Review of the DPA Classification System

Australian Government Department of Health

17 December 2021



Disclaimer:

Nous Group (Nous) has prepared this report for the benefit of the Department of Health (the Client).

The report should not be used or relied upon for any purpose other than as an expression of the conclusions and recommendations of Nous to the Client as to the matters within the scope of the report. Nous and its officers and employees expressly disclaim any liability to any person other than the Client who relies or purports to rely on the report for any other purpose.

Nous has prepared the report with care and diligence. The conclusions and recommendations given by Nous in the report are given in good faith and in the reasonable belief that they are correct and not misleading. The report has been prepared by Nous based on information provided by the Client and by other persons. Nous has relied on that information and has not independently verified or audited that information.

© Nous Group

Contents

1	Exec	cutive summary	1			
2	The DPA measures workforce need					
	2.1	Health outcomes decline with remoteness	9			
	2.2	DPA classification provides access to a broader pool of doctors	10			
	2.3	Determining the DPA status of GP catchment areas	11			
	2.4	Understanding the DPA calculation	12			
	2.5	The MMM classification of a GP catchment area impacts its DPA status	14			
3	Review methodology					
	3.1	The review addressed three primary questions	16			
	3.2	The methodology comprised four distinct phases	17			
	3.3	Some limitations need to be considered when interpreting the findings of this report	21			
4	Арр	lication of the DPA classification system	22			
	4.1	Key line of enquiry 1: How effectively does the application of DPA identify need	22			
	4.2	Key line of enquiry 2: To what extent does the implementation of the DPA address that need	J? 29			
5	Stak	ceholder views and insights	45			
	5.1	Key line of enquiry 1: How effectively does the DPA address community need?	46			
	5.2	Key line of enquiry 2: How well does the implementation of the DPA address need?	51			
	5.3	Key line of enquiry 3: Stakeholder suggestions for improvement	55			
6	Scei	Scenario analysis				
	6.1	Granting DPA status to all GP catchment areas in MM3-4 locations	57			
	6.2	Removing DPA status from all MM1 locations	62			
	6.3	Introducing a population cap for areas with DPA status	64			
	6.4 calc	Including GP Medicare billing (in addition to patient Medicare billing data) in the DPA ulation	66			
7	Finc	Findings and recommendations				
	7.1	Findings from review of DPA classification system	70			
	7.2 to G	Recommendations: Key line of enquiry 3, what changes to the DPA will improve equitable ac P services for people living in regional, rural and remote areas of Australia?	cess: 72:			
8	Acro	onyms	78			
9	Refe	erences	80			

Access to GP services is not equal across Australia

The level of health care accessed by Australians is among the best in the world, the majority of Australians are able to access services in response to need. However, in some areas of the country access to services is more challenging due to geographical issues, workforce shortages and maldistribution. There are areas of unmet need in Australia where the absence of general practitioners (GPs) and practices are significantly impacting regional, rural and remote communities, and communities with lower socio-economic status. In primary care there has been a long-standing issue of poorer levels of access to services, which decline with distance from major urban centres. Associated with poorer access, measures of health status also decline with increased remoteness – for example life expectancy is negatively associated with measures of remoteness and potentially avoidable hospitalisations can be 2.5 times higher in remote areas than in cities.

A series of initiatives have aimed to provide better access

For many years, successive governments at both the federal and the state and territory levels have sought to address these needs, demonstrated by a series of programs, measures and initiatives to address the maldistribution of GPs and practices across Australia. However, the challenges continue. Across Australia, regional, rural and remote communities continue to face GP workforce shortages, exacerbated by COVID-19 and more Australian trained GPs opting for other specialities over general practice or opting to work in more metropolitan areas ¹. At the federal level there exists a significant number of programs that are linked to geographical classifications and seek to either provide incentives for GPs to practice in areas that have poorer access or, in the case of overseas trained doctors, actively direct doctors to those areas for a mandated period of time.

The Distribution Priority Area is a geographical classification system linked to programs aimed at redistributing doctors to regional, rural and remote locations

The Distribution Priority Area (DPA) is one such measure. It was introduced in 2019 as a sophisticated measure of a locality's need for primary care services. The DPA classification system considers factors such as age, gender, socio-economic status and Medicare billing rates to produce a measure of access to services which is then compared with a national benchmark. If the measure is below the national benchmark, then the location is assigned DPA status and becomes eligible for particular programs.

Since its introduction, there have been a number of complaints raised, by GPs/practices, community members and representatives that the non-DPA status of their area is the reason that GPs are unable to be recruited and the current methodology does not contemporaneously reflect local circumstances, such as unmet demand, changes in population or reductions in Medicare services.

An expedited review was commissioned to identify opportunities to improve the measure of services access, better identify areas where health services are needed, and identify potential amendments to the DPA methodology that considers contemporaneous factors and other areas of concern.

An expedited review was commissioned to determine the effectiveness of the DPA in identifying and addressing community need and practical amendments to improve the measure

Nous Group (Nous) was engaged by the Australian Government Department of Health (the Department) to undertake a comprehensive review of the DPA to provide a view of how well the classification system is

¹ Melbourne Institute: Applied Economic and Social Research, the University of Melbourne, the impact of COVID-19 on GPs and non-GP specialists in private practice.

operating and the degree to which it is meeting its goals. The review considered stakeholder views on the effectiveness of the classification system, conducted data analysis, and developed evidence-based and practical recommendations for change.

Following a series of discussions at project kick-off and building upon the original request for quotation, it was determined that the review should assess the effectiveness of the DPA by investigating three key lines of enquiry:

- 1. How effectively does the DPA identify community need for GP services?
- 2. To what extent does the implementation of the DPA address this need?
- 3. What changes to the DPA will improve equitable access to GP care for people living in rural and remote areas in Australia?

In undertaking the review, it was considered crucial that the voices of the individuals and groups most affected were heard. In accordance with this, we held more than 79 interviews and small focus groups over a five-week period. The groups interviewed included general practices, Rural Workforce Agencies (RWAs), Primary Health Networks (PHNs), peak bodies, professional colleges, state and territory governments and the Australian government. These interviews were supplemented by a review of the methodology used to derive the measure, data analysis and scenario modelling. The review methodology comprised four distinct phases:



For the most part DPA has been effective in identifying need with the proportion of DPA status catchments increasing with remoteness; however, there are areas for improvement

Stakeholder consultation has found broad support for the DPA as a mechanism and there is an appreciation that it is a more sophisticated measure for identifying community need than the previous District of Workforce Shortage (DWS) measure. Anecdotal evidence from some national organisations

indicated that the number of complaints received about the DPA in comparison to the DWS have reduced considerably, with one organisation estimating that complaints had reduced tenfold. Data support these stakeholder views and suggest the DPA, at a national level, has been an effective indicator of GP workforce shortages, with DPA status increasing with the distance of catchments from metropolitan areas. Nearly three quarters of GP catchments across Australia have DPA status, 71 per cent of catchments with DPA status are in MM5–7 locations, and they collectively receive 31 per cent of all GP services received in Australia. States and territories (TAS, ACT and NT) in which most

"The DPA is crucial to the rural healthcare scene and is the backbone of these communities. We need to get more IMGs onto rural and remote areas through the DPA."

- quote from stakeholder consults.

of the population live in MM3 and above locations have the highest proportion of DPA status catchments and services and over half of all DPA status catchments are in MM5 areas.

However, there a few marginal areas across MM2–4 where community need is not accurately reflected by the DPA. For example, the GP full time equivalent (FTE) per 1,000 residents in non-DPA MM2 catchments in NSW is surprisingly low at 0.40 GP FTE per 1,000 residents (the average GP FTE per 1,000 residents is 1.19). More work needs to be done to understand the reason for the low GP FTE per 1,000 residents in these marginal MM2–4 locations.

The implementation of the DPA moderately helps to address this need with an overall improvement in GP FTE, particularly in MM2–4 catchments that gained DPA status

There have been significant changes in the rural GP workforce since the DPA system came into effect in 2019. Several factors, including the move from DWS to DPA, a range of other rural health workforce policies, programs and incentives such as the Stronger Rural Health Strategy (SRHS), Rural Health Workforce Support Activity Program, as well as COVID-19 have all likely influenced the GP workforce across Australia. Given these factors, it can be stated that the DPA has been correlated with an improvement in GP FTE in rural and remote areas; however, it is not possible to know what proportion of the changes can be attributed to the DPA system.

On average, since 2019, the GP FTE working across Australia has been increasing. This improvement in the GP FTE per 1,000 residents occurred steadily in MM1–4 areas while MM5, MM6 and MM7 have been relatively unchanged. This was supported by stakeholder groups who agreed that the DPA is a threshold indicator that provides the ability to seek access to a series of important programs like the Bonded Medical Program, International Medical Graduates (IMGs), Foreign Graduates of Accredited Medical Schools (FGAMS) and Five-Year Overseas Trained Doctors (OTD), Practice Experience Programs (PEP) and the More Doctors for Rural Australia Program (MDRAP). The majority of stakeholders agreed that the DPA plays an important role in rural and remote health.

Catchments that gained DPA status have improved to equal non DWS/DPA catchments in the GP FTE per 1,000 residents. However, for MM5–7 catchments that previously had DWS and were given DPA status their GP FTE remained unchanged or trended downwards. Most (60 per cent) of the catchments that lost DWS status under the reclassification continued to see growth in their GP availability after the change, indicating that, in the short-term, these reclassifications were appropriate.

The catchments that were most negatively affected by losing DWS status were concentrated in MM2. This may suggest that the DPA calculation methodology is disproportionally unfavourable to outer-metropolitan and regional catchments. "The DPA has increase the proportion of IMGs going to regional, rural and remote communities. IMGs are the backbone of these communities. We need to find ways to attract, recruit and retain more GPs for these communities."

- quote from stakeholder consults.

This is worth noting because this cohort already had an average GP FTE below the national median. The review considers that there may be catchments with non-DPA status that are experiencing GP shortages, particularly within the MM2 classification. This would require further investigation than has been possible in the review timeframes to determine if there are elements within the formula that can be adapted to account for the characteristics of these cohorts. In the meantime, the review believes the best approach is to ensure the Exceptional Circumstances Framework (ECF) is timely and clear, and leverages Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) data to provide a nuanced understanding of an individual area within a GP catchment.

There are opportunities to improve the DPA to facilitate equitable access to GPs for people living in rural and remote areas in Australia

Insights drawn from qualitative analysis, stakeholder consults, and quantitative data gathered throughout the review suggested multiple possible changes to the DPA system. The review conducted scenario analysis to understand the potential impacts of these changes and used the findings of the scenario analysis to inform the recommendations of the review.

The review considered analysis of the following scenarios:

- granting automatic DPA status to all GP catchment areas in MM3-4 locations
- removing DPA status from all MM1 locations
- introducing a population cap for locations to be eligible for DPA status
- including Medicare billing data from GPs (in addition to patient level billing) in the DPA calculation.

For each of these scenarios, the review considered an overview of the approach and rationale, analysis on the nature and magnitude of the change, and an assessment of potential impact including key risks and benefits.

The recommendations developed aim to improve the DPA's application, outcomes, and impact. Each recommendation is described below.



Recommendation 1: Confirm the DPA policy intent

Throughout the consultation process, many stakeholders expressed views that were, at times, inaccurate. A key insight drawn from the consultation process is that the majority of stakeholders did not always have a correct understanding of the DPA's policy intent and calculation methodology, at times leading to frustration. Some stakeholders viewed the DPA's aim as being to identify areas of unmet need across Australia as a whole, while others believed it should be focused on rural and remote areas of unmet need only.

Based on the information provided by the Department, it is clear that the policy intent is to identify areas in regional, rural and remote Australia with unmet need lacking access to GP services. In addition to existing information regarding the DPA that exists on its website, the Department should find ways to actively and clearly confirm the DPA's policy intent with stakeholder groups in an on-going, multipronged manner.



Recommendation 2: Improve DPA communications and transparency

Very few stakeholders interviewed as part of this review said they understood the calculations used in the measure and they identified this lack of transparency as an issue that affected their trust in the system. Improved communication and transparency about the DPA measure and the ECF through clear, active, ongoing, and multipronged communication targeting stakeholder groups through a variety of channels is needed.

The review considered publicly available information regarding the DPA and ECF, discussed the types and content of communications received by stakeholder groups regarding the DPA and ECF, and was provided with a draft internal document from the Department about the DPA. During the review process publicly available information, particularly regarding the ECF, was evolving and being updated.

To leverage these findings, stakeholder access to clear, active, ongoing, and multipronged communication would strengthen stakeholder engagement, and support for the DPA, specifically regarding the DPA's:

- policy objective
- data and methodology used to determine the DPA status of GP catchments
- annual changes to DPA status of GP catchments
- annual publication of GP FTE per 1,000 residents per GP catchment timed to coincide with the annual changes to DPA status of GP catchments

- exceptional circumstance submission process, data requirements and timelines²
- incentives and support for GPs and general practices in MM1–7 locations.³

To reach GPs and general practices, multipronged communications through a variety of channels would leverage their contact points with professional colleges, regulatory agencies and other peak bodies, PHNs, RWAs, state and territory health departments, as well as the Department.



Recommendation 3: Extend the automatic rule to include all MM3 and MM4 locations, and exclude all MM1 locations

Automatic extension to MM3 and MM4

In light of the clarification of the policy intent of the DPA, which is to identify areas in regional, rural and remote Australia with unmet need lacking access to GP services, the review has recommended that the DPA automatic rule be extended to include all GP catchments classified as MM3–7. An announcement of this change was made by the Minister for Regional Health, the Hon Dr David Gillespie MP, towards the end of the review period.

Many stakeholders support the view that the DPA classification system should prioritise rural and remote parts of Australia before all metropolitan catchments, even those with a shortage of health workers. Figure 28 shows that, historically, extending DPA status to large- and medium-sized rural catchments (MM3 and MM4) has resulted in a meaningful increase in their GP availability. Hence, automatically providing DPA status to all rural locations, MM3–7 (where currently it is offered by default only to MM5–7), may contribute to alleviating the maldistribution of Australia's GPs.

This would address the issues reported by many non-DPA GP catchments in MM3–4 locations that report significant workforce shortages that are not reflected in the current DPA calculation (see Figure 32 and section 6.1). It will also expand the number of locations available for the programs that are tied to the DPA.

The review notes that this extension could potentially disadvantage MM5–7 locations by increasing the competition for IMGs. Additionally, if all MM3–4 locations were automatically included, it is possible that some areas that do not experience workforce shortage would be granted status. These impacts are not considered likely to cause significant disruption to the programs that use the DPA as the impacts would be at the margin only, given the small number of catchments involved.

Excluding all MM1 locations

Removing DPA eligibility from MM1 areas would further align with the DPA's policy intent of identifying areas in regional, rural and remote Australia with unmet need lacking access to GP services. Currently, outer-metropolitan catchments in MM1 are eligible for DPA status. Some stakeholders reported that granting DPA status to any MM1 locations undermines the benefits that the system can provide for rural and remote areas, as many IMGs would prefer to be based in cities rather than rural and remote areas. Some stakeholders also recommended a de-prioritisation of metropolitan and densely populated areas. Despite representing 68 per cent of catchments that lost DWS status under the 2019 reclassification, MM1 areas continue to see growth in GP availability. This continued growth is evident even in the cohort of MM1 catchments that lost status, which has seen a 2.2 per cent increase in median GP FTEs per 1,000 residents since 2019 (as shown in Figure 31). MM1 catchments are likely to continue to attract and retain a sufficiently large GP workforce even without being eligible for DPA status.

² Department of Health, 2021, Request a review of a DPA or DWS classification, <https://www.health.gov.au/initiatives-and-programs/doctorconnect/about-working-in-australia/request-a-review-of-a-dpa-or-dws-classification>

³ Department of Health, 2021, Incentives and support for GPs and general practices in MM locations,

<https://www.health.gov.au/resources/collections/incentives-and-support-for-gps-and-general-practices-in-mm-locations>

A potential alternative to excluding all MM1 locations would be to update the "Inner Metro/Outer Metro" classification to ensure that privileged city locations are not included in the DPA.



Recommendation 4: Refine the Exceptional Circumstances Framework

As an overarching principle, the ECF should be a timely, clear, data driven process diving into workforce and population health data, giving a nuanced understanding of an individual area within a GP catchment.

The review notes that the government has publicly outlined the process to request a review of a DPA classification; however, to ensure a timely, clear, data driven ECF process, the review proposes the ECF process would:⁴

- Utilise HeaDS UPP and other data to better understand contemporaneous community use and access to health services and the health workforce, for example patient flows, GP FTEs and the mix of GP subspecialities.⁵
- Consider population health data to better understand the needs of the GP catchment, for example rates of chronic conditions, addiction and mental health needs, rates of disability.⁶
- Require PHN and RWA support as part of the application process to ensure greater room for discretion and understanding of the nuances in GP catchment areas, including working with the RWA to understand the workforce planning and recruitment strategies across the catchment.



Recommendation 5: Investigate changes to the DPA calculation

Further investigate changes to the DPA calculation:

- To improve the way the DPA captures workforce shortages. It is likely that including both the demand side and the supply side measure of billing data would increase the accuracy of the DPA calculation as a tool for determining workforce shortage (see section 6.4). Further scenario modelling and analysis of potential impacts is required to provide a conclusive recommendation.
- To determine if the use of MM2 is an appropriate benchmark for granting access to DPA for IMG dependent programs. The benchmark used to determine whether a GP catchment has DPA status and access to DPA IMG dependent programs is MM2. The review was unable to find a rationale for why this benchmark is used and notes that a national average benchmark is used for the Bonded Medical Program. It would be timely for the Department to further consider the use of this benchmark as it relates to DPA dependent programs and how this benchmark aligns with the DPA's policy intent to support regional, rural and remote Australia.
- To include additional data. In line with stakeholder comments recommending the inclusion of additional and contemporaneous data to provide a more nuanced and accurate depiction of a GP catchment's population profile, the Department could investigate additional data that might be used as part of the DPA methodology and calculation. Examples include data available in HeaDS UPP or other population health data.

However, the review cautions that including additional data will make the DPA's calculation more complex and may make it more difficult to communicate and be understood by stakeholder groups.

⁴ Department of Health, 2021, Request a review of a DPA classification, <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa/request-review>

⁵ Department of Health, 2021, HeaDS UPP, <https://hwd.health.gov.au/headsupp/>

⁶ Department of Health, 2021, Population health data, <https://www.health.gov.au/health-topics/preventive-health/population-health-data>



Recommendation 6: Review the Modified Monash Model classification system

The link between the DPA and Modified Monash Model (MMM) was a consistent theme through the national stakeholder consultation process. Many stakeholder groups expressed challenges understanding the MMM's methodology and the level to which it impacts the DPA's calculation – particularly in areas that border locations with different MMM statuses (see section 5.1.4 and Figure 38). It is timely to review the use of the MMM classification, and its methodology, in determining DPA status of a GP catchment given:

- MMM classifications are updated using data points that are not contemporary.
- Health programs began transitioning to the updated MMM 2019 from 1 January 2020, for example the Rural Pharmacy Maintenance Allowance program; however, the impact of their MMM classification on access to programs, incentives and support has not been evaluated.
- Road access was not accounted for in the MMM calculations.⁷ Seasonal road access in far-north, remote Australia can vary enormously between wet and dry seasons, with the wet periods making many roads inaccessible for significant periods of time. MMM does not account for seasonal access and to do so requires the Index of Access to have two scores – one each for wet and dry seasons.



Recommendation 7: Review GP catchments

The methodology for the Department's custom geography, known as GP catchments, was developed as part of the HeaDS UPP tool, used by the DPA and should now be reviewed. The catchments are specific to primary care and differ from the secondary services catchment areas that relate to the use of hospital services. All GP practices within a GP catchment are accorded the same DPA status (except that an Aboriginal Medical Service (AMS) within the catchment is automatically assigned DPA status).

The GP catchments were constructed using data points that are non-contemporary, specifically the Australian Bureau of Statistics' (ABS) Australian Statistical Geography Standard (ASGS) 2016 along with five years' worth of Medicare data, and demographic data such as the ABS Australian Population Grid and Residential Mesh Blocks 2016.⁸ It is timely that they be reviewed to assess if they represent appropriate contemporary groupings for the purposes of the calculation of DPA status and the workforce programs that use DPA status.



Recommendation 8: Coordinated and cohesive approach to the broader system of rural health measures, programs and incentives

Aligned with the review of the GP catchments, it would be beneficial to bring together the various measures the Department has in place to improve the maldistribution of Australia's GP workforce and to encourage GPs to practice in regional, rural and remote locations. Such a comprehensive review was sought by many stakeholders through the consultation process. It would allow a more cohesive and integrated response to workforce need in these locations. This coordinated and cohesive response should:

- define the primary goal of the various measures, programs and incentives
- quantify the impact of each program in achieving its policy objective
- understand the linkages, dependencies and challenges
- streamline the measures, programs and incentives to work in unison.

 ⁷ McGrail MR Humphreys JS, 2015, Discussion paper: Development of a national Index of Access for primary health care in Australia.
 ⁸ Department of Health, 2021, Health Workforce Distribution Priority Area fact sheet,

<https://www.health.gov.au/sites/default/files/health-workforce-distribution-priority-areas-factsheet.pdf>

As part of the review, consideration could be given to innovative approaches to address some of the short-, medium- and long-term implications of GP maldistribution in outer-metro, regional, rural and remote Australia. This work could then support the current and on-going development of a national medical workforce strategy, comprising of three specific sub-strategies focused on metro, regional, rural and remote Australia.⁹ The concurrent evaluation of the government's SRHS also provides an opportunity to assess the measures that address rural workforce in a more cohesive manner.

⁹ Department of Health, 2021, National Medical Workforce Strategy 2021-2031, <https://www.health.gov.au/initiatives-and-programs/national-medical-workforce-strategy-2021-2031>

2 The DPA measures workforce need

The DPA Classification System was introduced in July 2019. DPA replaced the previous DWS system as a measure to identify areas that would benefit from access to a small number of workforce programs. The objective of both systems is to identify locations in Australia with a shortage of medical practitioners in order to help facilitate the placement of GPs into communities with the greatest need. While the DWS system used Medicare billing statistics and population data to create a GP-to-population ratio in its classification, the DPA uses a more sophisticated and complex method of calculating level of need.

The DPA considers the characteristics of individuals living in a GP catchment area to identify locations where there is inadequate access to doctors. It considers a defined GP catchment's access to services by constructing a population demographic weighted average service benchmark, including the age, sex and Socio-Economic Indexes for Areas (SEIFA) of the catchment's population. DPA status is calculated by comparing the weighted average service level of a GP catchment area with the weighted average service benchmark. DPA status is assigned to GP catchments where the weighted average service level is below the benchmark. Catchments with DPA status are categorised as having unmet need and can access a series of programs to increase the available recruitment pool and fill vacancies in GP practices.

Since the introduction of the DPA, there have been a number of complaints raised, centred around not having DPA status; the underlying calculation of the DPA not adequately reflecting changes in local circumstances in a contemporaneous manner; lack of transparency and communication of the DPA calculation and the overarching principles; and the difficulty in recruiting GPs to locations without DPA status. These complaints and concerns need to be addressed against the backdrop of the government's desire to target services to where they are most needed in order to address health inequalities while ensuring a fair and transparent approach to access workforce assistance programs.

2.1 Health outcomes decline with remoteness

Significant inequalities in health outcomes exist across Australia and one of the most pronounced is that faced by Australians who live outside major cities. In general, the health status of individuals declines the more remote their locality. The Australian Institute of Health and Welfare (AIHW) has noted that potentially avoidable hospitalisations can be 2.5 times higher in remote areas than in cities, that life expectancy decreases with remoteness and that people in remote areas report high levels of difficulty in accessing medical services including GPs.¹⁰ While some of the reasons for this lie outside the remit of the health sector, such as poorer access to educational opportunities and lower levels of employment, a key determinant is access to health services.

The availability of medical practitioners, especially GPs, in regional, rural and remote locations has a direct impact on the health outcomes in regional, rural and remote Australia. Where the market does not provide appropriate access, the government has developed mechanisms to intervene. A key strategy to address the poorer health status is to increase access to primary health practitioners, in particular GPs.

Successive governments have made access to practitioners in rural and remote areas a priority. Governments have for many years tried to address inequalities in health status by improving access to both health facilities and practitioners. The focus on improving workforce access is based on the premise that it is preferable, within available resources, to treat people closer to their place of residence rather than have people travel long distances for treatment. It is also acknowledged that the availability of medical practitioners brings benefits over and above direct health benefits – medical practices can be a key aspect

¹⁰ Australian Institute of Health and Welfare, 2019, Rural & remote health Web Report, <https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary>

of making locations attractive for people to both relocate to and to stay. This means that there are multiple stakeholders who have an interest in the ability of localities to attract and retain GPs.

2.2 DPA classification provides access to a broader pool of doctors

DPA classification provides threshold access (subject to other requirements) to a range of programs for general practices to increase their workforce. In essence, DPA status is a threshold that must be crossed before a practice can apply for access to various workforce programs involving engagement of a broader recruitment pool of doctors. DPA status does not guarantee access to this workforce – it just grants the ability to seek access. The programs reliant on DPA status to trigger access are outlined in Figure 1.

Figure 1 | DPA status is linked to a series of workforce programs

VISAS FOR GPS 成	INTERNATIONAL MEDICAL GRADUATES	BONDED MEDICAL
is an initiative that ensures IMGs work in communities needing more primary health care services, which makes it easier for people in regional, rural and remote areas to access doctors and creates more training and employment opportunities for Australian medical graduates.	must work in areas that most need them to ensure people have access to the health care they need. Once 19AB GPs obtain their medical registration in Australia, they must work for at least 10 years in a location with DPA status.	uses the DPA indicator to identify where program participants (Australia and New Zealand trained doctors) can work when returning their service obligations.
MORE DOCTORS FOR RURAL AUSTRALIA (MDRAP)	PRACTICE EXPERIENCE PROGRAM (PEP)	FIVE YEAR OVERSEAS TRAINED DOCTOR (OTD) SCHEME
supports non-vocationally recognised (non-VR) doctors, junior doctors and locums to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway.	is a self-directed education program that helps non-VR doctors prepare for fellowship exams. It is co-funded by the Australian Government Department of Health as part of the SRHS.	encourages IMGs and FGAMS to work in regional, rural and remote DPA or DWS locations by allowing a reduction of moratorium time.

DPA status is used as part of the section 19AB provisions within the *Health Insurance Act 1973* which aims to move IMGs and FGAMS to regional, rural and remote areas by providing them with access to Medicare in these areas only.¹¹ IMGs and FGAMS GPs can only work in an area classified as DPA to access Medicare under section 19AB of Australia's *Health Insurance Act 1973*. It is possible for GPs, upon application, to gain an exemption from section 19AB and practice in non-DPA areas if they are providing particular services.¹²

The Visas for GPs Program is a linked initiative that facilitates visas for IMGs to work in communities needing more primary healthcare services (and meet the DPA threshold) which makes it easier for people in regional, rural and remote areas to access doctors.¹³ The program aims to regulate the number of IMGs

¹¹ Department of Health, 2021, Section 19AB restricted doctors and access to Medicare, <https://www.health.gov.au/health-topics/doctors-and-specialists/what-we-do/19ab>

¹² Department of Health, 2021, Section 19AB exemptions, <https://www.health.gov.au/health-topics/doctors-and-specialists/what-we-do/19ab/exemptions>

¹³ Department of Health, 2020, Visas for GPs Program, <https://www.health.gov.au/initiatives-and-programs/visas-for-gps-program>

entering Australia through the skilled migration program to work in the primary healthcare sector and direct them to areas of workforce shortage (away from over-serviced metropolitan and outer metropolitan areas to areas of workforce need, especially rural and remote areas).

Australian-trained bonded doctors with return of service obligations (RoSO) can also only work in DPA locations to access the Medicare Benefits Schedule (MBS). Practices located in a DPA location can employ these GPs to increase the workforce and improve the community's access to subsidised Medicare services¹⁴.

MDRAP supports non-vocationally recognised (non-VR) doctors to gain general practice experience in rural and remote communities prior to joining a college fellowship pathway. MDRAP also supports junior doctors and locums providing services in rural and remote communities. The objective of this program is to ensure that MBS fees payable reflect recognised levels of qualification, reward and incentivise investment in postgraduate specialist qualifications, and ultimately encourage more doctors to work in rural and remote areas.

PEP is an education and support program for non-VR doctors working towards fellowship in regional, rural and remote Australia. It is received across the country in partnership with training organisations and is funded under the Non-Vocationally Registered Fellowship Support Program as part of the Department's SRHS.¹⁵ One of the application requirements for PEP is proof your practice was located in a DPA when you commenced contract negotiations.

2.3 Determining the DPA status of GP catchment areas

The DPA combines Medicare and demographic data into a classification system that aims to identify areas in which populations are utilising primary healthcare services at a low rate. This is used as an indicator of workforce shortage. The DPA calculation methodology analyses services used in 829 non-overlapping geographical GP catchment areas.

The DPA classification system also utilises the MMM classification system to overlay automatic rules based on geographical remoteness. GP catchments in inner metropolitan areas (within MM1) are automatically deemed non-DPA. GP catchment areas in MM5–7 are automatically deemed DPA, as well as all GP catchment areas in the NT. This reflects the high priority placed on small rural, remote and very remote communities. Other areas (i.e., MM1 outer metropolitan, MM2, MM3 and MM4) are classified as DPA when the level of health services for the population does not meet the defined service benchmark.

The DPA is reviewed and updated annually to reflect the latest available data. This includes the latest calendar year MBS patient billing and population statistics from the ABS 2019-20 Estimated Residential Population (ERP).

¹⁴ Because of the complexity of the system, IMGs and FGAMS often have the ability to move away from regional, rural and remote areas to more urban locations through a range of exemptions.

¹⁵ Royal Australian College of General Practitioners (RACGP), PEP, Helping non-VR doctors prepare for fellowship exams, 2021, <https://www.racgp.org.au/education/imgs/fellowship-pathways/fellowship-programs-for-imgs/practice-experienceprogram/practice-experience-program-standard-stream>

2.4 Understanding the DPA calculation

The DPA status of a GP catchment area is determined by comparing the level of GP services used by patients to a benchmark that reflects adequate access to healthcare services.^{16, 17} There are two benchmarks:

- 1. DPA for IMG uses a benchmark calculated based on the weighted average patient Medicare expenditure across all MM2 areas in Australia. If a GP catchment is lower than the benchmark (and not impacted by any of the automatic MMM rules) the catchment receives DPA status. This process is described in further detail in Figure 2.
- 2. DPA for Bonded Medial Programs uses a benchmark calculated based on the weighted average patient Medicare expenditure at a national level. If a GP catchment is lower than the benchmark (and not impacted by any of the automatic MMM rules) the catchment receives DPA status.

Throughout this report, the definition of "catchments with DPA status" equates to catchments that are eligible for programs that provide access to both IMGs and BMPs (i.e., they are below both the national and MM2 benchmark), (described in more detail in section 4.2.1 and section 3.3). There are a further 11 catchments that are eligible for BMPs, although not IMGs – approximately one per cent of the total. Based on this, our data analysis uses the MM2 benchmark for IMGs. This was also done because the MM2 benchmark was frequently discussed during consultations and was considered the most relevant for analysis.

The level of services accessed by patients (measured through patient Medicare billing data) within each GP catchment is weighted by the demographic profile of a community, including age, sex, and SEIFA ranking. This means that the level of services accessed by patients in a GP catchment is compared against a benchmark of the level of services received in MM2 areas by patients with an identical demographic profile (i.e., the same age profile, the same gender profile, and the same level of socio-economic disadvantage). This provides the weighted average level of patient Medicare expenditure.

Incorporating SEIFA ensures the DPA methodology considers the socio-economic conditions of a geographic area. SEIFA is a product developed by the ABS that ranks areas in Australia according to relative socio-economic advantage and disadvantage.¹⁸ SEIFA consists of four indexes: relative socio-economic disadvantage, relative socio-economic advantage and disadvantage and disadvantage, education and occupation, and economic resources.

It is worth noting that the DPA calculation only incorporates standard GP services, as opposed to all services delivered by a GP. For example, if a rural GP provides anaesthetic services in the hospital, these additional services are not included in the DPA calculation. This is intended to avoid disadvantaging (mostly rural) communities where GPs typically have a broader scope of practice.

Exceptional Circumstances Framework

A recently introduced review process called the ECF for DPA is intended to support GP catchment areas with non-DPA status who feel that the tool does not capture the level of need in their GP catchment. To

¹⁶ GP Catchments are based on GP services being received and where patients access those services. It is a complement to existing geographies in operation across the department as the basis with which to conduct supply and demand modelling, visualisation and scenario planning tools for workforce planning. GP catchments consider patient flows, demographics, accessibility and physical landscape, and other barriers to access services.

¹⁷ Department of Health, Health Workforce supply, Demand and Geographical Distribution Project, General Practitioner (GP) Catchments.

¹⁸ Australian Bureau of Statistics, 2018, Socio-Economic Indexes for Areas, SEIFA provides a measure of the socio-economic conditions by geographic area, https://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa

review an area's DPA classification, the Department has tasked its Distribution Working Group (DWG) to:^{19,20}

- provide independent advice in response to concerns raised about an area's DPA classification
- assess applications to review and re-assess an area's DPA status
- considers all changes to DPA and any amendments to the existing DPA methodology.

Applicants may seek a review of their DPA status by submitting a formal application to the DWG. The DWG takes the following principles into account when reviewing the application:

- support of the local RWAs
- changes to health services, workforce or health system
- patient demographics or changes
- absence of services.

The DWG is required to assess requests within three weeks of submission and provides advice to the Minister for Regional Health in order for a decision to be made. The Department then advises applicants of the outcome within two weeks of the DWG's decision and publishes the outcomes for transparency. If approved, an area acquires DPA status and can then access the programs triggered by DPA status for that year, until the next schedule review on 1 July.

The ECF aims to respond to unforeseen workforce and population challenges that impact access to local health services within GP catchment areas. These challenges can include sudden illness or death of a GP, unforeseen events (e.g., COVID-19 related services) and demonstrated difficulties in recruiting or retaining doctors. Addressing growing criticism of the DPA's inflexibility, the ECF seeks to provide a layer of discretion for areas with demonstrated inequitable access to GPs.

¹⁹ Department of Health, 2021, Annual update of Distribution Priority Area (DPA) and District of Workforce Shortage (DWS) classifications, https://www.health.gov.au/initiatives-and-programs/doctorconnect/about-working-in-australia/annual-update-of-distribution-priority-area-dpa-and-district-of-workforce-shortage-dws-classifications

²⁰ The DWG provides independent advice to the Australian Government on the health workforce distribution in Australia, and its membership includes rural health peak bodies, the National Rural Health Commissioner, the Department of Health and independent medical advisers.

Figure 2 | Determining the DPA status of a GP catchment area



In GP catchment area 1 census data is used to calculate the number of people in each demographic cohort (across the dimensions of age, gender and SEIFA). This data is used to create population cohort weightings, which is the percentage of the total population in each demographic cohort. If the catchment is a mid-sized rural town, the population cohort weightings for higher age brackets and lower SEIFA categories are likely to be large.

worked example with duminy data, weighted patient medicare expenditure for GP catchment							
i	Age	Gender	SEIFA	No. of people	Population cohort weighting	Average annual Medicare expenditure per person	
1	0-4 yrs	Female	1	1000	0.4%	\$100	\$100,000
2	0-4 yrs	Female	2	900	0.9%	\$120	\$108.000
3	0-4 yrs	Female	3	600	1.2%	\$140	\$84,000
4	0-4 yrs	Female	4	500	1.4%	\$180	\$90,000
5	0-4 yrs	Female	5	200	2.5%	\$200	\$40,000
6	0-4 yrs	Male	1	1500	0.4%	\$150	\$225,000
7	0-4 yrs	Male	2	700	0.8%	\$180	\$126,000
						Total mainhead and and items	******

Medicare patient billing data is used to calculate the **average annual Medicare expenditure per person** in each demographic category. These averages are multiplied by the population cohort weighting to determine the **weighted average Medicare expenditure** for each population cohort. This is combined across all population cohorts to calculate the **total average weighted expenditure** for the CP catchment area.

2.5 The MMM classification of a GP catchment area impacts its DPA status

The MMM (Figure 3) classifies metropolitan, regional, rural and remote areas according to geographical remoteness, as defined by the ABS, and town size. Areas classified MM2 to MM7 are regional, rural or remote. People living in these areas can find it harder to get medical help, accessing doctors can take longer and cost more.

Figure 3 MMM Classifications

MM1	Metropolitan areas: major cities accounting for 70 per cent of Australia's population, For example: Sydney, Brisbane City, Adelaide.
MM2	Regional centres that are in, or within a 20km drive of a town with over 50,000 residents. For example: Ballarat, Mackay, Toowoomba, Kiama, Albury, Bunbury.
MM3	Large rural towns that are not MM2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents. For example: Dubbo, Lismore, Yeppoon, Busselton.
MM4	Medium rural towns that are not MM2 or MM3, and are in, or within a 10km drive of a town with between 5,000 to 15,000 residents. For example: Port Augusta, Charters Towers, Moree.
MM5	Small rural towns. For example: Mount Buller, Moruya, Renmark, Condamine.
MM6	Remote communities: remote mainland areas and remote islands less than 5kms offshore. For example: Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland. Additionally, islands that have an MM5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM6. For example: Bruny Island.
MM7	Very remote communities. For example: Longreach, Coober Pedy, Thursday Island, and all other remote island areas more than 5kms offshore.

A location's MMM classification is used to determine eligibility for a range of health workforce programs, such as rural Bulk Billing Incentives, Workforce Incentive Program (WIP) and the BMP Scheme.²¹ These programs are designed to encourage junior doctors, GP registrars and qualified GPs to train and work in rural communities.

There are three current challenges to using MMM thresholds in determining DPA status of a catchment:

- Although MMM updates contain the most up to date, validated data sets, these are not real-time data sets and the lag between data collection, cleansing and data becoming available means that MMM updates rely on aged data sets. The MMM 2019 was updated on 1 July 2019 and uses the following data sets: ASGS 2016 Statistical Area 1 and Urban Centres and Localities as the geographic bases; ASGS Remoteness Area 2016 as the ABS remoteness classification (based on Accessibility and Remoteness Index of Australia (ARIA+)); Estimated Resident Population 2016; and Public Sector Mapping Agency 2018 Australian road network.²² The MMM classification for remoteness currently linked to the 2020/2021 DPA allocation is, in some cases, outdated.
- Health programs began transitioning to the updated MMM 2019 from 1 January 2020; however, the impact of their MMM classification on access to programs, incentives and support has not been evaluated.
- Road access was not accounted for in the MMM calculations. While distance is taken into account, other issues are not. As an example, seasonal road access in the far-north, remote Australia can vary enormously between wet and dry seasons, with the wet periods making many roads inaccessible for significant periods of time. MMM does not account for seasonal access and to do so requires the Index of Access to have two scores one each for wet and dry seasons.²³ Another example is time taken to travel, particularly in rural and remote areas. In some parts of North QLD, distance between communities may be 200km, but the travel time may take four plus hours.

²¹ Department of Health, 2019, Modified Monash Model, <https://www.health.gov.au/sites/default/files/documents/2020/07/modified-monash-model-fact-sheet.pdf>

²² Department of Health (data.org.au), MMM 2019 CSV., https://data.gov.au/data/dataset/modified-monash-model-mmm-2019/resource/7af3b211-60a0-4515-96ba-2e72b4cd7119

²³ McGrail MR & Humphreys JS, 2015, Discussion paper: Development of a national Index for Access for Primary Health Care in Australia, Centre of Research Excellence in Rural and Remote Primary Health Care, Monash University, School or Rural Health, pp 35.

3 Review methodology

Nous was commissioned by the Department to undertake a comprehensive review of the DPA to determine how well the classification system is working and to identify practical recommendations to deliver on the DPA's goal, which is to identify GP catchments with a shortage of GPs.

The review aimed to understand the effectiveness of the DPA classification and to examine the validity of concerns that have been raised by GPs, general practices, community representatives, peak bodies, colleges and PHNs.

Fundamental to the conduct of the review is recognition that the DPA classification is only one part of a broader system with many programs, incentives and initiatives aimed at building a sustainable, high quality health workforce that is distributed across the country according to community need – particularly in regional, rural and remote communities. The review was commissioned in the last quarter of 2021. It commenced on 15 October 2021, with this report being delivered to the Department on 17 December 2021.

The initial review aim and objectives were to:

- Evaluate the effectiveness of the existing indicator in identifying areas of GP services access need by patients.
- Assess its use by key programs that currently use DPA to target the distribution of GPs to regional, rural and remote areas of Australia.
- Assess the data and methodology used to determine DPA status and any contemporaneous and agile changes needed along with other factors that might see the DPA represent an area's circumstances more accurately.

The review needed to ground-truth the indicator and its use as a distribution tool as well as considering flow-on impacts of DPA-status and access to other health services including rural accident and emergency services provided to patients seeking primary care, access and waiting times for GP services and whether patients seek out-of-area GP services as a result of these issues.

Following consultation with the Department during the initial project scoping stage the objective of the review was refined to focus on three key lines of enquiry detailed in section 3.1. The objective of the review was refined to reflect:

- A substantial increase in the number of stakeholder consultations. Overall, the review conducted ~80 small group focus groups and interviews with over 90 stakeholders.
- A reduced timeline. The review was planned over a nine-week period; however, kick-off delays reduced the review timeline to seven weeks.
- **Timely access to data**. The availability of data relevant to the review to facilitate additional data analysis, scenario modelling and cost benefit analysis was also a factor.

3.1 The review addressed three primary questions

The sections below define the key lines of enquiry for the review, map these to the reviews' initial objective and describes the methodology.

The review assessed the effectiveness of the DPA by investigating three primary questions.



3.2 The methodology comprised four distinct phases

The tailored methodology had four distinct phases (Figure 4).





3.2.1 Scoping: Mapping out the DPA classification; DPA formulae and programs

The aim of the scoping phase was to gain a better understanding of the DPA calculation and assumptions, as well as reviewing additional documents provided by the Department and written submissions, and other information provided by stakeholders. The key activities in this phase included:

- A desktop review of stakeholder submissions, information from the Department and other publicly available documents to understand the effectiveness of the DPA's application to key programs that use it to identify need and target the distribution of GPs in Australia (Figure 5).
- An in-depth assessment of data provided by the Department to analyse the methodology, formula and data behind the DPA calculation to develop a quantitative understanding of the program and its effectiveness.

Figure 5 | Overview of documents from desktop review



3.2.2 Consultation: Stakeholder perspectives and opportunities for improvement

An important part of the review was an intensive national stakeholder consultation. The concerns of stakeholders were heard and considered in line with how accurately the DPA identifies community need for GP services and to discuss additional factors that need to be considered in determining where workforce incentives and programs could be provided.

A total of 79 one-on-one and small-group virtual meetings were conducted with GPs and general practices, colleges and peak bodies, RWAs, PHNs, community representatives, Australian Government and state and territory government representatives. Figure 6 provides an overview of the stakeholder consultation process. One or two facilitators and one scribe from Nous attended each consultation to ensure all insights were recorded accurately.



3.2.3 Synthesis: Triangulating quantitative data and stakeholder feedback

The review applied a mixed-method and highly consultative approach, triangulating information from quantitative (Figure 5) and qualitative (Figure 6) sources to assess the effectiveness of the DPA.

Methodology for data analysis

The quantitative analysis conducted during this review was based on two key data sources:

- 1. A snapshot of the DPA dataset used in the DPA calculation.
- 2. Data on the supply of GP services from the HeaDS UPP tool.

Methodology for analysing data from the DPA calculation

For patient Medicare expenditure data analysed from the DPA dataset included:

- a list of the 829 GP catchments, their state and MMM classification
- the number of GP catchments with both full and partial DPA status for IMGs and BMPs
- the DWS status of GP catchments (prior to the transition to DPA)

- the weighted average patient Medicare billing in each GP catchment
- the weighted benchmark (both MM2 and national) in each GP catchment
- the number of GP services received by patients, the Medicare benefits paid and the total scheduled fee for each GP catchment (reported from the perspective of patient's residences, providers practice location and instances where the patient and provider locations are both within the same catchment).

This data was used to determine the number and distribution (by state and MMM location) of GP catchments with DWS and DPA status. For the purposes of this review DPA status was defined as eligibility for both IMG and BMP programs. Catchments with partial DPA status (catchments that span multiple MMM locations that interact with the automatic rules) were considered as DPA status if greater than 50 per cent of the GP catchment (based on population) was in areas with DPA status. Similarly, the MMM classification of GP catchments were determined based on the location that the majority of the catchment was in.

The data was also used to analyse the demand for GP services, measured by weighted average patient Medicare billing in each GP catchment. As the analysis was conducted at a state/territory level, three GP catchments that are categorised as Overseas Territories (Christmas Island, Cocos Island and Norfolk Island) were excluded from the analysis.

Data analysed from the HeaDS UPP tool included:

- estimated resident population of each GP catchment
- the number of GPs and GP FTE in each catchment
- the proportion of patients receiving GP services within their own catchment
- the proportion of GPs providing a very small amount (<10 per cent) of their services in a catchment).

All data analysed for the review was from FY 2015-16 to FY 2020-21. However, in some places different time periods are referenced to focus on meaningful changes before and after the introduction of the DPA classification system.

This data was combined with the DPA dataset to analyse the change in supply of GP services between 2015 and 2021. The HeaDS UPP data set calculates GP FTE using an estimate of how long a GP spends on each Medicare item claimed, GP and patient demographic characteristics, a GP's average non-billable time, and clinical time comprising billable and non-billable time. Further information on this can be found in the Department of Health Method Paper of General Practice Full Time Equivalent.²⁴ Fellows, GP registrars, non-VR doctors working in general practice are all included in the count of GP FTE.

It is important to note that the DPA dataset and HeaDS UPP tool include different MBS items when determining GP FTE and patient Medicare billing. Therefore, these measures cannot be directly compared.

3.2.4 Analysis: Scenario modelling, recommendations and conclusions

Scenario analysis (described in section 6) was conducted on a series of potential improvements identified from the qualitative and quantitative. Findings of the scenario analysis are used to inform the recommendations of the review.

²⁴ Department of Health, Method Paper: General Practice Full Time Equivalent (GPFTE) – Workforce, <https://hwd.health.gov.au/resources/information/methods-gp-full-time-equivalent.pdf>

3.3 Some limitations need to be considered when interpreting the findings of this report

We encountered three key challenges when collating insights for this report that should be considered.

- 1. Limitations on interpretation of the data:
 - a. Data analysis has been conducted on changes in the supply and demand of GP services between 2015 and 2021, before and after the introduction of the DPA. However, a number of other policy changes, including GP catchments, MMM classifications, the launch of the SRHS, have also been introduced during this time period. Therefore, while changes in GP services over this time period may provide an indication of the impact of the policy, it is not possible to fully attribute any changes to the DPA.
 - b. The report does not look at how to apply the demographics overlay to assess community need, as this was not possible in the timeframe. This means the report cannot make a sophisticated assessment of whether the demographics being overlaid on the DPA are accurately determining whether a community is being under or over serviced.
 - c. The definition of DPA status in catchments that are eligible for both IMGs and BMPs (i.e., they are below both the national and MM2 benchmark). There are a further 11 catchments that are eligible for BMPs, although not IMGs. This is approximately one per cent of all catchments. Based on this, data analysis uses the MM2 benchmark for IMGs. This was also done because the MM2 benchmark was frequently discussed during consultations and seemed most relevant for analysis.
- 2. The COVID-19 pandemic as a major confounder for all outcomes. The COVID-19 pandemic has had a major and still unknown impact on health services. A potential impact of COVID-19 is highlighted in Figure 25 which shows the reduction in the number of GPs that provide less than 10 per cent of services within a single catchment area. Although this may have resulted from an increase in GP FTE per 1,000 residents within a catchment, and a reduced reliance on GPs that deliver 10 per cent of services, it may also demonstrate the reduced mobility that GPs because of the COVID-19 pandemic. Similarly, insights provided from stakeholders during the consultation sessions highlighted the impact of COVID-19 on the healthcare system, particularly in recruiting IMGs with border closures, the increased workload of GPs undertaking telehealth appointments and conducting vaccination clinics.
- 3. Number of consultations and availability of specific cohorts of stakeholders. The number of consultations undertaken was limited by the availability of stakeholders. 129 stakeholders were contacted as part of the national stakeholder consultation process, 75 of these stakeholders were GPs or GP practices. 49 did not respond or declined to be a part of the consultation process. Although the consultation process involved a broad range of stakeholders (Figure 6) including PHNs, GPs and practices, peak bodies and colleges, Australian Government representatives, state and territory health services and RWAs, the review was limited in the number of AMS or National Aboriginal Community Controlled Health Organisations (NACCHO) interviewed as part of this process. Only one AMS opted into the consultations.

4 Application of the DPA classification system

The objective of this section is to provide a greater understanding of the DPA classification system and its impact on workforce shortages. This section uses the first two lines of enquiry to structure the presentation of data.

- Key line of enquiry 1: how effectively does the application of DPA identify need?
- Key line of enquiry 2: to what extent does the implementation of the DPA address that need?

The following findings have been developed by analysing indicators of GP availability in GP catchments across Australia. The analysis does not consider patient demographics or level of need in each of these catchments and therefore does not provide a complete view. The data on the level of need within catchments was unavailable during the compressed timeframe of the review. Further, the availability of GPs in regional, rural and remote Australia is the subject of numerous other factors such as state, territory and Commonwealth policies, and a range of workforce policies, including SRHS. We suggest that the trends observed here are attributable to the DPA reclassification; however, a direct causal relationship has not been firmly established.

The illustration below lists the data analysis that was conducted as part of this review.

REFIN ENQL	IED KEY LINES OF JIRY	Data analysis: the application of the DPA classification system for GPs
1	How effectively does the DPA identify community need for GP services?	 Distribution of DPA areas and services across MMM locations and states/territories. Analysis of GP workforce against indicators of workforce shortage: average annual patient Medicare billing number of GP FTE/1,000 residents proportions of patients that receive GP services within their own catchment the proportion of GP FTE providing <10 per cent services in a catchment.
2	To what extent does the implementation of DPA address need?	 The impact of the transition from DWS to DPA including: ✓ the number and distribution of catchments that lost or gained DPA status ✓ impact of the transition from DWS to DPA on the workforce shortage.
3	What changes to the DPA will improve equitable access to GP services for people living in regional, rural and remote areas of Australia?	Addressed in sections 5 and 7.

4.1 Key line of enquiry 1: How effectively does the application of DPA identify need

The following sections illustrate the distribution of DPA areas and services across MMM locations and states/territories, and uses four metrics (patient Medicare expenditure, distribution of GP FTE, proportion of patients that receive services in their own catchment and proportion of GP FTE the deliver less than 10

per cent of services in a catchment) to understand the distribution of GP workforce in relation to DPA status of catchments.



4.1.1 Distribution of DPA areas and services across MMM locations and states/territories

A total of 69 per cent of all GP catchment areas have DPA status²⁵

Of the 829 GP catchments in Australia, 565 (69 per cent) have DPA status. All catchments in MM5–7 locations have DPA status. Over half of the catchments in MM2–4 locations have DPA status. A small percentage of catchments in outer metropolitan MM1 locations have DPA status. These distributions are shown in Figure 7.



Figure 7 | DPA status across MMM locations

²⁵ DPA status refers to catchments that are eligible for both IMG and BMP programs. There are a further 11 catchments that are not eligible for the IMG program, although are eligible for the BMP program. This represents one per cent of all catchments.

States and territories with smaller populations have the highest proportion of DPA status catchments

States and territories with smaller populations, including the NT, TAS, WA and SA, have DPA status in over 75 per cent of GP catchments. This is because significant proportions of the population live outside metropolitan areas. States with larger populations, including NSW, VIC and QLD, have higher proportions of the population living in metropolitan areas and therefore lower proportions of DPA status catchments if MM1 catchments are included. This is shown in Figure 8.





Despite most catchments being DPA, only 23 per cent of all GP services received in Australia are received in catchments with DPA status

There is significant variation in the population of GP catchments across Australia. Therefore, while 69 per cent of catchments have DPA status, only 23 per cent of national GP services are received in DPA catchments, as DPA GP catchments tend to have lower populations and fewer doctors. Specifically, as of financial year 2020-21, non-DPA catchments had a median population of 64,714, while catchments with DPA have a median population of 4,151. Only 19 per cent of Australians live in GP catchments with DPA status.

In WA, QLD, NSW and VIC fewer than 20 per cent of GP services are received in DPA catchments. This is shown in Figure 9.





23 per cent of GP services delivered nationally are delivered in catchment areas that have DPA status.

WA, QLD, NSW and VIC have the smallest proportion of services delivered in DPA catchments.

One third of GP services received in DPA catchments are received in MM5-7 locations

The majority of catchments with DPA status are located in MM5–7. Despite this, the majority of services provided in areas with DPA status are not received in these rural and remote areas. Over two thirds (69 per cent) of services received in DPA catchments are done so in MM1–4.

- MM1–2 areas comprise only nine per cent of DPA catchment areas; however, as these catchment areas have larger populations, they account for 34 per cent of services received in DPA areas.
- MM3–4 areas comprise 20 per cent of DPA catchments and 34 per cent of services received in DPA areas. This is shown in Figure 10.
- A total of 47 per cent of DPA catchments are in MM5 areas and account for 26 per cent of the services received.



Figure 10 | Distribution of DPA catchments and GP services received across MMM locations

4.1.2 Analysis of the GP workforce against indicators of workforce shortage

GP workforce shortage in some areas results from the maldistribution of GPs across Australia. In this section, four key metrics have been used to explore GP workforce in relation to DPA status and the way this has changed over time:

- 1. Average annual patient Medicare expenditure per person reflecting the level of demand for and access to healthcare services within a GP catchment.
- 2. Median number of GP FTE per 1,000 residents26 reflecting the level of supply of healthcare services within a GP catchment.
- 3. The proportion of patients that receive GP services within their own GP catchment reflecting patient flows between catchments to access healthcare services.
- 4. The proportion of GP FTE providing a very small amount (less than 10 per cent) of their services in a catchment reflecting the size of the temporary workforce within a GP catchment.

Each of these metrics is examined in more detail below. Note that not all GPs counted under these metrics are equally qualified. This dataset includes both vocationally recognised and non-VR doctors.

²⁶ All analysis including the number of GP FTE per 1,000 residents across multiple catchments (e.g. at a state/territory or MMM level) is calculated the median GP FTE per 1,000 residents across those GP catchments.

Distribution of average annual patient Medicare expenditure per person

Average annual patient Medicare expenditure per person across GP catchments provides an indicator of the level of population demand for and access to healthcare services. This indicator forms the basis of the DPA calculation.

Across Australia the average annual patient Medicare expenditure per person is \$311. There are significant variations in the level of expenditure per person across MMM locations and states/territories; however, patient Medicare billing is higher in non-DPA GP catchments than DPA GP catchments across all locations (with the exception of VIC). This reflects the reduced levels of access to healthcare services in DPA catchments and greater reliance on supplementary health services like the Royal Flying Doctors Service.

Residents of DPA catchments access fewer MBS services than residents of non-DPA catchments at every MMM level

Non-DPA GP catchments in MM3–4 areas have the highest level of patient Medicare billing. It is also in MM3 and MM4 that we see the greatest discrepancy between DPA and non-DPA catchments. MM7 areas have the lowest by a considerable margin, being 36 per cent below the national average. This may partly reflect lack of access to healthcare services. It may also reflect that models of care in MM7 areas differ significantly from other parts of Australia, relying less heavily on Medicare services.

Patient Medicare billing in MM1–2 areas is below the level of MM3–4 areas for both DPA and non-DPA GP catchments. This may reflect the differing role of GP services in metropolitan and rural/remote areas. Patients in metropolitan areas have access to a wider range of non-GP health services such as specialists and allied health. In rural/remote areas, GPs are likely to be involved in a wider range of healthcare needs. This is shown in Figure 11.



Figure 11 | Average annual patient Medicare expenditure per person by MMM

VIC, NSW and TAS have the highest level of average patient Medicare billing per person, while the ACT and NT have the lowest

There is less variability between the level of patient Medicare billing in DPA and non-DPA catchments on a state-by-state basis. Patient billing is similar across all GP catchments in VIC, NSW, TAS and ACT. There is greater variability between DPA and non-DPA in states with higher proportions of the population in rural and remote areas, including SA, WA and NT. These states also have lower patient Medicare billing in DPA and non-DPA and non-DPA GP catchments.

The level of patient Medicare billing in the ACT is 28 per cent below the national average. It also has a lower-than-average GP availability of 0.85 GP FTEs per 1,000 residents, as shown in Figure 22. However, this is unlikely to be indicative of a GP shortage. The ACT is a primarily metropolitan area with a high SEIFA

index, resulting in its residents having lower morbidity and mortality, and greater access to private specialised providers, allied health services and walk-in clinics.

Patient Medicare billing in the NT is the lowest across Australia, being 54 per cent below the national average. This is likely to be a result of reduced access to healthcare services; however, it may also reflect a greater reliance on services which do not claim items on the MBS like the Royal Flying Doctor Service and Aboriginal Health Services. The low patient billing rates in the NT may also be attributed to the state's reliance on Rural Generalists, which provide services that would typically be received in a general practice setting instead within a hospital. These trends are shown in Figure 12.



Figure 12 | Average annual Medicare billing per person by state

Distribution of GP FTE per 1,000 residents

The number of GP FTE per 1,000 residents provides an indication of the level of supply of GP services. As discussed above, this measure examines the supply of health services per 1,000 residents. It does not include supplementary services, like the Royal Flying Doctors, or other health professionals that operate within rural, remote and regional locations, such as Rural Generalists.

Across the whole of Australia there are 25.7 million residents and 30,736 GP FTE. Therefore, there are 1.19 GP FTE per 1,000 residents. Of course, these GP FTE are not distributed equally across MMM locations or states and territories. The median number of GP FTE per 1,000 residents by GP catchments is 1.05.²⁷ The distribution of GP FTE per 1,000 residents across MMM locations reflects the trend of workforce shortage in DPA catchments, with the degree of shortage increasing with the level of remoteness.

DPA catchments in MM2 and MM5–7 locations have the lowest number of GP FTE per 1,000 residents

The trends in the number of GP FTE per 1,000 residents mirror the trends in average patient Medicare billing, shown in Figure 11. Non-DPA GP catchments consistently have a higher number of GP FTE per 1,000 residents than DPA catchments. Non-DPA MM3 and MM4 locations have the highest number of GP FTE per 1,000 residents, which may be an indicator of the greater reliance on GPs in regional and rural areas.

DPA GP catchments in MM6–7 areas have the lowest number of GP FTE per 1,000 residents. DPA GP catchments in MM2 areas also have notably low numbers of GP FTE, being 0.22 below the national median and comparable to MM6 locations. This is shown in Figure 13. As mentioned earlier, the reason why MM5–

Nous Group | Review of the DPA for GPs Classification System | 17 December 2021

²⁷ Median across GP catchments is the measure used for all analysis relating to the level of GP FTE per 1,000 residents.

7 regions have less average Medicare expenditure and lower GP FTE per 1,000 residents may be attributed to Rural Generalists providing more services in hospitals that other GPs.



Figure 13 | Number of GP FTE per 1,000 residents by MMM location and DPA status

Variability across states within MM2 areas provides further insight into the low level of GP FTE per 1,000 residents in MM2 DPA GP catchments. This distribution by state is shown in Figure 14. Both ACT and SA are excluded as the sample size of MM2 GP catchments with active GPs in these states is very low ²⁸.

There are five MM2 catchments with DPA status in NSW and 10 in TAS (out of a total eight MM2 catchments in NSW and 14 MM2 catchment in TAS). These catchments are also significantly below the national median. MM2 DPA catchments in NT, QLD and VIC have a higher number of GP FTE (WA does not have any DPA catchments in MM2 areas). Non-DPA catchments in MM2 WA have a GP FTE per 1,000 residents above the national median, while non-DPA catchments in MM2 NSW have a significantly lower number of GP FTEs per 1,000 residents, even lower than MM2 catchments in the other states and territories that do have DPA status. This may be indicative of a systemic issue in the DPA calculation; however, this conclusion cannot be drawn without an in-depth analysis of patient need within these catchments.



Figure 14 | Number of GP FTE per 1,000 residents in MM2 areas by state and DPA status

 28 n = 1 for ACT (Majura) and n = 2 for SA (Gawler, Adelaide Hills).

Nous Group | Review of the DPA for GPs Classification System | 17 December 2021

The proportion of patients that receive GP services within their own catchment

The proportion of patients that receive GP services within their own catchments indicates the proportion of residents that leave their home catchment to seek GP services. In some instances, residents may leave their home catchment to seek GP services as a result of personal choice and convenience, such as seeing a GP close to one's place of work. In other instances, it may be an indication of GP shortage in an individual's home catchment. The multiple factors influencing this metric means that interpretation of the data must be undertaken with caution. This metric is most likely to be an indicator of workforce shortage in remote and very remote areas, where there are often greater distances travelling between catchments.

MM3–4 areas have the highest proportion of patients that receive GP services within their own GP catchment

The proportion of residents that receive GP services in their home catchment is lowest in MM1 locations. It is likely that this reflects choice and convenience, rather than workforce shortage, as residents of MM1 locations may access GP services in other catchment areas that are, for example, closer to their place of work. The proportion of patients that receive GP services in their own catchment is significantly higher in MM3–7 locations.

MM3–4 areas have the highest proportion of patients receiving services in their own catchments. This mirrors the trends in patient Medicare billing and number of GP FTE per 1,000 residents. The proportion of residents that receive services in their own catchment in MM5–7 areas (which are all DPA) is approximately 60 per cent. As mentioned earlier, this may be attributed supplementary services, like the Royal Flying Doctors, or other health professionals that operate within rural, remote and regional locations, like Rural Generalists. This shown in Figure 15.



Figure 15 | The proportion of residents that receive services in their own catchment by MMM area

Non-DPA catchments in MM3–4 areas have the highest proportion of patients receiving services in their own catchment, while DPA GP catchments in MM1–2 areas have the lowest.

4.2 Key line of enquiry 2: To what extent does the implementation of the DPA address that need?

As outlined earlier, the DPA replaced the DWS as the threshold for access to a range of GP workforce programs in 2019. The following sections discuss the magnitude of the change from DWS to DPA, including the number and distribution of catchments that lost or gained DPA status and explores the impact of these changes on the rural GP workforce.

SUMMARY OF DATA ANALYSIS BASED ON KEY LINE OF ENQUIRY 2: to what extent does the implementation of the DPA address that need?

Overall, the transition to DPA appears to have had a positive impact, particularly on those catchments that gained DPA status and became eligible for a suite of targeted programs and incentives aimed at reducing workforce shortages.

2

Most (60 per cent) of the catchments that lost DWS status under the reclassification continued to see growth in their GP availability after the change, indicating that, in the short-term, these reclassifications were appropriate. The catchments that were most negatively affected by losing DWS status were concentrated in MM2. This does not appear to be a result of the change in benchmark from a national one to one based on GP availability in MM2 catchments. The DPA calculation methodology may be disproportionally unfavourable to outer-metropolitan and regional catchments.

Catchments in MM6–7 locations have seen an increase in the proportion of patients that receive services within their own catchment, while MM2 areas have notably decreased since 2019. MM1 catchments have continued to see growth in GP availability, despite a large proportion of these regions losing DPA status under the reclassification. The distribution of GPs is improving with the GP FTE per 1,000 residents increasing by nine per cent since 2015; however, the improvement is mostly felt in MM1–4 areas.

Catchments that gained DPA status have improved to equal non DWS/DPA catchments in the GP FTE per 1,000 residents since 2019. The catchments that gained DPA status capitalised on the increased access to workforce programs. However, for catchments that previously had DWS and were given DPA maintaining their ability to accept IMGs, among other incentives, benefits and supports - GP availability is trending downwards. This implies that these catchments continue to experience long term GP shortages. Revoking DWS status from areas of high GP availability did not redirect them to these areas of long-term shortage.

The majority of GP catchment areas that lost status were in MM1 locations. A total of 58 GP catchments lost status following the transition from DWS to DPA. A total of 40 of these catchments (69 per cent) were in MM1 locations. These catchments accounted for 14 per cent of services received across Australia.

4.2.1 Impact of the transition from DWS to DPA

A total of 58 catchments lost DWS status, while 43 catchments gained DPA status

In the 2019 transition from DWS to DPA, most catchments (88 per cent) did not change status. The remining 12 per cent, a total of 101 catchments, fully or partially changed status.²⁹ This includes 58 catchments that lost DWS status and 43 catchments that gained DPA status. Overall, there are 15 fewer catchments with access to the relevant workforce programs following the transition to DPA. It is important to note that, during this time, several complementary programs were being implemented that aimed to attract and retain doctors in regional, rural and remote Australia – principally under the SRHS.

²⁹ Partial changes of status occurred in catchments that span multiple MMM locations. For example, if a catchment is 50 per cent MM5 and 50 per cent MM4 (with the MM4 area not having DWS status) and falls below the national benchmark, the MM4 portion of the catchment gains DPA status. This is partial change in status as the MM5 section already had DPA status under the automatic rules.

Some states experienced a net increase in the number of GP catchments with DPA status, while others experienced a net decrease

Overall, TAS, SA and ACT experienced a net increase (i.e., number of GP catchments gained – number of GP catchments lost) in the number of GP catchments with DPA status, while QLD, WA, VIC and NSW experienced a net decrease. The number of catchments with DPA status in the NT was unchanged as the entire NT continues to receive automatic DPA status.

TAS experienced the greatest net increase in the number of GP catchments with DPA status (five), while NSW experienced the greatest net decrease in number of catchments with DWS status (10). WA experienced the greatest net decrease in GP services received in DPA areas (4.7 per cent). This is shown in Figure 16. Further analysis needs to be conducted to understand the reason for the differences in the number of catchments gained and lost across states and territories (e.g., this might represent broader health system construct issues) quantify the impact of the change and identify potential improvements to the DPA methodology.

Figure 16 | Net change in GP catchments with DPA status and proportion of services received in DPA locations



The majority of GP catchments that lost status were in MM1 locations across NSW, VIC, QLD and WA

A total of 58 GP catchments lost status following the transition from DWS to DPA. A total of 40 of these catchments (69 per cent) were in MM1 locations (all 40 GP catchments were outer metro). These catchments accounted for 14 per cent of GP services received across Australia. NSW, QLD, VIC and WA lost the most catchments while TAS, ACT and NT did not lose any catchments. This is shown in Figure 17.

Figure 17 | Distribution of catchments that had DWS status, although were not granted DPA status by MMM locations



43 catchments, distributed across all states and territories (except NT), gained DPA status

The majority of GP catchments that gained status were in MM3 locations (40 per cent) and MM4 locations (also 40 per cent) across VIC, NSW and QLD. Four GP catchments that gained status were in MM1 locations. This is shown in Figure 18.

Figure 18 | Distribution of catchments that did not have DWS status and were granted DPA status by MMM locations



Most the of the catchments that gained DPA status were already performing better than most of the catchments that lost DWS status in the transition from DWS to DPA

In most cases, particularly for MM2 and MM3, the catchments that lost status in the move to DPA in 2019 were performing worse than the catchments that gained DPA by: GP FTE per 1,000 residents; percentage of services received by patients within their own catchment; and percentage of GPs providing a very small (<10 per cent) proportion of their services in the catchment. Further analysis is required to understand the reason for the underperformance of MM2 and MM3 areas.



Figure 19 | Median of key metrics for catchments that gained and lost DPA classification by MMM location in 2019

4.2.2 Impact of the transition from DWS to DPA on workforce shortage

There have been significant changes in the rural GP workforce since the DPA classification came into effect in 2019. It is important to note that the move from DWS to DPA is one of many factors that may have influenced the rural GP workforce, including a range of other rural health workforce policies and programs, as well as COVID-19.³⁰

Overall, the transition to DPA appears to have had a positive impact, particularly on those catchments that gained DPA status. The data suggests that most changes in DPA status (loss or gain) were well targeted and appropriate. However, a small number of catchments appear to have experienced significant negative impacts as a result of losing DPA status.

GP catchments that did not change status, particularly MM5–7 areas, have not experienced the same growth in rural GP workforce as GP catchments in MM1–4 areas. However, these is no evidence to suggest that these catchments have been negatively impacted by the transition to DPA.

Changes in median GP FTE per 1,000 residents between 2015 and 2021

The number of GPs working in rural and remote areas has been increasing since 2015

The median number of GP FTE working GP catchments in MM2–7 areas has increased by nine per cent since 2015.³¹ The improvement in the distribution of GPs is shown in Figure 20.

³⁰ Therefore, it is not possible to be certain of the proportion of changes that can be attributed to the introduction of the DPA system. ³¹ All analysis including the number of GP FTE per 1,000 residents across multiple catchments (e.g. at a state/territory or MMM level) is calculated the median GP FTE per 1,000 residents across those GP catchments.


Figure 20 | Distribution of GP FTE per 1,000 residents across all GP catchments

This improvement has been mostly felt in MM1-4 areas

The number of GP FTE per 1,000 residents has been increasing steadily in MM1–4 areas. MM3 areas have the highest number of GP FTE per 1,000 residents (1.23) and have experienced the fastest growth since 2015, increasing by 17 per cent. MM1 locations have the second highest number of GP FTE per 1,000 residents (1.19), experiencing 10 per cent growth since 2015.

MM4 areas have 1.10 GP FTE per 1,000 residents and have experienced 12 per cent growth, while MM2 areas have a lower 1.00 GP FTE, however, have experienced high growth of 15 per cent.

MM5 areas have a similar number of GP FTE per to MM2 areas, at 0.95 FTE per 1,000 residents. However, MM5 locations have only grown three per cent since 2015. MM6 areas have fluctuated, although overall have not increased since 2015. MM7 locations grew strongly between 2015 and 2017 (24 per cent), although have since stagnated, not increasing since 2017.

MM1–6 areas have all experienced upticks in growth since the introduction of the DPA in 2019 (though increases in MM5–6 areas are smaller than the gains felt in MM1–4 areas). MM7 areas have remained unchanged. This is shown in Figure 21.



Figure 21 | Change in GP FTE per 1,000 residents by MMM area

QLD, NSW and VIC have the highest number of GP FTE and have experienced the strongest growth

QLD has the highest number of GP FTE per 1,000 residents (1.13) and has experienced the fastest growth since 2015 (13 per cent). NSW and VIC have similarly high GP FTE (1.12 and 1.11 respectively) and have also grown strongly since 2015 (seven per cent and 10 per cent respectively).

SA is below these three leading states, with 1.00 GP FTE per 1,000 residents. SA has been stagnant since 2015, experiencing only three per cent growth. The number of GP FTE has declined by one per cent since 2018. TAS is similarly stagnant experiencing no growth since 2015 and remaining at 0.96 GP FTE per 1,000 residents.

ACT has fewer GP FTE per 1,000 residents at 0.85, however, has experienced strong growth of 25 per cent since 2015. WA has a similar level of GP FTE, although has experienced slower growth of eight per cent since 2015.

NT has a significantly lower number of GP FTE per 1,000 residents than any other state and territory (0.52). NT experienced very strong growth from 2015 to 2018 at 29 per cent, although has since declined 12 per cent.

NSW, VIC and TAS have experienced upticks in growth since the introduction of the DPA in 2019. No states/territories have experienced declines in the number of GP FTE per 1,000 residents. This is shown in Figure 22.

Each of these conclusions have been drawn from the state and territories taken as a whole across MM1–7. As shown in Figure 21, these gains are consistent across MM1–5, with only MM6 and MM7 catchments seeing stagnant growth in GP availability.



Figure 22 | Change in GP FTE per 1,000 residents by state

Changes in the proportion of patients that receive GP services within their own catchment

The percentage of patients that receive services within their own catchment can be a measure of workforce shortage, particularly in more rural and remote areas. This measure should be interpreted in the context of the geography being considered. A lower proportion of patients receiving services within their own catchment in MM1–2 areas may not be an indication of unaddressed patient need, but a reflection of the relative ease of travelling between catchments in metropolitan areas. It is more difficult to travel between catchments in MM5–7 as they tend to be much larger, geographically. A high proportion of patients receiving services outside of their home catchment in MM5–7 areas is likely an indication of unaddressed patient needs and a genuine GP shortage.

GP catchments in MM6–7 areas have seen increases in the proportion of patients receiving GP services within their own catchment

This measure provides a more positive outlook for MM6–7 areas, which have experienced six and seven per cent respective growth in the percentage of patients receiving services in their own catchment since 2015. MM5 areas have seen a decline of six per cent. MM1 and MM3–4 areas have remained constant. Narrowing in on the possible effects of the DPA reclassification: MM2 areas have experienced a two per cent decrease since 2015, but a six per cent increase since 2018. This is shown in Figure 23.





The 30 catchments within the NT have seen a large (29 per cent) increase in the proportion of services provided to patients within their own catchment, bringing them to a similar level to TAS, VIC, WA, SA and QLD. This change may be due to a number of factors. It is possible that GPs (and Rural Generalists) in NT are operating on an increasingly effective outreach basis, improving their ability to provide care to patients with the same number of GPs. Patients in the ACT receive the lowest proportion of services within their own catchment. This is likely to be a reflection of lack of barriers to traveling between GP catchments in the ACT given the small geography of the territory. These trends are shown in Figure 24.



Figure 24 | Change in proportion of patients that receive GP services in their own catchment by state

Nous Group | Review of the DPA for GPs Classification System | 17 December 2021

³² This metric does not capture health services that are not included in the MBS, such as Royal Flying Doctor Service visiting clinics.

Change in the percentage of GPs that provide less than 10 per cent of their services within a catchment

The proportion of GPs who provide less than 10 per cent of their annual services within a catchment reflects the proportion of the GP workforce that is temporary within a catchment.³³ This can be an indicator of workforce shortage in rural and regional catchments, though it may not indicate workforce shortage in very remote catchments that operate medical services on a predominantly outreach basis.

A number of MMM locations and states/territories have seen declines in the proportion of the workforce providing less than 10 per cent of their services within a GP catchment

MM2 and MM4 areas have experienced notable decreases in the proportion of GPs that provide less than 10 per cent of their services within a catchment (23 per cent, 30 per cent respectively) since the introduction of the DPA. This supports the hypothesis of overall improving levels of workforce in these areas. This trend may be temporary. Engagement with rural and remote stakeholders have indicated that these figures may be impacted by travel restrictions imposed to control the spread of COVID-19.

MM5 areas have also experienced a significant (24 per cent) decline in the proportion of GPs that provide less than 10 per cent of their services within a GP catchment. This aligns with the increasing number of GP FTE per 1,000 residents, however, differs from the trend of a decreasing proportion of patients receiving services within their own catchment.

MM1 and MM7 areas have experienced slight increases, though this is unlikely to be related to workforce shortage. MM6 was increasing rapidly until the introduction of DPA and has since remained steady. These trends are reflected in Figure 25.



Figure 25 | Change in the proportion of GPs that provide less than 10 per cent of their services within a catchment by MMM

All states except the ACT and NSW have experienced declines in the proportion of GPs that provide fewer than 10 per cent of their services within a catchment since the introduction of the DPA. This is shown in Figure 26.

Nous Group | Review of the DPA for GPs Classification System | 17 December 2021

³³ This metric is intended to approximate the size of the locum workforce within each catchment.



Figure 26 | Change in the proportion of GPs that provide less than 10 per cent of their services within a catchment by state

4.2.3 Impact of changes in DPA catchment status

To further explore the impact of the transition to DPA this section considers four key cohorts:

- No-DWS; No-DPA Catchments that did not have DWS status and did not gain DPA status.
- No-DWS; Yes-DPA Catchments that did not have DWS status and gained DPA status.
- Yes-DWS; No-DPA Catchments that had DWS status and lost DPA status.
- Yes-DWS; Yes-DPA Catchments that had DWS status and maintained DPA status.

The purpose of this section is to gauge the effectiveness of the DPA classification system in identifying areas underserved by the health workforce and identify whether it performs this role more effectively than the previous classification system, DWS.

Grouping GP catchments by the four cohorts described above enables us to do this. For example, we can consider GP catchments that held DWS status, but were not granted DPA status. If their GP availability remained stable or increased following the change, this would indicate that the selection made under the reclassification was appropriate. These catchments continued to attract and retain GPs without having access to IMGs. However, if these catchments were to see a decline in GP availability following the change, especially if this positioned their GP availability below the national median, then the change may not have been appropriate – the DPA reclassification would have taken IMG eligibility from a catchment reliant on them to deliver an acceptable baseline of health services. These conclusions are caveated as the review could not draw direct connections between change in DPA status and GP availability. The ability for each catchment to attract and retain GPs is the cumulative result of many state, territory and Commonwealth health policies, program, incentives, supports and external factors.

Gaining DPA status appears to benefit GP catchments; however, in catchments that had both DWS and DPA status the number of GP FTE per 1,000 residents is stagnant

GP catchments that both did not hold DWS status and were not granted DPA status (No-DWS; No-DPA) have the highest number of GP FTE per 1,000 residents (1.31). This has been increasing steadily, rising by 11 per cent since 2015 and four per cent since 2019.

GP catchments that did not hold DWS status but were granted DPA status (No-DWS; Yes-DPA) have converged on the aforementioned No-DWS; No-DPA cohort, with 1.30 GP FTE per 1,000 residents in 2021. The No-DWS; Yes-DPA cohort has had stronger growth rate, with GP FTE per 1,000 residents increasing by

14 per cent since 2015 and eight per cent since 2018. These trends suggest that catchments that gain DPA status experience significant benefits.

GP catchments that had their DWS status revoked (Yes-DWS; No-DPA) were growing strongly between 2015 and 2018 at 14 per cent; however, have since slowed to grow four per cent between 2019 and 2021. The number of GP FTE per 1,000 residents in this cohort is significantly lower than the No-DWS; No-DPA and No-DWS; Yes-DPA cohorts. The reason for this is explored further below.

GP catchments that held both DWS status and now hold DPA status (Yes-DWS; Yes-DPA) have the lowest number of GP FTE per 1,000 residents (0.89) and have declined one per cent since 2019. This is also explored in more detail below. These trends are shown in Figure 27.





4.2.4 The impact of gaining DPA status

GP catchments that gained DPA status appear to have benefited significantly, with increased growth rates in the number of GP FTE per 1,000 residents

GP catchments that are No-DWS; No-DPA have high levels of GP FTE per 1,000 of all MMM areas. Within No-DWS; No-DPA, MM4 areas have the highest GP FTE per 1,000 at 1.40, while MM2 areas have experienced the strongest gains, increasing by 19 per cent since 2015. MM3 areas have also grown strongly, by nine per cent since 2015. MM1 areas have grown strongly at eight per cent since 2015, however, sit below the rest of the cohort at 1.26 GP FTE per 1,000. The transition to DPA does not appear to have impacted the growth trajectory of No-DWS; No-DPA catchments.

GP catchments that are No-DWS; Yes-DPA (gained status) have converged on No-DWS; No-DPA. This has resulted from strong growth across MM3–4 areas which have both risen by 15 per cent since 2015. This growth has been particularly strong since these catchments gained DPA status in 2019. MM2 areas have experienced six per cent growth since 2015.

The difference between No-DWS; No-DPA and No-DWS; Yes-DPA catchments across MMM areas is shown in Figure 28. Comparing the level of GP FTE per 1,000 residents in 2018 (before the introduction of DPA), catchments that gained status had lower level of GP FTE than catchments that did not gain status. MM2 and MM4 areas that gained status were seven per cent and 13 per cent respectively below areas that did not gain status in 2018. This indicates that, on average, catchments that gained DPA status were well targeted when compared with catchments that did not have DWS or DPA status. Further, the increase in growth of GP FTE per 1,000 residents in catchments that gained status indicates the policy has been successful in these areas.

However, it is notable that No-DWS; Yes-DPA catchments have significantly higher numbers of GP FTE per 1,000 residents than both Yes-DWS; Yes-DPA and Yes-DWS; No-DPA, which are 38 and 21 per cent lower respectively.



Figure 28 | Change in GP FTE per 1,000 residents between 2015 and 2021 – No-DWS; No-DPA and No-DWS; Yes-DPA

A number of GP catchments that gained DPA status have experienced strong growth in the GP FTE per 1,000 residents

As shown on the right side of Figure 28, catchments that gained status experienced a strong uptick in growth, especially in MM2, MM3 and MM4 areas which increased eight per cent, three per cent and six per cent respectively following the transition to DPA. A sample of six catchments that gained DPA status and experienced strong growth in GP FTE per 1,000 residents is shown in Figure 29. The names of these individual communities have been anonymised.



Figure 29 | Change in GP FTE per 1,000 residents for catchments that gained DPA status

These catchments also experienced increases in the proportion of patients receiving services within their own catchment. This is shown in Figure 30.





The impact of losing DPA status

The impact of losing DPA status varies across MMM areas

In GP catchments that are Yes-DWS; No-DPA (i.e., catchments that lost status) there is significant variability between MMM areas. GP catchments in MM1 areas have relatively high GP FTE per 1,000 residents (1.12 – above the national median). This has grown strongly at 21 per cent since 2015, continuing to grow following the introduction of the DPA. This suggests that MM1 catchments were well targeted for the removal of DPA status and have not experienced negative impacts. This is a significant finding as a total of 40 GP catchments in MM1 areas lost status following the transition to DPA. This was 69 per cent of all catchments that lost status.

There are 12 GP catchments in MM2 areas that lost status. These catchments have only 0.59 GP FTE per 1,000 residents, the lowest of any status cohort or MMM area. As shown in Figure 31, these catchments have experienced a 22 per cent decline since losing status with the introduction of the DPA, indicating that at least some of these catchments have been significantly negatively impacted.

Figure 31 below presents the percentage change in the median number of GP FTE per 1,000 residents between 2018 (prior to the introduction of DPA) and 2020 (one year after the introduction of DPA). It is worth reinforcing that it is challenging to draw a direct connection between change in DPA status and GP availability. The ability for each catchment to attract and retain GPs is the cumulative result of many state, territory and Commonwealth health policies, programs, incentives and supports, and a series of external factors not captured in this review.



Figure 31 | Percentage change in median number of GP FTEs per 1,000 residents by cohort and MMM location between 2019 and 2021

There are three GP catchments in MM3 areas that lost DPA status. They have a relatively low 0.70 GP FTE per 1,000 residents; however, this has grown 13 per cent since 2015, with growth continuing after the transition to DPA.

There are three GP catchments in MM4 areas that lost DPA status. These catchments are above the national median with 1.16 GP FTE per 1,000 residents; however, they experienced a five per cent decline following the loss of status.

The transition to DPA status does not appear to have significantly impacted MM5-7 areas

In GP catchments that are Yes-DWS; Yes-DPA (this cohort includes all MM5–7 GP catchments) the number of GP FTE per 1,000 residents is the lowest across all four status cohorts (0.89) and has not increased since 2015. These catchments are overwhelmingly MM5–7 (82 per cent) and comprise a large proportion of WA (75 per cent of catchments) and all of the NT.

The small number of MM1 area catchments in this cohort (2.1 per cent) have grown very strongly (39 per cent) since 2015. Meanwhile GP catchments in MM2, MM3 and MM4 areas have grown slowly, gaining

only eight per cent, nine per cent and six per cent additional GP FTE per 1,000 residents respectively since 2015. GP catchments in MM5 areas have remained unchanged since the introduction of the DPA. MM6 areas have decreased by nine per cent while MM7 areas have increased by four per cent. Slight upticks in growth across this cohort may indicate some positive impact of the transition to DPA; however, the trend is not strong enough to definitively make this conclusion.

The difference between Yes-DWS; Yes-DPA catchments and Yes-DWS; No-DPA catchments is shown in Figure 32. These trends suggest that in MM1 and MM4 areas the catchments that lost status were well targeted, as they had significantly higher numbers of GP FTE per 1,000 residents than catchments that maintained status. However, MM2–3 catchments had lower numbers of GP FTE per 1,000 residents than catchments that maintained status, suggesting that from a supply side perspective, these catchments may not have been well targeted to lose DPA status.





Some MM2 and MM4 areas that lost status were adversely impacted by the transition to DPA

Four of the catchments that experienced a decline in GP FTE per 1,000 residents following the loss of DPA status were in MM2 areas. As shown in Figure 33, these four catchments experienced declines between 2018 and 2021. Although only a small number of catchments experienced a decline following their reclassification, the impact it had on individual communities was significant. The names of these communities have been anonymised.



Figure 33 | GP catchments within MM2 areas that experienced declines in GP FTE per 1,000 residents following the loss of DPA status

These catchments also experienced declines in the percentage of patients that receive services within their own catchment, as shown in Figure 34. This may be a further indicator of increasing GP workforce shortage following the removal of DPA status, suggesting that these catchments cannot attract and retain a sizable workforce without the ability to import IMGs.





5 Stakeholder views and insights

To gain a deeper understanding of the effectiveness of the DPA, the review conducted 79 consultation sessions with key stakeholder groups to identify features of the DPA that are working well, the challenges and areas for improvement. This comprehensive consultation approach was designed to ensure that the review gathered insights at the local, jurisdictional and national levels within a compressed timeframe. Analysis of the consultations identified key themes against three overarching questions:

REFINED KEY LINES OF ENQUIRY		Stakeholder consultations identified the following key themes		
1	How effectively does the DPA identify community need for GP services?	 The majority of stakeholders agreed there is a need for DPA. Stakeholders identified workforce shortages in non-DPA areas. The DPA classification methodology is not transparent. The role of the MMM classification in the DPA method is seen by many as problematic. Targeted workforce and succession planning strategies were also seen as important in addressing workforce shortages. 		
2	To what extent does the implementation of DPA address need?	 Access to IMGs is seen as a key benefit of DPA status despite subsequent recruitment challenges. DPA is particularly critical in addressing challenges in rural and remote areas. DPA enables access to well-regarded programs. 		
3	What changes to the DPA will improve equitable access to GP services for people living in regional, rural and remote areas of Australia?	 Confirm the policy objectives of the DPA. Test the impact of extending the DPA automatic rule to MM3–7. Test the impact of including provider as well as patient billing Medicare data. Ensure the ECF is simple, transparent and data driven. Consider providing additional incentives for GPs and practices in MM5–7 catchments. Conduct a system-wide review of the mechanisms, programs, incentives and supports aimed at addressing health workforce issues. 		

Stakeholders generally agreed that the DPA system uses a more nuanced approach to identifying areas of unmet need than the DWS scheme. RWAs, for example, expressed the view that the DPA is generally working to distribute GPs into areas with DPA status, reporting complaints against the system at one-tenth of the volume received under DWS.

Stakeholders view recruitment of GPs as time-consuming and tedious. Moreover, there are distinct challenges in retaining doctors once they are no longer required to stay in DPA locations.

Although the implementation of the DPA is considered by stakeholders to have been effective in identifying the need in rural, remote and very remote GP catchments (MM5–7), there are also catchment areas without DPA status that experience GP shortages.

GPs and practices in locations without DPA status also have access to a range of programs and incentives based on their MMM status; however, the communication about these programs has been less clear.

Key stakeholders from Aboriginal and Torres Strait Islander backgrounds or representing communities with high Aboriginal and Torres Strait Islander populations, such as the Australian Indigenous Doctors Association, were also engaged as part of the stakeholder consultation process. These sessions provided useful insights that were key considerations in the development of final recommendations.

The following sections summarise the key themes and trends identified by stakeholder groups during the national consultation process against each of these three key lines of enquiry. The figures below document

key quotes from stakeholders during the consultations. Quotes have been grouped by the extent to which they strongly agree, agree, disagree, or strongly disagree with the themes listed above. The majority view signpost has been included to indicate the most common view across all stakeholder consultation sessions. The Stakeholder 'Heat Map' illustrates where different stakeholder cohorts lie along this spectrum. All quotes provided by stakeholders have been de-identified across all themes.

Throughout the consultation process, many stakeholders expressed views that were, at times, inaccurate. A key insight drawn from the consultation process is that the majority of stakeholders did not always have a correct understanding of the DPA's policy objective and methodology. Across each of the themes detailed below, inaccurate statements have been highlighted with an (*) asterisk to provide an indication of the lack of understanding and in some cases confusion, across the broader stakeholder group.

5.1 Key line of enquiry 1: How effectively does the DPA address community need?

Overall, stakeholders believed the DPA does identify community need for GP services, but that pockets of unmet need exist in non-DPA catchments.

The DPA's effectiveness in identifying community need for GP services was an important consideration for all stakeholders and the level to which stakeholders believed the DPA was effective varied considerably across groups interviewed. Key themes that emerged through this process include non-DPA GP catchments are experiencing shortages; the need for the DPA as a classification system; the DPA's lack of transparency; the role of the MMM; and the impact of poor workforce planning by practices on GP shortages within communities.

5.1.1 The majority of stakeholders agreed there is a need for the DPA

There is widespread agreement of the need for the DPA tool to identify GP workforce shortages in regional, rural and remote areas. Overall, the DPA is seen by most stakeholders as more effective than the DWS scheme. Peak bodies working closely with GPs and practices reported a reduction in the number of complaints from GPs and GP practices, an increase in the number of IMGs, BMPs and an overall improvement in the distribution of GPs to regional, rural and remote areas.

As represented in in Figure 20, there is strong evidence to support the view that, when aggregated to a national level, GP distribution and availability is improving. Data analysis also supports the stakeholder view that gaining (or losing) DPA status has meaningfully impacts on the ability of catchments to attract and retain GPs. This is reflected both in the positive change following the gain of DPA status represented in Figure 29 and the decrease shown in Figure 33 following its loss.



Figure 35 | The majority of stakeholders agreed there is a need for the DPA

5.1.2 Stakeholders identified workforce shortages in non-DPA areas

Several stakeholder groups highlighted that some GP catchments with non-DPA status are experiencing GP shortages caused by challenges with recruiting and retaining GPs. Some of these areas identified during the consultations included lower socio-economic outer-metro areas, such as NSW Central Coast, the WA Pinjarra region and non-DPA areas across QLD. Stakeholders were often of the view that the MMM rules for automatic DPA status should be extended from MM5–7 to MM3–7. This argument is supported in Figure 32, catchments that lost status in the transition from DWS to DPA, MM2 and MM3 areas, have significantly lower GP FTE per 1,000 residents than the national median, indicating GP workforce shortages may continue to occur within these communities.

However, some stakeholders noted that extending the automatic inclusion rule to include MM3 and MM4 would impact the recruitment and distribution of GPs to MM5–7 areas, with IMGs and BMPs preferring to live closer to urban areas. Insights provided in this section informed the development of recommendation two, to extend the automatic rule to include all MM3 and MM4 locations.



Figure 36 | Stakeholders identified workforce shortages in non-DPA areas

5.1.3 The DPA classification method is not transparent to stakeholders

Stakeholder groups overwhelmingly agreed that there is a distinct lack of transparency and communication with the principles of the DPA methodology and calculations. This includes unclear communication on the policy objectives, methodology, as well as key contacts within the Department for additional support and clarification. Stakeholders also expressed a lack of awareness of the additional programs and incentives offered by the Commonwealth for GP catchments without DPA status. Insights provided in this section informed the development of recommendation three, to improve DPA communications and transparency.



Figure 37 | The DPA classification method is not transparent to stakeholders

5.1.4 The role of the MMM classification in the DPA method is seen by many stakeholders as problematic

The link between the DPA and the MMM was a consistent theme throughout the national stakeholder consultation process. Many stakeholder groups expressed a lack of understanding of the MMM's methodology and the level to which it impacts the DPA's calculation. Many stakeholder groups focused primarily on the MMM during consultation sessions and conveyed several historical challenges with understanding and the application of the MMM classification system. Stakeholders representing MM2–4 catchment areas in particular expressed dissatisfaction with the automatic DPA rule for MM5–7 and how this does not capture the unmet need experienced in their locations. Suggestions by stakeholders to better identify areas of unmet need included using more up-to-date population data and incorporating the demand for services within a catchment (i.e., the role of Fly-in Fly-out workforces or the breakdown of patient flows into and out of catchment areas).

Insights provided in this section informed the development of recommendation six, to review the MMM classification system.



Figure 38 | The role of the MMM classification in the DPA method is problematic

5.1.5 Targeted workforce and succession planning strategies were also seen as important in addressing workforce shortages

Several stakeholders stated that "the DPA was not a silver bullet." In their view, assigning DPA status to a GP catchment area will not immediately resolve the challenges with GP recruitment and retention. Although DPA status is linked to a range of programs and incentives that does provide access to a pool of IMGs and BMPs to address workforce challenges, there are a series of workforce development and succession planning that practices can deploy to ensure their sustainability. The role of workforce and succession planning in managing need was an important consideration for many stakeholders. Stakeholders like colleges and peak bodies consistently expressed the view that GP shortages in non-DPA areas, particularly in outer-metro locations, was impacted heavily by a lack of workforce and succession planning strategies from local general practices. These stakeholders suggested that the degree to which GP practices in non-DPA locations are engaging in training, workforce development and succession planning should be one of the criteria for granting exemption in the ECF and assigning DPA status.

Insights provided in this section informed the development of recommendation seven, to review the broader system of rural health measures, programs and incentives.

TARGETED WORKFORCE PLANNING MAY ADDRESS WORKFORCE SHORTAGES		Poor operating practices and workforce planning strategies may contribute to GP difficulties in filling vacancies		
Stakeholder Heat Molder Aappodes Aappodes	RWAs d	tate health PHNs (GPs GPs DPA) (non-DPA)	
AGREE	N			DISAGREE
 Strongly Agree We are rewarding practices for going into crisis with their workforce planning, rather than engaging in workforce planning. How can we instead reward proactiveness? The DPA could take into consideration workforce planning as a data point. MM1 and outer metro has watered down workforce strategy – IMGs get to parts of Melbourne, Sydney, Brisbane, with no compulsion to get Fellowship, go rural; yet others are required to do so, 10-year moratorium (not useful anymore). Moratoriums don't work anymore, just go to outer metro locations. I believe some of these regions have GP shortages due to a lack of workforce planning and poor workplace culture. These are common in practices that rely heavily on the DPA for IMGs. 	 Somewhat Agree The Department of Health could provide additional support to GP practices in rural areas (such as workforce planning toolkits). Many of the practices expressing concerns have not undertaken adequate workforce planning and relied too heavily on the DWS/DPA to govern their recruitment strategies. There are many options to source workforce without involving DPA. What are the other things you need to do before you access DPA – what is your workforce strategy and succession planning? 	 Neither Agree nor Disagree PHNs can play the role of providing strategies to poorly run practices, as opposed to penalising areas or suburbs that have need. Workforce planning is difficult because many of the models we have don't fit well with rural/remote areas as it's not a one-size-fits-all. People working in rural/remote areas need a little more autonomy to do what they need to do than metropolitan areas. 	 Somewhat Disagree The DPA classification could be more effective if it took into account workforce planning, but I don't have any complaints about how it has been compared to the DWS. 	 Strongly Disagree Practices should be supported through succession planning, but this is not the main cause of GP shortage. The DPA is only one of many considerations when it comes to workforce planning.

Figure 39 | Targeted workforce planning may address workforce shortages

5.2 Key line of enquiry 2: How well does the implementation of the DPA address need?

Understanding the extent to which the implementation of the DPA addresses workforce needs across GP catchment areas was the second key question for all stakeholder groups. Key themes emerging from the consultations are discussed below and included:

- the role of IMGs in DPA locations
- the extent to which the DPA is critical for rural areas
- the DPA's role among other rural health programs
- the inconsistencies presented by the DPA in relation to other health programs available.

5.2.1 Access to IMGs is seen as a key benefit of DPA status despite subsequent recruitment challenges

The majority of stakeholders agreed that IMGs are critical to the delivery of GP services in areas of unmet need, highlighting access to IMGs from the section 19AB program as one of the most important recruitment tools available in regional, rural and remote areas. However, they also outlined the challenges with recruiting and retaining IMGs in these communities. For example, stakeholder groups in regional, rural and remote areas highlighted the lengthy and time-consuming process to recruit an IMG, sometimes taking up to 18 to 24 months from first contact to when they can start working in a practice. General practice managers and owners state this delay is due to lengthy recruitment and relocation periods that are, in many cases, unavoidable. The delay results from the time spent finding IMGs that are best suited to the work in a regional, rural or remote practice setting, as well as relocating IMGs and their families to Australia.

Views expressed by stakeholders within this section often relate to other Commonwealth rural health schemes and may not directly address the effectiveness of the DPA. This highlights the interconnectedness of many rural health programs and the DPA's reliance on other programs like section 19AB.

ACCESS TO IMGS IS SEEN BENEFIT OF DPA STATUS RECRUITMENT CHALLE	AS A KEY DESPITE NGES	has increased the pro and re	oportion of IMGs go mote areas	ing to regional
ta de GPs Colle GPs Colle Heat (non-DPA) RWAs per bod	ges/ State health ak departments lies	GPs PHNs (DPA)		
AGREE	YVIEW			DISAGREE
 Strongly Agree During the DWS-era, only 20 per cent of IMGs went to rural/remote areas, compared to this year where 60 to 65 per cent of IMGs have been placed in these areas under the DPA. (Figures provided by stakeholder during consultation session) IMGs are crucial to the rural healthcare scene and are often the backbone of these communities. We need to get more IMGs onto rural and remote areas through the DPA. We need to do more to keep these doctors in these communities by way of incentives and support. 	 Somewhat Agree Many of these doctors like our rural areas but we make it hard for them and their families to stay. We need to introduce more IMGs into rural areas, we are making it so difficult for them to come here. IMGs often require level one supervision which they cannot always get in DPA locations. If we were to encourage more training/supervision in these regions, that would increase the number of IMGs in 	 Neither Agree hor Disagree 60 to 70 per cent of any DPA practice would be IMGs. I feel sorry for them because they're trying to learn the landscape. No Australian doctors choose to come up to these areas unless for RoSOs. Even really savvy practices find it really hard recruit. Really rare that a locally trained doctor can be recruited. 	 Somewhat Disagree It is so difficult to get IMGs into Australia. It can take anywhere between 18 to 24 months from door to door. The DPA is inflexible, some practices that might need to wait a year to get IMGs will just close down. That is causing a lot of stress for these practices. 	 Strongly Disagree I hate the system that takes IMGs who have a totally different type of medicine and plunk them in rural areas with no support (often with a family). We have a lot of issues with IMGs completing their exams. And when they do complete them, they move off to bigger cities like Melbourne or Sydney.

Figure 40 | Access to IMGs is seen as a key benefit of DPA status despite recruitment challenges

5.2.2 The DPA is particularly critical in addressing workforce challenges in rural and remote areas

The majority of stakeholders consulted agreed that the DPA classification system is critical in providing access to programs that address workforce challenges in regional, rural and remote communities. General practices within catchments with DPA status noted how critical DPA status is for the sustainability of their practices and the continued delivery of healthcare services to their communities. This view is strongly reflected in the available data. As shown in Figure 28, gaining DPA status has a transformative effect on GP availability in MM3 and MM4 catchments.

These benefits include an ability to better manage patient demand over time, accessing a pool of candidates that are willing to practice in rural or remote areas, as well as being better able to manage GPs leaving or retiring.

Recruitment and retention of GPs in these catchments, however, is time-consuming and tedious. There was a strong view that the government should assist in simplifying the process. There were also calls for a partnership approach with local community representatives, and state and territory health representatives to provide more incentives and support to attract and retain GPs for longer in these communities. Suggestions provided include the provision of housing, or additional support to improve GP work-life balance. General practice owners reflected on the need for IMGs to be better supported in their transition into rural areas. Suggestions provided by stakeholders include providing central housing within the GP catchment area, addressing the lack of employment opportunities for spouses, as well as the lack of education facilities for the children of GPs.

Similarly, the majority of stakeholders agreed that the implementation of the DPA has resulted in more IMGs moving to very rural, remote and very remote GP catchments (MM5–7). However, this view is not strongly reflected in the available data. As shown in Figure 21, GP availability in MM6 and MM7 catchments has been relatively stagnant since 2017, with MM5 seeing only a minor increase since the DPA reclassification. This relationship is also observed in the proportion of patients that receive GP services in their own catchment in Figure 23. However, this dataset is both low-resolution (indexed yearly) and small in size. The views of these stakeholders provide a timelier view of GP availability which may be indicative of future trends.

Insights provided in this section informed the development of recommendation one, to clearly define the DPA's policy objective.

Figure 41 | The DPA is particularly critical in addressing workforce challenges in rural and remote areas

THE DPA IS PARTICUL ADDRESSING WORKFOR RURAL AND REM	ARLY CRITICAL IN CE CHALLENGES IN IOTE AREAS	Some catchment areas report that DPA status is critical to their ability to provide health care to their communities		
ча рев Colleges Veak State health bodies departments t	PHNs RWAs (non-DP.	GPs A) (DPA)		
AGREE	TYVIEW			DISAGREE
· · · · · · · · · · · · · · · · · · ·	• •	•	•	•
Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
 The DPA is crucial to the rural healthcare scene and is the backbone of these communities. We need to get more IMGs onto rural and remote areas through the DPA. We in fact get some great feedback about working in rural/remote areas, particularly in the Northern Territory. These are people who have generally gone out there early, thoroughly enjoyed the process and got settled in at an earlier age. The DPA does work in putting IMGs in rural/remote areas. It absolutely helps and it was better than the DWS, but there are definitely opportunities to fine-tune and communicate it better. 	 It is not unreasonable for IMGs to spend five to seven years in a rural/remote area as they play a critical role in these rural areas. My role is getting people into positions, and it is crucial that MM5–7 maintains status. I'm ok with MM4 getting the DPA if market forces will dictate whether they need to recruit at all. Amendments to the system needs to appropriately disincentivise the over- supplied areas, rather than make the rural/remote areas then compete with the peri- urban areas. 	 If we are making an assertion that a region is DPA, it needs to go beyond just IMGs and BMPs and extend to things like training, additional resources, allowances, etc. Both DPA and non-DPA have the same issues when it comes to those areas. The present support structures are not in place to encourage a GP to remain in rural/remote areas. 	 Doctors are generally most interested in their RoSO. This has an impact on how long these doctors will be in rural/remote area or in different locations. Improving access to GPs in rural/remote Australia requires thinking beyond DPA and about attractiveness of GP as a profession: medical school for rural and regional placements, ensuring GPs in country areas work to top of scope of practice, supports are in place both professionally and private/family. 	 I am on the ground and talking with GPs/Allied Health Professionals and it is heartbreaking. There are so many workforce shortages in some areas where GPs are working really long hours, especially in really rural/remote areas where they know they are the backbone of the community.

5.2.3 The DPA enables access to well-regarded programs

Stakeholder groups agreed that the DPA is a threshold indicator that grants the ability to seek access to a series of important programs like BMP, IMGs, FGAMS, Five Year IMGs and the MDRAP, among others. The majority of stakeholders agrees that the DPA plays an important role in rural and remote health, and can often operate as a "gate-keeper" to other rural health programs. This view was also expressed by general practices in MM2–4 locations without DPA status, who state their frustration in their belief that they are unable to access these additional programs to support their practices and the community.

Insights provided in this section informed the development of recommendation seven, to review the broader system of rural health measures, programs and incentives.



Figure 42 | The DPA enables access to well-regarded programs addressing maldistribution of GPs

5.3 Key line of enquiry 3: Stakeholder suggestions for improvement

Throughout the review process, stakeholder groups made a number of suggestions to improve the implementation of the DPA.

The majority of stakeholders suggested that providing better communication on the principles of the DPA methodology and the calculations would be useful. Other suggestions raised by stakeholders were:

- Confirm the policy objective of the DPA is it a classification system to identify areas of unmet need across Australia (excluding MM1 inner metropolitan GP catchments) or primarily to identify areas of unmet need within regional, rural and remote communities (i.e., GP catchments with MM3–7 status).
- Test the impact of extending the DPA automatic rule from MM5–7 to include MM3 and MM4, and quantifying the impact this extension would have on the number of practices with DPA status and the proportion of services received in catchments with DPA status.
- Review the MMM methodology to ensure it is accurate in categorising rurality, particularly in areas that border locations with different MMM status.

- Consider using the degree to which GP practices in non-DPA locations are engaging in training, workforce development and succession planning as one of the criteria for granting exemption in the ECF and assigning DPA status.
- Work more closely with RWAs, PHNs, colleges and key GPs/practice stakeholders to co-develop a
 general workforce development succession planning strategy that can be tailored to meet local
 community needs.
- Provide increased incentives for GPs and general practice operators in very rural and remote areas in MM5–7 locations. An expanded incentive and benefits structure for these locations will aim to mitigate against a drain of IMGs and BMPs from very remote locations into more developed MM3–4 catchments.
- Conduct a system-wide review of the mechanisms, programs, incentives and support aimed at addressing health workforce issues. Quantify the impact of each program in achieving the overarching goal. Understanding the linkages, dependencies, challenges and streamline the mechanisms, programs, incentives and supports to work in unison.
- Ensure the ECF is simple and transparent when communicated to stakeholders, uses a robust review process that is data-driven and leverages tools like HeaDS UPP, and receives timely contextual information from key bodies like PHNs and RWAs.

Where practical, improvement provided by stakeholders were analysed for their feasibility and the most effective have been included with further detail in the scenario modelling and recommendations section of this report.

6 Scenario analysis

Insights drawn from qualitative and quantitative data gathered throughout the review suggested multiple possible changes to the DPA system.

Many stakeholders support the view that the DPA classification system should prioritise regional, rural and remote parts of Australia. Figure 28 shows that, historically, extending DPA status to MM3 and MM4 catchments has resulted in a meaningful increase in their GP availability. Hence, automatically extending DPA status to, MM3–7 (where currently it is offered by default only to MM5–7), may contribute to alleviating the maldistribution of Australia's GPs.

Stakeholders also recommended a commensurate de-prioritisation of metropolitan and densely populated areas. Despite representing 68 per cent of catchments that lost DWS status under the 2019 reclassification, MM1 areas continue to see growth in GP availability. This continued growth is evident even in the cohort of MM1 catchments that lost status, which has seen a 2.2 per cent increase in median GP FTEs per 1,000 residents since 2019 (as shown in Figure 31). MM1 catchments may continue to attract and retain a sufficiently large GP workforce without being eligible for DPA status.

We have also seen that MMM location is not the only predictor of GP availability – these trends can vary significantly by state, as shown in Figure 14. Some stakeholders have suggested that DPA status should not be based on a national benchmark of MM2 catchments, but one that takes the state context into account. Some have also suggested that the DPA should retain its national basis, but factor additional variables like Medicare billing data.

This section conducts scenario analysis to understand the potential impacts of these changes. Findings of the scenario analysis are used to inform the recommendations of the review.

Analysis of the following scenarios is presented:

- granting automatic DPA status to all GP catchment areas in MM3-4 locations
- removing DPA status from all MM1 locations
- introducing a population cap for locations to be eligible for DPA status
- including Medicare billing data from GPs (in addition to patient level billing) in the DPA calculation.

Analysis of each scenario includes an overview and rationale, analysis on the nature and magnitude of the change, and an assessment of potential impact including key risks and benefits, and recommendations.

6.1 Granting DPA status to all GP catchment areas in MM3–4 locations

6.1.1 Overview and rationale

The majority of stakeholders were supportive of the suggestion to automatically grant DPA status to all GP catchments in MM3–4 areas. However, some stakeholders expressed concern that this would drain workforce from more remote MM5–7 locations. Analysis of this scenario identifies all the GP catchments in MM3–4 areas that do not currently have DPA status. The relative magnitude and associated impacts of granting these catchments DPA status is then explored.

6.1.2 Nature and magnitude of the change

A relatively small proportion (18 per cent) of all GP catchments areas are in MM3–4 locations. These catchments represent eight per cent of all GP services received across Australia. A much larger proportion (33 per cent) of GP catchments are in MM5 locations. These catchments account for six per cent of services received nationally.

The majority of GP catchments in MM3 (68 per cent) and MM4 (80 per cent) locations already have DPA status. DPA status catchments account for 60 per cent of all services received in MM3 and 71 per cent of all services received in MM4 locations. This is shown in Figure 43.

Figure 43 | Current proportion of catchment areas, DPA status and nationally received services in MM3– 4 locations



Granting DPA status to all GP catchments in MM3–4 locations would result in 37 catchments gaining full or partial DPA status

Including all GP catchments in MM3–4 locations would result in 37 additional catchments gaining full or partial DPA status. These 37 catchments are in NSW, VIC, QLD, SA and TAS. In total, they would represent a 6.1 per cent increase in the number of GP catchments with DPA status across Australia, accounting for 4.3 per cent of all services received across Australia. This is shown in Figure 44.





Including all MM3–4 catchments in DPA status would add 37 catchments across NSW, VIC, QLD, SA and TAS. This is a 6.2 per cent increase in the number of DPA catchments across Australia.

These 37 catchments represent 4.3 per cent of services delivered across Australia.

The most significant impact of this scenario is on NSW, which would experience a 15 per cent increase in the number of catchments that have DPA status

In this scenario an additional 24 catchments would gain DPA status in NSW. Of these, 13 are in MM3 locations and 11 are in MM4 locations. These catchments would represent an 8.4 per cent increase in state services being received in DPA catchments. The geographic distribution of the additional DPA status GP catchments is shown in Figure 45.



Figure 45 | Geographic distribution of 24 additional DPA catchments in NSW

VIC and QLD would experience more minor impacts

In this scenario an additional six catchments in VIC and four catchments in QLD would gain DPA status. This would result in a 5.8 per cent and 4.0 per cent respective increase in the proportion of state services received in GP catchments with DPA status. The geographic distribution of additional catchments is shown in Figure 46.





SA and TAS would experience minimal impacts

In this scenario an additional two catchments in SA and one catchment in TAS would gain DPA status. This would result in a 5.1 per cent and 2.2 per cent respective increase in the proportion of state services received in GP catchments with DPA status. The geographic distribution of additional catchments is shown in Figure 47.



Figure 47 | Geographic distribution of additional DPA catchments in SA and TAS

Summary of the change

A summary of the change associated with granting DPA status to all GP catchments in MM3 and MM4 locations is shown in Figure 48.

Figure 48 | Summary of the key changes that would result from granting DPA status to all GP catchments in MM3 and MM4 locations



6.1.3 Assessment of potential impact

Granting automatic DPA status to all GP catchments in MM3 and MM4 locations would provide much needed support to areas that reported significant workforce shortages that impacted on their ability to provide quality care to communities.

The key risk associated with including all MM3–4 locations in DPA status is draining resources from more rural and remote locations. On a national scale this risk appears to be minimal as the magnitude of change is relatively small.

However, localised areas may experience more significant impacts. MM3 locations include larger regional towns such as Coffs Harbour (78,000 people), Port Macquarie (population 52,000) and Shepparton (population 57,000). DPA status for these towns may drain workforce from the surrounding region. Examples of this were reported by GPs located one to two hours outside regional centres. These GPs experienced increased workforce shortages after nearby regional centres gained DPA status.

MM3 and MM4 locations also include highly liveable and desirable locations unlikely to experience workforce shortages. Granting DPA status for these areas may also result in increased shortages in surrounding areas.

6.1.4 Policy considerations

The decision on whether to grant DPA status to all MM3 and MM4 GP catchments depends on the policy intent of the DPA program. If the policy intent of the DPA is to support regional, rural and remote areas experiencing workforce shortage, then MM3 and MM4 locations could be considered for automatic inclusion. This would address the issues reported by many non-DPA GP catchments in MM3 and MM4 areas that report significant workforce shortage that are not reflected in the current DPA calculation.

Extending DPA status to all MM3 and MM4 catchments may also support innovative models of primary care such as "hub and spoke" models of service delivery in which regional centres service surrounding areas on an outreach basis. Advances in telehealth could further support this possibility.

However, this change may disadvantage MM5-7 areas by increasing the competition for IMGs.

6.2 Removing DPA status from all MM1 locations

6.2.1 Overview and rationale

The stated intention of the DPA is to re-distribute GPs to areas experiencing workforce shortage, with a focus on regional, rural and remote areas. The definition of an MM1 area is "metropolitan", including both inner and outer metropolitan areas. This covers major cities and accounts for 70 per cent of Australia's population.

Currently, only outer-metropolitan catchments in MM1 are eligible for DPA status. Some stakeholders reported that granting DPA status to any MM1 locations undermines the benefits that the system can provide for rural and remote areas, as many IMGs would prefer to be based in cities over rural and remote areas. They suggest that the automatic ineligibility of inner-metro MM1 catchments for DPA status should extend to all of MM1, outer-metro catchments included.

Excluding all MM1 catchments from DPA status is likely to provide additional benefits to GP catchments in MM2–7 areas. However, it is possible that some GP catchments in outer-metropolitan MM1 locations do experience workforce shortage and rely on the DPA to access programs and support that provide care to their communities.

6.2.2 Nature and magnitude of the change

There are 210 GP catchments in MM1 locations. Of these catchments, 101 (48 per cent) are "inner metro" and 109 (52 per cent) are "non-inner metro". Catchments in inner metro areas are not able to access DPA status, regardless of their position in relation to the benchmark (of the 101 inner metro catchments, 42 are above the benchmark and 59 are below the benchmark). Catchments in non-inner metro areas are granted DPA status if they are below the benchmark, under the same principles as catchments in MM2–4 locations.

There are 17 GP catchments in non-inner metro MM1 locations that are below the benchmark and have DPA status

There are 17 catchments in MM1 areas that have DPA status. These catchments represent 4.5 per cent of all GP service received across Australia and 19.9 per cent of all GP services received in DPA areas. ACT has the most GP catchments in MM1 locations that have DPA status (41 per cent). Based on data from FY 2020-21, Figure 49 illustrates the distribution of MM1 GP catchments with DPA status.



Figure 49 | Catchments in MM1 locations that have DPA status

6.2.3 Assessment of potential impact

Removing DPA status from GP catchments in MM1 locations is likely to result in higher proportions of IMGs choosing to work in MM2–7 locations, delivering benefits by alleviating workforce shortage. This change would also have the benefit of simplifying the DPA system through the introduction of an "automatic rule" exclusion for all MM1 locations.

Many GP catchments in MM1 locations that have DPA status are in areas with relatively affluent populations. A total of 65 per cent of GP catchments in MM1 locations that have DPA status are in local government areas (LGAs) in the eighth SEIFA decile and above.³⁴ These GP catchments are in densely populated and high-income city locations, such as Belconnen and East Canberra in the ACT, that are unlikely to experience workforce shortages. The reason that patient Medicare billing in these GP catchments is below the benchmark is unclear. One possibility relates to specialist and allied healthcare services. Populations in GP catchments that are privileged and well-serviced are likely to access specialist and allied healthcare services at a high rate. This may be a substitute for GP services. In contrast, populations in regional, rural and remote GP catchments are likely to rely more heavily on GPs to meet all of their health-related needs. It is unlikely that removing DPA status from GP catchments that are in the eighth SEIFA decile and above will result in significant negative impacts on workforce or health outcomes.

However, there are some GP catchments in MM1 locations that have DPA status that are significantly less privileged. A total of 35 per cent of GP catchments in MM1 locations that have DPA status sit in the sixth SEIFA decile and below. Removing DPA status from these areas may result in negative impacts on population health.

Policy considerations

Removing DPA status for all GP catchments in MM1 areas would benefit MM2 and above areas by decreasing competition for IMGs. However, this may disadvantage some MM1 catchments that rely on DPA status. A potential alternative is updating the "Inner Metro/Outer Metro" classification to ensure that densely populated and high-income city locations are not included in the DPA. Further investigation is required to fully assess the potential impact of this change.

³⁴ Australian Bureau and Statistic, SEIFA by LGA, 2021.

6.3 Introducing a population cap for areas with DPA status

6.3.1 Overview and rationale

Some stakeholders expressed the view that DPA status in medium-large regional centres (MM2 and occasionally MM3 areas) may drain workforce from more rural and remote locations. They argue that, like with the distinct outer-metropolitan and inner-metropolitan cohorts within MM1, not all catchments within MM2 and MM3 should be treated equally. The larger population centres in these MMM bands may enable them to attract and retain more GPs, have sufficient demand to sustain private practice and support a broader range of specialised and private health services that are not covered by the MBS. Introducing a population cap for locations with DPA status would reduce the number of DPA catchments. This may increase re-distribution of workforce away from well-served regional centres and to areas of greater need through the programs offered in DPA catchments.

GP catchments with smaller populations are more likely to have DPA status

GP catchments with smaller populations are more likely to experience workforce shortage and therefore have DPA status. This can be seen by comparing the average population across GP catchments with and without DPA status within each MMM location, shown in Figure 50.



Figure 50 | Average GP catchment population by DPA status

6.3.2 Nature and magnitude of the change

The impact of a population cap on the GP catchments that receive DPA status depends on where the population cap is set. The intention of a population cap is to filter out large towns as they are less likely to experience workforce shortage and may drain workforce from surrounding areas if they gain DPA status.

This scenario models three possible population caps of:

- 100,000 people
- 75,000 people
- 50,000 people.

The scenarios are modelled applying the caps across all GP catchments (MM1–7) to include any unusually highly populated catchments in rural and remote Australia.

A population cap of 100,000 people

There are 78 GP catchments with a population over 100,000 people. Seven of these currently have DPA status. Five are in MM1 areas and two in MM2 areas. These catchments include:

- five catchments in VIC Geelong, Ballarat, Bendigo, Brimbank and Mornington
- one catchment in the ACT Belconnen
- one catchment in SA Onkaparinga.

These catchments represent 4.7 per cent of all GP services received across Australia and 21 per cent of services received in DPA catchments.

A population cap of 75,000

There are 119 catchments with a population of over 75,000 people, with the vast majority not holding DPA status. A total of 12 of these currently have DPA status. Seven are in MM1 areas and five are in MM2 areas. The five additional catchments (that are between 75,000 and 100,000) people include:

- two catchments in the ACT Gungahlin and Tuggeranong
- one catchment in NSW Albury-Wodonga
- one catchment in QLD Bundaberg
- one catchment in TAS Launceston.

The 12 DPA catchments that have a population of over 75,000 represent 6.2 per cent of all services received in Australia and 27.6 per cent of all services received in DPA catchments.

A population cap of 50,000

There are 174 GP catchments with a population over 50,000 (this represents 21 per cent of all catchments). A total of 18 of these catchments currently have DPA status (however, two are in the NT and are consequently excluded from this analysis). The four additional catchments (that are between 50,000 and 75,000 people) include:

- two in NSW Tamworth and Wagga Wagga
- one in VIC Mildura
- one in QLD Rockhampton.

The 16 DPA catchments with a population of over 50,000 represents 7.1 per cent of all services received in Australia and 31.6 per cent of all services received in DPA catchments.

6.3.3 Assessment of potential impact

Large DPA catchments represent a significant proportion of services received in DPA areas. However, some large catchments may also be experiencing significant workforce shortage resulting in reduced access to health services. Revoking their DPA status may exacerbate this issue. Further, some of these more densely populated regional centres provide healthcare to a network of nearby rural communities in a hub and spoke model, removing the DPA status from larger regional centres may also impact smaller surrounding communities.

6.3.4 Policy considerations

Introducing a population cap, above which catchments cannot hold DPA status, is unlikely to be a successful or an appropriate policy change. Instead, catchment population could be included as additional data that may be relevant to the granting of DPA status.

6.4 Including GP Medicare billing (in addition to patient Medicare billing data) in the DPA calculation

6.4.1 Overview and rationale

The current DPA calculation is based on patient Medicare billing data. This is a measure of the demand for healthcare services, as it reflects the volume of medical care accessed by patients. The demand for GP services is a key measure of access to healthcare services and the logic of the DPA calculation assumes that if demand (patient Medicare billing) is low, access to healthcare must be limited, implying a shortage of GP services. This measure does not consider the supply side of workforce shortage and access to healthcare services is reflected in GP Medicare billing data, which is not currently included in the DPA calculation.

In certain contexts, the demand side measure of access to healthcare services may not tell the full story of workforce shortage within a catchment. This can occur when patients move between catchments to seek GP services. Using the demand side measure of patient access to Medicare services within each GP catchment obscures patient movement between catchments. When an individual sees a GP, their Medicare billing data is recorded in their home catchment, not the catchment where the GP is located. If there is a shortage in GP services within a catchment, patients may be required to travel outside of the catchment to see a GP. This movement is not reflected in the DPA calculation.

The difference between patient and provider Medicare billing within a catchment sheds light on patient flows

In half of all non-DPA catchments, patient Medicare billing exceeds provider Medicare billing. If the population is accessing a higher level of GP services than the level provided within the catchment, patients are travelling outside of the catchments to access services. In some cases, this may be voluntary, such as individuals travelling for employment and choosing to access a GP near their place of work. In other cases, it is likely that travelling outside of a catchment to see a GP reflects a shortage of available services in an individual's home catchment.

The majority (75 per cent) of catchments in which patient Medicare billing exceeds provider Medicare billing are in MM1 areas. In these areas this is unlikely to be an indicator of workforce shortage. A total of 14 catchments in which patient Medicare billing exceeds provider Medicare billing are in MM3–4 locations. Individuals in these catchments face greater barriers (travel distance) to seeking GP services outside of their home catchment, therefore this measure is more likely to indicate workforce shortage in MM3–4 areas.

The number and distribution of non-DPA catchments in which patient billing exceeds provider billing is shown in Figure 51.



Figure 51 | Non-DPA status GP catchments in which patient billing is greater than provider billing

In half of non-DPA GP catchments in which patient billing exceeds provider billing, patient billing exceeds provider billing by more than 10 per cent

The magnitude of difference between patient billing and provider billing provides an indication of what proportion of individuals are going outside of their GP catchment to access GP services. In 52 per cent of catchments, patient billing exceeds provider billing by more than 10 per cent, indicating that a significant proportion of the population are leaving their GP catchment to access services. Patient billing is much more likely to exceed provider billing by more than 50 per cent in regional and rural catchments than metropolitan ones, where this is true for only two per cent of catchments. In MM2, MM3 and MM4 the patient billing exceeds the provider billing by more than 50 per cent in 19 per cent, 33 per cent and 13 per cent respectively of the non-DPA catchments. The distribution of the gap between patient and provider billing across MMM location is shown in Figure 52.





The difference between patient billing and provider billing provides an indication of what proportion of individuals are going outside of their GP catchment to access GP services.

In the majority of catchments, patient billing exceeds provider billing by less than 10 per cent.

There are six catchments in MM3 and MM4 locations in which patient billing exceeds provider billing by more than 10 per cent

Five of these catchments in are NSW. This distribution is shown in Figure 53. In rural catchments (MM3 and MM4 areas) in which patient billing exceeds provider billing by more than 10 per cent it is highly likely that the catchment is experiencing GP shortage.



Figure 53 | Geographical distribution of MM3 and MM4 areas non-DPA GP catchments in which patient billing exceeds provider billing by more than 10 per cent

6.4.2 Nature of magnitude of the change

Due to limitations in the data and tools that were accessed and the time constraints for this review, it is not possible to comment on the potential methodology for including GP provider billing in the DPA calculation. Similarly, it is not possible to determine how this change would impact the number and distribution of DPA status catchments.

6.4.3 Assessment of potential impact

Including provider Medicare billing in the DPA calculation is likely to increase the number of MM3–4 catchments with DPA status. Further investigation is required to fully assess the potential impact of this change.

6.4.4 Policy considerations

The current DPA calculation is based on patient Medicare billing data (demand side). It does not include the supply side (GP Medicare billing data) of workforce shortage and access to healthcare services. In certain contexts, the demand side measure of access to healthcare services may not tell the full story of workforce shortage within a catchment. This can occur when patients move between catchments to seek GP services. The data identified a number of non-DPA rural GP catchments in which a significant proportion of patients are traveling outside of their catchment to access GP services. This was highlighted during consultations where stakeholders noted practices in non-DPA rural catchments reported extreme difficulty in recruiting GPs, resulting in closing books to new patients and long wait times for appointments.

It is likely that including the supply side measure of provider billing data would increase the accuracy of the DPA calculation as a tool for determining workforce shortage. However, further scenario modelling and analysis of potential impacts is required to provide a conclusive answer.
7 Findings and recommendations

This section describes the key findings and recommendations from this review. The findings and recommendations were developed from insights drawn from qualitative and quantitative data gathered throughout the review, including the data analysis of DPA's identification of areas of workforce shortage and the impact of implementation of DPA in addressing workforce shortages identified, stakeholder views and insights gained throughout the national consultation process and the scenario modelling.

7.1 Findings from review of DPA classification system

The findings set out in this section are based on the data analysis, stakeholder insights and scenario modelling undertaken for this review. They are presented against the three key lines of enquiry.

7.1.1 Key line of enquiry 1: How effectively does the DPA identify community need for GP services?

The review has found that the DPA is a generally effective indicator in identifying regional, rural and remote areas where there is a greater need for access to GPs. While there are some areas where the review has identified areas for improvement, it is clear from the analysis of the impact and from the stakeholder consultations that the DPA is serving a useful purpose.

Stakeholder consultation has found broad support for the DPA as a mechanism (Figure 34), and there is an appreciation that it is a more sophisticated measure for identifying community need than the previous DWS measure. Stakeholders broadly agreed the DPA is particularly critical in addressing workforce challenges in rural and remote areas (Figure 40), and it enables access to programs that address GP maldistribution (Figure 41).

Data supports these stakeholder views and suggests the DPA, at a national level, has been an effective indicator of GP workforce shortages, with DPA status increasing with the distance of catchments from metropolitan areas (Figure 7). GP catchments in MM5–7 areas make up 71 per cent of all DPA catchments and these represent 31 per cent of GP services received in DPA catchments (Figure 9).

However, there a few marginal areas across MM2–4 where community need is not accurately reflected by the DPA (see section 4.3.4). More work needs to be done to understand the reason for the low GP FTE per 1,000 residents in these marginal MM2–4 locations.

The role of the DPA in meeting community need would be better understood if its policy intent was made clearer. Throughout the consultation process, many stakeholders expressed views that were, at times, inaccurate. A key insight drawn from the consultation process is that the majority of stakeholders did not always have a correct understanding of the DPA's policy objective and calculation methodology, at times leading to frustration. Some stakeholders viewed the DPA's aim as being to identify areas of unmet need across Australia as a whole, while others believed it should be focused on rural and remote areas of unmet need only.

The review also found that it was inappropriate for any areas within MM1 to be classified as DPA, given the policy intent of the DPA is to address workforce shortages in regional, rural and remote locations.

7.1.2 Key line of enquiry 2: To what extent does the implementation of DPA address need?

The review has found that the implementation of the DPA addresses workforce needs across GP catchment areas by ensuring that the programs that use DPA are targeted to the neediest locations.

Most stakeholders agreed IMGs are critical to the delivery of GP services in areas of unmet need, highlighting access to IMGs from the section 19AB program as the most important recruitment tool available in regional, rural and remote areas (Figure 40).

Overall, most stakeholders agreed the DPA classification system is critical in providing access to programs that address workforce challenges in regional, rural and remote communities (Figure 41).

The data analysis supports these views. On average, since 2019, the GP FTE working across Australia has been increasing (Figure 20). This improvement in the GP FTE per 1,000 residents occurred steadily in MM1–4 areas while MM5, MM6 and MM7 have been relatively unchanged (Figure 21). Stakeholder groups agreed the DPA is a threshold indicator that grants the ability to seek access to a series of important programs, such as BMP, IMGs, FGAMS, Five Year IMGs PEP and the MDRAP (Figure 42).

The analysis also showed that the catchments that gained DPA status have improved to equal non DWS/DPA catchments in the GP FTE per 1,000 residents (Figure 27). However, for MM5–7 catchments that previously had DWS and were given DPA status, their GP FTE remained unchanged or trended downwards (Figure 27). Most (60 per cent) of the catchments that lost DWS status under the reclassification continued to see growth in their GP availability after the change, indicating that, in the short-term, these reclassifications were appropriate (Figure 28).

The review found that there has been a lack of communication and transparency about the DPA that has hindered community understanding and increased frustration. Throughout the consultation process, many stakeholders expressed views that were, at times, inaccurate. Stakeholder groups consistently agreed that there is a distinct lack of communication and transparency about the DPA. This includes unclear communication around its policy objectives, methodology, advising if a GP catchment's DPA status has changed, as well as a lack of understanding around who to contact within the Department for further support.

Information about the DPA and the ECF are currently available on the Department's website and have been updated during the review process.^{35,36} The review found that although the communications from the Department regarding DPA and the establishment of the ECF process is useful and relevant, it would be more helpful if the communication approach was more active, tailored to meet stakeholder group requirements and clearly identified opportunities to provide feedback. This could be achieved by leveraging existing networks within the Department, PHNs, Rural Workforce Agency Network (RWAN), and state and territory health services.

During the consultations, stakeholders noted that many of the existing measures, programs and incentives to support the design and delivery of primary healthcare services in regional, rural and remote Australia have been developed in silos and their linkages and dependencies with DPA not clearly understood. There is a belief among stakeholder groups that the DPA should be reviewed as part of a broader analysis of the wider system supporting rural and remote health.

³⁵ Department of Health, 2021, Distribution Priority Area, <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa>

³⁶ Department of Health, 2021, Request a Review of a DPA classification, <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa/request-review>

7.2 Recommendations: Key line of enquiry 3, what changes to the DPA will improve equitable access to GP services for people living in regional, rural and remote areas of Australia?

Throughout the review process, recommendations to improve the implementation of the DPA were identified through the stakeholder consultations and tested with data analysis and scenario modelling. The review's recommendations are described below.

7.2.1 Recommendation 1: Confirm the DPA policy intent

Based on the review's finding that the policy intent of the DPA is not well understood by stakeholders, the review suggests that clarifying the DPA's policy intent will allow for greater transparency of the DPA as a tool and facilitate DPA achieving its policy objective, which in turn would improve stakeholder's understanding of the DPA and reduce frustration.

Based on the information provided by the Department, it is clear that the policy intent is to identify areas in regional, rural and remote Australia with unmet need lacking access to GP services. The Department should find ways to actively and clearly confirm the DPA's policy intent with stakeholder groups in an on-going, multipronged manner (see recommendation two).

7.2.2 Recommendation 2: Improve DPA communications and transparency

Improved communications and greater transparency in the information made available about the DPA measure and the ECF process would assist in removing some of the frustrations evident during stakeholder consultations. This could be achieved by clear, active, ongoing and multipronged communication that targets stakeholder groups through a variety of channels.

The review consulted publicly available information regarding the DPA and ECF, discussed the types and content of communications received by stakeholder groups regarding the DPA and ECF, and was provided with a draft internal document from the Department about the DPA. During the review process publicly available information, particularly regarding the ECF, was evolving and being updated.

Stakeholder access to clear, active, ongoing and multipronged communication would strengthen stakeholder engagement and support for the DPA, specifically regarding the DPA's:

- policy intent
- data and methodology used to determine the DPA status of GP catchments
- annual changes to DPA status of GP catchments
- annual publication of GP FTE per 1,000 residents per GP catchment timed to coincide with the annual changes to DPA status of GP catchments
- exceptional circumstance submission process, data requirements and timelines ³⁷
- incentives and support for GPs and general practices in MM1–7 locations.³⁸

Additionally, while some information is currently available on the Department website regarding the DPA and additional programs and incentives for GPs and practices, a passive communications approach only reaches actively engaged stakeholders already "in the know" or working in policy development and program delivery.

³⁷ Department of Health, 2021, Request a review of a DPA or DWS classification, <https://www.health.gov.au/initiatives-and-programs/doctorconnect/about-working-in-australia/request-a-review-of-a-dpa-or-dws-classification>

³⁸ Department of Health, 2021, Incentives and support for GPs and general practices in MM locations,

<https://www.health.gov.au/resources/collections/incentives-and-support-for-gps-and-general-practices-in-mm-locations>

To reach GPs and general practices, multipronged communications through a variety of channels would leverage their contact points with professional colleges, regulatory agencies and other peak bodies, PHNs, RWAs, state and territory health departments, as well as the Department.

This would allow for greater transparency of the DPA both as a tool and in meeting its policy objectives, which could improve stakeholder understanding of the DPA and reduce frustration. Messaging from the Department should provide a systems perspective and how the DPA fits into the range of programs and incentives for GPs and practices in rural and remote Australia.

The Department should develop a communications and stakeholder engagement strategy that would:

- leverage the current structure in place utilising professional colleges, RWAs and PHNs to build DPA awareness and understanding among GPs, practices and communities (LGAs)
- outreach to stakeholders within GP catchments, particularly those vulnerable to losing DPA status, early on and prior to the DPA's annual determination
- develop a program of continuous engagement identifying key opportunities throughout the year to communicate with stakeholder groups.

7.2.3 Recommendation 3: Extend the automatic rule to include all MM3 and MM4 locations and exclude all MM1 locations

Automatic extension to MM3 and MM4

In light of the clarification of the policy intent of the DPA, which is to identify areas in regional, rural and remote Australia with unmet need lacking access to GP services, the review has recommended that the DPA automatic rule be extended to include all GP catchments classified as MM3–7. An announcement of this change was made by the Minister for Regional Health, the Hon Dr David Gillespie MP, towards the end of the review period.

Many stakeholders support the view that the DPA classification system should prioritise rural and remote parts of Australia before all metropolitan catchments, even those with a shortage of health workers. Figure 28 shows that, historically, extending DPA status to large and medium-sized rural catchments (MM3 and MM4) has resulted in a meaningful increase in their GP availability. Hence, automatically providing DPA status to all rural locations, MM3–7 (where currently it is offered by default only to MM5–7), may contribute to alleviating the maldistribution of Australia's GPs.

This would address the issues reported by many non-DPA GP catchments in MM3–4 locations that report significant workforce shortages that are not reflected in the current DPA calculation (see Figure 32 and section 6.1). It will also expand the number of locations available for the programs that are tied to the DPA.

The review notes that this extension could potentially disadvantage MM5–7 locations by increasing the competition for IMGs. Additionally, if all MM3–4 locations were automatically included, it is possible that some areas that do not experience workforce shortage would be granted status. These impacts are not considered likely to cause significant disruption to the programs that use the DPA as the impacts would be at the margin only, given the small number of catchments involved.

Excluding all MM1 locations

Removing DPA eligibility from MM1 areas would further align with the DPA's policy intent of identifying areas in regional, rural and remote Australia with unmet need lacking access to GP services. Currently, outer-metropolitan catchments in MM1 are eligible for DPA status. Some stakeholders reported that granting DPA status to any MM1 locations undermines the benefits that the system can provide for rural and remote areas, as many IMGs would prefer to be based in cities rather than rural and remote areas. Some stakeholders also recommended a de-prioritisation of metropolitan and densely populated areas.

Despite representing 68 per cent of catchments that lost DWS status under the 2019 reclassification, MM1 areas continue to see growth in GP availability. This continued growth is evident even in the cohort of MM1 catchments that lost status, which has seen a 2.2 per cent increase in median GP FTEs per 1,000 residents since 2019 (as shown in Figure 31). MM1 catchments are likely to continue to attract and retain a sufficiently large GP workforce even without being eligible for DPA status.

A potential alternative to excluding all MM1 locations would be to update the "Inner Metro/Outer Metro" classification to ensure that privileged city locations are not included in the DPA.

Removing DPA status for all GP catchments in MM1 areas would benefit MM2 and above areas by decreasing competition for IMGs in regional, rural and remote locations.

7.2.4 Recommendation 4: Refine the Exceptional Circumstances Framework

As an overarching principle, the ECF should be a timely, clear, data driven process that dives more deeply into workforce and population health data, giving a nuanced understanding of an individual area within a GP catchment.

The assessment of DPA classification follows an impartial methodology and is updated annually taking effect on 1 July.³⁹ However, to address criticism of the DPA's inflexibility and inability to consider more recent circumstances and anomalies within a GP catchment, the ECF seeks to provide a layer of discretion for locations who may still have inequitable access to GP services.

The ECF allows anyone in a non-DPA area, such as a general practice, to seek a reassessment by the DWG of their catchment's DPA status. Any change in DPA status applies to the whole catchment, not just the GP or practice that applied. An important step in the assessment process is applicants working with and having the support of the RWA in their state or territory.⁴⁰

The review notes that the Government has recently publicly outlined the process to request a review of a DPA classification.⁴¹ However, to further ensure a timely, clear, data driven ECF process, the review proposes the ECF process should:

- utilise HeaDS UPP and other data to better understand contemporaneous community use and access to health services and the health workforce, for example patient flows, GP FTEs and the mix of GP subspecialities⁴²
- consider population health data to better understand the needs of the GP catchment, for example rates of chronic conditions, addiction and mental health needs, rates of disability⁴³
- require PHN and RWA support as part of the application process to ensure greater room for discretion and understanding of the nuances in GP catchment areas, including working with the RWA to understand the workforce planning and recruitment strategies across the catchment.

³⁹ Department of Health, 2021, Request a review of a DPA or DWS classification, <https://www.health.gov.au/initiatives-and-programs/doctorconnect/about-working-in-australia/request-a-review-of-a-dpa-or-dws-classification>

⁴⁰ Department of Health, 2021, Distribution Priority Areas exceptional circumstances review for GPs,

<https://www.health.gov.au/ministers/the-hon-dr-david-gillespie-mp/media/distribution-priority-areas-exceptional-circumstances-review-for-gps>

⁴¹ Department of Health, 2021, Request a review of a DPA classification, <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa/request-review>

⁴² Department of Health, 2021, HeaDS UPP, <https://hwd.health.gov.au/headsupp/>

⁴³ Department of Health, 2021, Population health data, <https://www.health.gov.au/health-topics/preventive-health/population-health-data>

7.2.5 Recommendation 5: Investigate changes to the DPA calculation

The review recommends that ongoing work be undertaken to further investigate the impact of three other changes to the DPA calculation:

- to improve the way MBS data are used to by the DPA to capture workforce shortages
- to determine whether the use of MM2 is an appropriate benchmark for granting access to DPA dependent programs (noting that in some programs a national average is used)
- to include additional data that may be relevant to the granting of DPA status (e.g., population caps).

MBS data

The current DPA calculation is based on patient Medicare billing data (demand side). This is a measure of the demand for healthcare services, as it reflects the volume of patients seeking medical care from GPs. However, this measure does not consider the supply side of workforce shortage and access to healthcare services. The supply of GP services is reflected in GP Medicare billing data.

In certain contexts, the demand side measure of access to healthcare services may not tell the full story of workforce shortage within a catchment. This can occur when patients move between catchments to seek GP services. Using the demand side measure of patient access to Medicare services within each GP catchment obscures patient movement between catchments. When an individual sees a GP, their Medicare billing data is recorded in their home catchment, not the catchment where the GP is located. If there is a shortage in GP services within a catchment, patients may be required to travel outside of the catchment to see a GP. This movement is not reflected in the DPA calculation.

The Department should investigate the impact of including both the demand side <u>and</u> the supply side data as part of the DPA calculation. It is likely that including both the demand side and the supply side measure of billing data would increase the accuracy of the DPA calculation as a tool for determining workforce shortage (see section 6.4). Further scenario modelling and analysis of potential impacts is required to provide a conclusive recommendation.

The appropriate benchmark

To determine if the use of MM2 is an appropriate benchmark for granting access to DPA for IMG dependent programs. The benchmark used to determine whether a GP catchment has DPA status and access to DPA IMG dependent programs is MM2. The review was unable to find a rationale for why this benchmark is used and notes that a national average benchmark is used for the Bonded Medical Program. It would be timely for the Department to further consider the use of this benchmark as it relates to DPA dependent programs and how this benchmark aligns with the DPA's policy intent to support regional, rural and remote Australia.

Additional data

In line with stakeholder comments recommending the inclusion of additional and contemporaneous data to provide a more nuanced and accurate depiction of a GP catchment's population profile, the Department could investigate additional data that might be used as part of the DPA methodology and calculation. Examples include data available in HeaDS UPP or other population health data.

However, the review cautions that the inclusion of additional data will make the DPA's calculation more complex and may make it more difficult to communicate and be understood by stakeholder groups.

7.2.7 Recommendation 6: Review the Modified Monash Model classification system

It is timely to review the MMM classification system, its methodology and use, given its key role in determining DPA status of GP catchments.

The DPA aims to bring statistical evidence into a classification system to produce a more nuanced approach to the maldistribution of GP workforce, and it utilises MMM boundaries and location classification to apply automatic rules for DPA inclusion or exclusion (see section 2.5).

The link between the DPA and MMM was a consistent theme through the national stakeholder consultation process. Many stakeholder groups expressed challenges in understanding the MMM's methodology and the level to which it impacts the DPA's calculation – particularly in areas that border alongside locations with different MMM statuses (see section 5.1.4 and Figure 38).

It is timely to review the use of the MMM classification, and its methodology, in determining DPA status of a GP catchment given:

- MMM classifications are updated using data points that are not contemporary.
- Health programs began transitioning to the updated MMM 2019 from 1 January 2020, for example the Rural Pharmacy Maintenance Allowance program; however, the impact of their MMM classification on access to programs, incentives and support has not been evaluated.
- Road access was not accounted for in the MMM calculations.⁴⁴ Seasonal road access in far-north, remote Australia can vary enormously between wet and dry seasons, with the wet periods making many roads inaccessible for significant periods of time. MMM does not account for seasonal access and to do so requires the Index of Access to have two scores one each for wet and dry seasons.

7.2.8 Recommendation 7: Review GP Catchments

The methodology for the Department's custom geography, known as GP catchments, was developed as part of the HeaDS UPP tool, used by the DPA and should now be reviewed. The catchments are specific to primary care and differ from the secondary services catchment areas that relate to the use of hospital services. All GP practices within a GP catchment are accorded the same DPA status, except that an AMS within the catchment is automatically assigned DPA status.

The GP catchments were constructed using data points that are non-contemporary, specifically the ABS ASGS 2016, along with five years' worth of Medicare data, and demographic data such as the ABS Australian Population Grid and Residential Mesh Blocks 2016.⁴⁵ It is timely that they be reviewed to assess if they represent appropriate contemporary groupings for the purposes of the calculation of DPA status and the workforce programs that use DPA status.

7.2.9 Recommendation 8: Coordinated and cohesive approach to the broader system of rural health measures, programs and incentives

Aligned with the review of the GP catchments, it would be beneficial to bring together the various measures the Department has in place to improve the maldistribution of Australia's GP workforce and to encourage GPs to practice in regional, rural and remote locations. Such a comprehensive review was sought by many stakeholders through the consultation process. It would allow a more cohesive and integrated response to workforce need in these locations. This coordinated and cohesive response should:

⁴⁴ McGrail MR Humphreys JS, 2015, Discussion paper: Development of a national Index of Access for primary health care in Australia.

⁴⁵ Department of Health, 2021, Health Workforce Distribution Priority Area fact sheet,

<https://www.health.gov.au/sites/default/files/health-workforce-distribution-priority-areas-factsheet.pdf>

- define the primary goal of the various measures, programs and incentives
- quantify the impact of each program in achieving its policy objective
- understand the linkages, dependencies and challenges
- streamline the measures, programs and incentives to work in unison.

As part of the review, consideration could be given to innovative approaches to address some of the short-, medium- and long-term implications of GP maldistribution in outer-metro, regional, rural and remote Australia. This work could then support the current and on-going development of a national medical workforce strategy, comprising of three specific sub-strategies focused on metro, regional and rural/remote Australia.⁴⁶ The concurrent evaluation of the Government's SRHS also provides an opportunity to assess the measures that address rural workforce in a more cohesive manner.

⁴⁶ Department of Health, 2021, National Medical Workforce Strategy 2021-2031, <https://www.health.gov.au/initiatives-and-programs/national-medical-workforce-strategy-2021-2031>

8 Acronyms

Acronym	Definition
AAPM	Australian Association of Practice Management
ABS	Australian Bureau of Statistics
ACRRM	Australian College of Rural and Remote Medicine
AIDA	Australian Indigenous Doctors' Association
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ARIA+	Accessibility and Remoteness Index of Australia
ASGS	Australian Statistical Geography Standard
BMP	Bonded Medical Places Scheme
DPA	Distribution Priority Area
DWG	Distribution Working Group
DWS	District of Workforce Shortage
ECF	Exceptional Circumstances Framework
ERP	Estimated Residential Population
FGAMS	Foreign Graduate of Accredited Medical Schools
FTE	Full Time Equivalent
GP	General Practitioner
HeaDS UPP	Health Demand and Supply Utilisation Patterns Planning
IMG	International Medical Graduates
LGA	Local Government Areas
LHD	Lower Health District
LHN	Local Hospital Network
MDRAP	More Doctors for Rural Australia Program

MBS	Medicare Benefits Schedule
MM	Modified Monash category
MMM	Modified Monash Model
MRBS	Medical Rural Bonded Scholarship
NACCHO	National Aboriginal Community Controlled Health Organisations
Non-VR	Non-Vocationally Recognised
NRHA	National Rural Health Alliance
OTD	Five Year Overseas Trained Doctors Scheme
PEP	Practice Experience Programs
PHN	Primary Health Networks
RACGP	The Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RoSO	Return of Service Obligation
RTO	Regional Training Providers
RWA	Rural Workforce Agency
RWAN	Rural Workforce Agency Network
SEIFA	Socio-Economic Indexes for Areas
SRHS	Stronger Rural Health Strategy
WIP	Workforce Incentive Program

9 References

References list

ACRRM, Framework and Guidelines for Telehealth Services, <https://www.acrrm.org.au/docs/default-source/all-files/telehealth-framework-and-guidelines.pdf?sfvrsn=ec0eda85_2>

Australian Bureau and Statistic, SEIFA by LGA, 2021.

Australian Health Practitioner Regulation Agency, 2021, Technology-based patient consultations, <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Technology-based-consultationguidelines.aspx?TSPD_101_R0=08c403b005ab200059ba3e588818ee309d543fd6e7f9bf9f1c327ace743336a9c8aee00d 52ccd4710809ac47701448000c47c9ed7db2b38a3bfec04b7902e21db7c57b982b930093a3b723a08a53f744fb513ff6b a15f14f39233b7d2186e512227bc8d6005cebe812b403ea97f77a67e69b21e5b31c11c5>

Australian Institute of Health and Welfare, 2019, Rural & remote health Web Report, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary

Deloitte Access Economics, 2019, General Practitioner workforce report 2019, <https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-generalpractitioners-workforce-2019-021219.pdf>

Department of Health (data.org.au), MMM 2019 CSV., <https://data.gov.au/data/dataset/modified-monash-model-mmm-2019/resource/7af3b211-60a0-4515-96ba-2e72b4cd7119>

Department of Health, 2021, Incentives and support for GPs and general practices in MM locations, https://www.health.gov.au/resources/collections/incentives-and-support-for-gps-and-general-practices-in-mm-locations>

Department of Health, 2019, Modified Monash Model, <https://www.health.gov.au/sites/default/files/documents/2020/07/modified-monash-model-fact-sheet.pdf>

Department of Health, 2021, Section 19AB restricted doctors and access to Medicare, <https://www.health.gov.au/health-topics/doctors-and-specialists/what-we-do/19ab>

Department of Health, 2021, Visas for GPs Program, <https://www.health.gov.au/health-topics/doctors-and-specialists/what-we-do/19ab>

Department of Health, 2021, Annual update of Distribution Priority Area (DPA) and District of Workforce Shortage (DWS) classifications, <https://www.health.gov.au/initiatives-and-programs/doctorconnect/about-working-in-australia/annual-update-of-distribution-priority-area-dpa-and-district-of-workforce-shortage-dws-classifications>

Department of Health, 2021, Incentives and support for GPs and general practices in MM locations, https://www.health.gov.au/resources/collections/incentives-and-support-for-gps-and-general-practices-in-mm-locations>

Department of Health, 2021, HeaDS UPP, <https://hwd.health.gov.au/headsupp/>

Department of Health, 2021, More Doctors for Rural Australia Program, <https://www.health.gov.au/initiatives-and-programs/more-doctors-for-rural-australia-program>

Department of Health, 2021, Population health data, <https://www.health.gov.au/health-topics/preventive-health/population-health-data>

Department of Health, 2021, Distribution Priority Areas exceptional circumstances review for GPs, <https://www.health.gov.au/ministers/the-hon-dr-david-gillespie-mp/media/distribution-priority-areas-exceptional-circumstances-review-for-gps>

Department of Health, Method Paper: General Practice Full Time Equivalent (GPFTE) – Workforce, <https://hwd.health.gov.au/resources/information/methods-gp-full-time-equivalent.pdf>

Department of Health, 2021, Providing health care remotely during COVID-19, <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-health-and-disability-sector/providing-health-care-remotely-during-covid-19>

Department of Health, 2021, Request a review of a DPA or DWS classification, <https://www.health.gov.au/initiativesand-programs/doctorconnect/about-working-in-australia/request-a-review-of-a-dpa-or-dws-classification>

McGrail MR & Humphreys JS, 2015, Discussion paper: Development of a national Index for Access for Primary Health Care in Australia, Centre of Research Excellence in Rural and Remote Primary Health Care, Monash University, School or Rural Health, pp 35.

Melbourne Institute: Applied Economic and Social Research, the University of Melbourne, the impact of COVID 19 on GPs and non-GPs specialists in private practice.

RACGP, 2017, On-demand telehealth services, <https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/health-systems-and-environmental/on-demand-telehealth-services#ref-num-2>

nous

ABOUT NOUS

Nous Group is an international management consultancy operating across Australia and New Zealand, the UK, Ireland and Canada. For over 20 years we have been partnering with leaders to shape world-class businesses, effective governments and empowered communities.



Australia | New Zealand | UK | Ireland | Canada

bold

engaging