Australian Government Response

Review of the Distribution Priority Area (DPA) Classification System

March 2022

Review of the Distribution Priority Area (DPA) Classification System

On 2 September 2021, the Minister for Regional Health, the Hon Dr David Gillespie MP, announced a formal review of the Distribution Priority Area (DPA) classification system (the Review). Following a competitive tender process, the Nous Group were selected to undertake the Review. The Review commenced in October 2021 and a final report was provided to the Department of Health (the Department) on 17 December 2021.

The Review assessed the effectiveness of the DPA by investigating three key questions:

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?

The Nous Group conducted more than 79 interviews and small focus groups with a broad range of stakeholders including general practices, Rural Workforce Agencies (RWAs), Primary Health Networks (PHNs), peak bodies, professional colleges, state and territory governments and the federal government. These interviews were supplemented by a review of the methodology used to derive the indicator, data analysis and scenario modelling.

The Review found that, for the most part, DPA has been effective in identifying patient services access and workforce needs across Australia. The proportion of DPA catchments increases with rurality and that there are some areas for improvement. There is broad support for the DPA as a mechanism that identifies areas for the targeting of a number of Australian Government workforce programs. There is also appreciation that it is more sophisticated in its calculation, with the addition of socio-economic and demographic factors, than the previous District of Workforce Shortage (DWS) classification.

At the time of the report, nearly three quarters of the more than 800 GP catchments across Australia had DPA status. Around 71 per cent of catchments with DPA status are in MM5–7 locations and these collectively deliver 31 per cent of all GP services in Australia.

There have been significant changes in the rural GP workforce since the DPA indicator 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, and COVID-19 have all likely influenced the GP workforce across Australia. Given these factors, it can still be stated that the DPA has been correlated with an improvement in the GP workforce in rural and remote areas (as measured by GP Full Time Equivalents (FTE)). However, it is not possible to know exactly what proportion of the changes can be attributed due to the interrelated nature of workforce programs.

The Review also identified a range of opportunities to improve the DPA to facilitate equitable access to GPs for people living in rural and remote areas in Australia. Various scenarios were modelled and tested, informing the Review's recommendations. The Review made eight recommendations to improve the DPA's application, outcomes and impact. The Government supports six of these recommendations and partially supports the remaining two. An overview of each of the recommendations and the Government's response is provided below.

Actions in Response to the Review of the Distribution Priority Area (DPA) Classification System

#	Recommendation	Analysis	Implementation
1	**Confirm the DPA's policy intent**	**Supported** • The Review identified significant stakeholder confusion regarding the purpose of the DPA and how it is calculated. • This supports the need for more detailed communication to clarify the methodology and goals of the DPA. • The DPA's purpose is to identify areas of Australia experiencing insufficient patient access to GP services and to meet the needs of the community, primarily in regional, rural and remote Australia. This allows the targeting of distribution mechanisms and incentive programs to improve GP access in these underserviced areas.	**Commence immediately** The Department will progressively publish new material online during 2022 that clarifies the intent and provides further information about the DPA.

2	**Improve DPA communications and transparency**	**Supported**
		• The effectiveness of the DPA depends on stakeholders understanding its objectives, methodology and process of implementation, as well as the workforce incentives and programs which aim to address doctor shortages.
		• The Department will improve communications and stakeholder engagement to build stronger understanding of the DPA. These changes will include:
		  ○ Clearer articulation of the DPA's role in improving GP access, including distribution mechanisms, programs and incentives.
		  ○ Clearer explanation of the Modified Monash Model's (MMM) role in the DPA.
		  ○ Better communication with stakeholders, leveraging the on-the-ground knowledge and contacts of Rural Workforce Agencies (RWAs).
		  ○ More detailed user guides explaining how DPA is used in different health workforce programs.
			Commence immediately
			
			The Department will progressively publish new material online during 2022 that improves the available information about the DPA and the use of the DPA in a range of health workforce programs.

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		○ Information regarding the range of options to practices experiencing recruitment challenges, including available programs and incentives.	
3	**Extend the automatic rule:** a) Extend the automatic rule to include all MM3 and MM4 locations b) Exclude all MM1 catchments	**(a) Supported** • On 10 December 2021, the Government announced a change to the automatic rules governing the DPA. From 1 January 2022, all MM 3-4 locations automatically became DPA, along with the existing MM 5-7 locations and the Northern Territory. **(b) Not supported** • Government recognises that GP shortages can occur in MM 1 outer metropolitan locations, in addition to regional, rural and remote areas of Australia. • Outer metropolitan areas can experience high population growth, often contain socio-economically disadvantaged patient cohorts and may suffer from under-developed public transport infrastructure. • Underserviced outer metropolitan MM 1 areas will therefore continue to be assessed against the DPA benchmark, with outcomes reported in the annual update. • Automatic non-DPA status will remain in place for MM 1 inner metropolitan areas which have better access to GP services than other areas.	**Commence immediately** Changes to the automatic rules to include MM 3 and MM 4 locations took effect on 1 January 2022. MM 1 outer metro catchments will continue to be assessed against the national DPA benchmarks as part of the annual update and for use by certain workforce programs. MM1 inner metro areas will continue to be automatically non-DPA.
4	**Refine the Exceptional Circumstances Framework (ECF)** a) Incorporate workforce data available to the Department of Health to generate insight into use of and access to services.	**(a) and (b) supported** • The ECF was designed to ensure consideration of possible exceptional circumstances not identified in the annual DPA update. • The ECF process commenced in November 2021 and was designed to be clear, efficient and data-driven.	**Currently underway** Further refinements to the DPA ECF will be made as part of the 2022 DPA annual update, due in July 2022.

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	b) Consider population health data to better understand the needs of individual catchments. c) Require Rural Workforce Agency (RWA) and Primary Health Network (PHN) support for ECF applications, including requirement for applicant to work with RWA in relation to workforce planning and recruitment strategies.	• Over 80 GP catchments have had their DPA status reviewed since November 2021. • The ECF's process of review is being improved as lessons are learned during implementation. • Future ECF assessments will include population and health workforce data, with further relevant data to be incorporated as it becomes available. **c) Not supported** • Compulsory support of the RWA or PHN would impose an unreasonable restriction on the ECF process. • RWAs in particular do not always have sufficient information on MM 1 outer-metropolitan areas to support applications. • RWAs and PHNs already have significant involvement in the ECF process. RWAs and PHNs are the primary on-the-ground resource for assisting practices experiencing recruitment and other workforce challenges. • ECF applications are open to all stakeholders and will not require RWA or PHN support. However, consultation with RWAs and/or PHNs may ensure a stronger ECF application.	
5	**Investigate changes to the DPA calculation** a) Introduce supply and demand MBS billing data to improve DPA accuracy b) Determine whether MM 2 is an appropriate benchmark for identifying GP shortages (noting that a national benchmark is used in some programs).	**Supported** a) <u>Supply and demand data to improve DPA accuracy and c) incorporate additional data into DPA assessment</u> • The DPA was introduced in 2019 as a replacement to the previously used Districts of Workforce Shortage (DWS) for GPs mechanism. • DPA uses a more sophisticated methodology to determine GP shortage relative to the needs of the community.	**Commence immediately** The Department will consider and incorporate additional data at the GP catchment level as part of the DPA annual update, due in July 2022. The DWG will consider the appropriateness of the MM 2

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	c) Incorporate additional relevant data into DPA assessments	• The Government does not support a wholesale change in the DPA methodology but recognises that it is important that system reflects contemporaneous circumstances.
		• The Government therefore acknowledges that additional refinements may improve the accuracy and utility of the mechanism.
		• In 2021, the Department published each GP catchment's range above or below the established benchmark. From 2022, the Department will provide more contextual health workforce related data on each catchment, including
		  ○ Catchment's SEIFA (disadvantage) score
		  ○ GP FTE and GP FTE per 1000 population
		  ○ Number of practices
		  ○ GP billing data
		  ○ Patient inflows and outflows
		• This additional information is intended to increase transparency and assist GPs, practices and RWAs with workforce planning, and assist programs with design of eligibility criteria.
		• Beginning in 2023, the Department will undertake a "ground-truthing" exercise involving in-depth analysis of a sample of GP catchments in order to ensure DPA assessments are correctly calibrated for their intended purpose of identifying areas of GP service shortfalls.
		
		b) <u>Evaluation of MM 2 benchmarks</u>
		• The Distribution Working Group (DWG) considered options for the DPA benchmark in 2017-18.
		• A national benchmark for IMGs and FGAMS was rejected due to the distorting effects of well-serviced MM 1 locations.
			benchmark and the process for "ground-truthing" a sample of GP catchments ahead of the 2023 DPA update, due in July 2023.

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		• A national benchmark was applied to Bonded Medical Program doctors, in recognition that their contractual return of service obligations may extend over many years and there may be a need for these doctors to work in MM 1 outer metropolitan locations. • Benchmarks were frozen until 1 July 2022 to allow areas with significant GP shortages to stabilise. • The DWG will examine the appropriateness of the MM 2 benchmark for the GP workforce during 2022.	

6	**Review the Modified Monash Model (MMM) geographical remoteness classification system**, including its methodology and utility in relation to distribution mechanisms.	**Supported**
		• The MMM was first adopted and introduced into rural health workforce programs in 2015, using 2011 ABS Census data.
		• The current MMM relies on 2016 ABS Census data, which is due to be updated to 2021 ABS Census data when this data becomes available in late 2022.
		• The Department will conduct a wide-ranging review of the MMM, examining:
		  ○ Potential improvements to methodology
		  ○ Whether the MMM is sufficiently granular
		  ○ Options to reduce boundary disparities, which sometimes see functionally contiguous areas (such as shopping strips on each side of the same road) classified differently.
		  ○ Updating inner and outer metropolitan sub-classifications.
		  ○ The MMM's interaction with GP catchments.
		• Stakeholders will be provided with opportunities for input into this review.
		• The review's findings will be incorporated into the next MMM update (using 2021 Census data) in 2023.
			Commence immediately
			
			The Department will conduct a review of the MMM. This review will commence in mid-2022 to inform an update to MMM in 2023.

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7	**Review GP catchments**	**Supported** • The 829 GP catchments in which DPA status is assessed are constructed using the most recently available Medicare billing data, together with current ABS population data. • The Department will commence work from early 2022 to review and update GP catchments to include the most recent ABS Census data and five years of Medicare billing data (2017-21).	**Currently underway** The Department will continue its review of GP catchments in 2022.
8	**Coordinated and cohesive approach to the broader system of rural health measures, programs and incentives**	**Supported** • To meet the Government's goal of equitable access to timely, reliable and high quality GP services for all Australians, it is critical that health workforce distribution and incentive programs work cohesively and in congruence (rather than in competition) with each other. • Work is currently underway to evaluate the Stronger Rural Health Strategy (SRHS) by October 2022 and health outreach programs (including the Rural Health Outreach Fund and Indigenous outreach programs) by the end of 2022. • All health workforce programs will be reviewed by 2023-24 to identify potential efficiency gains by streamlining programs and discontinuing underperforming programs. • The Department will also conduct additional work to map out linkages between existing programs to ensure coherence and complementariness in their goals.	**Commence immediately** The Department will continue evaluations of key programs that are currently underway to inform a broader review of health workforce programs by 2023-24.