded to promote the development of innovative employment models and Regional Workforce Modelling – an expansion of the ‘4Ts’ and the Murrumbidgee model. The underlying objective would be to support medical workforce development in a sub-region, aided by Initiative revenue to be invested in salaried positions.

## 5 THE WAY FORWARD: OPTIONS FOR PROGRAM REFINEMENT

### BENEFITS OF OPTION 3

In addition to benefits identified for Option 2 (a), this extension to sub-regional governance would ensure that:

- Funding through the Initiative complements use of resources from other relevant locally delivered programs and strengthens sustainability of resultant services and programs
- There is a mechanism for co-investment in workforce that can span primary and secondary care, which is essential for maintaining local health service capability (e.g. connection between midwives, theatre nurses and GP Obstetricians for the delivery of a comprehensive sub-regional maternity service)
- planning and investment to support smaller communities still occurs, even though access to revenue through the Initiative may be minimal

**Jurisdiction feedback on the option:** there was no support for this option from jurisdictions. The y considered it outside the scope of the Initiative.

### OPTION 4: ADMINISTRATIVE REFINEMENT TO PROGRAM PROCESSES

This option proposes a series of program rule refinements. These would be reflected in amendments to the next round of MOUs negotiated with jurisdictions, and adjustments to the Department's SOPs. Each individual refinement listed below can be considered as standalone option.

#### Option 4(a): Periodic refresh of operational plans

**Scope and rationale:** sites should be required to update the operational plan at least once an MOU cycle (at present the majority of sites are operating on plans that were cleared at the time of their original application, between 2008 and 2015).

### BENEFITS OF OPTION 4(A)

- The operational plan will more closely align with current circumstances, including changes to the level of local involvement of a range of other funding programs that may operate in a locality, including services funded or commissioned by RWAs, PHNs, NDIS, and locally available community support services
- Local stakeholders have an opportunity to reassess their position about the operation of the Initiative, based on changed local circumstances
- Annual reporting by sites would consider revised service delivery arrangements introduced since the original approval to participate in the Initiative

**Jurisdiction feedback on the option:** subject to further editing and refinement, there was overall support for this option from all jurisdictions.

Option 4(b): Processes for dealing with changes to site eligibility where a site no longer meets the eligibility criterion of being located in MMM 5 to 7

**Scope and rationale:** The current MOU contains no review mechanism to assess the impacts of removing a site's entitlement to participate in the Initiative. A transparent review process for sites that no longer meet the eligibility criterion would be welcomed if it could ensure ongoing stability in service delivery access. We suggest a structured review process to deal with such circumstances:

- The ineligible local site prepares a report on
  - what is being billed and delivered at the site under the Initiative arrangements
  - evidence that the Initiative has directly and measurably met the objectives of the program, and
  - local clinicians and stakeholders provide written support for ongoing continuation of the service delivery and billing arrangements.
- The review report could be submitted to the sub-regional governance committee proposed in Option 2(a).

## 5 THE WAY FORWARD: OPTIONS FOR PROGRAM REFINEMENT

- If there is ongoing support locally from the sub-regional governance committee, the review report could then be forwarded to the Commonwealth / jurisdiction committee proposed in Option 2(b). This would examine state or territory commitments to maintain and/or expand their contribution to the service, so that the scope of the Commonwealth role does not drift beyond facilitating access to MBS funding.

### BENEFITS OF OPTION 4(B)

- Subject to stakeholder support and jurisdiction commitment of funds, the proposed review mechanism could provide a pathway for ensuring service delivery arrangements are not disrupted by the change to eligibility status

**Jurisdiction feedback on the option:** subject to further editing and refinement, there was overall support for this option from all jurisdictions.

An alternative approach to dealing with ineligibility based on changed population levels of a town could be access to PHN support for innovative workforce models using RGs. This would avoid modifying the underlying population eligibility rule of the Initiative, which has strong stakeholder support.

### Option 4(c): Facilitating jurisdiction and site level knowledge sharing

**Scope and rationale:** at present extensive effort is involved in preparing local patient consent forms, check lists for in-scope MBS items, and application forms and processes for new registered provider numbers. New and existing sites are often unclear whether particular types of expenditure meet the reinvestment rules of the program.

An on-line clearing-house could be developed to store these materials and curate responses to site queries. One jurisdiction could be asked to support this on-line function on behalf of all participating jurisdictions.

### BENEFITS OF OPTION 4(C)

- Operation of an on-line clearing-house would reduce duplication of administrative effort at a site and jurisdiction level. The Commonwealth would

have a forum where it could distribute advice on rule interpretation and efficiently get feedback from jurisdictions and sites

**Jurisdiction feedback on the option:** there was overall support for this option from all jurisdictions. One jurisdiction (NSW) considered the clearing-house should be managed by the Commonwealth and a second (WA) said the resources shared must be consistent with Medicare and MOU requirements.

### Option 4(d): Jurisdiction reporting – revise the reporting template and submission processes

**Scope and rationale:** at present site annual reports are due by 31 August each year. Sites must list how the MBS funds received by the site were reinvested by categories specified in the MOU. The reporting template contains no link to the original Operating Plan.

Understanding of how the MBS funds are being used at a site level would be enhanced if submission and storage of annual report data were enabled by an online portal linked to a database to facilitate data management. Sites could enter their data online and edit this data up to the 31 August close-off. The database should contain links to the Operating Plan. Submissions should be required to explain how the reinvestment is in alignment with the Operating Plan or varies from the Plan.

The Commonwealth program area should produce annual reports on how the MBS funds have been reinvested at a site and jurisdiction level. This information could be shared with jurisdiction and sub-regional committees.

### BENEFITS OF OPTION 4(D)

- Transparency of how Initiative funds are reinvested would be increased and assist with local area resource planning and service development

**Jurisdiction feedback on the option:** there was support for the principles of this option but reservations about use of a portal by some jurisdictions because of perceptions this data collection method may increase administrative complexity.

# 6 APPENDICES

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## APPENDICES

### APPENDIX A DETAILED EVALUATION QUESTIONS SPECIFIED IN THE RFQ

The approach to data collection described in Chapter 3 was informed by the evaluation questions specified in the RFQ. This specified that the evaluation was to address two broad areas in relation to the Initiative:

- (1) **The underlying appropriateness / relevance of the program.** Within this area the RFQ states that the detailed evaluation questions to be answered are
  - (a) **Does the Section 19(2) Initiative continue to meet the need to improve access to primary care in rural and remote areas?**
    - (i) To what extent does this Program still contribute to resolving this issue?
    - (ii) Is this policy still the right response to the issues and context which led to its development?
    - (iii) To what extent does the Program remain contemporary in aligning with government approaches to primary healthcare delivery in rural and remote areas including the Innovative Employment Models trials and Sub-Regional Workforce Modelling activities currently being supported by Health Workforce Division, Commonwealth Department of Health.
  - (b) **Are the current Section 19(2) Initiative eligibility criteria appropriate?**
    - (i) Is the need for sites to be located in categories five through seven of the MMM classification system appropriate to achieve the Initiatives objectives?
    - (ii) Should the eligibility criteria be modified and if so, how should it be changed?
  - (c) **Are the current administrative arrangements and processes appropriate for management, accountability and transparency purposes and if not, how can these be improved?**
    - (i) Does the existing MOU provide both parties adequate explanation and clarity in terms of expectations?
    - (ii) Are the reporting requirements adequate in terms of measuring:
      - the impact of the Initiative and its appropriateness?
      - Site MBS billing accountability and appropriateness of claims?
    - (iii) Are the Department of Health administrative processes in terms of application assessment, approval, ongoing management and reporting adequate for review purposes?
- (2) **The effectiveness of the program.** Within this area the RFQ states that the detailed evaluation questions to be answered are:
  - a. **Do patients attending an approved eligible Section 19(2) site have improved access to primary healthcare services?**
    - i. Has the Section 19(2) Initiative improved patient access to primary care in approved sites?
    - ii. What barriers exist that still prevent patients from accessing primary healthcare services at an approved eligible Section 19(2) site?
  - b. **What effects has the MBS billing reinvestment had on approved eligible sites?**
    - i. Has the funding improved the provision and consistency of primary care initiatives at the sites and in what areas is it reinvested?
    - ii. Has there been an increase in primary healthcare community health programs in this location, and if so, can this be attributed to the Section 19(2) Initiative?
    - iii. Has the Section 19(2) Initiative improved workforce attraction and retention in eligible sites?

## APPENDICES

APPENDIX B LIST OF OTHER S19(2) EXEMPTION SITES

## S19(2) Exemptions Initiative in New South Wales

Categories of S19(2) Exemption, by Service / Location				
COAG	ACCHO	Indigenous Health	Murrumbidgee	RVTS
Barham MPS Batlow MPS Berrigan HS Bingara MPS Boorowa MPS Coolamon MPS Culcairn MPS Dungog Community Hospital Finley HS Gloucester Soldiers Memorial Hospital and CHC Gundagai MPS Guyra MPS Hay Hospital Henty MPS Hillston Hospital and HS Holbrook Hospital Jerilderie Hospital and HS Junee MPS Kyogle MPS Lake Cargelligo Hospital and HS Lockhart Hospital and HS Manilla MPS Merriwa MPS Murrumburrah-Harden Hospital and HS Narranderra HS Nimbin HS Nyngan Hospital and CHS Quirindi HS Scone Hospital and CHC	Aboriginal Medical Service Cooperative Limited, Redfern Albury Wodonga Aboriginal Health Service, Glenroy Armajun Aboriginal Health Service, Inverell Awabakal Ltd, Newcastle Biripi Aboriginal Corporation Medical Centre, Purfleet Bourke Aboriginal Health Service, Bourke Bulgarr Ngaru Medical Aboriginal Corporation, Grafton Bullinah Aboriginal Health Service, Ballina Condobolin Aboriginal Health Service Inc, Condobolin Coomealla Health Aboriginal Corporation, Dareton Coonamble Aboriginal Health Service, Coonamble Cummeragunja Housing & Development Aboriginal Corporation, Moama Durri Aboriginal Corporation Medical Service, Kempsey Galambila Aboriginal Health Service Inc, Coffs Harbour Griffith Aboriginal Medical Service Incorporated, Griffith Illawarra Aboriginal Medical Service, Wollongong Katungul Aboriginal Corporation Regional Health and Community Services, Narooma Maari Ma Health, Broken Hill Orange Aboriginal Medical Service Inc, Orange Pius X Aboriginal Corporation, Moree Riverina Medical & Dental Aboriginal Corporation, Wagga Wagga South Coast Medical Service Aboriginal Corporation Nowra Waminda South Coast Women's Health & Welfare Aboriginal Corporation, Nowra Tamworth Aboriginal Medical Service, Tamworth Tharawal Aboriginal Corporation Tobwabba Aboriginal Medical Service, Forster		Cootamundra Deniliquin Gundagai Narranderra Temora Young	Cobar Primary Health Care Centre Lake Cargelligo Family Practice



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Categories of S19(2) Exemption, by Service / Location				
COAG	ACCHO	Indigenous Health	Murrumbidgee	RVTS
Temora HS Tocumwal HS Tottenham MPS Trundle MPS Tullamore MPS Tumbarumba MPS Urana MPS Urbenville MPS Warialda MPS Wee Waa Hospital and CHC Wentworth Hospital West Wyalong Hospital Wilson Memorial Hospital Murrundi and Murrundi CHC	Walgett Aboriginal Medical Service, Walgett Walhallow Aboriginal Corporation Weigelli Centre Aboriginal Corporation, Woodstock Wellington Aboriginal Corporation Health Service, Wellington Werin Aboriginal Corporation Medical Clinic, Port Macquarie Yerin Aboriginal Health Services (Eleanor Duncan Aboriginal Health Centre), Wyong			

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## S19(2) Exemptions Initiative in Queensland

Categories of S19(2) Exemption, by Service / Location				
COAG	ACCHO	Indigenous Health	Murrumbidgee	RVTS
Babinda Hospital	Aboriginal and Torres Strait Islander Community Health	Thursday Island and Surrounding Communities		Badu Island PHC
Barcaldine MPS	Service Brisbane Ltd, Woolloongabba	Badu Island		Centre
Biggenden MPS	Aboriginal and Torres Strait Islander Community	Bamaga		Clermont Doctors
Blackall Hospital	Health Service Mackay Ltd, Mackay	Boigu Island		Surgery
Blackall MPS	Apunipima Cape York Health Council Limited, Bungalow	Dauan Island		Mt Isa – Gidgee
Boulia PHC	Bidgerdii Community Health Service, Rockhampton	Erub (Darnley) Island		Healing
Capella OC	Carbal Medical Services, Toowoomba	Iama (Yam) Island		
Cardwell CH	Charleville and Western Areas Aboriginal and Torres Strait	Kubin Island		
Childers MPS	Islander Community Health Limited, Charleville	Mabuiag Island		
Chillagoe PHC	Cherbourg Regional Aboriginal and Islander Community	Masig (Yorke) Island		
Chinchilla HS	Controlled Health Service, Cherbourg	Mer Island		
Collinsville Hospital	Cunnamulla Aboriginal Corporation for Health, Cunnamulla	Moa (St Pauls) Island		
Dimbulah PHC	Galangoor Duwalami Primary Healthcare Service Ltd, Pialba	Ngurapai (Horn) Island		
Dirranbandi MPS	Gindaja Treatment and Healing Indigenous Corporation,	Poruma (Coconut) Island		
Eidsvoll HS	Yarrabah	Saibai Island		
Gayndah Hospital	Goolburri Aboriginal Health Advancement Corporation,	Sibuwani Ngurpai Meta		
Gemfields OC	Toowoomba	Waiben (Thursday) Island		
Gin Gin Hospital	Goondir Health Service, Dalby	Warraber Island		
Hughenden HC	Gurriny Yealamucka Health Services Aboriginal	Injinoo		
Inglewood MPS	Corporation, Yarrabah	New Mapoon		
Injune HS	Indigenous Wellbeing Centre Ltd, Bundaberg	Umagico		
Isisford PHC	Institute for Urban Indigenous Health Ltd, Bowen Hills	Seisia		
Jandowee HS	Kalwun Health Service, Miami	Aurukun		
Jundah PHC	Kambu Aboriginal and Torres Strait Islander Corporation for	Coen		
Longreach Hospital	Health, Ipswich	Cooktown		
Miles HS	Mamu Health Service Limited, Innisfail	Hope Vale		
Millmerran MPS	Mookai Rosie Bi-Bayan (Aboriginal & Torres Strait Islanders	Kowanyama		
Millmerran MPS	Corporation), Edmonton	Laura		
Outreach (Cecil Plains)	Mount Isa Aboriginal Community Controlled Health Services	Lockhart River		
Mitchell Hospital	Ltd (Gidgee Healing), Mt Isa	Mapoon		
Monto HS	Mulungu Aboriginal Corporation Primary Health Care	Napranum		
Mossman MPS	Service, Mareeba	Pormpuraaw		
Mundubbera HS	Nhulundu Health Service, Gladstone	Weipa		
Mungindi MPS	North Coast Aboriginal Corporation for Community Health,	Wujal Wujal		
Nanango HS	Birtinya	Jumbun		

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Categories of S19(2) Exemption, by Service / Location			
COAG	ACCHO	Indigenous Health	Murrumbidgee RVTS
Oakey HS	NPA Family and Community Services Aboriginal and	Yarrabah	
Proserpine Hospital and	Torres Strait Islander Corporation, Bamaga	Woorabinda	
CHC	Townsville Aboriginal and Islander Health Services, Garbutt	Cherbourg	
Quilpie MPS	Wuchopperen Health Service Ltd, Manoora	Goondiwindi	
Richmond HC	Yulu-Burri-Ba Aboriginal Corporation for Community Health,	North Stradbroke Island	
Springsure MPS	Dunwich	The Southern Queensland Centre of	
Stanthorpe Hospital		Excellence	
Surat Hospital		in Aboriginal and Torres Strait Islander Primary	
Tambo PHC		Health Care, Inala	
Tara Hospital		Charleville	
Taroom Hospital		Cunnamulla	
Tully Hospital		Ayr	
Wallumbilla HS		Home Hill	
Windorah PHC		Palm Island	
Winton MPS		Burketown	
		Cloncurry	
		Camooweal	
		Dajarra	
		Doomadgee	
		Julia Creek	
		Karumba	
		Mornington Island	
		Normanton	

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## S19(2) Exemptions Initiative in Western Australia

Categories of S19(2) Exemption, by Service / Location				
COAG	ACCHO	Indigenous Health	Murrumbidgee	RVTS
Bridgetown Hospital Carnarvon Hospital Derby Hospital Exmouth HS Fitzroy Crossing HS Halls Creek Hospital Jerramungup HC Katanning HS Kununurra District Hospital Laverton District Hospital Leonora District Hospital Meekatharra Hospital Norseman District Hospital Onslow Hospital Plantagenet HS Shark Bay Nursing Post Warmun HC Warren HS Wyndam District Hospital	Bega Garnbirringu Health Service Incorporated, Kalgoorlie Broome Regional Aboriginal Medical Service, Broome Derbarl Yerrigan Health Service, East Perth Derby Aboriginal Health Service, Derby Geraldton Regional Aboriginal Medical Service, Rangeway Kimberley Aboriginal Medical Services, Broome Mawarnkarra Health Service, Roebourne Ngangganawili Aboriginal Health Service, Wiluna Ord Valley Aboriginal Health Service Corporation, Kununurra Paupiyala Tjarutja Aboriginal Corporation Tjuntjuntjara Community, Kalgoorlie Puntukurnu Aboriginal Medical Service, Newman South-West Aboriginal Medical Service Aboriginal Bunbury Wirraka Maya Health Service Aboriginal Corporation, South Hedland Yura Yungi Medical Service Aboriginal Corporation, Halls Creek			Fitzroy Crossing – Fitzroy Valley HS

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## S19(2) Exemptions Initiative in the Northern Territory

Categories of S19(2) Exemption, by Service / Location				
COAG	ACCHO	Indigenous Health	Murrumbidgee	RVTS
Adelaide River HC Batchelor HC Gove District Hospital Jabiru CHC Katherine Hospital Tennant Creek Hospital Yulara HS	Ampilatwatja Health Centre Aboriginal Corporation, Ampilatwatja Community Anyinginyi Health Aboriginal Corporation, Tennant Creek Bagot Community Health Centre, Ludmilla Central Australian Aboriginal Congress, Alice Springs Danila Dilba Health Service, Darwin Katherine West Health Board Aboriginal Corporation, Katherine Laynhapuy Homelands Aboriginal Corporation, Yirrkala Mala'la Health Service Aboriginal Corporation, Maningrida Marthakal Homeland and Resource Centre Association, Galiwinku Miwatj Health Aboriginal Corporation, Nhulunbuy Naaanvatiarra Health Services, Alice Springs Nganampa Health Council Inc, Alice Springs Pintupi Homelands Health Service, Kintore Sunrise Health Service Aboriginal Corporation, Katherine Urapuntja Health Service, Utopia Wurli-Wurlinjang Health Service, Katherine	Belyuen CHC, Cox Peninsula Maningrida CHC Minjilang (Croker Island) CHC Nauiyu Nambiyu (Daly River) CHC Nganmariyanga (Palumpa) CHC Oenpelli (Gunbalanya) CHC Peppimenarti CHC Wadeye (Port Keats) CHC Warruwi (Goulburn Is) CHC Woodycupaldiya CHC, Daly River Binjari CHC, Katherine Numbulwar Health Centre Pine Creek CHC Robinson River CHC Alyangula (Groote Eylandt) HC Angurugu CHC Gunyangara (Marngarr) CHC Laynhapuy Homelands HC Milingimbi CHC Milyakburra (Bickerton Is) CHC Umbakumba CHC Yirrkala CHC  Alpurrurulam (Lake Nash) CHC Amunturmgu (Mt Liebig) CHC Aputula (Finke) CHC Atitjere (Harts Range) CHC Bonya (Baikal Bonja) CHC Engawala (Alcoota) CHC Ikuntji (Haasts Bluff) CHC Kaltukatjara (Docker River) CHC Imanpa Community Laramba (Napperby) CHC Ntaria (Hermannsburg) CHC Nturiya (Ti Tree Station) CHC		

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Categories of S19(2) Exemption, by Service / Location				
COAG	ACCHO	Indigenous Health	Murrumbidgee	RVTS
		Nyirripi (Waite Creek) CHC Papunya CHC Pmara Jutunta (Ti Tree 6 mile) CHC Tara (Neutral Junction) CHC Ti Tree CHC Titjikala (Maryvale) CHC Utju (Areyonga) CHC Wallace Rockhole Health Centre Watarrka (Kings Canyon) CHC Wilora (Stirling) CHC Wirilyatjarrayi (Willowra) HC Yuelamu (Mt Allen) CHC Yuendumu CHC Ali Curung/ Alekarenge (Warrabi) CHC Barkly Mobile Canteen Creek (Orwatijilla) HC Elliott CHC Epenarra (Wutunugurra) HC Borroloola Borroloola Health Clinic Tiwi Islands Julanimawu Milikapiti HC Pirlangimpi		



## APPENDICES

## S19(2) Exemptions Initiative in South Australia, Victoria, Tasmania and Australian Capital Territory

Categories of S19(2) Exemption, by Service / Location				
	ACCHO	Indigenous Health	Murrumbidgee	RVTS
South Australia	Yadu Health Aboriginal Corporation, Ceduna Moorundi Aboriginal Community Controlled Health Service Incorporated, Murray Bridge Nunukuwarrin Yunti of South Australia Incorporated, Adelaide Nunyara Aboriginal Health Service Inc, Whyalla Stuart Oak Valley (Maralinga) Aboriginal Corporation Inc, Ceduna Pangula Mannamurna Aboriginal Corporation Inc, Mount Gambier Pika Wiya Health Service Aboriginal Incorporated, Port Augusta Port Lincoln Aboriginal Health Service Inc, Port Lincoln Tullawon Health Service Incorporated, Yalata Umooona Tjutagku Health Service Aboriginal Corporation, Coober Pedy			Mid-Eyre Medical Centre-(4 locations) Cleve, Kimba, Elliston, Cowell Streaky Bay and District Medical Centre
Victoria	Ballarat & District Aboriginal Cooperative, Ballarat Bendigo and District Aboriginal Cooperative, Bendigo Budja Budja Aboriginal Cooperative, Halls Gap Dandenong and District Aborigines Cooperative Ltd - Bunurong Health Services, Dandenong Dhauwurd-Wurrung Elderly & Community Health Service Inc, Portland First Peoples Health and Wellbeing, Thomastown Gippsland & East Gippsland Aboriginal Cooperative Ltd, Bairnsdale Goolum Goolum Aboriginal Cooperative, Horsham Gunditjmara Aboriginal Cooperative, Warrnambool Kirrae Health Service Incorporated, Purnim Lake Tyers Health and Children's Services Association, Lakes Tyers Mallee District Aboriginal Services, Mildura Moogji Aboriginal Council East Gippsland Inc, Orbost Murray Valley Aboriginal Cooperative, Robinvale Njernda Aboriginal Corporation, Echuca Ramahyuck District Aboriginal Corporation, Sale Rumbalara Aboriginal Cooperative Ltd, Mooroopna Victorian Aboriginal Health Service Co-operative, Fitzroy Wathaurong Aboriginal Cooperative, North Geelong Winda-Mara Aboriginal Corporation, Heywood			Robinvale District Medical Centre
Tasmania	Flinders Is Aboriginal Assoc, Barron			Smithton – Ochre Med Centre

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Categories of S19(2) Exemption, by Service / Location				
	ACCHO	Indigenous Health	Murrumbidgee	RVTS
	South East Tasmanian Aboriginal Corporation, Cygnet Tasmanian Aboriginal Centre Inc, Hobart			
ACT	Winnunga Nimmityjah AHS, Narrabundah			

## APPENDICES

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### APPENDIX C AUSTRALIAN GOVERNMENT PROGRAMS TARGETING DEVELOPMENT OF THE RURAL WORKFORCE

On the following pages (see Table 6.1 and Table 6.2) we outline current Australian Government policies and programs to increase the size of the rural health workforce.

Note that many of the programs described in the tables have had previous iterations or may be an amalgamation of earlier initiatives.

## APPENDICES

**Table 6.1:** Australian Government rural health workforce training and professional development initiatives

YEAR	POLICY	FOCUS	STRATEGY AND ACTIVITIES
1997 and ongoing	<b>Rural Health Multidisciplinary Training Program</b> – previously the University Department of Rural Health Program and the Rural Clinical Training Support Program	To provide infrastructure and academic network in regional, rural and remote areas to improve the distribution of the health workforce through the delivery of rural training experience.	16 UDRHs and 19 RCSs establish and maintain networks of rural clinical supervisors and placements to expose undergraduate medical and health professional students to rurally based clinical training and practice to promote interest in, and uptake of, a rural health career.
2016	<b>Rural Locum Assistance Program</b> funded under the Health Workforce Program – administered by Aspen Medical since April 2016 with an annual appropriation of around \$11.5 million (currently to June 2022).	To enhance ability of specialists (obstetrics and anaesthetics), procedural GPs, nurses and allied health professionals in rural Australia to undertake leave for recreation or to undertake continuing professional development.	Supports eligible rural health professionals to access CPD or take leave, metro-based GPs to upskill in emergency medicine to better prepare for rural locum work, and urban based health professionals to experience rural practice by undertaking a locum.
2017	<b>Health Workforce Scholarship Program</b>	To increase access to health services in rural and remote areas where there is skill shortage. This program replaced a number of scholarship programs including Nursing and Allied Health Scholarship Support Scheme and Rural Australian Medical Undergraduate Scheme.	Provides bursaries and scholarships to existing health professionals committed to rural service. RWA administer program (\$33 m over three years to June 2020) to deliver HWSP in MMM 3–7. Informed by the RWA’s Health Workforce Needs Assessment.
2017	<b>Rural Workforce Support Activity – Go Rural</b>	Grow the sustainability and supply of the health workforce.	RWAs engaging with Rural Health Clubs to promote careers to rural secondary school students; university student rural immersion activities; Supporting clinical placements for nursing and allied health students; linking students with mentors to guide rural journey.
2018	<b>John Flynn Prevocational Doctor Program (JFPDP)</b> – announced as part of the 2021-22 Federal Budget	The JFPDP will commence from 1 January 2023 and will consolidate the two funding streams (core and Rural Generalist) under the Rural Junior Doctor Training Innovation Fund (RJDITIF). The RJDITIF arrangements will continue until 31 December 2022. JFPDP will expand the number of rural primary care rotations available each year and increase rural primary care rotations for hospital-based	Will boost the required training capacity in Australia, for the next generation of doctors and will ensure the supply of junior doctor positions in primary care settings better meet projected demand by increasing the rural training opportunities and exposure to a career in general practice.

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YEAR	POLICY	FOCUS	STRATEGY AND ACTIVITIES
		prevocational doctors (Postgraduate Year 1-5) in rural areas.	
2018	<b>Stronger Rural Health Strategy – Bonded Medical Programs</b> (reformed).	Aim of the reform is greater flexibility and more support for bonded doctors and better target return of service to underserviced areas in most need.	From 1 January 2020, participants of Bonded Medical Program can complete Return of Service Obligation through working in eligible location in MMM 2–6, Distribution Priority Areas (DPA) for GPs areas, outer Metro and Districts of Workforce Shortages for the participants chosen specialty.
2018	<b>Stronger Rural Health Strategy – Strengthening the role of the nursing workforce</b>  <b>Train in the region, stay in the region</b>	Nursing in Primary Health Care (NiPHC)  Murray-Darling Medical Schools Network	This program aims to build capacity among the primary health care (PHC) nursing workforce by promoting employment of, and providing support to, nurses working in PHC settings. There are three components to this Program: the Transition to Practice Program, which aims to increase the confidence, skills and knowledge of recently graduated, and experienced, nurses starting work in primary healthcare settings; the Building Nurse Capacity project, which aims to build the capacity of primary healthcare teams by optimising the role of nurses in care delivery; and the Chronic Disease Management and Healthy Ageing workshops, which aim to support the professional development of nurses by providing evidence-based, best practice education on management of chronic diseases and healthy ageing for nurses working in primary healthcare.  Establishing five rural medical school programs in the Murray-Darling region of NSW and Victoria, to provide end-to-end medical training in rural areas to improve the future distribution of the medical workforce.
2018	<b>Stronger Rural Health Strategy – Support for Aboriginal and Torres Strait Islander Health Professional Organisations</b>	This aims to build and support the Aboriginal and Torres Strait Islander health workforce and continue to increase the cultural capability of the broader health workforce to better meet the needs of Aboriginal and Torres Strait Islander people.	This initiative funds a variety of activities, including training, mentoring, support, and activities to promote health careers to Aboriginal and Torres Strait Islander people.
2018	<b>More Doctors for Rural Australia Program (MDRAP)</b>	The MDRAP is a workforce program designed to support non-vocationally recognised (non-VR) doctors to deliver general practice services in rural	Non vocationally registered doctors participating in the program will be able to access a Medicare benefit while working toward entry to a fellowship program.

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YEAR	POLICY	FOCUS	STRATEGY AND ACTIVITIES
		and remote Australia and prepares them to join a formal fellowship pathway. Overseas and Australian trained doctors are eligible to join the MDRAP.	
2018	<b>National Rural (Medical) Generalist Pathway</b>	To improve workforce supply by coordinating the training pipeline for rural generalists to deliver quality healthcare in rural, remote and regional communities (focusing on MMM 3–7)	Facilitate a coordinated and efficient medical training pathway with nationally recognised skills. Establish or expand coordination units within each jurisdiction to bridge the gap between national objectives and regional programs. Expansion of the Rural Junior Doctor Training Innovation Fund (RJDITIF) will support the pathway. The Commonwealth has provided funding for 100 RG GP training positions commencing 2021. These will be delivered through the Australian College of Rural and Remote Medicine (ACRRM) Rural Generalist Training Scheme (RGTS).
2020	<b>Allied Health Rural Generalist Workforce and Education Scheme (AHRGWES)</b> – Managed by Services for Australian Rural and Remote Allied Health	To extend the Allied Health Rural Generalist training pathway to non-government organisations and private practices working in aged care, disability and primary healthcare.	This is a pilot program running to December 2021, supports 40 new graduates and early career health professionals to develop clinical and non-clinical skills to provide safe and high-quality healthcare in rural and remote settings. The AHRGWES provides a Workplace Training Grant to the employing organisation to provide intensive support and supervision and scholarship to the trainee to complete formal accredited training.
2018	<b>Remote Health Workforce Education, Support &amp; Professional Services Program</b>	Support to health professionals working in remote areas, or other circumstances of professional isolation, with education, mental health and well-being support, and professional services that are relevant to their context of practice.	Supports the provision of: relevant education, training and professional development opportunities for health professionals working in remote and isolated areas of Australia; mental health and wellbeing support to remote healthcare professionals (and their families); and professional services contributing to the recruitment and retention of a stable remote health workforce.



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**Table 6.2:** Financial incentives to support rural health workforce attraction, recruitment and retention

YEAR	POLICY	FOCUS	STRATEGY AND ACTIVITIES
2017	<b>Rural Workforce Support Activity</b> managed by Rural Workforce Agencies (RWAs)	Aims to improve access and continuity of access to essential primary healthcare.	Providing locum support to GPs, private allied health providers and nurses and relocation grants.
2020	<b>Stronger Rural Health Strategy – Workforce Incentive Program (transitioning from the GP Rural Incentive Program and Practice Nurse Incentive Program)</b>	The Workforce Incentive Program (WIP) provides targeted financial incentives to encourage doctors to deliver services in rural and remote areas (Doctors Stream). The WIP also provides financial incentives to support general practice to engage the services of nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals (Practice Stream).	From 1 January 2020, eligible medical practitioners in MMM 3–7 locations receive annual incentive payment of between \$4,500 and \$60,000 under the WIP – Doctors Stream.  From 1 February 2020, eligible general practices can claim up to \$125,000 per year to engage eligible health professionals for a combined minimum of 63 hours and 20 minutes per week under the WIP – Practice Stream. In addition, practices located in Modified Monash 3–7 receive a rural loading in addition to the incentive payment, in recognition of the difficulties rural and regional areas face attracting and retaining health professionals. Different levels of rural loading will apply depending on the rurality of the practice.
2020	<b>MDRAP Support Activity</b>	Managed by RWAs – enhances the implementation of the MDRAP by providing funding to support supervision and education needs for MDRAP doctors.	Doctors within the program will be provided with tailored learning and supervision to meet their needs and that of their region. This will ensure the safe delivery and quality of care is of the highest standard.

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APPENDIX D LIST OF STAKEHOLDERS CONSULTED**Table 6.3:** Stakeholders consulted – Departmental, RWA and peak bodies

STATE	NAME	TITLE	ORG/DEPARTMENT/AREA
<b>Internal contacts, Department of Health</b>			
	Sandra Downie	Assistant Director	Health Care Homes Governance, Reporting and Engagement Section
	Alan Stephen	Departmental Officer	Health Care Homes Governance, Reporting and Engagement Section
	James Newhouse	Assistant Director	Geospatial and Hospital Analytics - HERD
	Loc Thai	Director	Geospatial and Hospital Analytics - HERD
	Emma Rowland	Assistant Director	Primary Health Care Policy Section, Indigenous Health Division
	Tony Lawrence	Assistant Director	MBS Analytics SN
	David Nott	Director	Provider Benefits Integrity and Digital Health Division - Director, Public Hospital Compliance Section, Compliance Audit and Education Branch
	Rohan Sanders	Departmental Officer	Provider Benefits Integrity
	Michael Ryan	Director	Diagnostic Imaging Section, Diagnostic Imaging and Pathology Branch, Medical Benefits Division
	Fifine Cahill (with Louise Larcon)	Assistant Secretary	National Health Reform Branch
	Professor Ruth Stewart	National Rural Health Commissioner	NHRC
	Gayle Nicholson	Senior Policy Officer	Medicare Providers, Services Australia
	Emma Phelan (written comments)	Director	Health Training Branch, HWA
	Tino Rizzo	Acting Director	GP Systems, Health Training Branch (Single Employer Trials)
	Louise Clarke	Assistant Secretary	Rural Access Branch, HWA
	Kathryn Yuile	Director	Health Workforce Strategic Policy Section, Health Workforce Reform Branch
<b>Jurisdictions</b>			
NSW	Josephine Hull	Senior Policy Officer	Strategic Reform and Planning Branch
NSW	Michelle Maxwell	Director, Strategic Change	Strategic Reform and Planning Branch
NSW	Samantha Reid	–	–
NT	Anthony Burton	Director	Intergovernmental Relations and Ageing
NT	Melissa Brooke	–	–
NT	Maja Van Bruggen	Director, Revenue Management	–
WA	James Thomas	Executive Director	Health Programs WACHS
WA	Anna McDonald	Project Coordinator	Health Programs WACHS
QLD	Ricky Barker	Principal Advisor	Revenue Strategy and Support Unit, Queensland Health
QLD	Karie Karvourn	–	Office of Rural Health

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STATE	NAME	TITLE	ORG/DEPARTMENT/AREA
<b>Non-participating jurisdictions</b>			
SA	Katie Bourke, Skye Jacobi, Hendrika Meyer	Principal Policy Officer	Strategy and Intergovernment Relations
SA	Chris McGowan	Chief Executive	Department for Health and Wellbeing
<b>Potential new States and Territories</b>			
VIC	Kate Boucher	Principal Policy Advisor /Allied Health Workforce	Health Workforce Policy
VIC	Nicola Farray	Director Commissioning and System Improvement	Victorian Department of Health
VIC	Catherine Harmer	Manager Rural Policy	Victorian Department of Health
VIC	Praveen Sharma	Project Director Healthcare Worker Protections	Medical Workforce
TAS	Rebekah Moore	N/A	Government Relations and Strategic Policy
TAS	Erin Taylor	Branch Manager	Government Relations and Strategic Policy
<b>Rural workforce agencies</b>			
QLD	Chris Mitchell	Chief Executive Officer	Health Workforce
WA	Tim Shackleton	Chief Executive Officer	Rural Health Workforce
WA	Kelli Porter	General Manager	Workforce - Rural Health Workforce
NT	Heather Keighley	-	Northern Territory PHN - Workforce
NT	Paul Connolly	-	Northern Territory PHN
NT	Robin Moore	Executive Director	Northern Territory PHN - Workforce
SA	Lyn Poole	Chief Executive Officer	Rural Doctors Workforce Agency
NSW	Richard Colbran	Chief Executive Officer	Rural Doctors Network
NSW	Michael Edwards	Policy Officer	Rural Doctors Network
<b>Peak bodies</b>			
	Pat Turner	Chief Executive Officer	NACCHO [written submissions requested]
	Peta Rutherford	Chief Executive Officer	Rural Doctors Association [discussion and written submissions received 31 May 2021]

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**Table 6.4:** Case study sites – stakeholders consulted

	NSW			QLD			WA		NT		Additional Sites	
	Nyngan	Quirindi	Temora	Tully	Longreach	Proserpine	Kununurra	Meekatharra	Tennant Creek	Jabiru	Gundagai	Babinda
<b>LHN</b>												
Chief Executive Officer (CEO)	✓	✓	✓	✓	✓							
Director, Medical Services	✓	✓	✓	✓	✓						✓	✓
Director, Finance	✓	✓	✓		✓							
Director, Primary Care			✓		✓							
Director/GM, Rural Services	✓	✓		✓		✓	✓	✓	✓	✓		
Director, Operations			✓				✓	✓	✓	✓		
Director, Allied Health					✓		✓	✓				
Director/ Manager, Innovation, Improvement, Change, Infrastructure	✓		✓		✓							
<b>PHN</b>												
CEO	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Executive Manager, Capability/ Innovation/ Improvement		✓		✓	✓	✓	✓	✓	✓	✓		
<b>Health Service</b>												
Health Service Manager	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Revenue Manager or Clerk	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Medical Officer	✓			✓	✓	✓	✓	✓	✓	✓		
<b>Private Practice</b>												
Practice Manager			✓	✓	✓						✓	✓
Practice Principal			✓				✓	✓			✓	✓
GP			✓	✓								
<b>Local ACCHO</b>		✓		✓			✓					
<b>RWA</b>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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## APPENDIX E MBS CLAIMS – FRAMEWORK FOR AGGREGATING INDIVIDUAL ITEMS

Definitions of the item categorisation used to derive aggregated items used in the MBS data analysis are given in Table 6.5.

**Table 6.5:** MBS data specification

S19(2) MBS Item aggregated category	MBS groups / subgroups	Associated variables
<b>'Non-Referred Attendances, 'NRA' (A/hrs and EPC to be separated out but retained as aggregated sub-category)'</b>	GROUP(S) A01, A02, A05, A06, A07, A11, A14, A17, A18, A19, A20, A22, A23, A27, A30, A34, A35, A39, A41, SUBGROUP(S) A1501, A3601, A3604, A4001, A4002, A4003, A4010, A4011, A4012, A4013, A4014, A4015, A4016, A4019, A4020, A4021, A4022, A4027, A4028, A4029, A4030, ITEM(S) 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035, 5036, 5042, 5044, 735, 739, 743, 747, 750, 758, 90264, 90265, 92170, 92171, 92176, 92177	Jurisdiction
		Date of service provision
		Service location
<b>Non-referred attendances – Practice Nurse</b>	GROUP(S) M12, SUBGROUP(S) M1823, M1824	
<b>Other Allied Health</b>	GROUP(S) M03, M06, M07, M08, M09, M10, M11, M15, M16, M17, M25, M26, SUBGROUP(S) M1801, M1802, M1803, M1804, M1806, M1807, M1808, M1809, M1811, M1812, M1813, M1814, M1815, M1816, M1817, M1818, M1819, M1820, M1821, M1822, M1825, M1826	
<b>Specialist attendances</b>	GROUP(S) A03, A04, A08, A09, A12, A13, A24, A26, A28, A29,	

S19(2) MBS Item aggregated category	MBS groups / subgroups	Associated variables
	A31, A32, A33, T06, SUBGROUP(S) A3602, A4004, A4005, A4006, A4007, A4008, A4009, A4017, A4018, A4023, A4024, A4031, A4032, A4033, A4034, A4035, A4036, A4037, A4038, ITEM(S) 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5039, 5041, 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864, 866, 871, 872, 880, 90266, 90267, 90268, 90269, 92172, 92173, 92178, 92179	
<b>Obstetrics</b>	GROUP(S) T04	
<b>Anaesthetics</b>	GROUP(S) T07, T10	
<b>Pathology</b>	GROUP(S) P10, P11, P13 GROUP(S) P01, P02, P03, P04, P05, P06, P07, P08, P09, P12	
<b>Diagnostic Imaging</b>	GROUP(S) I01, I02, I03, I04, I05, I06	
<b>Operations</b>	GROUP(S) T08	
<b>Radiotherapy and Therapeutic Nuclear Medicine</b>	GROUP(S) T02, T03	
<b>Other MBS services</b>	GROUP(S) C01, C02, C03, D01, D02, M01, M13, M19, O01, O02, O03, O04, O05, O06, O07, O08, O09, O11, T01, T11	
<b>Nurse Practitioners</b>	Group M14, SUBGROUP(S) M1805, M1810	
<b>After Hours Non-Referred Attendances</b>	Identified as separate sub-categories of items.	
<b>Enhanced Primary Care</b>		

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## APPENDIX F MBS BENEFITS PAID UNDER THE INITIATIVE, 2019–20, BY JURISDICTION &amp; AGGREGATED CATEGORY

Table 6.6: NSW MBS benefits paid by aggregated MBS categories of all participating sites (n=36)

MBS Aggregated Categories	Total claims for all sites	Percent of total for all sites	Mean claims per site (\$)	Median claims, per site (\$)	Range of values, all sites (min and max)	No. of sites with zero claims
<b>1. Non-referred Attendance) – common items</b> (e.g. 3, 23, 36, 44)	\$565,991	27.9%	\$15,722	\$12,831	\$0–\$75,656	0
<b>2. After-hours Non-referred Attendance</b>	\$1,221,034	60.1%	\$33,918	\$19,515	\$0–\$217,057	1
<b>3. Assessment related items, including disease management and other primary care professionals (sub-total)</b>	\$13,705	0.6%	\$63	\$0	\$0–\$3,980	
<i>3a. A14 (Health Assessments)</i>	\$0	0.0%	\$0	\$0	\$0–\$0	36
<i>3b. A15 (GP care plans)</i>	\$409	0.0%	\$11	\$0	\$0–\$263	34
<i>3c. A20 (GP mental health treatment)</i>	\$2,912	0.1%	\$81	\$0	\$0–\$1,311	27
<i>3d. Nurse Practitioner</i>	\$8,841	0.4%	\$246	\$0	\$0–\$3,980	28
<i>3e. Practice Nurse</i>	\$90	0.0%	\$3	\$0	\$0–\$6	34
<i>3f. Allied Health</i>	\$1,453	0.1%	\$40	\$0	\$0–\$1,453	35
<b>4. Other MBS items (sub-total)</b>	\$230,343	11.3%	\$914	\$0	\$0–\$24,898	
<i>4a. Anaesthetics</i>	\$153	0.0%	\$4	\$0	\$0–\$153	35
<i>4b. Pathology</i>	\$0	0.0%	\$0	\$0	\$0–\$0	36
<i>4c. Diagnostic Imaging</i>	\$0	0.0%	\$0	\$0	\$0–\$0	36
<i>4d. Operations</i>	\$74,548	3.7%	\$2,071	\$1,277	\$0–\$10,461	2
<i>4e. Obstetrics</i>	\$678	0.0%	\$19	\$0	\$0–\$556	32
<i>4f. Specialist Services</i>	\$0	0.0%	\$0	\$0	\$0–\$0	36
<i>4g. Other MBS</i>	\$154,964	7.6%	\$4,305	\$2,513	\$0–\$24,898	2
<b>Total</b>	\$2,031,073	100%	\$56,419	\$34,134	\$76–\$303,368	



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**Table 6.7:** QLD MBS benefits paid by aggregated MBS categories of all participating sites (n=39)

MBS Aggregated Categories	Total claims for all sites	Percent of total for all sites	Mean claims per site (\$)	Median claims, per site (\$)	Range of values, all sites (min and max)	No. of sites with zero claims
<b>1. Non-referred Attendance(sub-total) – common items (e.g. 3, 23, 36, 44)</b>	\$2,698,422	50.1%	\$69,190	\$23,197	\$0–\$430,238	1
<b>2. After-hours Non-referred Attendance – common items (sub-total)</b>	\$1,474,463	27.5%	\$38,096	\$20,315	\$0–\$295,586	5
<b>3 Assessment related items, including disease management and other primary care professionals (sub-total)</b>	\$113,454	2.2%	\$905	\$0	\$0–\$41,282	
<i>3a. A14 (Health Assessments)</i>	\$11,029	0.2%	\$703	\$0	\$0–\$5,191	31
<i>3b. A15 (GP care plans)</i>	\$31,729	0.6%	\$1,233	\$0	\$0–\$17,453	30
<i>3c. A20 (GP mental health treatment)</i>	\$14,262	0.3%	\$786	\$0	\$0–\$3,059	20
<i>3d. Nurse Practitioner</i>	\$52,392	1.0%	\$1,763	\$0	\$0–\$41,282	29
<i>3e. Practice Nurse</i>	\$1,175	0.0%	\$450	\$0	\$0–\$1,053	34
<i>3f. Allied Health</i>	\$2,867	0.1%	\$493	\$0	\$0–\$2,744	35
<b>4. Other MBS items (sub-total)</b>	\$1,352,604	20.2%	\$4,371	\$0	\$0–\$102,187	
<i>4a. Anaesthetics</i>	\$3,087	0.1%	\$499	\$0	\$0–\$1,462	32
<i>4b. Pathology</i>	\$8,827	0.2%	\$645	\$26	\$0–\$6,331	11
<i>4c. Diagnostic Imaging</i>	\$38,877	0.7%	\$1,417	\$0	\$0–\$20,532	33
<i>4d. Operations</i>	\$265,345	4.9%	\$7,188	\$3,235	\$0–\$63,635	1
<i>4e. Obstetrics</i>	\$89,620	1.7%	\$2,718	\$0	\$0–\$43,103	26
<i>4f. Specialist Services</i>	\$90,751	1.7%	\$2,747	\$0	\$0–\$45,950	34
<i>4g. Other MBS</i>	\$586,097	10.9%	\$15,383	\$4,908	\$0–\$102,187	1
<b>Total</b>	\$5,369,118	100%	\$137,437	\$55,366	\$8,024–\$968,524	

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**Table 6.8:** WA MBS benefits paid by aggregated MBS categories of all participating sites (n=11)

MBS Aggregated Categories	Total claims for all sites	Percent of total for all sites	Mean claims per site (\$)	Median claims, per site (\$)	Range of values, all sites (min and max)	No. of sites with zero claims
<b>1. Non-referred Attendance</b>	\$2,171,528	53.0%	\$197,412	\$188,257	\$12,976–\$524,398	0
<b>2. After-hours Non-referred Attendance</b>	\$531,821	13.0%	\$48,347	\$35,442	\$0–\$161,918	2
<b>3. Assessment related items, including disease management and other primary care professionals (sub-total)</b>	\$241,025	6.0%	\$3,652	\$0	\$0–\$64,616	
<i>3a. A14 (Health Assessments)</i>	\$76,063	1.9%	\$6,915	\$492	\$0–\$54,745	3
<i>3b. A15 (GP care plans)</i>	\$78,884	1.9%	\$7,171	\$1,167	\$0–\$46,368	2
<i>3c. A20 (GP mental health treatment)</i>	\$14,748	0.4%	\$1,341	\$238	\$0–\$7,838	2
<i>3d. Nurse Practitioner</i>	\$68,122	1.7%	\$6,193	\$0	\$0–\$64,616	9
<i>3e. Practice Nurse</i>	\$3,208	0.1%	\$292	\$0	\$0–\$3,184	8
<i>3f. Allied Health</i>	\$0	0.0%	\$0	\$0	\$0–\$0	11
<b>4. Other MBS items (sub-total)</b>	\$1,156,338	28.2%	\$15,017	\$267	\$0–\$416,619	
<i>4a. Anaesthetics</i>	\$404	0.0%	\$37	\$0	\$0–\$286	8
<i>4b. Pathology</i>	\$2,845	0.1%	\$259	\$177	\$8–\$706	1
<i>4c. Diagnostic Imaging</i>	\$801,995	19.6%	\$72,909	\$60	\$0–\$416,619	4
<i>4d. Operations</i>	\$108,365	2.6%	\$9,851	\$5,227	\$0–\$38,982	1
<i>4e. Obstetrics</i>	\$32,473	0.8%	\$2,952	\$163	\$0–\$22,999	1
<i>4f. Specialist Services</i>	\$13,131	0.3%	\$1,194	\$0	\$0–\$7,767	8
<i>4g. Other MBS</i>	\$197,125	4.8%	\$17,921	\$9,556	\$479–\$60,165	0
<b>Total</b>	\$4,100,827	100%	\$372,803	\$217,050	\$17,606–\$1,042,564	

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**Table 6.9:** NT MBS benefits paid by aggregated MBS categories of all participating sites (n=6)

MBS Aggregated Categories	Total claims for all sites	Percent of total for all sites	Mean claims per site (\$)	Median claims, per site (\$)	Range of values, all sites (min and max)	No. of sites with zero claims
<b>1. Non-referred Attendance) – common items (e.g. 3, 23, 36, 44)</b>	\$1,219,613	58.6%	\$203,269	\$150,224	\$37,725–\$565,240	0
<b>2. After-hours Non-referred Attendance</b>	\$350,727	16.8%	\$58,454	\$337	\$0–\$217,641	3
<b>3. Assessment related items, including disease management and other primary care professionals (sub-total)</b>	\$191,860	9.3%	\$5,329	\$154	\$0–\$32,656	
<i>3a. A14 (Health Assessments)</i>	\$56,785	2.7%	\$9,464	\$7,329	\$0–\$32,656	1
<i>3b. A15 (GP care plans)</i>	\$90,973	4.4%	\$15,162	\$17,193	\$0–\$29,456	2
<i>3c. A20 (GP mental health treatment)</i>	\$18,857	0.9%	\$3,143	\$2,781	\$93–\$6,480	0
<i>3d. Nurse Practitioner</i>	\$1,221	0.1%	\$203	\$0	\$0–\$1,221	5
<i>3e. Practice Nurse</i>	\$24,024	1.2%	\$4,004	\$1,764	\$0–\$13,740	2
<i>3f. Allied Health</i>	\$0	0.0%	\$0	\$0	\$0–\$0	6
<b>4. Other MBS items (sub-total)</b>	\$319,731	15.4%	\$7,613	\$1,318	\$0–\$74,325	
<i>4a. Anaesthetics</i>	\$800	0.0%	\$133	\$0	\$0–\$585	4
<i>4b. Pathology</i>	\$36,764	1.8%	\$6,127	\$7,256	\$559–\$10,064	0
<i>4c. Diagnostic Imaging</i>	\$0	0.0%	\$0	\$0	\$0–\$0	6
<i>4d. Operations</i>	\$53,359	2.6%	\$8,893	\$2,275	\$1,034–\$25,771	0
<i>4e. Obstetrics</i>	\$24,170	1.2%	\$4,028	\$1,648	\$1,068–\$15,081	0
<i>4f. Specialist Services</i>	\$10,721	0.5%	\$1,787	\$0	\$0–\$10,382	4
<i>4g. Other MBS</i>	\$193,917	9.3%	\$32,320	\$22,869	\$6,140–\$74,325	0
<b>Total</b>	\$2,081,930	100%	\$346,988	\$213,314	\$104,665–\$893,877	

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