

EXPLANATORY STATEMENT

Migration Regulations 1994

MIGRATION (LIN 19/049: SPECIFICATION OF OCCUPATIONS AND ASSESSING AUTHORITIES FOR SUBCLASS 186 (EMPLOYER NOMINATION SCHEME) VISA) INSTRUMENT 2019

(Paragraph 5.19(8)(a), paragraph 5.19(8)(c), subregulation 5.19(11) and paragraph 186.234(2)(a) of the Regulations)

1. The instrument, LIN 19/049 is made under paragraph 5.19(8)(a), paragraph 5.19(8)(c), subregulation 5.19(11) and will specify assessing authorities under paragraph 186.234(2)(a) of Schedule 2 to the *Migration Regulations 1994* (the Regulations).
2. The instrument repeals *Migration (IMMI 18/049: Specification of Occupations and Assessing Authorities—Subclass 186 Visa) Instrument 2018* (F2018L00298) (the old law) made under paragraphs 5.19(8)(a) and (c), paragraph 5.19(11) of the Regulations and in accordance with subsection 33(3) of the *Acts Interpretation Act 1901* (the AIA). Subsection 33(3) of the AIA states that where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character, the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.
3. The instrument operates to specify the skilled occupation and assessing authorities in relation to nominations for the Employer Nomination Scheme (ENS) visa (Subclass 186). The specified occupations are allocated to the Medium and Long-term Strategic Skills List (MLTSSL).
4. The instrument is to specify skilled occupations in the MLTSSL for the purposes of regulation 5.19 of the Regulations, and specify assessing authorities for the ENS visa for the purpose of paragraph 186.234(2)(a) of the Regulations.
5. The purpose of the instrument is to list the occupations for the MLTSSL. The occupation allocations are based on labour market advice from the Department of Jobs and Small Business. The changes from the old law, ensure that the occupations

specified in the lists remain relevant and responsive to changes in the Australian labour market.

6. The instrument changes, that differ from the old law are as follows:
 - a. the following eight occupations are added to the MLTSSL:
 - i. arts administrator or manager (ANZSCO code 139911);
 - ii. dancer or choreographer (ANZSCO code 211112);
 - iii. music director (ANZSCO code 211212);
 - iv. artistic director (ANZSCO code 212111);
 - v. telecommunications network planner (ANZSCO code 313213);
 - vi. pressure welder (ANZSCO code 322312);
 - vii. tennis coach (ANZSCO code 452316); and
 - viii. footballer (ANZSCO code 452411).

7. The instrument also specifies two new inapplicability conditions. They are as follows:
 - a. the instrument imposes a new inapplicability condition (24) for the occupations of general practitioner (ANZSCO code 253111), medical practitioners (nec) (ANZSCO code 253999) and resident medical officer (ANZSCO code 253112) (medical practitioner occupations).

The inapplicability condition stipulates if a current health workforce certificate for the position and the occupation is not presented to the Department of Home Affairs, the nomination will not be accepted. A health workforce certificate sets out the name and date of birth of a nominee, the position that the certificate relates to, and the location of the position.

The certificate will be issued by an entity specified in paragraph 4(c) of the definition of *health workforce certificate* in the instrument. Those entities will consider the qualifications of the applicant, and the nominating agency including whether the nominated position is located in an area of workforce need before a health workforce certificate is issued to a nominee.

This change aims to better regulate the number of overseas trained doctors entering Australia under the skilled migration program and to direct them to areas of workforce shortage. This is an initiative of the Department of Health.

- b. item 25 applies to a position which has a nominated annual earnings of less than AUD120,000. This is now a condition of the occupation of footballer (ANZSCO code 452411) listed in the MLTSSL.
8. In the table of assessing authorities in column 3, section 7(1) of the instrument, the following changes have been made:
- a. the ‘Australian Podiatry Association’ (APodA) as an assessing authority as it is no longer a relevant assessing authority for the occupation of ‘Podiatrist’; and
 - b. ensuring the name of the following assessing authorities match those registered with the Australian Securities and Investments Commission (ASIC):
 - i. Architects Accreditation Council of Australia Inc to Architects Accreditation Council of Australia;
 - ii. Australian Association of Social Workers to Australian Association of Social Workers Limited;
 - iii. Australian Computer Society to Australian Computer Society Incorporated;
 - iv. Australian Community Workers Association to Australian Community Workers Association Inc.;
 - v. Australian Dental Council to Australian Dental Council Limited;
 - vi. Australian Institute of Quantity Surveyors to The Australian Institute of Quantity Surveyors;
 - vii. Australian Institute for Teaching and School Leadership to Australian Institute for Teaching and School Leadership Limited;
 - viii. Australian and New Zealand Podiatry Accreditation Council Inc. to Australian and New Zealand Podiatry Accreditation Council Limited;
 - ix. Australasian Osteopathic Accreditation Council to Australasian Osteopathic Accreditation Council Limited;
 - x. Australian Orthotic Prosthetic Association to Australian Orthotic Prosthetic Association Limited;

- xi. Australian Physiotherapy Council to Australian Physiotherapy Council Limited;
- xii. Australian Pharmacy Council to Australian Pharmacy Council Limited;
- xiii. Australian Psychological Society to Australian Psychological Society Limited;
- xiv. Australasian Veterinary Boards Council Inc. to Australasian Veterinary Boards Council Incorporated;
- xv. Institution of Engineers Australia to The Institution of Engineers Australia;
- xvi. Institute of Public Accountants to Institute of Public Accountants Ltd;
- xvii. National Accreditation Authority for Translators and Interpreters to National Accreditation Authority for Translators and Interpreters Ltd;
- xviii. Optometry Council of Australia and New Zealand to Optometry Council of Australia and New Zealand Limited;
- xix. Occupational Therapy Council (Australia and New Zealand) Limited to Occupational Therapy Council of Australia Limited;
- xx. Speech Pathology Australia to The Speech Pathology Association of Australia Limited; and
- xxi. Surveying and Spatial Sciences Institute to Surveying and Spatial Sciences Institute Limited.

9. The instrument (excluding item 24 of the table in section 8) will apply prospectively to:

- a. an application for approval of a nomination in the Direct Entry stream of the ENS visa made on or after commencement.
- b. an application for an ENS or a related application for approval of a nomination in the Direct Entry Stream of that the ENS visa if the relevant application is made on or after the day the instrument commences.

10. The old law will continue to apply to:

- a. an application for approval of a nomination made before the date of commencement of the instrument; and
- b. an application for an ENS visa in the Direct Entry stream made before, on or after the commencement of this instrument, if the related application for

approval of a nomination was made, on or after 18 March 2018; but before the day this instrument commences.

11. The instrument notes in section 4 that '[a] number of expressions used in this instrument are defined in the Regulations, including ANZSCO.' Regulation 1.03 of the Regulations provides the following definition of ANZSCO: '**ANZSCO** has the meaning specified by the Minister in an instrument in writing for this definition.' The instrument made under regulation 1.03 for the definition of ANZSCO, as in force on the date of commencement of this instrument, is *Migration (LIN 19/051: Specification of Occupations and Assessing Authorities) Instrument 2019* (LIN 19/051). Section 5 of LIN 19/051 provides:

For the purpose of regulation 1.03 of the Regulations, ANZSCO means that Australian and New Zealand Standard Classification of Occupations published by the Australia Bureau of Statistics.

ANZSCO may be accessed on the Australian Bureau of Statistics website (<http://www.abs.gov.au/>).

12. Consultation was undertaken before the instrument was made as follows:
- a. the community was given an opportunity to provide submissions responding to the proposed changes, where 204 submissions were received;
 - b. 78 meetings with employers and industry peak bodies were held, including 8 industry roundtables; and
 - c. inter-departmental committee meetings were held with the Department of the Prime Minister and Cabinet, the Department Industry, Innovation and Science, the Department of Education and Training, the Department of Agriculture and Water Resources, the Department of Foreign Affairs and Trade, the Department of Communications and the Arts, the Department of Infrastructure, Regional Development and Cities, and the Department of Health.
13. The Office of Best Practice Regulation (OBPR) have advised that a Regulatory Impact Statement (RIS) for the changes to the STSOL, MLTSSL and ROL is not required (OBPR Reference: 23806).

14. The OBPR has been consulted in relation to the Visas for GPs amendments, and has advised that the Regulation Impact Statement is compliant with the Government's requirements. The OBPR Reference is 23390. The RIS is at [Attachment A](#).
15. Under section 10 of the *Legislation (Exemptions and Other Matters) Regulation 2015*, the instrument is exempt from disallowance and therefore a Statement of Compatibility with Human Rights is not required.
16. The instrument commences on the day after registration on the Federal Register of Legislation

Attachment A

Standard Form Regulation Impact Statement (RIS)

Name of proposal: Stronger Rural Health Strategy
Office of Best Practice Regulation (OBPR) ID number: 23390

Background

The Stronger Rural Health Strategy ('the Strategy') aims to build a sustainable, high quality health workforce that is distributed across the country according to community need, particularly in rural and remote communities. The Strategy reflects the Government's commitment to improve the health of people living in regional, rural and remote Australia.

In operational terms, the Strategy is comprised of 12 complementary measures that collectively represent:

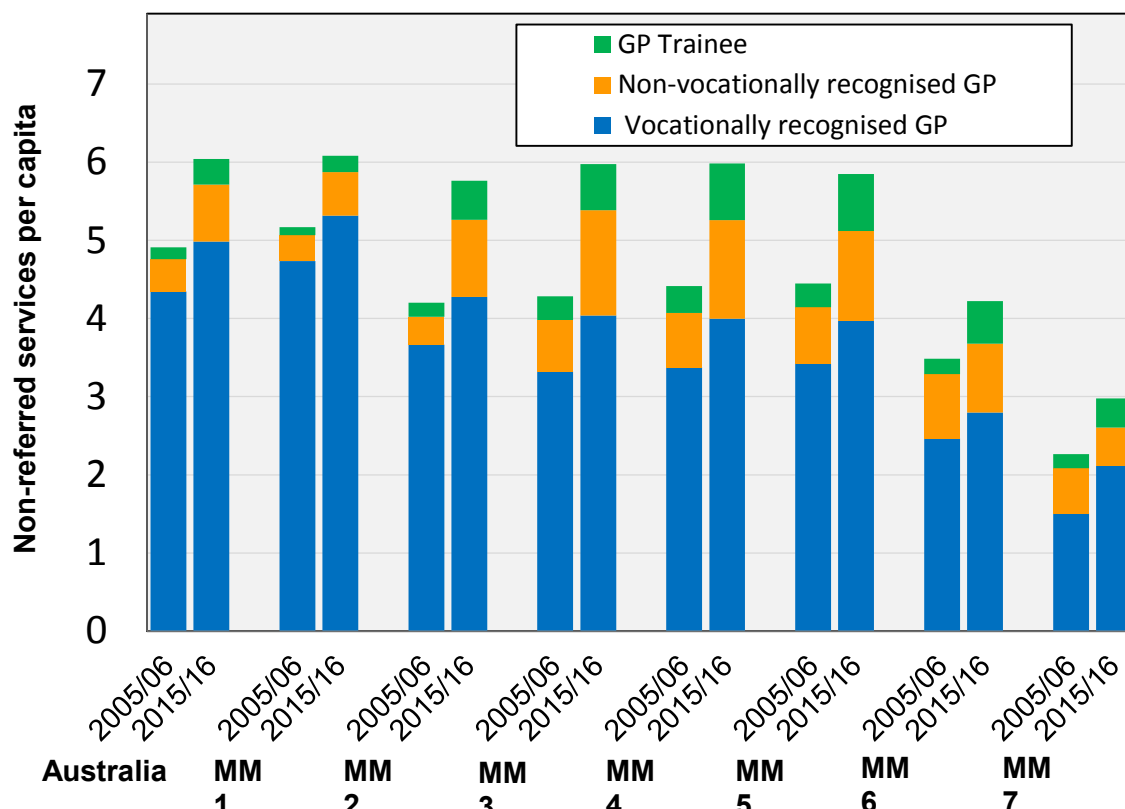
- a considered approach to recalibrating and updating several key Government policies, programs and incentives that share the objective of improving access to health services, particularly in regional, rural and remote Australia;
- a key step towards developing data tools to support collaborative health workforce planning and future policy development; and
- a renewed commitment that health and medical professionals are appropriately trained to meet service needs in varied clinical settings.

An examination of Australia's medical workforce provides an important illustration of the need for this approach to reform. Australia's medical workforce is supplied through domestic medical training of local and international students and is supplemented through immigration. The Department of Health (Health) undertakes health workforce supply and demand studies to evaluate how well Australia's health workforce is meeting community health care needs. These studies highlight the following medical workforce issues:

1. Australia continues to face a significant maldistribution of the medical workforce, with regional, rural and remote areas receiving less access to medical services than the major cities. This workforce distribution issue is most evident when considering general practitioners (GPs) and exists despite a:
 - significant increase in the per capita number of GPs practising across Australia; and
 - substantial growth in the per capita number of non-referred GP services performed under the Medicare Benefits Schedule (MBS) across Australia between 2006 and 2016. Figure 1 compares the overall level of services provided across each Modified Monash Model (MMM) remoteness category during this period.
2. While the MBS access rules encourage doctors to qualify as GPs, a significant portion of the growth in the delivery of MBS-subsidised primary care services is being driven by non-vocationally recognised (non-VR) doctors. This is particularly true in regional, rural and remote areas where the majority of this growth is from doctors who do not hold GP qualifications and who are not formally training with a college. Figure 1 shows this trend.
3. Despite definable workforce shortages, the continued growth of the medical workforce needs to be carefully managed. For example, the 2014 *Australia's Future Workforce – Doctors* report estimates a potential oversupply of up to 7,000 doctors by 2030. Internal modelling confirms this potential and supports the need to re-examine workforce arrangements that increase doctor numbers.
4. New policy settings and program arrangements are required that are calibrated to the current medical workforce in terms of its size, composition and geographic distribution. These recalibrated arrangements will form the basis for controlling the growth and geographic distribution of doctors, particularly those working in general practice, as well as ensuring doctors receive appropriate support to choose and train for a postgraduate medical qualification.

The Strategy is an appropriate response to these types of challenges to improving access to medical and health services for rural Australia, primarily through improved training and distribution of the health workforce.

Figure 1: Aggregate number of non-referred GP attendances under the MBS by MMM Remoteness Category (2006 to 2016)



The graph omits approximately 1% of services whose postcodes could not be geographically located. Patient data is based on postcodes where Modified Monash Model proportions are based on population distribution within each postcode.

When considering doctors, the Strategy has a specific focus on addressing 29 years of regulatory and administrative amendments to the rules for doctors to practise under the MBS in general practice settings, which are no longer working as originally intended; it is timely to review their impact both individually and in aggregate. Whilst previous Health-led policy and regulatory changes have addressed specific vulnerabilities, a broad set of strategic reforms is required to provide a sustainable regulatory environment that supports vulnerable communities with attracting and retaining appropriately qualified GPs.

The Strategy will support vulnerable communities by:

- revising current training and distribution measures so that they align the growing health workforce (including GPs) with service needs at the local community level. This includes improving opportunities for doctors to formally train and gain clinical experience in rural general practice settings; and
- reaffirming the link between MBS item claiming rights in general practice settings and the attainment of a postgraduate GP qualification. This is expected to increase the number of fully-qualified GPs over time, with the greatest increase in representation of these doctors in rural and remote communities that currently rely on non-VR doctors to address local GP shortages. In 2016-17, the non-VR GP workforce represented over 15 per cent of the total GP workforce, but in rural areas, this proportion climbs to over 23 per cent, or nearly one in four. The difference in composition contributes to limits in medical service delivery outside of the major cities.

While the Strategy must consider the settings for doctors to enter primary care settings, it is important that they are considered in tandem with arrangements that support other health professionals to truly drive improved access to care. The Strategy addresses this through several proposals to expand the roles of nurses, Aboriginal and Torres Strait Islander Health Professionals and Practitioners, and other allied health professionals beyond the major cities.

The long-term impact of these policy and program-level reforms would be supported by a Health-led evaluation strategy and new data tools to support collaborative workforce planning.

Problem Definition

Addressing inequities in access to quality care and the geographic distribution of the health and medical workforce in Australia have been long standing and ongoing challenges. The impact of these inequities is particularly evident in rural and remote communities, where reduced access to quality primary health care contributes to individuals experiencing, in general, poorer health outcomes than people living in major cities. For example, rural Australia has had a lower representation of doctors and these doctors are less likely to hold postgraduate qualifications than their counterparts who practise in the major cities. A strategic approach, in the form of complementary reforms, is required to address these types of inequalities and provide an appropriately skilled and better distributed workforce.

Access to quality primary medical care

In Australia, general practice is a recognised medical specialty with professional development standards that differ from those of other specialist fields of medicine. Doctors training in the Australian system become fully qualified as a GP once they successfully complete a postgraduate GP Fellowship qualification. Upon attaining Fellowship, the doctor is deemed to have met each of the standards for working independently as a GP. Felloed GPs are qualified to a standard beyond medical registration and can offer care to consumers of all ages in a broad variety of primary care and residential settings.

For MBS item claiming purposes, the attainment of Fellowship is referred to as being ‘vocationally recognised’ (VR). Most workforce programs, particularly the MBS eligibility programs, distinguish between VR (qualified GPs) and non-VR doctors. These programs generally have their basis in the *Health Insurance Act 1973* (the HIA) and subordinate regulatory material, which also collectively provide the legislative framework for MBS payments. This includes the basis for calculating the amount payable for a service by referring to specific fees that are set out in prescribed tables, currently the *Health Insurance (General Medical Services Table) Regulations* (the GMST).

For general practice, the VR standard is supported by both MBS eligibility rules and a related MBS item differential. Doctors who meet this standard are differentiated from non-VR doctors by being able to:

- perform services in a greater number of private employment engagements because they do not require supervision; and
- claim a higher MBS fee for most standard general practice consultations. A doctor’s VR status entitles them to claim a higher fee for a broad range of standard and non-standard private attendances.

In terms of MBS eligibility, section 19AA of the HIA was introduced in November 1996 and defines the VR standard by compelling doctors to attain a Fellowship qualification. It is a quality standard that links MBS claiming rights to successful completion of training with an Australian specialist medical college, which prepares the practitioner for engaging in long-term continuing professional development (CPD) that is linked to their vocation. The relevant general practice qualifications are Fellowship of the Royal Australian College of General Practitioners (FRACGP) or Fellowship of the Australian College of Rural and Remote Medicine (FACRRM).

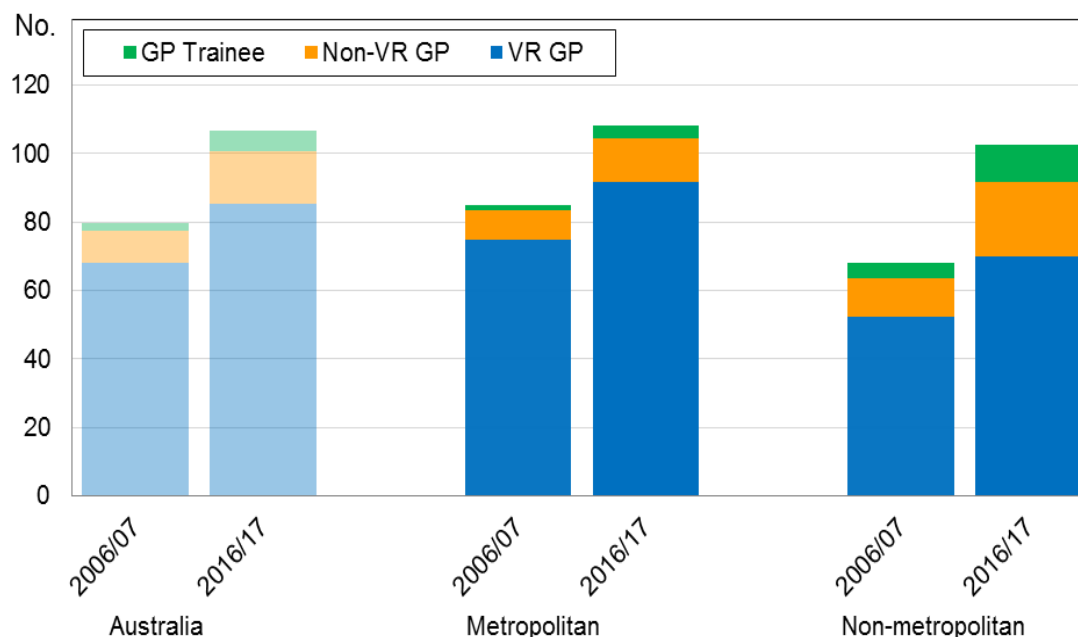
By introducing section 19AA, the Government has set an expectation that all doctors who were registered from 1 November 1996, would attain FRACGP or FACRRM as a condition for working under the MBS in general practice settings. This expectation has been introduced without any regulatory mechanism to completely exempt non-VR doctors from the requirement to qualify, even those practising in geographic areas that have workforce supply challenges. The section 19AA requirements have been structured in this way to confirm the Government’s commitment that general practice will be a vocation and its related aspiration that doctors working as primary caregivers will both fully qualify and engage in meaningful CPD.

While section 19AA establishes an expectation that doctors will qualify as GPs, there are additional considerations that allow non-VR doctors to work in general settings prior to meeting this standard. These considerations:

- primarily apply to GP trainees and non-VR doctors on clinical experience programs who are working towards their Fellowship qualification; and
- also allow many overseas trained doctors (OTDs) to practise under the MBS in communities underserved for general practice, called districts of workforce shortage (DWS), before satisfying the VR standards. These DWS areas include most rural and remote communities and have been identified using the latest residential population data as having below the national average access to MBS-subsidised services.

Figure 2 illustrates how the section 19AA considerations for non-VR doctors have contributed to a disproportionate increase in the overall representation of these doctors in non-metropolitan primary care workforces between 2006 and 2016.

Figure 2: GP Full-time Service Equivalent (FSE) doctors per 100,000 persons, 10 year



The net effect is a tension between the need to:

- apply a uniform general practice quality standard that is linked to attaining formal qualifications; and
- address current workforce shortages by allowing non-VR doctors, including OTDs, to work in areas that have a shortage of qualified GPs.

Figure 2 shows that GP trainees address some of the immediate workforce distribution problems. However, the current regulatory settings allow a significant non-VR workforce (largely comprised of OTDs) to work independently of college-sanctioned training for extended periods and the above figure shows that it is this cohort of doctors that has grown most substantially.

These current settings that enable non-VR doctors to practise under the MBS were created to address a potential undersupply of doctors before the Government introduced alternate measures to improve capacity to train doctors locally. A strategy that defines the expectations of doctors working in general practice within the context of a growing, locally-trained workforce is required. This includes revising current program arrangements to ensure long-term workforce distribution activities give appropriate consideration to the quality standards under section 19AA so that underserved communities receive improved access to fully-qualified GPs as an outcome of Government action.

General practice MBS item differential

In addition to the section 19AA MBS eligibility rules, the Government has applied an MBS item differential that distinguishes qualified GPs and trainees from non-VR doctors who are working in general practice. This differential was first introduced in 1989 and had the purpose of providing greater remuneration through the MBS to qualified GPs. While this fee structure supported the introduction of the section 19AA quality standards in 1996, the effectiveness of the differential has diminished over time because:

- it is primarily concerned with differentiating the fee payable for standard general practice consultations;
- it has not been applied uniformly to each new group of GP MBS items introduced for non-standard consultations – this means that non-VR doctors can claim the same fees as qualified GPs for a number of different types of services (for example, chronic disease planning and management) despite their lack of GP qualifications; and
- as responses to some historical workforce distribution issues, the Government implemented several Other Medical Practitioners (OMPs) Programs – the Rural Other Medical Practitioners (ROMPs), the After-Hours Other Medical Practitioners (AHOMPs), the MedicarePlus for Other Medical Practitioners

(MOMPs) and Outer Metropolitan Other Medical Practitioners (OM-OMPs) Programs. Each of these arrangements allows non-VR doctors to claim the full GP MBS items in lieu of holding a Fellowship qualification.

The item differential was introduced as a means of recognising general practice as a specialty and assigning a defined financial value in the MBS to consultations performed by qualified GPs. The assigned value was greater than the pre-existing items for non-VR doctors in an attempt to encourage doctors entering general practice to attain GP qualifications.

In 2001, the Government commenced introducing separate administrative OMPs Programs in order to use the MBS item differential to address specific workforce maldistribution issues. Non-VR doctors participating in these programs would receive approval under the GMST rules to claim the full GP MBS items if they were working in an eligible practice location relevant to their program, specifically:

- ROMPs Program participants must be practising in an eligible regional, rural or remote area defined using the Rural Remote Metropolitan Areas (RRMA) classification system;
- AHOMPs Program participants can claim GP MBS items for non-urgent after-hours consultations and any urgent attendances performed during the unsociable after-hours period;
- OM-OMPs Program participants are doctors who were registered in Australia before 1 November 1996 and must be working in an outer metropolitan practice; and
- MOMPs Program participants are also doctors who were registered in Australia before 1 November 1996 and must be working in a DWS for general practice.

The OMPs Programs have addressed short-term workforce distribution concerns by allowing non-VR doctors to claim in these areas as if they were qualified GPs. However, as MBS items in the GMST for non-VR doctors are not indexed for inflation, an increasing segment of the primary care workforce has become reliant on these programs.

Close to 90 per cent of all working non-VR doctors claim the full GP MBS items through participation in an OMPs Program. An increasing segment of the workforce views the collective OMPs Program arrangements as mechanisms that address the lack of non-VR doctor item indexation instead of being incentives that promote Fellowship.

Additionally, with the exception of the AHOMPs Program, the OMPs Programs do not set formal participation timeframes. The lack of timeframes has created a disincentive for participants to work towards GP qualifications and the programs have led to the generation of opportunistic business models. An example that was addressed through the MBS Review Taskforce process was an increase in the use of MBS items for urgent after-hours home visits in metropolitan areas that significantly exceeded needs attributable to population growth. The Taskforce found that the structure of urgent after-hours items supported the provision of comparatively low-value health care and changes were made to the claiming rights of non-VR doctors working during this period, including AHOMPs Program participants.

At a structural level, non-VR doctors who enter general practice under these types of practice models are:

- subject to limits in their scope of clinical experience that are based on claimable MBS fee amounts instead of community needs; and
- limited in their capacity to obtain the broad range of clinical experience to assist their entry into formal general practice training and the attainment of a GP Fellowship qualification. These doctors face a longer path to satisfying the VR standard set out under section 19AA of the HIA.

These models increase the cost to the health system through higher MBS billing and diagnostic referral rates. In 2016, non-VR doctors billed diagnostic procedures at almost twice the rate of VR GPs (94 per cent more services billed) and made 30 per cent more referrals (within their specific referral restrictions).

The current MBS GP fee differential and related rural bulk-billing incentives require recalibration to reward VR doctors and those who work in rural locations defined according to the latest geography standard - the MMM. Consideration should also be given to expanding the rebate differential so that it applies uniformly to standard and non-standard general practice consultations to give clear encouragement to all doctors to attain VR.

Medical workforce maldistribution

The Government has implemented several measures to improve the geographic distribution of the health workforce between metropolitan and regional and rural areas. In broad terms, the collective measures comprise a mix of:

- MBS eligibility settings for doctors - primarily doctors working in general practice with some more limited arrangements applying to specialists and consultant physicians; and
- several incentive arrangements that seek to increase the number of health professionals practising outside of the major cities and the structure of rural and remote medical practices. These incentive programs also seek to influence the scope of care being offered to patients and, in particular, improve access to multidisciplinary health care in rural and remote settings.

As a preliminary concern, these activities have been introduced over time and therefore do not currently conform to a consistent remoteness area classification. This means some incentive payments, an example being the incentives offered through the MBS to subsidise bulk-billed general practice consultations, are not uniformly encouraging health professionals to practise in areas that currently have workforce shortage.

While this is a concern, it is partially mitigated by the use of the DWS system to distribute doctors under these measures. The DWS system identifies communities that have the most significant medical shortages relative to the national average. To ensure currency, DWS determinations are updated annually and refer to the latest residential population estimates from the Australian Bureau of Statistics and MBS billing data.

While not a workforce planning tool, DWS is an effective mechanism for examining the current distribution of doctors in private settings and determining short-term distribution priorities for this segment of the workforce. DWS determinations are made for all medical specialties and Health supports recruitment and medical workforce planning activities by making these classifications available to the public through the DoctorConnect website (www.doctorconnect.gov.au).

Key workforce distribution programs that target the recruitment of doctors into recognised DWS areas are:

1. section 19AB of the HIA, which places a ten year moratorium on the MBS eligibility of OTDs and foreign graduates of an accredited medical school (doctors who enrolled as temporary residents at an Australian Medical Council-accredited medical school). Doctors who are subject to the moratorium must obtain Health approval before obtaining a Medicare provider number and the key consideration for approving requests is DWS work, with some metropolitan considerations for trainees and after-hours engagements.
2. the bonded medical programs – the Bonded Medical Places (BMP) Scheme, and the Medical Rural Bonded Scholarship (MRBS) Scheme – which provide Australian students with a place in a medical degree in return for a commitment to practise in DWS areas for a specified period upon completing their Fellowship. While the return of service period is not uniform across the current bonded arrangements, the return of service commences once the doctor is a fully qualified GP, specialist or consultant physician. These commitments are structured to provide underserved communities with access to fully-qualified care providers.

Although these measures have maintained a clear distribution focus and have supported some improvement in the geographic distribution of doctors, they have not achieved parity in medical service access between rural and metropolitan locations.

Further, the section 19AB rules interact with the section 19AA quality standard in a way that has contributed to a view in some parts of the medical sector that OTDs face fewer barriers to entering general practice than their Australian trained counterparts. This view has been primarily influenced by the current considerations that allow temporary resident non-VR OTDs to work in DWS areas and after-hours clinics. These doctors are not compelled to participate in a workforce or experience program for MBS access like their Australian trained counterparts; these considerations were included in the MBS rules at a time when:

- the general practice training and experience programs were more limited in terms of their collective number of placements and their geographic reach; and
- the lack of local training capacity contributed to a need to source doctors from abroad.

The interaction of the section 19AA and 19AB MBS eligibility rules contributes to a situation where OTDs are being employed in underserved communities that are unable to source Australian trained non-VR doctors. As temporary resident OTDs can practise on a long-term basis without committing to attaining Fellowship, the current settings may be promoting a situation where underserved communities, particularly in rural and remote areas, must wait for extended periods to build a fully-qualified local GP workforce.

While the Government has attempted to improve the distribution of Australian trained doctors through the bonded medical programs, the return of service elements of these programs do not apply to participant doctors

until they are fully qualified GPs, specialists or consultant physicians. The delay between entering bonding arrangements and commencing return of service creates two issues:

1. the workforce distribution impacts of the bonding programs have not yet been fully realised. Participants must complete medical training, hospital experience and their postgraduate training before considering their return of service. Completion of these training requirements requires more than a decade and this is why the majority of bonded doctors are yet to complete their bonding arrangements.
2. bonded doctors have difficulty planning for their return of service. While the Government has taken steps to provide transparency regarding options for completing future return of service obligations, this work does not actually connect postgraduate training with return of service requirements for these doctors. The impact is that many bonded doctors are likely to be required to move into an underserved community for return of service purposes, rather than complete these requirements as an extension of postgraduate training that was completed outside of the major cities. This is particularly true for general practice due to the diversity of vocational training arrangements.

In addition to the section 19AB MBS rules and bonded arrangements to define MBS eligibility, the Government has attempted to improve the distribution of fully qualified doctors and other health professionals through incentive payments. Examples of key health workforce incentive payments are the:

1. rural bulk-billing incentives – which have been designed to support the cost of providing fully bulk-billed consultations under the MBS in rural and remote communities;
2. Practice Nurse Incentive Program (PNIP) – which provides support to general practices and Aboriginal and Torres Strait Islander Community Controlled Health Services to offset the cost of employing Practice Nurses or Aboriginal and Torres Strait Islander Health Workers and Practitioners;
3. GP Rural Incentives Program (GPRIP) – which provides incentives to doctors to practise in regional, rural and remote areas as a means of promoting careers in rural medicine. GPRIP payments adopt a scaled payment structure so that the highest financial incentives are paid to eligible doctors who practise in the most remote parts of Australia.

While these incentives address the cost of providing care in rural settings, they are not effectively interlinked. Additionally, the current incentives for rural bulk-billing and Practice Nurses use an outdated remoteness area classification system to determine incentive eligibility and this undermines the Government's intent to protect the delivery of these services in the most vulnerable underserved communities.

Without policy intervention, existing programs which direct the workforce to specific areas of workforce shortage will continue to struggle to achieve equity of distribution. For example:

- the reliance on non-VR doctors, particularly OTDs, to address lack of access to qualified GPs in rural and remote communities will continue;
- Australian trained doctors who participate in the bonding programs will continue to experience difficulty with planning and completing return of service obligations in underserved communities; and
- incentives for multidisciplinary care and team-based approaches will continue to be inconsistent, which limits their reach and capacity to respond to the changing needs of the community.

If the current medical workforce distribution mechanisms are not recalibrated, the medical workforce will not be positioned to respond to community needs. Rural communities and the health providers that support them would be most adversely impacted by a lack of change. The impact of this current maldistribution of the medical workforce is illustrated by the following data concerning Australians who suffer from chronic conditions:

- an Australian Institute of Health and Welfare (AIHW) study on health conditions and remoteness indicated that, in 2007-08, 35 per cent of the population reported having at least one of the following chronic conditions: asthma; type 2 diabetes; coronary heart disease; cerebrovascular disease (largely stroke); arthritis; osteoporosis; Chronic Obstructive Pulmonary Disease; depression; or, high blood pressure. By 2014-15, this figure had grown to 50 per cent.
- in 2014-15, people living in regional, rural and remote areas were more likely to have long-term health conditions including arthritis, asthma, back problems, deafness, long-sightedness, diabetes, heart disease, stroke and vascular disease.
- from June 2000 to June 2015, the proportion of people who were aged 60 years and over increased from 16.6 to 20.4 per cent, while the proportion aged 80 years and over increased from 2.9 to 3.9 per cent. From 2015 to 2030, these figures are expected to increase to 23.8 and 5.4 per cent, respectively. The prevalence of multiple chronic conditions increases with patient age, with around 30 per cent of people aged 80 years and older having seven or more chronic conditions. Whilst this data includes both

metropolitan and rural/regional areas of Australia, the impact of an ageing population and associated increases in chronic health conditions may be exacerbated in rural areas if issues of equitable workforce distribution and the level of post-graduate training are not addressed.

- Table 1 provides data on the type of disease by remoteness in 2014-15, using data from the AIHW study.

Table 1: Type of disease by remoteness, 2014-15.

Disease type	Major cities	Inner regional	Outer regional/ Remote
Arthritis	14%	20%	18%
Back pain and problems	16%	18%	16%
Asthma	10%	12%	12%
COPD	2.4%	3.4%	2.7%
Blindness	0.5%	0.9%	0.8%
Deafness	9.8%	15%	14%
Diabetes	4.7%	6.0%	6.7%
CVD	4.7%	6.7%	5.8%
Cancer	1.6%	1.7%	1.8%
Mental health problems	17%	19%	19%

Notes

1. '%' represents prevalence of chronic diseases in each region (excluding *Very remote* areas of Australia).
2. Proportions are not age-standardised, and in some instances higher prevalence may reflect the older age profiles in *Inner regional* and *Outer regional/Remote* areas.
3. 'COPD' refers to chronic obstructive pulmonary disease.
4. 'Blindness' includes partial and complete blindness.
5. 'CVD' refers to heart, stroke and vascular disease.

Continued medical workforce maldistribution and lower levels of GP qualification in rural and remote areas will likely continue to contribute to poorer access to quality primary care services in those areas which, in turn, will contribute to higher rates of chronic health conditions and potentially preventable hospital admissions (admissions that may potentially have been avoided through effective and timely access to quality primary and community-based care).

Access to multidisciplinary care

Whilst there is a pressing need to improve the distribution of doctors and increase the number of fully qualified GPs, this must be considered in the context of reforms to other health professions. Nurses and allied health professionals (such as podiatrists, physiotherapists and psychologists) must be appropriately skilled and available to deliver essential care to individuals within multidisciplinary and team-based service models, led by GPs within primary health care settings.

Nurses

If multidisciplinary models of care are to thrive, the Australian Government must pay particular attention to the role of nurses, as they account for over 40 per cent of the health workforce and in many settings are the health professional with the highest contact rates with patients. This is particularly the case in acute care settings, aged and residential care, and many remote communities. Given the diversity of roles performed by nurses, there is a need to ensure nurses are appropriately skilled to meet health needs across the lifespan and fully engage with expanded and changing roles within Australia's rapidly evolving health system.

The need to consider current arrangements for training nurses is informed by:

- criticism from employers and some nursing associations that Australia's current tertiary programs are not producing work ready nurses. Specific concerns are that current arrangements do not provide adequate clinical experience or a sufficient focus on specialty areas, such as aged care, mental health or primary care. This is coupled with increased pressure on degree providers to add additional theoretical content to already compressed degree structures in an attempt to account for changes in health service delivery; and
- high attrition rates in nursing degrees.

In addition to training, the role of nurses in primary care settings requires particular attention if the Government is to support team-based approaches to service delivery in vulnerable communities and as a more general driver of improved access to services. A key requirement is to strengthen the role in primary care settings of Nurse Practitioners – registered nurses with postgraduate level qualifications that enable them to diagnose and treat patients.

The Government admitted Nurse Practitioners under the MBS and Pharmaceutical Benefits Scheme (PBS) in 2010 in order to improve workforce flexibility and access to services in vulnerable communities. While this has led to an increase in the nurse practitioner workforce (an approximate increase of 15.5 per cent), the overall numbers remain low. In 2016, there were 1,417 registered nurse practitioners, which represented 0.4 per cent of the then total nursing and midwifery workforce.

The slow uptake of these arrangements is due to the small number of established nurse practitioner roles. The small number of these roles can be at least partially attributed to care providers and their consumers not yet fully understanding the improvements to care delivery that can be achieved through the increased use of this important segment of the workforce.

The Government has attempted to increase the number of nurses in primary care settings by funding the Australian Primary Health Care Nurses Association (APNA) to deliver the Nursing in Primary Health Care (NiPHC) Program. The NiPHC Program has been a successful mechanism for recruiting and retaining nurses in primary care settings, but it is not a long-term arrangement. It therefore does not currently have the scope to influence the current structural determinants of the role performed by nurses in primary care settings.

Aboriginal and Torres Strait Islander health professionals and practitioners

There is also a need for continued promotion and support for significant growth in the Aboriginal and Torres Strait Islander health workforce. This growth has been significant in recent years, as evidenced by:

- a 25 per cent increase in the number of Aboriginal and Torres Strait Islander health professionals (3,401 to 4,249) working across the various vocations between 2013 and 2015;
- a 28 per cent increase in the number of Aboriginal and Torres Strait Islander students (1,678 to 2,148) choosing to study health in higher education between 2010 and 2015; and
- a 67 per cent increase in the number of Aboriginal and Torres Strait Islander students enrolled in health training in the Vocation and Training Sectors.

In addition to promoting these careers, the Implementation Plan of the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 identifies activities to increase the capacity of this workforce to meet current and future service demands in Indigenous communities. This growing segment of the health workforce will require continued support in the form of mentoring, professional and leadership development programs, and professional networking opportunities. There is also a need to increase the number of health providers offering culturally appropriate care through the provision of cultural safety programs.

Mental Health professionals

Mental health conditions such as depression, anxiety and substance abuse disorders are one of the leading causes of illness in Australia. Whilst the prevalence of mental health conditions appears similar between major cities and rural and remote communities, the lower prevalence of mental health professionals outside of major cities contributes to a significant and unmet need for mental health services in rural and remote areas. The current level of unmet need is compounded by a maldistribution of those segments of the health workforce that are most qualified to provide these services (i.e. psychiatrists, psychologists, and mental health nurses).

In Australia, availability of access to an appropriately qualified health workforce decreases according to the level of remoteness (see Table 2.). The numbers of psychiatrists, psychologists and mental health nurses in regional and rural areas in 2015 were 36 per cent, 57 per cent, and 78 per cent, respectively, of those in metropolitan areas.

Table 2. Prevalence of mental health professionals by remoteness areas*

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
	Clinical Full Time Equivalent per 100,000 population				
Psychiatrists	13	5	4	5	2
Psychologists	73	46	33	25	18
Mental Health Nurses	83	74	46	53	29

* This Data set uses the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) Classification System. This system was widely used in 2015.

Dental Health professionals

People living in rural and remote areas generally have poorer dental health, including higher rates of gum disease; and the proportion of people with untreated tooth decay increases with remoteness. As with mental health, there is a significant and unmet need for dental health services in regional, rural and remote areas. There are more than three times as many dentists practising per 100 000 population in major cities (59.5) than in remote/very remote areas (17.9).

Without policy intervention, the Government will not be able to appropriately influence access to a broader range of health services in vulnerable regional, rural and remote areas. This translates to these communities facing a longer wait to develop and implement team based care models that have been shown to be effective in treating people with complex care needs and generally poorer health outcomes when compared to major cities. The above demonstrates a significant need to influence the behaviour of a more diverse segment of the health workforce and makes a case for a strategic approach to responding to this challenge.

Objective of Government Action

Providing all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country, is a priority across all governments and is one of four strategic priorities of the National Healthcare Agreement (2017¹). The Government is committed to improving the health of people living in regional, rural and remote Australia. The Strategy aims to do this through a range of

¹ <https://meteor.aihw.gov.au/content/index.phtml/itemId/629963>

initiatives that support a well-distributed health workforce across Australia and by improving the quality of the health workforce.

The Strategy seeks to improve health care access and the quality of health services to people living in regional, rural and remote Australia, addressing an imbalance which exists when compared to metropolitan areas. It seeks to introduce a range of funding and administrative reforms to support a well distributed workforce across Australia. It will also provide opportunities for Australian doctors through key initiatives via a renewed focus on teaching, training, recruitment and retention.

Objectives of the Strategy are to:

1. address the current profile of the medical workforce which contains a high proportion of non-VR doctors, particularly in rural and remote areas, and the resultant increased burden on the MBS;
2. address the inability of current workforce policies to achieve equity of workforce distribution;
3. better manage supply-driven expenditure growth generated through the current inability to control certain aspects of the OTD medical supply pipeline and its responsiveness to health workforce distribution needs; and
4. improve the responsiveness of primary health care to the needs of people with comorbidities (chronic and/or complex conditions).

Policy Options

The Strategy includes a package of 12 initiatives to support the policy objectives. More detailed information on the various initiatives is provided at [Attachment A](#).

Option 1: (Status Quo – Do Nothing)

Option Overview

This option would not implement the proposed reforms proposed under the Strategy or any alternate changes and would continue current arrangements across all policies and programs.

Impacted Parties

The health and medical community; State and Territory and Commonwealth Governments; and the general community, particularly in rural and regional Australia.

Impact Analysis

Current policy and program settings are not appropriate to address inequalities in access to health services and the generally poorer health outcomes of Australians living in rural and remote areas. Continuing the current settings will lead to increases in unmet demand for health services and related significant economic impact manifesting as costs to Government.

The current settings do not uniformly reinforce the Government's aspiration under section 19AA of the HIA that all doctors registered after 1 November 1996 will attain a postgraduate qualification. This is particularly true in general practice, where the current MBS eligibility settings do not provide consistent encouragement or support to qualify as GPs.

The Government recognises that non-VR doctors have played an important role in addressing gaps in service access for many regional, rural and remote communities. However, the current MBS eligibility settings do not address the potential that the most vulnerable communities will remain reliant on these doctors in the long term. The current settings also do not provide the most appropriate mix of factors to motivate all non-VR doctors to qualify due to a:

- lack of structured pathways that take a non-VR doctor from their entry to general practice commencement to their attainment of FRACGP or FACRRM; and
- general practice MBS item structure that has not been uniformly indexed over time and that has introduced claiming rights that are not linked to the attainment of FRACGP or FACRRM.

While the current settings apply some effective workforce distribution mechanisms, their intent is limited to distributing the current workforce. An example is the DWS classification system, which distributes GPs, specialists and consultant physicians on the basis of local community needs that are identified according to the distribution of MBS-subsidised services relative to the current national average.

DWS determinations are effective for identifying and addressing short term workforce priorities for most fields of medicine. However this system is not a workforce planning tool and does not:

- link workforce shortage determinations to a defined long-term medical workforce distribution objective;
- apply considerations beyond local access to private doctors, meaning current needs analysis does not examine local service needs in the context of how the complete medical workforce is geographically distributed; or
- address, in any long-term sense, system pressures that are a feature of a long-term cycle of under and oversupply of appropriately qualified health professionals.

A strong case in support of moving to a more structured workforce planning approach, is made in *Australia's Future Workforce – Doctors*, which indicates that the workforce costs almost two thirds of health care expenditure. Current settings do not sufficiently emphasise workforce planning in the context of emerging health service needs as a means of:

- informing expenditure on training health professionals;
- structuring activities that examine the value of MBS expenditure to the community, such as the current MBS Review Taskforce; and
- matching the supply of health professionals with emerging service needs, which provides the basis for cost-effective, high-value health care.

While the importance of creating the settings to adopt a workforce planning approach cannot be overstated, preserving the current arrangements would also mean missing an important opportunity to modernise key workforce distribution programs and incentives. This includes failing to take the opportunity to either:

- enforce an updated and cohesive workforce distribution standard by linking current programs and incentives to the latest remoteness area classification system – the MMM. Some current workforce arrangements, such as the MBS Bulk-Billing Incentive Payments, will lose their effectiveness because they will misidentify local-area workforce priorities that are based on outdated remoteness classification systems. Over time, these incentives are likely to contribute to the maldistribution of health professionals by continuing to provide incentives in areas that are no longer underserved; or
- revise the bonded medical programs – the BMP Scheme and the MRBS Scheme – to simplify and standardise return of service requirements.

Health could attempt to pursue amendments to the current workforce distribution programs independently. However, this approach would not link the required distribution reforms to changes that provide health professionals, particularly medical practitioners, with the best possible support to fully qualify to the relevant standards for their vocation.

A decision to continue the current settings would mean losing an opportunity to introduce meaningful reform to PNIP and GPRIP payments to improve their support for multidisciplinary care arrangements for disadvantaged population groups and communities that experience challenges in providing adequate access to services. While the Government could pursue reforms to incentive payments independently of a broader workforce strategy, they lose effectiveness unless they are applied in conjunction with changes to the underlying conditions that determine the right to practise in key vocations, such as general practice.

Continuing the current settings would not place an additional regulatory impost on the health sector. The current settings and determinants for employing health professionals are well established and are broadly understood. The Commonwealth, represented by Health and the Department of Human Services (DHS), would not need to modify current information or approaches to assisting the sector with understanding how current arrangements inform the recruitment, selection, employment and retention of health professionals.

Option 2: Recalibrate the general practice MBS fees without changing other policy settings

Option Overview

This option would recalibrate the long-standing general practice MBS fee differential as an exclusive initiative. Under this option, the recalibrated fee differential would provide a clearly defined financial incentive for doctors to attain VR and this would be applied as an independent initiative in an attempt to improve the quality of private practitioners.

The MBS fee recalibration proposed under the Strategy would create a dedicated MBS item group for non-VR doctors to cover all standard and non-standard general practice attendances and pay 80 per cent of the fee that can be claimed by VR GPs. Under the proposed changes, these items will be available to non-VR doctors who

work in MM 2 to 7 areas as a means of supporting medical workforce distribution. Non-VR doctors who enter general practices in the major cities (MM1) will not have access to the new items for standard general practice attendances and will remain subject to the original MBS fees that have not been indexed for inflation. Table 2 provides further details of the GP MBS fee type by location and doctor cohort.

The creation of a dedicated non-VR doctor item group would provide the basis for differentiating the fees paid to primary care doctors on the basis of their level of postgraduate qualification. From a policy standpoint, recalibrating MBS fees in this way will:

- substantiate the value of postgraduate general practice qualifications, as qualified GPs will be able to continue billing the full GP MBS items;
- provide an opportunity to create non-VR MBS items that cover the spectrum of standard and non-standard general practice services; and
- allow for the eventual removal of the administrative OMP Programs.

Table 3 shows that the new non-VR MBS items would mirror standard and non-standard general practice attendances. The introduction of the revised structure would mean that non-VR doctors who work under the MBS in general practice settings had the right to claim 80 per cent of the fee paid to GPs across the scope of primary care work.

Table 3: Proposed MBS item group eligibility – non VR doctors and OMPs Program participants

Service type	MM 1 locations	MM 2-7 locations	ROMPs, MOMP and OM-OMPs Participants	AHOMPs Participants
Standard GP Consults	A2	A7.2	A1	N/A
Prolonged Consults	A7.3	A7.3	A5	N/A
Group Therapy	A7.4	A7.4	A6	N/A
Health Assessment	A7.5	A7.5	A14	N/A
Chronic Disease Management	A7.6	A7.6	A15	N/A
Medication Management	A7.7	A7.7	A17	N/A
Standard GP Consults (PIP)	A19	A7.8	A18	N/A
Mental Health	A7.9	A7.9	A20	N/A
Standard After Hours	A7.10	A7.10	A22	A22
Pregnancy Support	A7.11 (must meet item credentialing)	A7.11 (must meet item credentialing)	A27 (must meet item credentialing)	N/A
Video Conference	A7.12	A7.12	A30	N/A

This option also proposes linking the new MBS items for non-VR doctors to future activities that index the GP MBS items. This will:

- ensure the new items maintain their relative value to the full GP MBS fees; and
- remove potential future pressures to introduce new OMPs Program arrangements to address workforce shortages created as a result of doctors not being remunerated through the MBS to a transparent and uniform standard.

The Government would need to carefully consider GP trainees (being doctors who are participating in the Australian General Practice Training (AGPT) Program, the Remote Vocational Training Scheme or the Australian College of Rural and Remote Medicine's Independent Training Pathway) and current participants in the OMPs Programs. Specifically:

- GP trainees currently have the right to claim the full GP MBS items for their training placements. These claiming rights have been provided because these doctors are engaged in clinical training that meets the standards set by the RACGP and/or the ACRRM and a decision to change the MBS item structure does not impact on the recognition of training. GP trainees will therefore not be subject to a change to their current MBS item claiming rights.
- non-VR doctors participating in the OMPs Programs have committed to addressing Government-defined workforce priorities on the basis of being able to claim the full GP MBS items. While there is evidence that some of these workforce distribution priorities have become outdated, there is a need to consider that current OMPs Program participants have made career choices in response to availability of these arrangements and should be given a sufficient time to fully qualify as GPs.

A restructured general practice MBS item structure that is linked to current geography standards (the MMM) provides the basis for the phased removal of the OMPs Programs. Once the revised MBS item structure is enshrined in legislation, the Government would move to close the OMPs Programs to doctors entering general practice. Additionally, OMPs Program participants (the final participant cohort) would be given a period of five years to attain either FRACGP or FACRRM before these arrangements are discontinued altogether. A period of five years is deemed sufficient for the doctors in the final participant cohort to either:

- fulfil any outstanding requirements they have for meeting the VR standard (for most this will mean obtaining either a FRACGP or FACRRM qualification); or
- progress to a general practice training program, which would provide them with the right to claim the full GP MBS items while training and remove any need they may have to remain in an OMPs Program).

The proposal moves away from the use of administrative arrangements to determine MBS item claiming rights. The new standard would be clearly structured general practice MBS fees in the GMST that reinforces the distinction between qualified GPs and non-VR doctors. This new standard provides the basis for ensuring that this distinction is carried forward whenever new general practice MBS items are created.

Impacted Parties

The proposed fee recalibration will impact non-VR doctors who are delivering GP services and some of the more corporate general practice arrangements that apply business models that are reliant on the recruitment of these doctors. Non-VR doctors entering general practice would no longer be able to use the OMPs Programs as a mechanism to claim the full GP MBS items. Over time, the right to claim the full GP MBS items will be limited to doctors who:

- are working towards Fellowship qualifications through joining a general practice training program recognised by either the RACGP or the ACRRM. The commencement of college-recognised, structured training allows a doctor to claim the full GP MBS items under the GMST rules for trainees; or
- have attained either FRACGP or FACRRM.

Non-VR doctors will have access to MBS items that are indexed for inflation. Indexation ensures that successive cohorts of doctors will receive the same treatment under the MBS during the non-VR stage of their career by being able to claim against MBS items that retain their financial value relative to the full GP MBS items over time.

Importantly, the proposed fee recalibration would not change the current arrangements for qualified GPs, GP trainees, or the subset of doctors who were included on the Vocational Register for General Practice before it closed in 1996 and who are not considered by the Strategy.

Impact Analysis

The impact of this option is largely limited to non-VR doctors who practise in general practice settings. The option addresses the maldistribution of registered doctors as a key segment of the health workforce in rural and remote areas and attempts to create conditions for the Government to achieve its aspiration that all doctors who are subject to the operation of section 19AA of the HIA will obtain a postgraduate medical qualification.

The Benefits of adopting this option would be that:

- non-VR doctor eligibility to bill against the new MBS items will depend on the remoteness classification of the employing practice, which more directly links MBS payments to a workforce distribution structure. Non-VR doctors practising in metropolitan areas (MM 1) will not be able to use all of the new items. They will:
 - continue to claim MBS items from the A2 Group for standard general practice services (these are currently worth approximately 60 per cent of the full GP MBS items);
 - continue to claim MBS items from the A19 Group for attendances associated with Practice Incentive Payments (these are substantially less than corresponding incentive payments for services performed by qualified GPs); and
 - claim items from the relevant new A7 subgroups (at 80 per cent of the VR rate) for all other services (including rural and remote cities).
- MBS fees are structured in a way that encourages non-VR doctors to both obtain clinical experience outside the major cities (i.e. in MM 2-7 locations) and attain a postgraduate general practice qualification. Table 2 provides further details of the GP MBS fee type by location.

This option would introduce an immediate change to the items claimable by non-VR doctors who currently work in primary care outside being engaged in general practice training or an OMPs Program. The introduction of the new MBS item structure is intended to have the most significant impacts on three cohorts of non-VR doctors:

1. doctors who are currently practising in the major cities without being engaged in formal general practice training. These doctors will be subject to a 20 per cent fee reduction for non-standard general practice services.
2. doctors who are not engaged in formal training and who work in non-metropolitan areas that are not covered by an OMPs Program. These doctors will have a 20 per cent fee reduction for non-standard general practice services while receiving a 20 per cent fee increase for standard general practice consultations; and
3. new entrants, who commence their general practice career outside of formal general practice training (either from other countries or from the hospital system). These doctors would commence their career under the revised MBS item structure.

As stated earlier, this option would include features to preserve the current claiming rights of GP trainees and to sunset the OMPs Program arrangements to allow pre-approved participants time to become qualified GPs. These features preserve the claiming rights of a significant portion of the current workforce; over 6,500 general practice trainees and OMPs Program participants.

Preserving these claiming rights would ensure that the MBS item structure is introduced with account for the current workforce and does not create an incentive for doctors to either leave general practice or attempt to relocate from underserved communities. When considering the final cohort of OMPs Program participants, the Government would take steps to preserve their access to the full GP MBS items for a period of five years. During this period, participants would be expected to become a qualified GP or enter formal general practice training, with the related ability to claim full MBS items that are linked to their training.

In proposing this five year timeframe, the Government has considered the variable rate at which non-VR doctors attain Fellowship on the basis of the level of their prior clinical experience when entering general practice. The broad standard is that doctors must obtain four years of general practice experience before completing exams for their qualification. The Government's five year sunset period for the OMPs Programs would therefore provide adequate coverage to all non-VR doctors participating in these arrangements when the revised item structure is introduced.

The Government anticipates that the revised general practice MBS item structure will clearly incentivise the attainment of the FRACGP and FACRRM qualifications. In behavioural terms, the new item structure is expected to translate to an increase in the rate at which non-VR doctors become fully-qualified GPs in order to both:

- attain the right to claim the full MBS items for all general practice attendances; and
- define their scope of clinical practice on this basis.

Effort will be required by medical practices and non-VR doctors to understand the changes to the MBS item structure. However, this is a standard feature of working under the MBS, as the scope of claimable items is subject to periodic change as the scope of general practice changes. The Government, as represented by the Health and DHS, has developed effective processes for communicating MBS item changes to the sector. These communication mechanisms would be employed to support understanding of the new MBS item structure should

this option be adopted. Employing changes of this type is not considered to fall outside of the ordinary operation of the MBS and accordingly, the introduction of this option is not anticipated to create a net change in the regulatory impact on business.

This option is centred on the medical workforce and therefore shares many limitations identified in relation to a decision to maintain the current policy settings and program arrangements. Specifically, this option would not address issues relating to the training and deployment of the non-medical practitioner segments of the health workforce, such as:

- the quality and appropriateness vocational training for nurses or mechanisms to increase the size of the primary care nursing workforce;
- the value of improving system capacity to offer team-based care;
- access to mental health and dental health services in rural Australia; or
- support for ATSIHPOs and the need to maintain improvements in the representation of Aboriginal and/or Torres Strait Islanders in the health workforce.

Additionally, it is important to consider that this option does not introduce a systemic response to improving the quality and distribution of GPs and non-VR doctors. A new MBS item structure does not directly change the conditions under which non-VR doctors, whether Australian or overseas trained, can actually qualify to work under the MBS. The application of a recalibrated MBS fee structure independently of changes to other Government workforce measures would not:

- address the view that there are barriers to recruiting Australian-trained non-VR doctors in rural or remote communities;
- directly address the continued growth in the medical workforce that can be attributed to OTDs; or
- improve the level of direct support non-VR doctors receive with attaining Fellowship qualifications and will therefore not directly increase the number of VR GPs. While the fee differential encourages the attainment of Fellowship, it does not directly address the circumstances that influence a doctor's chances of meeting this standard.

This option also does not revise other financial incentives, including bulk-billing payments for the MBS or incentives that are provided on the basis of the location and structure of the medical practice. Changing the general practice item structure in isolation of reforming these other arrangements increases the risk that incentives are inconsistently applied and fail to increase the number of qualified GPs or, at minimum, improve the distribution of non-VR doctors.

While the recalibration of the fee differential is an important element in recognising the value of general practice qualifications, implementing this as a single initiative does not directly support any element of the medical workforce with satisfying the Government's longstanding expectation that private doctors attain a postgraduate medical qualification in order to provide the highest-level of independent care under the terms of the MBS. Other initiatives proposed as part of the Strategy, such as providing financial and educational support for non-VR doctors to attain vocational registration through FRACGP or FACCRM, are necessary components of the strategic approach to improve workforce distribution and qualifications.

Option 3: Implement the proposed package of initiatives to address the identified current and future workforce policy challenges

Option Overview

This option would implement 12 complementary initiatives under a Strategy that will collectively improve access to health services in regional, rural and remote Australia. More detailed information on the individual measures that comprise the proposed Strategy is provided in Attachment A. These initiatives would interact to:

- improve linkages between primary and postgraduate medical training and long-term rural medical careers;
- revise the general practice entry conditions to provide better opportunities for Australian medical graduates to pursue general practice as their vocation;
- streamline general practice training with additional support for non-VR doctors to qualify;
- reconfigure the GP MBS items so that they are a driver for the Government's aspiration that private doctors attain postgraduate qualifications and an increase in the number of GPs who are qualified to this level across Australia;
- apply a more direct influence on the distribution of OTDs;
- invest in improving access to non-medical health services;

- reconfigure the current incentive payment programs to support the sustained delivery of affordable primary care in regional, rural and remote areas; and
- develop and implement workforce planning tools.

The following explores the key interactions.

Improve linkages between primary and postgraduate medical training and long-term rural careers.

If this option for a strategic approach to reforms is implemented, a primary focus would be to increase training opportunities for Australian medical graduates in regional, rural and remote Australia. This responds to evidence that doctors who train outside of the major cities are more likely to pursue a long-term medical career in regional, rural and remote Australia. Recalibrating current training settings would be a mechanism to address medical workforce distribution concerns with Australian trained medical practitioners.

The Government's current workforce settings are primarily concerned with distributing placements offered through the general practice training and experience programs that are linked to the MBS access rules. The placements are appropriate for doctors (Australian and overseas trained) who are at a stage in their medical career where they can commit to general practice as a vocation. While some alternate arrangements are available for Australian medical graduates who are at an earlier stage in their career, there are more limited in their scope and ability to genuinely influence medical workforce distribution.

Under this option, the Murray Darling Medical Schools Network would establish a Murray Darling Medical School and offer new, rurally-based university medical school programs. Under these programs, medical students would be able to undertake the majority of their study in the Murray-Darling region of New South Wales and Victoria. This initiative would enable many medical students to stay in their communities while they train to become a doctor, increasing their likelihood of pursue a rural career in medicine.

This option also seeks to implement measures that would place more doctors in the postgraduate training phase of their career into rural communities by:

- revising the current bonding arrangements, so that participants would be able to complete part of their return of service when undertaking their postgraduate training in regional, rural or remote settings. These revisions would address concerns that the current bonding arrangements do not encourage participants to consider regional, rural and remote training options (when they are available) and that participants must qualify as a GP, specialist or consultant physician before considering how to discharge their return of service obligations to the Government.
- funding increased opportunities for Australian trained Junior Doctors, to work and train in rural primary care and private hospital settings. This activity would provide access to placements so that a broad range of medical students could gain rural clinical experience and, in particular, experience work in a general practice setting to inform their choice of postgraduate vocation.
- introducing a consolidated general practice experience program, the MDRAP, which would allow non-VR doctors to work with MBS access in Modified Monash (MM) 2 to 7 areas. The MDRAP would replace and broaden the scope of current experience programs, such as the RLRP, to cater to a greater number of non-VR doctors who are seeking to make general practice their vocation. Linking the MDRAP to the MMM classification system would ensure placements are being offered in regional, rural and remote areas that are identified according to the latest geography.

Importantly, the current general practice training programs would also be streamlined and placed under the administration of the RACGP and the ACRRM. In addition to the significant benefits this carries in terms of the colleges being able to improve the link between training selection processes and their respective qualification standards, Health would ensure that funding arrangements build on the current standards influencing an equitable distribution of training placements. This would ensure that the significant presence of formal GP trainees in regional, rural and remote communities is maintained beyond implementation of this option.

Implementing the strategic approach proposed under this option creates the settings for introducing an end-to-end approach to rural training. The significant emphasis on linking primary and postgraduate medical training to regional, rural and remote communities would create the basis for improving the future distribution of doctors and encourages Australian medical graduates to pursue a rural general practice career.

Revise the general practice entry conditions to provide better opportunities for Australian medical graduates to pursue general practice as a vocation.

Measures under this option also respond to sector concerns that the current MBS eligibility rules potentially impede Australian medical graduates in choosing general practice as their vocation and delay their entry into primary care settings. The related concern being that employers, particularly those in underserved communities, become reliant on employing OTDs to address service gaps.

This option would provide a strategic response to these concerns by:

- funding increased opportunities for Australian trained Junior Doctors to work and train in rural primary care settings. This activity would provide access to placements so that a broad range of medical practitioners could gain rural clinical experience and, in particular, experience work in a general practice setting to inform a decision to choose this their postgraduate vocation.
- introducing a consolidated general practice experience program, the MDRAP, which would allow non-VR doctors to work with MBS access in MM 2 to 7 areas. The MDRAP would replace and broaden the scope of current experience programs, such as the RLRP, to cater to a greater number of non-VR doctors who are seeking to make general practice their vocation. The introduction of the MDRAP would also present an opportunity to define appropriate supervision arrangements for participant non-VR doctors that consider their level of clinical experience (including prior overseas work) at entry to the program. This would ensure the MDRAP caters to the full variety of general practice models in regional, rural or remote areas.

These measures provide the basis for improving opportunities for Australian medical graduates without redefining the underlying MBS eligibility rules. This ensures the new opportunities created under these measures do not undermine the Government's expectation under section 19AA of the HIA that doctors ultimately attain postgraduate medical qualifications.

Streamline general practice training with additional support for non-VR doctors to qualify

As stated above, this option places a specific emphasis on streamlining general practice training and placing this under the administration of the RACGP and the ACRRM. This includes providing support for non-VR doctors to attain Fellowship of one of the Colleges and thereby meet the expectations set by section 19AA of the HIA.

By creating the conditions for streamlined training arrangements, the Government would be addressing the fact that non-VR doctors are currently attempting to qualify as GPs through multiple pathways. These pathways are not uniformly linked to the college standards. The move to two pathways overseen by the respective colleges would:

- improve the navigability of the system for non-VR doctors who are at the stage of meeting postgraduate experience requirements and considering either FRACGP or FACRRM;
- provide better visibility of the GP training pipeline for future workforce planning and policy development activities;
- bring general practice training into line with other vocational programs that are being provided for specialists and consultant physicians; and
- improve the interface between clinical experience offered in general practice settings and how doctors are assessed for the FRACGP and FACRRM qualifications.

The Government would continue to provide funding for 1,500 training places per year under the Australian General Practice Training Program (AGPT), which will be distributed between the two new college pathways. The overall number of GP training places, both funded AGPT placements and independent training placements, would be capped. While this cap would be administered by the RACGP and the ACRRM, it would be determined by the Department of Health and endorsed by the National Medical Training Advisory Network to ensure an appropriate distribution of GP trainees.

The Government, through its continued involvement through funding training places would ensure that general practice training does not become centralised and that appropriate standards for ensuring the distribution of training places are maintained under the streamlined program structure.

This option also proposes an additional financial investment to deliver a one-off Fellowship Support Program between 2019 and 2023 through the Colleges. This will provide financial support to non-VR doctors who are currently working in general practice settings with meeting outstanding requirements for attaining either the

FRACGP or FACRRM qualification. It is envisaged that this financial support would be delivered through the respective colleges and would support participants who enter the new streamlined arrangements with meeting the costs of their training.

Reconfigure the GP MBS item structure so that it is a driver for the Government's aspiration that private doctors attain postgraduate qualifications and an increase in the number of fully qualified GPs across Australia. This option would link a recalibrated general practice MBS item structure to a reformed general practice program structure that better supports doctors with attaining qualifications. More specifically, this option introduces systemic reform that covers the current determinants and incentives for a doctor to meet the long-term requirements of section 19AA of the HIA by attaining FRACGP or FACRRM.

This option proposes the recalibration of the general practice MBS item structure through the creation of a dedicated item group for non-VR doctors who practise in general practice settings. This is the same recalibrated fee structure proposed in Option 2 and has the following features:

- a dedicated MBS item structure in the GMST that provides claimable fees for non-VR doctors for standard and non-standard general practice attendances;
- the new non-VR doctor MBS items would provide 80 per cent of the full GP fee for services provided to patients attending regional, rural and remote settings (MM 2-7 areas); and
- the new item structure would apply a workforce distribution incentive by limiting non-VR doctors practising in major cities (MM1 areas) to claim the current A2 MBS items for standard consultations, which provide approximately 60 per cent of the fee claimable by qualified GPs. These doctors would be able to claim the 80 per cent fees for non-standard consultations.

The new MBS item group for non-VR doctors would be indexed at the same rate as the GP MBS items so that they maintain their relative value over time. The recalibrated GP MBS item structure would be implemented in tandem with arrangements to preserve the current claiming rights of GP trainees and to sunset the OMPs Programs over a five year period while participants become qualified GPs. These features would preserve the claiming rights of a significant portion of the current primary care workforce (over 6,500 doctors) and ensure that the new claiming rules primarily apply to doctors entering Australian general practice.

The Government anticipates that the revised general practice MBS item structure sets a clear value on general practice qualifications and will clearly incentivise the attainment of either FRACGP or FACRRM. In behavioural terms, the new item structure is expected to translate to an increase in the rate at which non-VR doctors become fully-qualified GPs in order to both:

- attain the right to claim the full MBS items for all general practice attendances; and
- define their scope of clinical practice on this basis.

A proposal to align this as part of a broader workforce strategy provides the opportunity to align this signal that improves options for doctors to attain qualification. This option proposes that the revised MBS item structure would be introduced with other targeted changes to existing workforce measures to assist doctors with qualifying, specifically:

- the introduction of a consolidated general practice experience program – the MDRAP – that provides more consistent clinical experience to non-VR doctors (particularly those in the earlier stages of their career) in regional, rural or remote areas;
- streamlined general practice training options that are delivered by the RACGP or the ACRRM and better linked to the respective Fellowship qualifications; and
- an investment to support the development of a Fellowship Support Program, to assist non-VR doctors who are not yet engaged in training to make the transition to either FRACGP or FACRRM.

The cumulative introduction of the proposed measures would create a situation where non-VR doctors are encouraged to qualify through financial incentives in the form of higher MBS items and an underlying suite of experience and training programs that offer a level of supervision and scope of clinical experience that is better linked to the qualification standards than the current arrangements.

Apply a more direct influence on the distribution of OTDs

The current regulatory settings, particularly the MBS eligibility rules, seek to create the conditions for OTDs to be predominantly practising in underserved communities. The interaction of section 19AB of the HIA and the DWS classification system ensures that the primary determinant of the MBS eligibility of most OTDs is whether

they are working in a capacity that addresses a defined workforce shortage or are engaged in training to meet Australia's vocational standard. Most OTDs will therefore be practising privately in a recognised DWS, in after-hours settings, or in supervised or formal training positions for MBS access.

This option would support current activities that focus on OTD distribution by reducing the number of placements offered under the Skilled Migration Program in metropolitan general practice settings. This measure would include a reduction in the number of these positions that can be filled by OTDs by 200 per annum.

Importantly, the reductions proposed under this measure would be limited to general practice positions that must be filled by MBS-eligible doctors. The proposed reductions would not be extended to metropolitan hospital positions. Structuring the reductions in this way would ensure:

- the state and territory governments will not need to modify current medical practitioner recruitment processes for hospitals; and
- OTDs can continue to enter Australia for the purpose of undertaking supervised occupational training, which is generally delivered in hospital settings.

This part of the Strategy would complement existing workforce distribution activities by gradually redirecting the external supply of GPs to regional, rural and remote areas. It also mitigates the potential that some metropolitan areas might have an oversupply of private doctors. This measure also complements other activities proposed under the Strategy, such as the recalibrated GP MBS item schedule, by more directly influencing the options available to doctors who are seeking to enter Australian general practice.

Invest in improving access to non-medical practitioner health services

The implementation of a strategic response to concerns about access to health services in regional, rural and remote Australia provides the scope to consider improvements to the settings for the non-medical practitioner segments of the workforce. As part of the Strategy, the Government would take several measures to strengthen the capacity of the non-medical practitioner segments of the workforce to respond to emerging needs for services in regional or remote communities.

The Government proposes to fund an independent review of how nurses are currently being prepared to enter the Australian workforce. This review would consider both national and international approaches to providing vocational training for the purpose of ascertaining the optimum preparation of the nursing workforce. This review process would be influenced by a Steering Committee that includes representation from the current National Nursing and Midwifery Education Advisory Network (NNMEAN) and the Department of Education.

The Government also proposes to implement measures to strengthen the role of nurses in primary care settings so that they may contribute to team-based approaches to health care. This would be achieved by funding the Australian College of Nurse Practitioners (ACNP) to undertake a communications strategy to improve awareness of the benefits of nurse practitioners. The Government would also continue funding for the NiPHC so that the APNA can continue working to place nurses in primary care settings.

In addition to activities to strengthen the contribution of nurses, the Government would provide investment to expand current advocacy and planning activities to support the continued development of the Aboriginal and Torres Strait Islander Health Workforce. This funding would specifically enable four key ATSIHPOs – the Australian Indigenous Doctors Association, the Congress of Aboriginal and Torres Strait Islander Nurses, Indigenous Allied Health Australia and the National Aboriginal and Torres Strait Islander Workforce Association – to continue to collectively implement strategies to improve the training, recruitment and retention of Aboriginal and Torres Strait Islander health professionals and practitioners.

The Government would also invest in the Royal Flying Doctor Service (RFDS) as a key deliverer of health services in the most remote areas that are beyond the reach of many other health services, including those that leverage telehealth technology. This funding would support the RFDS with continuing to perform aeromedical evacuations, to offer dental services beyond March 2019 and to introduce a mental health outreach clinic program.

These collective measures will be integral to supporting better access to non-medical health services, particularly in the most rural parts of Australia. These measures address capacity issues that are not affected by efforts to distribute doctors and will provide a basis for improving access to team-based health interventions outside of the major cities.

In addition to recalibrating the current settings under which doctors and other health professionals are trained and are granted entry into the health system, a strategic approach would allow the government to reconsider key workforce incentives. This would achieve better alignment between key incentives and the scope of clinical practice they were implemented to encourage.

Reconfigure the current incentive payment programs to support the sustained delivery of affordable primary care in regional, rural and remote areas

As part of this proposal to adopt the Strategy, the Government would update the Rural-Bulk Billing Incentive Program and the PNIP to reflect the current remoteness area classifications under the MMM. This addresses the concern that payments are based on outdated information and will move to a state where this incentive meets its stated objective of protecting access to fully MBS –subsidised medical services in the most vulnerable rural and remote communities.

The Government would also replace the PNIP and GPRIP arrangements with a single, consolidated arrangement – the Workforce Incentive Program (WIP). The WIP would base incentive amounts on the current MMM remoteness area classification, with payments being delivered through Practice and Doctor Streams.

It is proposed that under the WIP:

- the PNIP would be replaced with the Practice Stream. Incentives would continue to be paid directly to eligible medical practices. Eligible practices would continue to have the discretion to determine how the incentive payments would fund additional health professionals. This flexibility extends to the type of health professionals who will be recruited (such as a nurse or Aboriginal and Torres Strait Islander Health Worker) and whether to use the incentive to recruit multiple health professionals.
- the GPRIP would transition to the Doctor Stream, with payments continuing to be made directly to doctors. The parameters for doctors to qualify for an incentive would not change, as these were revised as part of the *Better Targeted Rural Financial Incentives for Doctors 2015-16 Budget Measure* and are now offer appropriately targeted support for recruitment into vulnerable communities.

In addition to providing more flexible arrangements to support practices with recruiting health professionals, the WIP would apply the MMM classification system as a determinant of all payments. This would ensure a consistent approach to delivering these payments going forward.

A revised suite of incentive payments supports the delivery of sustainable primary care in regional, rural or remote parts of Australia. The recalibrated arrangements would also provide the type of flexible financial assistance for improving capacity to offer team-based approaches to care in underserved areas.

Develop and implement workforce planning tools

While this option proposes several measures that are concerned with improving current training pathways and recalibrating workforce distribution programs and incentives, it also proposes developing new tools to support collaborative health workforce planning activities. The size and composition of the health workforce is influenced by several factors that make estimates of an appropriate stable state difficult. This option addresses this difficulty by proposing the development of better tools to inform health policy and workforce planning. This includes:

- taking action beyond a continued reliance on current workforce distribution measures, like DWS, which are limited to resolving short-term workforce shortfalls; and
- improving capacity to analyse demands for services across the spectrum of health professions with linkages to socio-economic indicators and demographic data.

To achieve this, this option proposes the development of the Health Demand and Supply Utilisation Patterns (HeaDS UPP) tool. This tool would provide access to consolidated and current data to policy makes and workforce planners. This tool would:

- move beyond a simple analysis of where services provided by comparing where consumers live with where they access their health services. This allows for the determination of meaningful health service catchment areas that could be used to inform better long-term health workforce policies and programs; and

- analyse demands for health services with consideration of socio-economic indicators and demographic data to inform workforce planning.

It is envisaged that this tool would bring together and map important source information such as MBS data, Admitted Patient Care data and RFDS data. By mapping these data sources, the tool would allow planners to view health workforce information for specific geographic areas. Information supporting the tool would be updated regularly (every 6 to 12 months) to account for changes in the composition and distribution of the health workforce.

The Government sees this tool as having significant potential to improve health workforce planning activities at several levels. It is expected that the tool, once implemented, would be available to key organisations that are involved in delivering health workforce programs. These include the Rural Workforce Agencies, the Primary Health Networks, Local Health Districts, Australia's Specialist Medical Colleges and the State and Territory Governments.

In addition to immediately improving the consistency of the evidence base, it is envisaged that the HeaDS UPP Tool would become the single source of consolidated information to inform workforce planning activities. The tool would also have significant implications for supporting the development, implementation, monitoring and evaluation of health workforce programs and policies. The application of the tool for these purposes will increase confidence in health program expenditure.

Impacted Parties

The following parties will be impacted:

1. health and medical community – Australian trained and overseas trained medical practitioners, post-graduate medical trainees, participants of bonding programs, general practices, primary health care employers, private sector hospital providers, nurses, nursing students, allied health practitioners, Aboriginal and Torres Strait Islander Health practitioners and workers, Rural Workforce Agencies, Primary Health Networks, Local Health Districts.
2. training organisations - GP training Colleges, Regional Training Organisations.
3. Australian health consumers and the broader community (indirectly impacted).

Impact Analysis

The impacts of the Strategy are significant, and include changes to:

- the way Australian medical graduates are trained, facilitating an increase in the rural focus of pre-vocational and general practice training;
- the structure of the GP workforce and how it is funded through the MBS;
- management of the pathways from attainment of primary medical degree to specialist GP status;
- the ways in which health and medical practitioners are encouraged and supported to practise in specified rural and remote areas; and
- the capacity of primary health care providers to develop multidisciplinary and team-based models of care.

The Government anticipates that the revised GP MBS item structure will provide an immediate financial incentive to attain Fellowship and will result in an increase in the rate at which non-VR doctors seek to become fully-qualified GPs. The Government also expects that an increased rate of doctors attaining qualifications will be realised under this option because the revised item structure is being introduced with a more navigable pathway to qualifying that features:

- streamlined, college-led general practice training; and
- a single experience program (the MDRAP) with the broad scope to accommodate different cohorts of non-VR doctors seeking clinical experience.

As the reforms to the GP MBS item structure are being introduced with arrangements that preserve current claiming arrangements for GP trainees and OMPs Program participants, the Government does not anticipate that the collective reforms will result in unintended changes to the current distribution of doctors. GPs and non-VR doctors who have made a commitment to attaining qualifications, including those gaining experience outside of the major cities, will continue to have access to the full GP MBS items with time to meet outstanding requirements for FRACGP or FACCRM.

In addition to changing the GP MBS item structure and underlying training and experience programs, the Government expects that the Strategy will address the perceived barriers to recruiting Australian medical graduates into general practice. While the long-term career aspirations of medical students and junior doctors are hard to measure, the MDRAP is expected to be instrumental in improving opportunities for Australian medical graduates to satisfy the MBS eligibility rules and either:

- experience general practice at a pre-vocational level as a means of informing their choice of medical specialisation; or
- move from the Australian hospital system into supervised general practice as a career step towards general practice training.

The Government also expects that the recalibration of the GP MBS item structure in tandem with updated other workforce distribution mechanisms is expected to improve the distribution of the primary care workforce.

The Government recognises that the Strategy does not directly address the fact that many rural communities are not of sufficient size to sustain a primary care clinic in addition to public hospital infrastructure. The Government has previously introduced a separate measure under the exemption provisions for section 19(2) of the HIA that allows services performed by hospital employees in smaller communities to qualify for MBS items. Doctors are generally restricted from claiming MBS items for services they have been funded to provide and the MBS items provided through this measure are used to fund the expansion of services (including nursing and allied health services) in these smaller communities.

The Strategy will indirectly support the intent of this section 19(2) by;

- encouraging more doctors to attain general practice qualifications, which means they would qualify for consideration under the 19(2) exemption for rural communities if they are working in eligible state and territory infrastructure; and
- introducing the conditions for preparing nurses and allied health professionals to work in the types of team-based care settings that the 19(2) exemption provision encourages.

In addition to improving support for medical practitioners, the Government expects that the Strategy would create the conditions for developing a stronger nursing and allied health workforce in rural communities. The proposed increases in funding to support the nursing workforce, the work of the ATSIHPOs, and the outreach work of the RFDS will improve capacity to deliver key non-medical practitioner services in the most vulnerable communities.

The streamlining of GP training and the introduction of the MDRAP will not impose direct regulatory change on medical practitioners.

These measures represent a reconfiguration of the general practice programs and the underlying MBS eligibility rules are not changing. Sections 19AA and 19AB of the HIA will continue to apply in the same way to the same cohorts of doctors, meaning there will be no cohorts of non-VR doctors who would lose MBS eligibility as a direct result of the reformed program structure.

While doctors who registered after 1 November 1996 would continue to be expected to attain postgraduate qualifications (FRACGP or FACRRM for those working in general practice), the reformed program structure proposed by the strategy will:

- improve navigability of the steps required to qualify; and
- allow the RACGP and the ACCRM to better link formal training to the standards for attaining their respective qualifications.

The recalibrated MBS item structure will introduce an immediate change to the claimable MBS items for non-VR doctors who practise outside of formal general practice training or an OMPs Program. This impact will apply to three cohorts of non-VR doctors:

1. doctors who are currently practising in the major cities without being engaged in formal general practice training. These doctors will be subject to a 20 per cent fee reduction for non-standard general practice services.
2. doctors who are not engaged in formal training and who work in non-metropolitan areas that are not covered by an OMPs Program. These doctors will have a 20 per cent fee reduction for non-standard general practice services while receiving a 20 per cent fee increase for standard general practice consultations; and
3. new entrants, who commence their general practice career outside of formal general practice training (either from other countries or from the hospital system). These doctors will commence their career under the revised MBS item structure.

Effort will be required by medical practices and non-VR doctors to understand the changes to the MBS item structure and the revisions to the rural bulk-billing incentives. However, this is a standard feature of working under the MBS, as the scope of claimable items is subject to periodic change as the scope of general practice changes. Employing changes of this type is not considered to fall outside of the ordinary operation of the MBS and accordingly, the introduction of this option is not anticipated to create a net change in the regulatory impact on business.

The Government is satisfied that the creation of the Murray Darling Medical School will not produce net changes to regulation. The entry standards for primary medical training are not changing and it is assumed if students did not undertake the training through the Murray Darling Medical School they would do so at another school where the compliance requirements would be comparable.

There is also no net regulatory impact created by the proposed:

- introduction of the HeaDS UPP tool;
- funding an independent review of training for nurses, noting that the outcomes of the review cannot be pre-empted; or
- the proposal to continue funding for the ACNP, the ATSIHPOs and the RFDS.

As the Strategy is primarily concerned with recalibrating and extending existing workforce programs and policy settings, there is limited risk that the reforms will not have their intended impact. As set out above, several activities being proposed under the Strategy correct unintended consequences created by existing programs.

In addition, the Strategy proposed the development and introduction of the HeaDS UPP tool, which will offer the comprehensive workforce data set required to plan the future workforce. The Government expects that this tool will be the basis for identifying more optimal health and medical practitioner workforces in terms of size, composition and geographic distribution. The tool will provide the basis for considering the workforce according to geographically identified population needs for services and support collaborative planning to meet emerging service needs at the local community level.

Consultation

Nature of consultation

The Minister for Health, The Hon Greg Hunt MP, publicly announced the transition of general practice training to the GP Colleges at the RACGP's annual conference, 'GP17,' on 27 October 2017. This announcement was met with strong support from members.

Development of the Strategy has been informed through both formal and informal stakeholder engagements. A series of targeted discussions via teleconference and face-to-face meetings has occurred with key stakeholders and peak representative bodies to test the policy parameters of the Strategy. Consultations have contributed significantly to the design of the proposed initiatives. Ongoing stakeholder engagement is critical to the success of the Strategy and will continue throughout the implementation phase and beyond.

Impacted Parties

Stakeholders consulted include:

- Australian Medical Association
- Royal Australian College of General Practitioners
- Australian College of Rural and Remote Medicine
- Rural Doctors Association of Australia
- National Rural Health Alliance
- Australian Medical Association Students Association
- Australian Council of Doctors in Training
- General Practice Supervisors Association
- Rural Workforce Agencies
- Rural Health Commissioner
- Allied Health Professionals Association
- National Medical Training Advisory Network
- States and territory governments

Key stakeholder feedback

Stakeholders, including the AMA, RACGP, ACRRM and the RDAA, have provided their in principle support for the Strategy. Health has responded to concerns raised by stakeholders and has worked to resolve issues, specifically:

- Tiering of the GP Medicare rebate - the original proposal for the Strategy was to establish a three-tiered GP Medicare rebate with VR doctors being eligible to claim the full (100 per cent) GP MBS items, non-VR doctors only 80 per cent of the items, and GP Registrars only 90 per cent. Feedback from the AMA and RACGP expressed concern in relation to the impact on GP Registrars, so agreement was reached on a two-tiered model.
- Impact on GPs from discontinuation of the OMPs Programs - during consultation, the AMA raised concerns around the grandfathering period for the MBS rebate changes. Following consultation, the initial four year grandfathering period was extended to five years. This period of should allow sufficient time for non- VR GPs on the OMPs Programs to attain FRACGP and FACRRM qualifications without impacting on the service scope of individual practices or the MBS claiming rights of non-VR GPs.

Preferred Option

In order to adequately address the current workforce policy challenges as outlined in this document, Option 3 is the preferred option.

Implementation

A Project Management Office (PMO) will be established to oversee administration, coordinate and manage the implementation of the Strategy and its initiatives. Specifically, the objective of the PMO will be to implement and support a project management methodology to enable the delivery of Budget measures on time, within scope, to budget and to a high quality. The PMO will provide a standardised set of project tools and support to project teams in undertaking a project management approach. The PMO will support strategic alignment of projects and provide the Executive with appropriate oversight through the establishment of and support for appropriate governance arrangements – the Executive Governance Committee (EGC) and the Implementation Working Group.

The EGC will provide strategic direction and high level endorsement on the agreed portfolio of projects for the Health Workforce Division of Health. The EGC already provides strategic advice and guidance to Project Sponsors and Project Managers. Members of the EGC include all Senior Executives within Health Workforce Division as well as an independent Senior Executive Service (SES) member from Program Assurance Committee Establishment within Health.

A Regulation Taskforce will also be established during implementation of Strategy initiatives that have regulatory components. The Taskforce will monitor, provide advice on, and manage any legislative issues and risks.

Evaluation of the Strategy is a key part of its implementation. The evaluation will:

- establish the right performance indicators to assess whether the objectives of regulatory change in the Strategy have been achieved, and to inform ongoing decision-making, including:
 - the numbers of OTDs entering Australia annually;
 - a measurement of the distribution of doctors according to workforce need;
 - the extent of billing against certain MBS item numbers;
 - the number and proportion of non-VR doctors who attain VR;
 - the number of registrations for and successful completions of bonded programs and other targeted training programs; and
 - the number of multi-disciplinary primary health care settings established.
- inform future decision-making around possible further initiatives to improve the quality and equity of distribution of medical services in regional locations;
- inform the design and implementation of initiatives, including identifying any gaps and dependencies;
- provide a consistent framework to enable comparisons within and across initiatives;

- support increasing the scale to incorporate all health workforce programs in order to provide a whole-of-Program perspective;
- inform new policy proposals (NPPs) and future strategy development;
- provide an effective engagement tool for government and stakeholders; and
- ensure a focus on workforce and community outcomes.

At the highest level, the evaluation will assess the success of the Strategy against the two core objectives of supporting a well-distributed health workforce across Australia, and improving the quality of the Australian health workforce. Through the Strategy, effective investment in workforce programs will improve the distribution of the health workforce by increasing the:

- number of GPs and medical practitioners training towards Fellowship under an accredited GP College program;
- number of non-general practice medical specialists;
- number of nurses working in general practices; and
- number of allied health practitioners.

The Strategy aims to ensure Australians have access to high quality services provided by qualified health practitioners through training delivered in all areas of Australia, by increasing the:

- percentage of medical practitioners working in general practice with fellowship of either of the GP Colleges;
- percentage of general practice training being undertaken outside major cities; and
- proportion of Specialist Training program activity in rural areas.

It is critical that the evaluation of the Strategy is conducted to a consistently high standard; this will be achieved by ensuring that evaluation of each initiative under the Strategy operates under a single framework. An overarching Evaluation Framework (the Framework) will be developed that will inform and be informed by the development of Monitoring and Evaluation Plans for each initiative. A data strategy will also be developed to target and streamline data capture and ensure data and information is available for quantitative and qualitative evaluation questions.

The monitoring and evaluation plans will be designed to meet the specific requirements of each initiative while maintaining a coherent measurement system around a common output and outcome framework. This approach will improve consistency and coordination of monitoring and evaluation efforts across the initiatives, and effectively link to the data strategy and the overarching Framework. Importantly, this evaluation approach will focus on establishing both a regular reporting schedule for long term evaluation, as well as data tools, e.g. the HeaDS UPP tool, to support ad-hoc monitoring of the initiatives and the Strategy as a whole. Ongoing monitoring will allow the Government to fine tune policy issues and promptly mitigate any risks as/if they arise.

Appendix 1

Regulatory Burden Estimate (RBE) Table

Average Annual Regulatory Costs (from business as usual)				
Change in Costs (\$m)	Business	Community Organisations	Individuals	Total change in cost
Total by Sector	\$0.008	\$0.003	\$0.558	\$0.569

Please also consider the offsets for the regulatory costs associated with the proposal. If no offset has been identified, has the Deputy Secretary or delegate warranted that the net regulatory target will be met by the end of the relevant reporting period?

Are all new costs offset?

- Yes, costs are offset, *please provide information below*
- Deregulatory, no offsets required

Total (Change in costs - cost offset) (\$ million): \$

What are the offsets for increases in regulatory costs associated with this proposal?

A regulatory offset has not been identified. However, Health is seeking to pursue net reductions in compliance costs and will work with affected stakeholders and across Government to identify regulatory burden reductions where appropriate.

Attachment A**Commonwealth Health Workforce Strategy 2018-19 Budget Initiatives and associated regulatory impact****Improving Access to Training in Rural Areas and the Private Sector through Junior Doctor Training**

Doctors that receive vocational training in rural and remote areas are more likely to continue providing services in those areas. In addition, there is currently a large concentration of junior doctors in public metropolitan hospitals who find it hard to access pathways for further training. The Junior Doctor initiative aims to create more opportunities for these doctors to move out of metropolitan hospitals and work and train in rural primary care.

The Junior Doctor initiative will consolidate and build upon existing Commonwealth junior doctor programs into one that provides education and support for junior doctors (including non-VR doctors) to train and practise in private practice and rural and remote settings. This new initiative will create two new streams to support training in rural primary care and in private hospitals:

- **Rural Primary Care Stream** – funding for educational support for junior doctors working and training in rural primary care settings
- **Private Hospital Stream** – salary support for junior doctors working in private hospitals.

Programs that will be consolidated from January 2019 include the Commonwealth Medical Internships, the Junior Medical Officer Program, and the Rural Junior Doctor Training Innovation Fund.

An additional investment of \$63.6 million over four years from 1 July 2018 will be provided for this initiative. This will bring the total investment to over \$174 million from January 2019. The existing Rural Junior Doctor Training Innovation Fund will continue under the new initiative.

The Rural Primary Care Stream will support up to 240 postgraduate Years 1 and 2 junior doctors to rotate into rural general practice by providing funds to support training and supervision. The Rural Primary Care Stream will also provide financial support for training and supervision to around 300 Postgraduate Years 3 to 5 junior doctors working in general practices. This funding will help junior doctors gain vocational registration through fellowship.

Around 40 per cent of hospitalisations in Australia are in private hospitals. The Private Hospital Stream aims to address a forecast shortage of around 1,000 advanced training places by 2030 by maximising the opportunity to increase training capacity in the private hospital sector. The Private Hospital Stream will ensure new doctors can access quality training in this part of the health system and will provide salary support to junior doctors working in private hospitals, including up to 100 internships in 2019 and up to 115 places in 2020. The Private Hospital Stream will also support Postgraduate Years 2 and 3 training placements that will be open to a broad range of medical graduates.

The regulatory and other impacts of this initiative include:

- Patients in rural, regional and remote areas are expected to benefit from increased delivery of health services and a more stable, locally trained workforce.
- Private sector hospital providers will benefit from continued Commonwealth investment in postgraduate training places. This will assist them to build their future medical workforce, as well as provide high quality health services to patients.
- This proposal will benefit future doctors by expanding training opportunities in areas of community need. It will help to ensure Australia has the required training capacity for the next generation of doctors and will broaden the scope of training to new settings.
- There are no identified changes in regulatory impact for business or individuals arising from this initiative

Improved Access to Australian Trained General Practitioners and Quality Care

The Improved Access to Australian Trained General Practitioners and Quality Care (Improved Access) initiative will streamline nine existing general practice training and qualification pathways to simplify and support non-VR doctors to attain specialist GP Fellowship. The Improved Access initiative will support existing non-VR doctors to qualify as a VR GP through a targeted Fellowship Support Program. The initiative will redesign the MBS GP rebate structure to pay lower rebates to non-VR doctors in recognition of the quality generated through

GP specialist training.

The regulatory and other impacts of this initiative include:

- Legislative change to:
 - tier GP MBS rebates;
 - discontinue OMPs programs;
 - ensure bulk-billing incentives intended for rural and remote areas are based on up-to-date geographic eligibility criteria under the MMM remoteness classification, and are not accessible in metropolitan areas; and,
 - simplify bonding program administration arrangements.
- support for GP Colleges (RACGP and ACRRM) to assume responsibility for GP specialist training pathways; general practices and non-VR doctors will no longer be eligible to make applications for OMP programs. This will remove an extra administrative step in the provider number process.
- Individual (non-VR) doctors will be impacted by the reduction in the amount of money they receive through Medicare for individual consultations. Medical practices may choose to charge a co-payment from the patient to meet this gap. Over time, the financial incentives are expected to encourage more non-VR medical practitioners to seek specialist status, resulting in more high quality GPs being available in regional, rural and remote areas.
- Practices and non-VR doctors will need to take some time to understand the changes to claimable items. However, this is not considered to be out of the ordinary and accordingly, no net change in the regulatory impact on business is anticipated.

Streamlining and Controlling General Practice Training to Produce Australian trained GPs for Where They are Needed

There are currently around 4,900 non-VR doctors in Australia and approximately 39 per cent of these currently work in rural and regional areas. The Streamlining and Controlling General Practice Training to Produce Australian trained GPs for Where They are Needed (Streamlining GP Training) initiative will support non-VR doctors to gain VR through GP fellowship and ensure the rural and remote communities that these doctors service have access to specialist GPs trained to the same standard as elsewhere in Australia. To achieve this, the Streamlining GP Training initiative will simplify existing GP training pathways and provide support through a targeted Fellowship Support Program. The initiative will also enable the Commonwealth to better regulate the number of entrants to the GP workforce via a cap on fellowship training places, starting from 2019. The cap will be regularly reviewed, determined by Health, and endorsed by the National Medical Training Advisory Network.

The Streamlining GP Training initiative will rationalise nine current pathways into two fellowship pathways that will be delivered through the RACGP and the ACRRM. Medical practitioners enrolled in the program will be able to access the higher tier (100 per cent) MBS items during training. Medical practitioners are not obligated to attain GP fellowship of either the RACGP or the ACRRM; however, those that have not attained fellowship by 1 July 2023 will only have access to 80 per cent of the full rate for MBS GP items, i.e. will not have access to the higher MBS tier.

An additional investment of \$82.6 million over four years from 2018 will support the Fellowship Support Program. The streamlined pathways will come into effect on 1 January 2019 and be delivered between 2019 and 2023. Transition from the AGPT Program to the GP college pathways will be staged between 2019 and 2021. The RACGP and ACRRM will hold full responsibility for Fellowship training pathways by 2022. Trainees on the AGPT Program, the Remote Vocational Training Scheme, and the ACRRM Independent Pathway will be able to continue to train without any material impact. The 3GA programs that currently allow non-VR doctors pursuing Fellowship to access MBS GP items under these programs will cease by 30 June 2023.

The Commonwealth will continue to fund 1,500 AGPT Program training places per year across the two college pathways, and will fund an additional 100 Rural Generalist places from 2021. Targets for the distribution of training places across regional, rural and remote areas will ensure a continued focus on GP workforce distribution in these areas.

The regulatory and other impacts of this initiative include:

- GP Colleges will be required to take on significant additional responsibility for the delivery of GP training, bringing them in line with other profession-regulated medical specialty training programs. Contracts in place with Regional Training Organisations and Remote Vocational Training Scheme Ltd,

who currently deliver the Commonwealth-funded training pathways, will be novated to the Colleges over time.

- All medical practitioners seeking to attain College Fellowship and Specialist GP status (and therefore VR) will be subject to the new streamlined Fellowship pathway arrangements.
- Current non-VR GPs will be able to take advantage of the one-off GP training assistance funding provided through the initiative, which is designed to support them to gain vocational recognition.
- While there will be some reduction in red tape through the rationalization of nine training pathways into two, this will approximately be balanced out by the increase in compliance requirements resulting from an increase in the number of training places. Consequently, no net changes in red tape are anticipated.

Educating the Nurse of the Future

Primary health care is often the first point of contact people have with the healthcare system. The nursing workforce, including nurse practitioners, has the skills and experience to meet many health care needs. It is a central part of the delivery of team-based and multi-disciplinary health care, especially for people with chronic and/or complex conditions, including those in rural and remote communities. The Educating the Nurse of the Future initiative aims to harness the skills of the nursing workforce in order to strengthen frontline delivery and provide support to GPs meeting complex care needs.

The Educating the Nurse of the Future initiative will support nurses to move to primary care, and test new, innovative ways to deliver care. The initiative will benefit both metropolitan and rural and remote nursing services and comprises three components: the **Nursing in Primary Health Care (NiPHC)** program; the **Raising Awareness of the Role (Raising Awareness)** project; and, the **Independent Review of current preparation of nurses entering the Australian health workforce** (the Independent Review).

The **NiPHC** program will fund training and mentoring to support nurses to transition to primary health care, as well as target training in areas of clinical need to support nurses working in regional and rural areas. The NiPHC will aim to promote employment and build capacity by recruiting around 250 nurses to transition to primary health care. It will also work to support around 15 primary health care organisations to implement nurse-delivered models of care to service local patients, and support training in clinical areas of need through approximately 70 two-day face-to-face training workshops in rural and urban locations. The NiPHC will commence from 1 July 2018.

The **Raising Awareness** project will promote the benefits, profile and role of the nurse practitioner through a number of communication activities.

The **Independent Review** will fund a review of the current undergraduate preparation of nurses in Australia, and facilitate a renewal of undergraduate nursing education programs so that graduating nurses effectively meet the current and future health needs of the Australian community. The review will consider national and international trends and consult extensively with consumers and representatives from the health, aged care, disability, education, and regulatory sectors. It will also look at student selection factors and how pathways can shape future careers.

An additional investment of approximately \$8.3 million over four years will be provided to the Australian Primary Health Care Nurses Association to deliver the **NiPHC** program. Up to \$350,000 over 12 months will be provided to the Australian College of Nurse Practitioners (ACNP) to deliver the Raising Awareness project. Funding is also provided for the Independent Review.

The regulatory and other impacts of this initiative include:

- The Australian community will be positively affected through access to nursing services delivered by an appropriately educated workforce.
- The tertiary education sector may be affected; however, the impact is dependent on the outcomes of the Review.
- Employers of nurses will be positively affected through access to a nursing workforce which is fit-for-purpose.
- Noting that participation in the training will not be necessary to satisfy a regulatory requirement, it will not represent a red tape impost on individuals. Accordingly, no net changes in regulation are anticipated.

Controlling Supply of Overseas Trained Doctors (OTDs)

This initiative will better target OTDs to areas of workforce need and reduce the number of OTDs entering Australia through the skilled migration program, in order to better regulate supply. Changes to the skilled migration occupation lists will occur, as required, as part of the regular process to update these lists.

The regulatory and other impacts of this initiative include:

- general practices who intend to engage an OTD will be required to submit an application with their local Regional Workforce Agency (RWA), requesting certification of the proposed vacant position. There will be no costs imposed on businesses for this assessment process except administrative costs associated with completing the application form.
- RWAs will be required to assess if a position falls within an area of workforce shortage and will either certify the position or reject the application. RWAs will provide benefit to patients through improved, independent, evidence-based management and distribution of incoming OTDs into areas of workforce shortage, thereby providing greater access to health care for patients, particularly in regional areas.
- skilled migration occupation lists are regularly updated from time to time and will incorporate any changes reflecting medical practitioner occupations. As this exercise is undertaken by government (Home Affairs), no red tape implications are applicable. Approximately 200 individuals seeking to migrate as doctors annually will no longer be eligible for grant of visas and, consequently, will no longer be required to complete migration application documentation. The savings in red tape associated with this measure have been estimated and are included in [Attachment A](#).

Addressing Doctor Shortages Across Rural and Remote Areas by Enhancing Bonded Programs

Australia faces a potential oversupply of medical practitioners but still has areas of doctor shortage, especially in rural and remote areas. Bonded programs are designed to address this issue by providing incentives for more doctors to work and stay in areas of need. Current bonded medical programs provide students with a medical place in return for a commitment to practise in areas of workforce shortage for a specified period.

The **Addressing Doctor Shortages across Rural and Remote Areas by Enhancing Bonded Programs** (Bonded Programs) initiative will increase program participation and completion rates and deliver higher numbers of VR GPs to areas of workforce shortage by delivering a more flexible system of engagement. The new system will simplify administrative arrangements by moving from complex individual contract arrangements to a legislated program, establishing a new, consistent three year return of service obligation (RoSO), and by developing interactive online tools to better support bonded students and doctors to manage their bonded arrangements.

New medical school students entering a bonded program will participate under the new arrangements from 1 January 2020. Approximately 9,000 students and doctors who currently participate in the existing Bonded Medical Places (BMP) and Medical Rural Bonded Scholarship (MRBS) Scheme will be eligible to access the new arrangements.

An investment of \$20.2 million over four years from 2018-19 will support the reforms under the Bonded Programs. Australians living and working in regional, rural and remote areas will benefit from this initiative through increased access to VR GPs. No net changes in regulatory impact are anticipated from this measure.

Supporting Rural and Remote Areas through Improved Targeting of Rural Bulk Billing Incentives

The Supporting Rural and Remote Areas through Improved Targeting of Rural Bulk Billing Incentives (Bulk Billing) program aims to ensure that bulk billing incentives intended for vulnerable populations in rural and remote areas (MBS items 10991, 64991 and 74991) are restricted to only those areas. These items are targeted to vulnerable patient groups, such as people with concession cards and children under 16 years of age in rural and remote locations. The incentive will update the eligibility requirements of the MBS items from Rural Remote and Metropolitan Areas (RRMA) 3-7 to MM remoteness classification 2-7.

Under this incentive, around 2,100 additional doctors in rural communities will have access to the rural bulk billing MBS items. A number of areas will lose access to the bulk billing incentives under this initiative. Importantly, use of the outdated classification system for the current incentive program has resulted in these areas having access to, but not a current need for, these items. Some of these areas currently have the highest concentration of doctors in Australia. Other areas have experienced major city growth since 1991 and now have populations greater than 20,000.

An impact of this initiative is that approximately 7,000 doctors in major cities that billed against items 10991, 64991 and 74991 will no longer be eligible to do so.

No net changes in regulatory impact for businesses are anticipated as the management of changes to MBS item numbers is considered a business-as-usual activity for GP practices. Similarly, there are no changes in net impact for individuals (doctors) since an item number need be allocated against each service provided under Medicare and only some item numbers eligible to be claimed against will change.

Improved Workforce Distribution through a Health Demand and Supply Planning (HeaDS UPP) Tool

Australian doctors are not optimally distributed according to local need. The HeaDS UPP tool will help address this maldistribution by delivering a health workforce analysis and planning tool that generates data to enable analysis of the health service needs of the community, the workforce required to meet that need, and the gaps in existing workforce capacity. The tool will be used by local, regional, jurisdictional and national workforce planners to inform workforce planning.

The tool will bring together important source information such as MBS data, Admitted Patient Care data, and Royal Flying Doctor Service data. It will then map them according to geographical regions, including newly created GP Catchment areas. GP Catchment areas are a custom-designed geography constructed using the Australian Statistical Geographical Standard and are based on a number of factors including patient flows, workforce, rurality, and topography. There are 829 non-overlapping GP Catchment areas. The HeaDS UPP tool will be updated every six to 12 months with new information and functionality.

Rural Workforce Agencies will use the tool in their assessment of applications from OTDs under the *Visas for General Practitioners – targeting areas of doctor shortage* initiative. An investment of \$14.4 million over four years from 2018-19 will support the creation of the HeaDS UPP tool.

The regulatory and other impacts of this initiative include:

- the HeaDS UPP Tool will be available to Australian Government policy makers and organisations with a health distribution planning role and;
- Health consumers, particularly those in rural and remote areas and current DWSs, will benefit from improved distribution of the primary health care workforce resulting from the use of information accessed through the HEADS UPP Tool;
- Health professionals may be impacted by resulting policy reforms to improve health workforce distribution;
- There are no identified red tape implications for business or individuals from this measure.

Workforce Incentive Program (WIP)

The WIP incentive aims to encourage the workforce to deliver primary care services in regional, rural and remote areas that have difficulty attracting and retaining a health workforce. The initiative will support growth of team-based and multidisciplinary care models in primary health care settings in areas of need so that they can better respond to complex and chronic health conditions. To do this, the WIP will streamline existing GP, nursing and allied health incentive programs and provide financial incentives to support GPs to engage nurses, Aboriginal and Torres Strait Islander Health Workers/Practitioners and other allied health professionals. Incentive payment levels will be determined using the MMM geographic classification.

Additional funding of \$181.9 million over four years will be provided through the WIP as a single workforce incentive payments program. The WIP will replace the Practice Nurse Incentive Program (PNIP) and the General Practice Rural Incentives Program (GPRIP) from 1 July 2019. It will be delivered through two streams: the **Doctor Stream** and the **Practice Stream**.

The regulatory and other impacts of this incentive include:

- regional, rural and remote communities will have increased access to multidisciplinary primary health care through the Practice Stream of the initiative. Under the Practice Stream, eligible practices can receive incentive payments of up to \$125,000 per year. A rural loading will be applied to practices located in MM 3-7.
- eligible medical practitioners located in MM 3-7 can receive an annual payment of between \$45,000 and \$60,000, depending on location. These financial incentive payments will increase the capacity of primary care practices to employ nursing and allied health professionals.
- doctors, nurses, allied health practitioners and Aboriginal and Torres Strait Islander Health Practitioners and/or workers, including non-dispensing pharmacists, will be impacted through increased opportunities and support to practise in rural and remote areas.

Guaranteeing Rural and Remote Access to Dental, Mental Health Services and Emergency Aeromedical Services through the Royal Flying Doctor Service

This initiative aims to support the provision of much needed health services to people living in some of Australia's most remote locations. It will provide additional capacity to the Royal Flying Doctor Service (RFDS) to increase the availability of dental services, deliver mental health services and ensure the reach of ambulance services in rural and remote Australia.

An additional investment of \$84.1 million has been provided to the RFDS to support ongoing aeromedical evacuations, extension of dental services beyond March 2019, and the introduction of mental health services. The mental health services include the establishment of a new Mental Health Outreach Clinic program that will provide needed services in areas where there are none and where telehealth technology is not available or is too costly. These mental health services will be available from 1 January 2019.

This investment brings funding to a total of \$327 million over four years for the RFDS to deliver these services, as well as other services such as primary health clinics. The RFDS provided approximately 42,000 patient consultations at primary health clinics across Australia in the 2016-17 financial year.

The impact of this initiative is that patients in rural and remote areas, who would otherwise not have access to these health services, will benefit through the increased availability of RFDS emergency aeromedical services, the introduction of mental health multidisciplinary outreach clinics and the continuation of outreach dental services.

There are no identified red tape implications arising from this initiative.

Continuation and Expansion of Support for Aboriginal and Torres Strait Islander Health Professional Organisations

Aboriginal and Torres Strait Islander Health Professional Organisations (ATSIHPO) are professional organisations that play a key role in increasing the number of people in the indigenous health workforce and support them in their careers. The increase in workforce leads to improved health outcomes for Aboriginal and Torres Strait Islander people.

ATSIHPOs also provide support to the broader workforce by being active in the quality of health workforce planning. ATSIPOs develop and implement strategies that:

- improve the skills and capacity, as well as the recruitment and retention, of Aboriginal and Torres Strait Islander health professionals in clinical and non-clinical roles across all health disciplines.
- promote culturally safe and responsive environments for Aboriginal and Torres Strait Islander health consumers and health professionals.
- Increase the number of Aboriginal and Torres Strait Islander students studying for health qualifications, and
- Improve completion and employment rates for Aboriginal and Torres Strait Islander health students.

This initiative will provide funding to four existing Aboriginal and Torres Strait Islander Health Professional Organisations so they can continue to support the Aboriginal and Torres Strait Islander health workforce, and expand their activities to meet the increasing demands on their services. The four organisations are:

- Australian Indigenous Doctor's Association
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Indigenous Allied Health Australia
- National Aboriginal and Torres Strait Islander Health Worker Association.

An additional \$33.4 million will be provided over four years from 1 July 2018 to the four organisations to continue and expand their work. The activities under this initiative will focus on improving cultural safety, professional development and mentoring, developing leadership, and student engagement and support. This funding signifies an increase in investment in core funding for ATSIHPOs by \$1.6 million a year.

The impacts of this initiative include a benefit to Aboriginal and Torres Strait Islander people through support to these four organisations to meet increased demand on their services. In addition, ATSIHPOs will be supported to provide Aboriginal and Torres Strait Islander people with better access to appropriate and culturally safe health care. There are no identified changes in regulatory burden arising from this measure.