Australian Government

Department of Health and Ageing

Report on the 2010 Review of the Medicare Provider Number Legislation

December 2010

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The review was completed with the assistance of Sue Woolfe and Deborah Gaudie, from the Medical Education and Training Branch, Health Workforce Division, Australian Government Department of Health and Ageing.

The review could not have been completed without the cooperation and assistance of industry stakeholders including members of the Medical Training Review Panel. We thank all those who contributed for giving their time and views, either through interviews or written submissions. All those involved in the consultation process are listed in Appendix 1.

The Hon Nicola Roxon
Minister for Health and Ageing
Parliament House
Canberra ACT

7 December 2010

Dear Minister

I am pleased to submit the 2010 Review of the Medicare Provider Number Legislation, as required under Section 19AA of the *Health Insurance Act 1973*.

The review was carried out under contract to the Australian Government Department of Health and Ageing.

I want to acknowledge the support and cooperation of the many people and organisations that made themselves readily available for this review. Of particular assistance were the members of the Medical Training Review Panel, who gave us advice about the issues to be covered and about the practicality of the recommendations.

I also want to recognise the work of the responsible Departmental officers, Sue Woolfe and Deborah Gaudie, whose assistance made it possible to complete the review in the scheduled time frame.

This report and the recommendations are tendered to you for your consideration and tabling in the Parliament.

Wendy Hodge
Principal Consultants
ARTD Consultants

Executive summary

The 2010 Review of the Medicare Provider Number Legislation was done to meet the requirement of s19AD (1) of the *Health Insurance Act 1973* (the Act).

The independent review was completed under contract to the Australian Government Department of Health and Ageing (DoHA) by ARTD Consultants in October and November 2010.

Industry stakeholders provided feedback about the legislation during one-to-one interviews or group meetings (65 participants); formal submissions (six organisations) or by completing a semi-structured electronic submission form (37 responses). Two stakeholder forums were also held: one at the start of the consultation period (29 October 2010) to ensure all relevant issues were being covered; and another on the 30 November 2010, to discuss the preliminary findings and the practicality of the recommendations.

Key findings

Overall

The review found that s19AA is well accepted by the medical profession. As in other specialist areas, vocationally trained medical practitioners are now seen as the norm in general practice. Section 3GA workforce and training programs assist with placing doctors in areas where it is difficult to attract doctors. At least 2,000 doctors a year are providing medical services in areas where it is difficult to attract doctors under s3GA placements.

But the review also found that general practice stakeholders hold differing views as to whether the Medicare Provider Number Legislation is achieving the right balance between workforce supply and quality care provision in rural areas. A related issue is the adequacy of resources and support for non-vocationally recognised general practitioners (GPs), many of whom are overseas trained doctors (OTDs) on workforce programs, to achieve vocational recognition. The sector also has differing views about the right way to recognise the skills and experiences of the estimated 600 experienced non-vocationally recognised general practitioners who graduated prior to 1996.

Another substantive finding is that implementing s19AA in conjunction with other related Medicare Provider Number Legislation is complex for Government officers, specialist colleges and practitioners alike. The review found there is a need to harmonise legislation in order to address anomalies of access to provider numbers that impact on the ability of registered doctors to practice and earn an income.

One continuing issue for industry is that the administration processes and requirements for allocating provider numbers are inefficient and place an unnecessary burden on medical practitioners. A medical practitioner is required to have a provider number that is specific for each practice location, meaning that a doctor who works across several locations needs several provider numbers. This is inefficient, delays service provision and works against the intent of the National Registration and Accreditation Scheme, which is to promote a more flexible and responsive workforce.

The review also identified parts of the *Health Insurance Regulations 1975* (the Regulations) that need updating to reflect changes in accreditation of training courses, specialist colleges, and where s3GA programs are defunct. In particular, the review found that the Australian College of Remote and Rural Medicine (ACRRM) Independent Pathway should be added to the Regulations as an approved program.

Many program stakeholders identified operational issues that should be addressed as a matter of course rather than waiting for the next legislative review or for DoHA to initiate a formal review of program guidelines.

Status of 2005 Biennial Review Recommendations

Just over half of the recommendations from the 2005 Biennial Review have been fully implemented with four recommendations being superseded over the five years since the last Review. The seven recommendations not yet fully implemented address issues that are still current. In most instances there is little information to explain why the recommendations were not actioned. The seven recommendations not yet implemented are listed below.

- **Recommendation 1:** Provide one more opportunity for doctors who meet the necessary criteria to be grandfathered onto the Vocational Register.
- **Recommendation 3.3:** Consider further investment to support the quality and training aspects of the Rural Locum Relief Program (RLRP); Approved Medical Deputising Service (AMDS) Program and other s3GA workforce programs because of their value in providing quality care to rural areas.
- **Recommendation 5.3:** Specifically, implement a staged program that over time will lead to ensuring that all medical practitioners participating in the RLRP for an extended period of time (e.g. more than 12 months) receive the appropriate assessment and training to achieve Fellowship of a recognised specialist college.
- **Recommendation 6.2:** The Divisions of General Practice and local Medical Deputising Service (MDSs) are to develop closer cooperation to promote coordination between general practice and MDSs with a particular emphasis on participation of MDSs in Division Aged Care GP Panels to assist in providing after-hours services to residential aged care facilities and the possible use of MDSs in providing in-hours care to these facilities.
- **Recommendation 8:** General Practice Education and Training Limited (GPET), the Australian Medical Council (AMC) and the relevant medical colleges to review the entry criteria for the Australian General Practice Training (AGPT) Program to enable OTDs with suitable qualifications (other than passing the Australia Medical College exam) and experience to enter the Program.
- **Recommendations 10.1 and 10.2:** The Australian Government to establish a review committee who will call for and respond to submissions on the problems and possible solutions associated with applications for provider numbers and Approved Placement Programs.

Findings for Workforce Programs

Since the 2005 Biennial Review, there have been major changes to systems for setting and managing clinical standards and assessing doctors' competencies in Australia. In July 2010, a national registration system managed by the Australian Health Practitioner Regulation Agency (AHPRA) commenced. Before this, a national assessment process was established in 2006. Together, these measures have addressed major issues raised by the 2005 Biennial Review regarding inconsistencies in assessment of qualifications and in the setting of conditions of registration and practice for doctors working on workforce programs.

AHPRA (through the Australian Medical Board) now sets conditions of practice and supervision requirements for all doctors. However, there remains uncertainty about the extent doctors are able to access the required level of supervision and the capacity of private practices to provide that supervision, particularly in general practice in rural areas.

Guidelines for workforce programs have been revised and sections relating to quality processes have been strengthened. For most workforce programs, doctors must now be working towards gaining vocational qualifications. The program guidelines also now stipulate that doctors on workforce placements must receive adequate mentoring and supervision.

Despite the changes to program guidelines, mentoring and support for doctors training on workforce programs is underfunded and inconsistent across programs. There needs to be more investment in training placements and support for non-vocationally recognised doctors to ensure they provide high quality services.

The current review identified specific issues related to individual workforce programs, which are described in the report.

Findings for Training Programs

Training programs are generally operating effectively. The sector has welcomed the recent increases in training places and funding for these, and the programs that promote expansion of training into private hospitals and other non-traditional settings. But the increasing number of medical graduates highlights the need for good data that will allow accurate monitoring of the demand for, and capacity of, specific sectors to provide training positions. General practice stakeholders are concerned that training positions (prevocational and vocational) will fall well short of requirements unless more teaching sites are recruited or larger numbers of trainees are placed at each site.

The review found that two specialist training programs that allow registrars to access Medicare rebates in private and/or community settings appear to have low uptake, in part because of a lack of clarity about how and when Medicare rebates can be claimed.

The review also identified specific issues related to individual training programs, which are described in the report.

Findings for the Medical Training Review Panel (MTRP)

The MTRP is monitoring the supply of medical training opportunities, although more needs to be done to monitor demand.

Stakeholders value the monitoring data on medical training published by the Panel and want the statutory role of MTRP to continue. There is also general support for the MTRP and Health Workforce Australia (HWA) to have formal links around medical training.

The current membership of the MTRP is appropriate. Three stakeholders expressed interest in becoming members of the Panel on the grounds that they have an interest in and involvement with training and workforce programs. These are the Remote Vocational Training Scheme Ltd (RVTS), the National Association of Medical Deputising Services (NAMDS) and Rural Health Workforce Australia (RHWA).

2010 Recommendations

2010 Recommendations for section 19AA

Recommendation 1

DoHA to review all relevant Medicare Provider Number Legislation to address issues in access to provider numbers and the ability of doctors to practice.

Recommendation 2

The Government to review eligibility criteria for access to vocational training programs so that OTDs' access to these is assessed on the basis of clinical skills and not on the basis of their residential status.

Recommendation 3

Eligibility for grandfathering of non vocationally recognised(VR) GPs who were qualified before 1996 to be determined in consultation with the profession and the Medical Board of Australia:

Provide one last opportunity to be grandfathered onto the vocational register because this recommendation was not actioned in 2005. If grandfathering is not possible because of the establishment of the national registration system; allow this group to access A1 rebates for a defined period whilst working towards Fellowship with ACRRM or the Royal Australian College of General Practitioners (RACGP).

Recommendation 4

For other non VR doctors working in general practice:

DoHA and industry stakeholders to investigate the barriers for non VR doctors in obtaining vocational recognition and how to provide better support to them, and act on the findings of the investigation.

Recommendation 5

DoHA to amend the relevant regulations and/or legislation to allow supervisors to bill for T8 items for specialist trainee doctors performing procedures in private settings.

2010 recommendations for administration of section 3GA programs

Recommendation 6

6.1: DoHA to update Schedule 5 Pt 2 of the Regulations to remove references to s3GA workforce programs that have been discontinued; namely, the Rural and Remote Area Placement Program, the Metropolitan Workforce Support Program, and the Assistance at Operations program.

6.2: DoHA to routinely update Schedule 5 of the Regulations when the status of s3GA programs change.

Recommendation 7

DoHA to remove reference to the RACGP and ACRRM as specified bodies for the Prevocational General Practice Placements Program (PGPPP) as the program is now managed by GPET.

Recommendation 8

DoHA (or relevant authority) to revise all s3GA workforce and training program guidelines to acknowledge the role of AHPRA in setting conditions for clinical practice and supervision requirements, and monitoring these conditions and requirements.

Recommendation 9

DoHA (or relevant authority) to revise relevant s3GA workforce and training program guidelines to ensure that both the RACGP and the ACRRM are both referred to as providers of general practice training, and to ensure that where the guidelines refer to Fellowship of the RACGP, they also reference the Fellowship of ACRRM.

Recommendation 10

DoHA and Medicare Australia to reduce red-tape involved in applying for provider numbers not only for doctors on s3GA workforce and training programs but across the whole sector; and to improve information services about application processes for the sector.

10.1: By 2012, DoHA to allow one application for each doctor on a s3GA workforce or training program to cover all practice locations and for the entire time they are on the program.

10.2: By 2014, Medicare Australia to issue one provider number to each medical practitioner and an identifying code number to each practice location, with the two numbers working in tandem to identify the practitioner and the location at which the service was provided.

10.3: By 2012, Medicare Australia to automatically renew provider numbers for doctors working for AMDSs when the Deeds of Agreement are renewed.

10.4: Relevant parts of the Government to improve information services so that specialist colleges, doctors, practice managers and others can get queries about the allocation of provider numbers answered in-person and in a timely way.

2010 general recommendations for section 3GA programs

Recommendation 11

DoHA to invest in support for doctors on workforce programs.

Recommendation 12

DoHA to fund a research project that assesses the extent that doctors on s3GA programs access the required level of supervision, and act on the findings of this research project. The research project could include an anonymous survey of doctors' experiences of the quality of supervision.

Recommendation 13

Relevant program areas in DoHA (or relevant authority) to establish a mechanism that allows regular industry input into operational issues in order to identify and address any problems in delivering services under the programs, rather than wait for the five year review of the Medicare Provider Number Legislation.

Recommendation 14

DoHA to add the ACRRM Independent Pathway (a fully accredited independent general practice training pathway) to Schedule 5 of the Regulations to facilitate access to Medicare provider numbers for registrars on this pathway.

Recommendation 15

15.1: DoHA to add Fellowships of the RACGP, ACRRM, the Australasian College of Sports Physicians and the College of Intensive Care Medicine of Australia and New Zealand to Schedule 5 of the Regulations, which lists organisations and courses for s3GA of the Act.

15.2: DoHA to routinely update Schedule 5 of the Regulations as Fellowship courses are certified by the AMC.

2010 Program specific recommendations for section 3GA workforce programs

Approved Medical Deputising Service Program

Recommendation 16

DoHA to actively monitor the impact of health reforms on the provision of after-hours care by AMDSs and revise the AMDS Program Guidelines as needed.

Queensland Country Relieving Doctors Program

Recommendation 17

17.1: Queensland Health to ensure that all junior doctors on a relief placement have access to direct supervision and endeavour to place more senior doctors in remote relief placements.

17.2: Queensland Health to monitor the achievement of this recommendation and report on its success at the next review of the Medicare Provider Number Legislation in 2015.

Rural Locum Relief Program

Recommendation 18

DoHA to fund rural health workforce agencies to provide support for doctors working under the RLRP.

Program specific recommendations for section 3GA training programs

Prevocational General Practice Placement Program

Recommendation 19

GPET to ensure that all junior doctors have access to direct supervision and endeavour to place more senior trainees in remote placements.

Specialist College Trainee Program

Recommendation 20

Medicare Australia, in consultation with the specialist colleges, to prepare new guidelines about the parameters of the Specialist College Trainee Program (SCTP) including who is eligible and under what circumstances rebates under the program can be claimed. The guidelines should also describe how the program relates to the Specialist Training Program managed by DoHA.

Recommendation 21

DoHA to clarify the items that can be claimed by registrars under the program and expand eligibility to item numbers to more accurately reflect the differing practices of each specialty.

Recommendation 22

DoHA to review the level of rebates (A2) that can be claimed under the program with a view to making these in line with VR (A1) items.

2010 Recommendations for section 3GC

Recommendation 23

The Government consider amending the legislation to allow the MTRP to undertake additional activities to monitor health services capacity in providing training places for prevocational and vocational doctors and provide advice to DoHA and/or HWA on these issues.

Recommendation 24

The Government consider amending the legislation to allow the MTRP to monitor the effectiveness of training programs in meeting workforce needs and demands.

Recommendation 25

The Government consider amending the legislation to allow the MTRP to provide advice about medical training and to develop formal links with HWA.

Chapter One — Approach to the 2010 Review

As the result of the 1996 Commonwealth Budget, there were major changes to the Act to include sections 19AA, 3GA and 3GC. The new sections of the Act, collectively known as the Medicare Provider Number Legislation, were designed to improve the quality of, and access to, patient care for all Australians.

Regular reviews of the Act are legislated and reviews have been conducted every two years between 1999 and 2005. This review examines how the legislation has performed over the five years between 2005 and 2010.

1.1 Objective and scope

The **objective** of the review was to report on the operation of the Medicare Provider Number Legislation contained under sections 19AA, 3GA and 3GC of the Act. In accordance with s19AD(1) of the Act, the Minister must table a report to Parliament about the operation of the Medicare Provider Number Legislation by 31 December 2010.

The **scope** of the 2010 Review is the operation of the legislation over the past five years (2005–2010).

For s3GC, the **scope** is the effectiveness of the MTRP in meeting its statutory requirements. The MTRP's work plan and governance were reviewed in 2008–09 and hence are not being covered by this review

1.2 Terms of reference

The review was to ensure all relevant stakeholder organisations are engaged and have the opportunity to present their views; and that the findings and recommendations of the review are based on a systematic and balanced assessment of these views and other available evidence.

The terms of reference are to review and report on

- the operation of the Medicare Provider Number Legislation contained under sections 19AA, 3GA and 3GC of the Act to facilitate tabling of a report in Parliament
- the progress towards addressing the recommendations of the 2005 Biennial Review
- any issues emerging since the 2005 Biennial review that impact on the way the legislation now operates, or any issues that have arisen as the result of recommendations made by the 2005 Biennial Review.

1.3 Document review

As part of the preparation of the review framework submissions from six key stakeholders were reviewed, with a further two submissions being received in November 2010 and 37 submissions via an electronic form submission process (see Table 1.1 and Appendix 1).

1.4 Consulting with the sector

Stakeholders were given a choice about how they wanted to contribute to the review. They could give feedback during a structured interview, as an electronic (survey) submission or by attending a workshop. These methods were chosen to ensure the data were collected efficiently, while giving stakeholders the opportunity to contribute to the review.

Consultation methods are summarised in Table 1.2, and a list of participants across all methods is included in Appendix 1.

Table 1.1: List of submissions received

Organisation	Date received
National Association for Medical Deputising Services	21 October 2010
Royal Australian College of General Practitioners	15 October 2010
Australian College of Rural and Remote Medicine	15 October 2010
Australian Medical Association, Council of Doctors in Training	22 October 2010
Melbourne Medical Deputising Service	20 October 2010
Remote Vocational Training Scheme Ltd	19 October 2010
Australian Medical Association	16 November 2010
Australian General Practice Network	23 November 2010

Note: The AMA's submission is public and is available from http://ama.com.au/node/6222

Other documents reviewed were:

- Biennial Review of the Medicare Provider Number Legislation, December 2005
- Record of Proceedings Special Meeting held on Friday, 24 February 2006 to discuss the report of the 2005 Biennial Review of the Medicare Provider Number Legislation.
- MTRP Review Background and Issues Paper For Consultation with the MTRP and Selected Industry Stakeholders.
- MTRP Review Report: Report on Consultation Feedback and Findings, April 2009.
- 3GA Program Guidelines: Approved Private Emergency Department Program; Special Approved Placements Program (SAPP) (2003); AMDSs Program (2007).

Table 1.2: Summary of consultation methods		
Consultation method	**Purpose**	**Responses received**
Initial written submissions (before 29 October 2010)	Identify issues to focus the review	Six submissions
Initial scoping interviews	Identify issues to focus the review	Five interviews (DoHA, s3GA managers)
Initial meeting with MTRP	Discuss review framework and issues	
Telephone/ face-to-face interviews/ group discussion	Discuss issues in detail	65 participants
Electronic submissions	Discuss issues in detail	37 responses in total, comprising APEDP n=2; AMDS n=3; MTRP n=30; SCTP n=2
Final written submissions (after 29 October 2010)	Discuss issues in detail	Two submissions
Stakeholder forum	Discuss findings, get consensus about importance of findings and refine recommendations	15 stakeholders

Chapter Two — Status of the 2005 Biennial Review of the Medicare Provider Number Legislation recommendations

Just over half of the recommendations from the 2005 Biennial Review have been fully implemented. Four recommendations were superseded over the five years since the Review and are no longer relevant (3.1, 3.4, 11.2 and 12).

The status of the recommendations and results are shown in Table 2.1. The recommendations that were not fully implemented are listed below.

Recommendations not implemented

- **Recommendation 1:** Provide one more opportunity for doctors who meet the necessary criteria to be grandfathered onto the Vocational Register.
- **Recommendation 3.3:** Consider further investment to support the quality and training aspects of the RLRP, AMDS Program and other s3GA workforce programs because of their value in providing quality care to rural areas.
- **Recommendation 5.3:** Specifically, implement a staged program that over time will lead to ensuring that all medical practitioners participating in the RLRP for an extended period of time (e.g. more than 12 months) receive the appropriate assessment and training to achieve Fellowship of a recognised specialist college.
- **Recommendation 6.2:** The Divisions of General Practice and local MDSss are to develop closer cooperation to promote coordination between general practice and MDSs with a particular emphasis on participation of MDSs in Division Aged Care GP Panels to assist in providing after-hours services to residential aged care facilities and the possible use of MDSs in providing in-hours care to these facilities.
- **Recommendation 8:** GPET, the AMC and the relevant medical colleges to review the entry criteria for the AGPT Program to enable OTDs with suitable qualifications (other than passing the Australian Medical College exam) and experience to enter the program.
- **Recommendations 10.1 and 10.2:** The Australian Government to establish a review committee (membership as specified in Recommendation 10.2) who will call for and respond to submissions on the problems and possible solutions associated with applications for provider numbers and 3GA programs.

The seven recommendations not yet fully implemented address issues that are still current; these are discussed in the following chapters. In most instances there is little information to explain why the recommendations were not actioned.

Three recommendations called for interagency committees to be involved in refining guidelines or addressing issues. It appears that although two of these recommendations were actioned, the organisation responsible for managing the programs did the work and formal interagency committees were not involved.

Table 2.1 Status and results of 2005 Biennial Review Recommendations			
No.	**Recommendation**	**Status**	**Results and comments**
1	*Provide one more opportunity for doctors who meet the necessary criteria to be grandfathered onto the Vocational Register.*	Not implemented.	Affected group of doctors and their patients disadvantaged financially.
2	*The MTRP be directed to monitor and report regularly on the activities and progress made to ensure adequate intern and training positions are in place to meet the increasing numbers of new graduates.*	Implemented.	MTRP Annual Reports provide data on intern placements. Data assists industry to understand training needs and initiatives to address these. More information needed about availability of Postgraduate year (PGY)1–3 and prevocational placements.
3.1	*The review concludes that there is a need to maintain the current list of s3GA training and workforce programs and sees no need for any additional programs.*	Superseded.	List has changed to meet changes in policy, and new circumstances. Approved placements meeting policy needs.
3.2	*There should be an increasing emphasis on standardised assessments, structured education, supervision and mentorship in all the workforce programs.*	Implemented.	National Assessment process for OTDs introduced. Guidelines on most workforce programs strengthened. Not implemented for SAPP and Temporary Resident Other Medical Practitioner (TROMP) Program. More support being provided but stakeholders remain concerned about quality of supervision/sufficiency of support for training.
3.3	*The Australian Government should consider further investment to support the quality and training aspects of the RLRP, the AMDS program and other s3GA workforce programs because of their value in providing quality care to the rural.*	Not implemented.	No additional investment made. Additional investment being sought.
3.4	*The Australian Government should continue to stress the need for medical boards to have a more consistent national approach to their assessment and approval processes.*	Superseded.	A standard national assessment process was introduced in 2008 and a national registration process in 2010. Both processes used by all workforce programs.

Table 2.1 Status and results of 2005 Biennial Review Recommendations			
No.	**Recommendation**	**Status**	**Results and comments**
4	*DoHA to monitor the progress of Queensland Health's review of the Queensland Country Relieving Doctors (QCRD) Program and the implementation of changes with particular attention to ensuring the guidelines provide for effective preparation, training and support and work towards achieving the same standards expected of other s3GA workforce programs.*	Implemented.	New program guidelines require supervisors to be identified and parameters set for adequate supervision. Compulsory induction and training courses to prepare locums developed. Queensland Health report locums are better prepared and have better access to support and supervision. Stakeholders remain concerned about adequacy of supervision given the inexperience of junior doctors on locums and associated risks.
5.1	*DoHA to establish a formal and representative committee including non-Rural Workforce organisations (e.g. groups associated with quality and training) to review the guidelines of the RLRP.*	Partly Implemented.	Guidelines reviewed in 2008 and 2010 by RHWA (2010 draft not approved by DoHA). Guidelines operating effectively, being followed. No interagency committee.
5.2	*The review of the RLRP should take into account the recommendations of the 2003 Review not already implemented with particular emphasis on addressing quality assurance issues around assessment, mentoring, supervision and training.*	Implemented.	Guidelines cover quality issues for mentoring and training. Assessment done under national assessment process, with States and jurisdictions having their own final assessment processes before recruiting. Supervision set by registration requirements. Adequacy of supervision remains a concern because of lack of capacity in some locations.
5.3	*Specifically, implement a staged program that over time will lead to ensuring that all medical practitioners participating in the RLRP for an extended period of time (e.g. more than 12 months) receive the appropriate assessment and training to achieve Fellowship of a recognised specialist college.*	Not implemented.	Additional Assistance Fund has waiting list and is underfunded; established in 2003. GPs can access $7,000 for training through Additional Assistance Scheme. Funding for this scheme was doubled in 2010–11 to address the waiting list.

Table 2.1 Status and results of 2005 Biennial Review Recommendations			
No.	**Recommendation**	**Status**	**Results and comments**
6.1	*DoHA to complete and implement the revised guidelines for the AMDS program in line with the recommendations of the 2003 review.*	Implemented.	Quality processes strengthened. New guidelines developed in 2007 and being implemented.
6.2	*The Divisions of General Practice and local MDSs are to develop closer co-operation to promote coordination between general practices and MDSs with a particular emphasis on: participation of MDSs in Division Aged Care GP Panels to assist in providing after-hours services to residential aged care facilities and the possible use of MDSs in providing in-hours care to these facilities.*	Not fully implemented.	MDSs not currently providing in-hours care to residential aged care facilities.
6.3	*To streamline the administration of the program, DOHA are to extend the duration of both the Deeds for MDSs and provider numbers to doctors.*	Implemented.	Improved administration of program for practices.
7.1	*The Australian Government monitor and plan to ensure that there are adequate positions available to cover the increase in demand that will result from an increase in the number of medical graduates.*	Implementation in progress.	Places on training programs are being expanded. Sufficient places available on AGPT program in 2010. RVTS had more applicants than places in 2010. Concerns over adequacy of infrastructure and capacity to provide GP training placements.
7.2	*The National Advisory Committee examine the feasibility of establishing some demonstration sites to test the feasibility of part-time placements.*	Implemented.	More flexibility for students and practices. Part-time placements allowed on PGPPP.
8	*GPET, the AMC and the relevant medical colleges to review the entry criteria for the AGPT to enable OTDs with suitable qualifications (other than passing the AMC exam) and experience to enter the program.*	Not implemented.	35% of current AGPT cohort are OTDs. Temporary residents are not eligible.
9	*DoHA to provide an extension for medical practitioners on the Approved Placements for Sports Physicians Program until the AMC makes a decision regarding recognition of their speciality and training program.*	Implemented.	Program extended until October 2010. Sports medicine recognised as a speciality in January 2010. Program removed from list as of 31 October 2010.

Table 2.1 Status and results of 2005 Biennial Review Recommendations			
No.	**Recommendation**	**Status**	**Results and comments**
10.1	*The Australian Government to establish a review committee who will call for and respond to submissions on the problems and possible solutions associated with applications for provider numbers and "Approved Placement Programs".*	Not implemented.	Appears no such committee was formed. Stakeholders remain frustrated about requirements for applications for provider numbers and timeliness of processing. DoHA reports recent administrative arrangements are reducing waiting times for exemptions and provider numbers.
10.2	*The committee should comprise amongst others the Australian Medical Association (AMA), GPET, the Australian Rural and Remote Workforce Agencies Group, NAMDS, Medicare Australia and DoHA.*	Not implemented.	Appears no such committee was formed.
11.1	*The Review concludes that there is a need to maintain the role of the MTRP.*	Implemented.	Role has been maintained since 2005. Valued forum with recognised expertise on medical training.
11.2	*The MTRP should improve the process for the more effective use of funding provider under the National Projects.*	Superseded.	The MTRP no longer administers National Project Funding.
12	*DoHA are to consider and if necessary meet with appropriate agencies to determine the best method of collecting data on the number of resident doctors who have been granted a provider number for six months or more.*	Superseded.	Information about primary visa applications granted medical practitioners by visa sub-class is available through the Australian Government Department of Immigration and Citizenship. Since the 2005 Biennial Review there have been significant policy changes impacting overseas trained doctors these include changes to the operation of s19AB of the Act, the issuing of non end dated s19AB exemptions under the Act and the introduction of national medical registration and accreditation.

Chapter Three — Operation of Section 19AA

This section discusses the operation of s19AA, including relevant recommendations from the 2005 Biennial Review and any emerging issues.

The legislation is operating as intended but there are mixed views about whether there is the right balance between managing the workforce and quality control aspects of the legislation. Some of the recommendations of the 2005 Biennial Review have been implemented, small changes to the legislation and/or regulations are needed to address the issues that continue to affect some doctors.

3.1 Section 19AA legislation intends to ensure doctors receive continuing professional development, resulting in higher quality medical care for all Australians

Section 19AA of the Act does not allow access to Medicare benefits for medical practitioners who were qualified after 1 November 1996, unless they are Fellows of a specialist college or are doing an approved placement on a s3GA program.

The purpose of the legislation is to ensure that all medical practitioners have or are working towards vocational registration, which would help them to deliver a high standard of medical care. Section 19AA of the legislation gives formal recognition to general practice as a medical speciality, whose practitioners need specific skills and competencies.

Section 19AB is a related section of legislation, which restricts OTDs'[1] and foreign graduates of accredited medical schools[2]' (FGAMs) access to Medicare benefits, for a period of generally 10 years, unless the doctor is working in a district of workforce shortage (DWS). This is commonly known as the '10 year moratorium'. OTDs and FGAMs can access Medicare benefits for the services they provide in a DWS if they obtain an exemption under s19AB of the Act. OTDs and FGAMs who are Australian permanent residents or citizens and who have yet to gain Fellowship of a specialist college or vocational recognition are also subject to s19AA of the Act. This group of OTDs are eligible to work under s3GA programs.

As s19AB is outside the scope of this review, views were not sought on the appropriateness of the moratorium. However, there were views from some stakeholders seeking its abolition because they say it is ineffective and discriminatory. Other stakeholders view it as essential for ensuring an adequate medical workforce is available, for example, for MDSs.

The Australian Government has recently announced the establishment of a formal House of Representatives Committee inquiry into the role of Australia's specialist medical colleges in the process of registering and supporting OTDs[3] (24 November 2010). In addition, the Health Workforce Ministerial Councils asked the Australian Health Workforce Advisory Council for independent advice to Ministers regarding the assessment requirements for registration with each of the specialist colleges.

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1 OTDs are doctors whose primary medical qualification was not obtained from an AMC accredited medical school in Australia or New Zealand.

2 Foreign graduates of accredited medical schools are doctors whose primary qualification was obtained at an AMC accredited medical school in Australia or New Zealand, and who was not a permanent resident of citizen of Australia or New Zealand at the time when they first enrolled.

3 http://www.aph.gov.au/house/committee/haa/overseasdoctors/index.htm

3.2 Findings for section 19AA

The findings of the 2010 review about the operation of s19AA largely concur with those made in 2005, including that the legislation is operating as intended and that there is unfinished business in regard to recognising doctors who qualified before 1996 and are not included on the vocational register.

One new issue identified in this review is an anomaly of the legislation that makes it hard to retain doctors in practices after they become permanent residents of Australia. The review has also identified parts of the relevant regulations that need updating.

3.2.1 Section 19AA is well accepted by the medical profession

As in other specialist areas, VR medical practitioners are now seen as the norm in general practice [4]. In 2010, the new national registration process also recognised general practice as a medical specialty accessible through Fellowship of the RACGP (FRACGP) or ACRRM (FACRRM); or on the general practice vocational register.

Industry stakeholders generally agree with the intent of the legislation, that is, to ensure medical graduates have vocational training that will develop their skills and ensure they are capable of working in unsupervised general practice or other speciality areas. Stakeholders involved in vocational medical training claim that the quality of services provided by GPs is now more consistent across Australia as a result of vocational training requirements.

The review found that the implementation of s19AA, along with other legislation that addresses access to provider numbers, is complex and there is a need to harmonise the various legislation.

3.2.2 The balance between workforce and quality policy objectives

Although supportive of the intent of s19AA, one group of general practice stakeholders feel that the legislation should try to achieve a better balance between workforce supply and quality care provision. These stakeholders argue that there are still medical workforce shortages in Australia, particularly in rural areas, and therefore more flexibility is needed to overcome shortages. Other stakeholders disagree with the policy on workforce programs and believe they are inherently discriminatory. These stakeholders say that working as a doctor in remote and rural areas is generally more challenging than other places, and that workforce programs reduce standards of practice by allowing non-qualified doctors to work in these areas, often without access to adequate supervision or sufficient support to achieve vocational qualifications. They also commented on the inconsistency of standards, which means a doctor is able to work in specific areas but not considered skilled enough to work elsewhere.

Some States now require OTDs with insufficient general practice experience to first work in a hospital in order to orient them to the Australian health system. Doctors may then transition to a supervised general practice environment. However, general practice stakeholders say that it is difficult to find in-hospital placements and that community based settings are generally a more viable training placement.

One reported issue for rural areas related to workforce objectives of the legislation, is that some OTDs are less able to provide after-hours care, emergency department services or procedural services for local hospitals. This is one of several factors that might jeopardise the operation of smaller hospitals.

4 In 2010, the ratio of GP Fellows to GP's on the Vocational Register was about fifty–fifty (Source: AMA personal communication).

3.2.3 Supporting non VR GPs to achieve vocational recognition

Non VR GPs and their patients are financially disadvantaged by receiving significantly lower Medicare rebates than their VR colleagues. In 2010, the rebates for non VR GPs are almost the same as nurse practitioners rebates, a situation that some stakeholders find unfair given the differences in training of the two professional groups [5].

More needs to be understood about the characteristics of non VR doctors working in general practice. There are an estimated 5,800 non VR GPs [6], approximately half of these are OTDs. Many non VR GPs work in metropolitan areas in specialist general medicine, for example: skin cancer medicine or cosmetic medicine; or in Aboriginal Medical Service; or in Family Planning clinics.

Non VR doctors who graduated before 1996

One group identified in previous reviews as being unfairly affected by s19AA, and subsequent changes to the way doctors are recompensed for services, is GPs who graduated before 1996 and who are not currently on the vocational register.

Although the group is difficult to define, there are four types of these pre-1996 graduates who are non VR:

- doctors who objected to the idea of vocational recognition and who have remained non VR
- doctors who missed the cut off date for grandfathering because they were overseas or on leave and have since chosen to not work towards a Fellowship
- doctors working in an area of general medicine that doesn't require them to be FRACGP/FACRRM, for example: skin cancer medicine or cosmetic medicine; Aboriginal Medical Service; or in Family Planning Clinics
- OTDs who came into Australia before 1996 or in the early 2000s and who have continued to work in DWS as part of s3GA programs and have not needed vocational recognition to access Medicare.

Across these groups, there are an estimated 600 GPs who graduated before 1996 and have at least five years experience in general practice who would be interested in having their skills recognised formally, or who could work towards a Fellowship [7]. It's believed that many of the doctors in this group are highly experienced doctors working in solo practices. Some stakeholders suggested that the cost of attaining Fellowship, both in terms of exam fees and the time cost of studying for the exams, might be the biggest barrier to Fellowship. Others surmise that factors including fear of failure, uncertainty about how to prepare for the exams and the effort it will take to pass the exams, are the reasons why these non VR doctors hesitate to do their Fellowship exams.

The 2005 Biennial Review recommended that the Australian Government 'provide one more opportunity for doctors who meet the necessary criteria to be grandfathered onto the Vocational Register', but this opportunity wasn't provided. In 2010, there are different views about how to assist and encourage non VR doctors to obtain recognition.

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5 Doctors on s3GA workforce programs in districts of workforce shortage are an exception, because they can access higher rebates (A1) by virtue of being on these programs.

6 5,800 non-VR doctors participate in RACGP Continuing Professional Development Program

7 RACGP estimates

One view is that, because the opportunity to be grandfathered wasn't provided after the last review and because there is no reason to believe that these doctors' standards of care are any different than their peers who graduated at the same time, another round of grandfathering should be offered. Stakeholders who support grandfathering argue that the new national registration arrangements will provide reassurance about the ongoing quality of their practice, similar to other medical practitioners.

Because more than half of the non VR GPs already have access to higher Medicare rebates through workforce programs, it's argued that the move to grandfather the non VR doctors would have a limited cost impact. The stakeholders argue that the move could help to retain this cohort of highly experienced GPs in the medical workforce and encourage them to increase their working hours.

Other stakeholders do not support grandfathering. This group suggests that because Fellowship is now the industry standard to ensure quality of care, and because grandfathering does not include an assessment of doctors' skills, that an additional round of grandfathering could jeopardise the credibility of vocational recognition. Another common argument against grandfathering is that most of non VR GPs who qualified before 1996, that are likely to do their Fellowship exams, have done them.

The regulatory landscape has changed since the last round of grandfathering for non VR GPs. If grandfathering occurred as the result of the current review, one issue to consider is whether this group of GPs would be eligible for specialist registration and hence able to access specialist rebates for services. Our initial advice is that this group could be outside s58 of the *Health Practitioner Regulations, National Law Act 2009* because they do not hold a 'qualification' and that an alternative administrative mechanism may have to be established.

In line with the argument that non VR GPs and their patients are financially disadvantaged, some stakeholders made suggestions for improving remuneration for non VR GPs.

- Allow non VR GPs to access higher Medicare rebates for a defined time period if they can show they are working towards Fellowship.
- Increase the 'other non-referred medical practitioner' Medicare items to 93 per cent of the VR Medicare rebate and ensure an indexation of Medicare rebates for all non VR GPs, in line with the current GP indexation arrangements.

Currently, there are programs available which offer medical practitioners the same access to the higher rebate as is available to GPs on the Vocational Register. The Medicare Plus for Other Medical Practitioners (MOMPs) Program provides access to the higher Medicare rebate for services provided by pre-1996 non VR GPs who provide services in DWS. After these practitioners have been on the program for a period of five years, their services will continue to attract the higher rebate regardless of where they subsequently practice. Although there is the condition to work in a DWS, this program affords this cohort of pre-1996 doctors the opportunity to access the higher rebate without obtaining vocational recognition.

Non VR GPs who graduated after 1996

General practice stakeholders indicated that all doctors who graduated after 1996 and who are working in general practice settings should have VR or be working towards this qualification.

The two general practice colleges, RACGP and ACRRM, both have pathways to Fellowship for non VR GPs that take into account their commitment to the profession, their past experience, and their involvement in continuing professional development. The RACGP offers a Practice Eligible Route to Fellowship, which is

open to doctors who have at least four years of fulltime general practice experience with at least one of these years in Australia. Doctors following the Practice Eligible Route do a three-part practice-based assessment of their skills before being awarded FRACGP. Likewise, ACRRM offers an Independent Pathway to Fellowship for experienced GPs, which is delivered to doctors enrolled in the RVTS.

3.2.4 Anomalies under the Act impact on OTDs' ability to practise

Once an OTD becomes a permanent resident or citizen of Australia, they are subject to s19AA of the Act and, if they don't have appropriate postgraduate qualifications, they need to be placed on a s3GA program in order to access Medicare benefits. The logic of this requirement is to ensure that doctors who remain permanently in the country have appropriate levels of qualifications.

Anomalies under s19AA mean that OTDs can suffer hardship and find it difficult to practice. Stakeholders described situations where a recent Australian permanent resident doctor, with a well established practice, may no longer be able to access Medicare rebates in that location due to becoming subject to the restrictions of s19AA of the Act. The result of situations like this is that doctors might need to leave their practice, or be unable to earn a satisfactory living unless they can access a suitable s3GA program.

Stakeholders expressed concern that maintenance of recognition on the vocational register can be influenced by the rules of individual Colleges, outside the need to keep up continuing professional development points. This issue has been raised with the Australian Medical Board who are currently developing a policy to address it.

3.2.5 Other issues

One result of s19AA is that doctors are less able to acquire training and skills to work in different but related work contexts or change their career pathways than was possible prior to 1996, for example, being able to move between emergency medicine and general practice. In regional Australia, where the bulk of emergency services are provided by GPs, this has led to challenges which ACRRM is addressing through its Fellowship program. The Australasian College of Emergency Medicine is considering offering additional diplomas that improve emergency medicine skills of other medical practitioners as a way of addressing this issue. Queensland Health has also introduced advanced specialist training in emergency medicine for generalists in the Queensland Health workforce.

An unintended consequence of s19AA is that many junior doctors have not had experience in general practice settings as part of their postgraduate training. Until the recent introduction of PGPPP, there has not been a dedicated workforce program that allows junior doctors' access to Medicare rebates while working in general practice.

This has meant it is more difficult to attract graduates to general practice. Instead, junior doctors tend to follow a hospital based training pathway and have limited experience in general practice settings in their first or second postgraduate years. General practice stakeholders are hopeful that by expanding PGPPP, most junior doctors will be able to get general practice experience in their first few years of practice. PGPPP is discussed further in chapter 6.

3.2.6 Changes needed to legislation and/or regulations to support vocational training in the private hospital sector

There are inconsistencies across medical specialist areas about access to Group T8 rebates. Currently, only supervising surgical specialists can bill for Group T8 items, that is, surgical procedures their registrars do under supervision. Non-surgical supervising specialists cannot bill in this way, which is a barrier to getting vocational training placements in private hospitals because of a potential loss of income.

The review understands that DoHA are considering the issue and are seeking advice as to whether changes are required to the relevant legislation or regulations to address this issue.

3.3 2010 Recommendations for section 19AA

Recommendation 1

DoHA to review all relevant Medicare Provider Number Legislation to address issues in access to provider numbers and the ability of doctors to practice.

Recommendation 2

The Government to review eligibility criteria for access to vocational training programs so that OTDs' access to these is assessed on the basis of clinical skills and not on the basis of their residential status.

Recommendation 3

Eligibility for grandfathering of non VR GPs who were qualified before 1996 to be determined in consultation with the profession and the Medical Board of Australia:

Provide one last opportunity to be grandfathered onto the vocational register because this recommendation was not actioned in 2005. If grandfathering is not possible because of the establishment of the national registration system; allow this group to access A1 rebates for a defined period whilst working towards Fellowship with ACRRM or RACGP.

Recommendation 4

For other non VR doctors working in general practice:

DoHA and industry stakeholders to investigate the barriers for non VR doctors in obtaining vocational recognition and how to provide better support to them, and act on the findings of the investigation.

Recommendation 5

DoHA to amend the relevant regulations and/or legislation to allow supervisors to bill for T8 items for specialist trainee doctors performing procedures in private settings.

Chapter Four — Operation of Section 3GA

Section 3GA of the Act permits medical practitioners who are subject to s19AA to provide professional services that attract Medicare benefits through placements on approved workforce or training programs. Workforce and training programs operate in different contexts and as such these two programs face different issues, which need to be treated differently from a policy and funding perspective.

This chapter describes s3GA of the Act and issues relevant to both workforce and training programs. In particular, administration processes and updating of regulations. The following two chapters describe the findings for workforce and training programs separately.

4.1 Section 3GA: A suite of workforce and training initiatives to ensure Australian communities have access to quality medical services

Section 3GA of the Act works to ensure that only doctors who are enrolled in a training course or program specified in Schedule 5 of the Regulations can provide services for which a Medicare benefit is payable.

To ensure that all communities in Australia have access to quality medical services, a number of training and workforce programs funded by State and Territory or Commonwealth governments exist. Doctors without vocational qualifications, or who are in the process of becoming vocationally qualified, can be part of these programs and thereby access Medicare rebates for their work.

The programs are a mix of workforce and training initiatives, and some are a combination of the two. Training programs are delivered by AMC approved providers and represent most of the vocational training opportunities available for doctors in Australia. Doctors may be on concurrent, multiple 3GA placements —for example, enrolled in a specified training placement and also accessing rebates under a workforce program.

At 30 October 2010, there are 11 training and workforce programs listed under Schedule 5 of the Regulations (see Table 4.1). There have been several changes to the training and workforce programs since the last review in 2005.

- RVTS is an independent training provider and was added to Schedule 5 *Part 2 Specified bodies and programs* in 2007.
- Approved Placements for Sports Physicians Program ceased on the 31 October 2010 when Sports Medicine was recognised as a speciality. The Sports Physicians Trainees are listed under Schedule 5 *Part 2 Specified bodies and programs*.
- PGPPP has been expanded and has replaced the Rural and Remote Area Placement Program.
- The Metropolitan Workforce Support Program has ceased.
- The Assistance at Operations is an obsolete program.

Table 4.1: Number of providers of at least one service for s3GA Programs by year of service between 2004 and 2010[a]

Program	No. of providers made claims[b]					
	2004–05	2005–06[c]	2006–07[d]	2007–08[e]	2008–09[f]	2009–10[g]
Approved Medical Deputising Program	108	141	165	206	215	271
Approved Private Emergency Department Program	8	6	19	14	18	21
Approved Placements for Sports Physicians Program (discontinued)[h]	8	8	7	8	14	13
Sports Physician Trainees Program	–	16	22	21	27	21
Metropolitan Workforce Support Program (discontinued)	8	8	4	1	0	–
Prevocational General Practice Placement Program	21	56	81	134	182	237
Queensland Country Relieving Doctors Program	161	260	301	293	340	366
Rural Locum Relief Program	660	554	551	583	657	767
Special Approved Placement Program	–	11	15	43	53	61
Temporary Resident Other Medical Practitioner Program[i]	70	84	98	106	105	110
Remote Vocational Training Program Trainees Program	10	10	13	16	26	30
Australian General Practice Training Program						2318[j]
RACGP Training Program[k]						
Specialist College Trainee Program[l]*						
Rural and Remote Area Placements Program (discontinued)						
Assistance at Operations (discontinued)						

(Note statistics not strictly based on financial year)

a Source: Deprtment of Health and Ageing

b To be counted, providers had to have claimed for at least one service on a valid date for the program in question

c Statistics for 2004–05 and 2005–06 had regard to claims processed up to the end of October 2006

d Statistics for 2006–07 had regard to claims processed up to the end of October 2007

e Statistics for 2007–08 had regard to claims processed up to the end of September 2008

f Statistics for 2008–09 had regard to claims processed up to the end of October 2009

g Statistics for 2009–10 had regard to claims processed up to the end of August 2010

h Based on advice from Medicare Australia, providers on program 187 were only counted if they had an end date of 30 June 2011 and they had a valid date for this program. Medicare Australia uses code 187 for 3GA and non-3GA providers

i The TROMP Program (198) and the Approved Placements for Sports Physician Trainees Program (187) were not location specific

j Source: GPET-2318 registrars currently; 1037 on rural pathway and 674 of these on 10 year moratorium

k Replaced by the Australian General Practice Training Program

l Not currently in list of Approved Placements Programs

4.2 Administration processes for allocating provider numbers need streamlining

Previous reviews have recommended that approval processes for provider numbers be improved. Although some improvements to the efficiency of administration processes to issuing Medicare provider numbers have been made in the last five years, these processes remain a common and continuing source of frustration. [8] Potential consequences of inefficient provider number approval processes are: delays in doctors commencing new training or workforce positions; disruptions to service provision; and reduced mobility of the medical workforce.

Stakeholders said that the processes for administering applications are inefficient and impose an unnecessary administrative burden on practice management. In some cases, the complexity and length of the application process also discourages practices and non-traditional providers of medical services from taking on trainees. In particular, the requirement that doctors have a separate provider number for all their work locations is seen as an unnecessary and inefficient way to organise the system. Another problem is that doctors on certain placements need to get new provider numbers if their placement is extended.

The actual application process is also complicated. For example, registrars on the AGPT program need new provider numbers when their placements are extended or changed. To apply for the new provider number, registrars must complete two forms: one is sent to the Regional Training Provider (who submits the form to Medicare) and the other is sent directly to Medicare. On some occasions there are delays in allocating provider numbers because only one form has been received. Registrars report that this is a cumbersome and confusing process.

In addition, the application requirements are the same no matter what the type of placement or risk level. For example, placement in a general practice requires the same level of information and paperwork as placement in a hospital setting. GPET, who manage this training program, considers that the level of information required should be commensurate with the level of risk for the placement.

A related concern is that it takes longer to process applications for a doctor subject to s19AB than it does for other applications. The review understands that DoHA and Medicare Australia implemented a more streamlined process for s19AB exemptions in June 2010, which has proved successful. The statutory processing time for these exemptions is 28 days. GPET indicated that there are eight steps in the application process for provider numbers for registrars on the AGPT program who are subject to s19AB, and processing these applications takes an estimated 60 days (eight weeks).

Stakeholders also reported that it is difficult to get timely advice about administrative requirements for allocating provider numbers. The program area in DoHA that processes requests for s19AB exemptions require any queries to be submitted in writing and do not offer any way of contacting officers by telephone. Industry stakeholders report that the email enquiry system is an inefficient way of sorting out issues and getting questions answered in a timely manner.

There are specific administrative requirements for certain programs. Table 4.2 summarises the way stakeholders believe these requirements should be changed to ensure a more streamlined way of applying for provider numbers.

8 For example, the timing of Deeds of Agreement for AMDSs

Currently, DoHA makes policy decisions about provider number processes, which Medicare Australia follows. Medicare Australia has indicated that it would be technically possible to streamline information requirements for personal and professional information based on doctors being known to Medicare Australia. There are new communication and information sharing arrangements between AHPRA and Medicare Australia, but at this stage these have not affected the provider number application processes.

Table 4.2: Stakeholder suggestions for streamlining program specific requirements for provider number applications

Administrative requirement	Suggested change
New provider number for every practice location	Issue each medical practitioner with one provider number, which can be combined with an identifying code number for each practice location, with the two numbers working in tandem to identify the practitioner and the location at which the service was provided.
Processing s19AB exemptions	Allow these to be processed while doctors are offshore to improve timeliness of processing. Allow GPET to approve exemptions for AGPT program applicants as part of placement approval process.
Applying for s3GA provider numbers on the AGPT program	AGPT program registrars complete and submit one application form whilst on the program. The form is specific to the program and the information carries them through work on multiple placements.
APEDP trainees must re-apply for a provider number every year	Require one application for the four years of advanced emergency training.

4.3 New programs for Schedule 5 of the Regulations

Only one new program for Schedule 5 was formally put up for consideration as part of the review—the ACRRM Independent Pathway. The ACRRM Independent Pathway program is a fully accredited general practice training pathway that has been independently assessed by the AMC as equivalent to other general practice vocational training programs. There are currently 35 registrars on this program.

Under current arrangements, ACRRM Independent Pathway registrars are treated differently to doctors on other vocational training programs. Registrars on the program are less recognised and face significant barriers in securing training posts and negotiating the same terms and conditions as their peers. Because the Independent Pathway is not a recognised s3GA program, registrars must deal with multiple agencies to get approvals (practice, college, workforce agency, Medicare and sometimes DoHA), which causes delays in completing training and obtaining Fellowship.

These registrars also have difficulty accessing Medicare provider numbers. They must negotiate access to Medicare provider numbers under a s3GA program, usually the RLRP. For doctors working in some larger centres, it might not be possible to access a provider number through a workforce program.

One issue, which was not widely canvassed but was raised by a stakeholder in the context of a request for an additional program to be listed under Schedule 5, is access to Medicare benefits by Career Medical Officers (CMOs)[9] in specific contexts. CMOs work in hospitals under the supervision of specialists

9 Career Medical Offices is NSW terminology

(Fellows of a specialist college) and are outside s19AA. These doctors meet a need for medical workforce in public hospitals. One stakeholder is seeking access to provider numbers for CMOs who treat privately insured public hospital in-patients[10], so long as the hospital maintains accreditation with the Australian Council on Healthcare Standards and each medical officer fulfils continuing professional development requirements that satisfy AHPRA.

One other related issue is the process for getting new programs onto Schedule 5, which stakeholders report is 'convoluted, tedious and slow'.

4.4 Changes needed to Schedule 5 of the Regulations

Schedule 5 lists specified organisations and courses for s3GA programs. The review identified areas where it appears that Schedule 5 of the Regulations need updating.

Part 1—Specified bodies and qualifications needs updating as it does not include Fellowships of:

- Royal Australian College of General Practitioners
- Australian College of Rural and Remote Medicine
- the Australasian College of Sports Physicians
- the College of Intensive Care Medicine of Australia and New Zealand.

Schedule 5 *Part 2—Specified bodies and programs* needs updating to remove references to programs that have been discontinued, namely:

- the Rural and Remote Area Placements Program
- the Metropolitan Workforce Support Program
- the Assistance at Operations program.

References to RACGP and ACRRM as the specified bodies for PGPPP should also be removed as the program is now managed by GPET.

Further, consideration should be given to updating Schedule 5 as and when colleges and course are accredited by the AMC.

10 These cases are not supposed to be paid by public hospitals but rather by third party insurers who receive premiums from their members but refuse to pay claims from medical providers not registered for Medicare benefits.

4.5 2010 recommendations for administration of section 3GA programs

Recommendation 6

6.1: DoHA to update Schedule 5 Pt 2 of the Regulations to remove references to s3GA workforce programs that have been discontinued; namely, the Rural and Remote Area Placement Program, the Metropolitan Workforce Support Program, and the Assistance at Operations program.

6.2: DoHA to routinely update the Regulations when the status of s3GA programs change.

Recommendation 7

DoHA to remove reference to RACGP and ACRRM as specified bodies for PGPPP as the program is now managed by GPET Limited.

Recommendation 8

DoHA (or relevant authority) to revise all s3GA workforce and training program guidelines to acknowledge the role of AHPRA in setting conditions for clinical practice and supervision requirements, and monitoring these conditions and requirements.

Recommendation 9

DoHA (or relevant authority) to revise relevant s3GA workforce and training program guidelines to ensure that both the RACGP and ACRRM are both referred to as providers of general practice training, and to ensure that where the guidelines refer to Fellowship of RACGP, they also reference the Fellowship of ACRRM.

Recommendation 10

DoHA and Medicare Australia to reduce red-tape involved in applying for provider numbers not only for doctors on s3GA workforce and training programs but across the whole sector; and to improve information services about application processes for the sector.

10.1: By 2012, DoHA to allow one application for each doctor on a s3GA workforce or training program to cover all practice locations and for the entire time they are on the program.

10.2: By 2014, Medicare Australia to issue one provider number to each medical practitioner and an identifying code number to each practice location, with the two numbers working in tandem to identify the practitioner and the location at which the service was provided.

10.3: By 2012, Medicare Australia to automatically renew provider numbers for doctors working for AMDSs when the Deeds of Agreement are renewed.

10.4: Relevant parts of the Government to improve information services so that specialist colleges, doctors, practice managers and others can get queries about the allocation of provider numbers answered in-person and in a timely way.

Chapter Five — Section 3GA workforce programs

This chapter outlines how effectively individual workforce programs are operating and makes recommendations to address operational issues.

Many program stakeholders identified operational issues that should be addressed as a matter of course rather than waiting for the next legislative review or for DoHA to initiate a formal review of program guidelines.

5.1 Overall findings across all workforce programs

Workforce programs are not generally funded measures, rather these programs are mechanisms to allow doctors access to Medicare benefits if they provide services to those communities in most need. Doctors can face restrictions on time allowed to practice and are expected to obtain vocational qualifications while working under a s3GA program, but in general the Government has not invested in support to assist these doctors in education.

5.1.1 Section 3GA workforce programs assist in placing doctors in placements where it is difficult to attract doctors

Rural Australia and outer metropolitan areas still struggle to recruit and retain doctors both in hospitals and general practice and governments are putting significant resources into solving the problem. The Australian Government has recently established Health Workforce Australia (HWA) to meet the future challenges of providing a health workforce that responds to the needs of the Australian Community.

Section 3GA is one mechanism by which doctors working towards vocational qualifications can work in DWS, including in rural Australia. There are at least 2,000 doctors[11] a year providing medical services in areas where it is difficult to attract doctors—an estimated 1,900 doctors provide general practice services under the RLRP (managed by RHWA), the AGPT program (Rural Pathway), the RVTS and ACRRM training programs.

Section 3GA also supports the recruitment of doctors into after-hours services, which is an area where it is difficult to attract doctors in urban Australia. The majority of doctors working for MDSs are on the AMDS program.

5.1.2 The guidelines and quality processes for section 3GA programs have been strengthened

The 2005 Review recommended ways to strengthen the quality systems for and services delivered under the s3GA workforce programs. This recommendation was somewhat overtaken by the introduction of two new systems in Australia: the national assessment process for OTDs (July 2008) and the national registration system (January 2010). As a result, doctors on most workforce programs are now required to be working toward qualifications and adequate supervision must be provided.

All of the program guidelines in the 2005 Biennial Review that were identified as being in need of revision were updated in response to the review's recommendations. The relevant professional and industry stakeholders appear not to have been involved in the review process of revising the guidelines, despite the review recommending their involvement.

11 Source: DoHA data, table 4.1

The 2010 review found anecdotal and inconsistent evidence about the impact of changes to guidelines and the health reforms on the quality of doctors' services. More evidence is needed and the Government could do some specific and targeted research in this area.

On one hand, program managers reported positive improvements in quality of services in the RLRP, the AMDS program and the QCRD program. But, general practice stakeholders say there are still problems with the competency and standards of care provided by some doctors on these programs.

In particular, general practice stakeholders are concerned about the appropriateness of junior doctors being placed in sole rural placements under the QCRD program. This view was supported by expert witnesses and the Queensland Coroner, who reported into the death of a patient under the care of a junior doctor providing relief in 2006.[12] Queensland Health have indicated that all of the Coroner's recommendations have been implemented and that Queensland Health is currently developing a senior relief pool, which is expected to reduce the risks for junior doctors and also has policies in place to ensure junior doctors have access to direct supervision.

5.1.3 Program guidelines require doctors to be working towards vocational recognition, but support for education is underfunded and inconsistent

This review considered whether the s3GA workforce programs are meeting the intent of the s19AA legislation, that is, all medical practitioners should have or be working towards vocational training to ensure that medical services are delivered to a high standard.

Although workforce programs have greater focus on mentoring and providing support to achieve vocational qualifications than they did five years ago, stakeholders still say that insufficient resources have been invested and that some doctors may face difficulties in accessing education and support.[13] Doctors on workforce programs also face barriers to meeting the four year time-frame for achieving VR such as being unable to take study leave due to work commitments.

How much mentoring and support is provided varies across programs and jurisdictions (see Table 5.1 and Chapter 6). Compared with training programs, funding for education and support is limited for doctors on workforce programs. Currently support for doctors on the RLRP to access education and training for Fellowship is limited to a one off payment of $7,000 under the Additional Assistance Scheme. Training organisations estimate that the real cost of general practice vocational training is between $20,000 and $30,000. Although welcome, the Additional Assistance Scheme allocation is underfunded—there are not enough funded places and the level of funding is too low. The Government doubled funding to the Scheme in 2010–11 to address the waiting list. In November 2010, there were 105 doctors on the wait list for Additional Assistance Scheme funding. The length of time doctors wait to receive Additional Assistance Scheme funding differs across States and Territories.

There are several suitable pathways to Fellowship for OTDs without vocational recognition, but stakeholders concur that the needs of this group are typically higher than other non VR doctors. Stakeholders suggest that additional funding and case management needs to be provided to OTDs to ensure they are enrolled in the most appropriate support program for their situation.

12 Coroner's Report of Inquest into the death of Jillian Peta McKenzie, 3 October 2008,

13 Although outside the scope of the review; RVTS Ltd is also concerned that 'there are many temporary resident doctors not subject to 19AA practicing in rural and remote areas with minimal or no education training and support'. This group of doctors are now eligible for training place on RVTS but it is likely that the RVTS has insufficient funded places to meet demand.

A pilot program to help non VR OTDs ran successfully between 2006 and 2008, and may be a good model for supporting non VR OTDs to Fellowship. The program provided an integrated medical education program to support OTDs to achieve FRACGP. The program incorporated assessment, learning resources, educational activities and support. The RACGP reported a high success rate in passing the qualifying examination and positive integration into the Australian health workforce. The program had non recurrent funding and has not been re-offered.

Table 5.1: How workforce programs support doctors to do vocational training

Program	Training requirements	Extent training needs supported	Extent doctors on placement achieve Fellowship	Comments
Approved Medical Deputising Program	Guidelines say doctors must work towards Fellowship.	Varies across services.	No information provided.	
Approved Private Emergency Department Program	Advanced medical training.	Fully supported	No information provided.	
Queensland Country Relieving Doctors Program	Onsite induction and Clinical Rural Skills Enhancement Program prior to placement. Not required to be involved in vocational training.	Doctors must complete specified training to support relief placement.	Not applicable.	
Rural Locum Relief Program	Guidelines say doctors must achieve Fellowship within four years (FACRRM/ FRACGP).	Additional Assistance of $7,000 per person available.	No information available.	Requirement introduced two years ago.
Special Approved Placement Program	Must be actively working toward vocational recognition/seeking placement on vocational training program.	No support for training.	No information available.	Provider numbers are time limited.
Temporary Resident Other Medical Practitioner Program	Encouraged to work towards vocational training.	Provided with a list of appropriate contacts.	No information available.	

5.1.4 *Setting supervision requirements is the responsibility of the Australian Medical Board, but there is uncertainty about doctor's ability to access supervision and the sector's capacity to provide adequate supervision*

Industry stakeholders believe that under the new national registration system, the Australian Medical Board rightly has the responsibility of assessing doctors' right to practice and terms of this practice including supervision. As a consequence, they feel it is inappropriate for workforce programs to impose additional supervision requirements as part of their guidelines.

The amount of supervision a doctor requires is linked to the type of registration conferred on them by the Australian Medical Board. Doctor's designated supervisors are responsible for implementing supervision. For positions in DWS, most OTDs are eligible for limited registration with requirements to comply with supervision and professional development plans. Their supervisors also submit regular reports on the doctor's safety and competence to the Australian Medical Board. If an OTD intends to work as a doctor in Australia for the longer term, they must also provide evidence to confirm satisfactory progress towards meeting the qualifications required for general registration or specialist registration.

Stakeholders agree that the level of supervision provided for doctors on the RLRP and the QCRD program has not always been adequate in the last five years, because of a lack of capacity within the system. For example, the available supervisors are stretched or identified supervisors not being onsite or readily contactable.[14] The consequences are instances where unqualified doctors are working largely unsupervised, or doctors working towards Fellowship can find it harder to meet expected competencies because they do not have access to adequate supervision or a mentor.

The review stakeholders acknowledge that the supervision needs of doctors depends on their experience and skills. Although direct onsite supervision for doctors who require a high level of supervision is ideal, the reality is that it can be difficult to provide onsite supervision for doctors in rural and remote practices. Professional bodies such as ACRRM are using supervision by distance models and the AMC has approved a number of pilot projects in remote supervision, which offer some way forward to addressing concerns about capacity to provide the required supervision. These projects will be evaluated in 2011.

Industry stakeholders indicate that having a mentor is an important way of providing additional clinical support for doctors requiring higher levels of supervision.

14 No evidence was provided to the reviewers about the numbers or proportion of doctors who do not get adequate supervision under workforce programs

Table 5.2: How supervision and mentoring is provided for doctors placed on workforce programs			
Workforce Program	**Requirements for supervision as specified in guidelines**	**Mentoring**	**Effectiveness of mentoring and supervision requirements**
Approved Medical Deputising program	Supervision arrangement as required by Australian Medical Board as part of registration. Also required by program guidelines but what and how much is provided depends on MDSs	Supervisors provide mentoring.	Anecdotal evidence only.
Approved Private Emergency Department program	Supervision arrangement as required by Australian Medical Board as part of registration. Supervision provided by supervisors.	Supervisors provide mentoring.	
Queensland Country Relieving Doctors program	Senior supervisor allocated.	Clinical Rural Skills Enhancement program prior to placement.	Anecdotal evidence that quality of supervision is inconsistent, sometimes no onsite supervision. Supervisors employed by Queensland Health. A new senior relief pool being established.
Rural Locum Relief Program	Supervision arrangements, as required by Australian Medical Board as part of registration.	Additional Assistance of $7,000 per person available.	Anecdotal evidence that quality of supervision is inconsistent, sometimes no onsite supervision.
Special Approved Placement Program	Supervision arrangement as required by Australian Medical Board as part of registration.	None provided.	No evidence provided about quality of supervision.
Temporary Resident Other Medical Practitioner program	Supervision arrangement as required by Australian Medical Board as part of registration.	None provided.	No evidence provided about quality of supervision. No program funding for supervision.

5.2 Approved Medical Deputising Service Program

5.2.1 About the Approved Medical Deputising Service Program

The program was established to expand the pool of available doctors who provide after-hours services on behalf of general practices. The program has allowed GPs based in metropolitan areas to provide after-hours services that attract Medicare rebates. There are no MDSs in rural locations.

The program allows doctors subject to Medicare provider number restrictions to work in metropolitan areas, for after-hours work only.[15] Access to Medicare rebates is time and location specific and the doctor will need a Medicare provider number for the specific practice location. Doctors on this program work for Australian MDSs. These services must be accredited by the Australian General Practice Accreditation Pty Ltd or GPA Accreditation and cannot be co-located within in-hours clinics. Essentially, the program provides the majority of the workforce for MDSs and encourages doctors to work towards Fellowship of the RACGP or ACRRM. MDS stakeholders agree that it would be difficult to recruit sufficient doctors without the AMDS program.

Offering after-hours services using MDSs is a growing business with the number of locations with MDSs more than doubling since 2005. These services are now being offered in 48 locations compared with 21 locations in 2005. The number of doctors who have provided at least one service under the AMDS program has increased two-and-a-half times over the last five years; from 108 in 2005 to 271 in 2010. MDSs receive 600,000 calls per annum for after-hours services.[16] Industry stakeholders observed that there is potential for more junior doctors to have placements in the industry.

MDSs are one way general practices can meet their accreditation requirements and access the After-Hours Practice Incentive Program (PIP), which encourages general practices to improve the quality of care provided to patients[17]. To be eligible to receive after-hours practice incentive payments, general practices must ensure all patients have access to 24-hour care (seven days a week) including access to out-of-hours visits at home, in a residential or aged care facility, and in hospital, where necessary and appropriate. Where an MDS is used, the general practice must have a formal arrangement with the deputising service. The PIP payments are used to augment rebates as Medicare rebates do not cover the cost of after-hours services.

5.2.2 Quality processes

Quality processes for the AMDS program are set by guidelines that came into effect in 2008 and are currently being implemented. The Guidelines also adopt the NAMDS definition of an MDS. The guidelines have a greater focus on quality than previously, for example, doctors are expected to work towards a Fellowship and MDSs must demonstrate how they will provide mentoring for doctors on the program. NAMDS reports that the program has been a positive pathway for doctors to obtain their Fellowship.

15 National Association of Medical Deputing Services estimated that 75 per cent of doctors on the program are international medical graduates

16 Australian Medical Association submission, p10

17 Audit Report No.5 2010–11, Performance Audit Practice Incentives Program Department of Health and Ageing, Medicare Australia. From November 2012 after-hours payments will be made retrospectively

The guidelines appear to have had a positive impact on service quality, although we have no systematic evidence about this issue. Stakeholders from the AMA and RACGP report that their members are generally positive about the work of MDSs, although one GP observed that there are good and bad services and another said that they had heard of instances of poor recording of patient's notes. General practices can readily change services if they are unhappy with services. DoHA indicated that the relevant program area has had no formal complaints about service coverage or quality of MDSs.[18]

The size of the MDS has an impact on the amount of training, supervision and support provided to doctors. NAMDS says that it can be difficult for smaller MDSs to provide effective supervision and support.

5.2.3 Issues

Our consultations uncovered several operational issues for the AMDS program, which are summarised below.

Impact of the removal of the After-Hours Practice Incentive Payment and health reforms on the viability of medical deputising services

There is a lot of uncertainty about what the role of MDSs will be when Medicare Locals become responsible for funding and coordinating after-hours care. In December 2010, the Government indicated that after-hours PIP will be maintained until 2013 when funding for after-hours care is expected to be transferred to Medicare Locals. Currently, after-hours PIP help fund the cost differential between the cost of providing an after-hours service and the available rebate.

Under the health reforms an after-hours call centre will also be established. However, based on the United Kingdom experience, it is unlikely to reduce the demand for after-hours services. General practice stakeholders believe that the reform process needs to take into account the economics and practicalities of providing after-hours services and if MDSs are not viable then patient's access to after-hours services in urban areas may be comprised.

Stakeholders indicate it will be important for DoHA to monitor the impact of health reforms on the provision of after-hours services.

RACGP accreditation standards do not include a definition of a Medical Deputising Service

MDS stakeholders claim that a lack of definition for MDSs in RACGP standards is impacting on service coverage, because it allows for ambiguity in what a service offers. An MDS may be accredited yet offer less after-hours coverage (e.g. no home visits) than is expected under the AMDS program guidelines. By doing so, an MDS could benefit commercially because of the high costs of home visits compared to providing extended clinic hours. We have no independent evidence about the extent that this occurs.[19] MDSs must state as part of their agreements with general practices that they have the capacity to provide out-of-clinics visits and are expected to do so when required.

18 DoHA

19 A 2010 Australian National Audit Office audit of 34 practices with low after-hours MBS item billings that were receiving after-hours practice incentive payments of almost $500 000 in 2008–09, showed that only half of the practices provided callers with an after-hours number for a practice doctor. The audit did not identify if the practices identified had agreements with MDSs to provide the after-hours services.

In-hours care for residents of aged care facilities
Two previous reviews raised the potential for MDSs to provide in-hours care for residents of aged care facilities. It may be time to reconsider this issue as doctors in metropolitan areas are increasingly unable to provide in-hours care to this group. NAMDS has submitted to the Government, a proposal for MDSs to be allowed to provide in-hours medical services to residents of aged care facilities.

RACGP member status and the After-Hours Other Medical Practitioners (AHOMP) Program
Associate membership of the RACGP gives doctors on the AMDS program access to broad RACGP information but doesn't give them access to online education, nor does it entitle them to have the College record the points they accrue as a result of completing RACGP accredited Quality Improvement and Continuing Professional Development (QI&CPD) activities. Associate members can only record QI&CPD points if they register with the RACGP as a participant in the AHOMP program. This requires an additional application to Medicare (that is, in addition to their provider number application) plus a separate application and declaration to the RACGP. One MDS believes all AMDS doctors should be associate members of the RACGP and that this membership should entitle them to have their RACGP QI&CPD points recorded by the College.

Continuing professional development requirements
The requirement for doctors on the AMDS program to amass 300 continuing professional development points over three years is higher than expected of RACGP Fellows. Industry stakeholders claim that the current requirement is onerous given the profile of their workforce in comparison to that required by the RACGP for their Fellows.

Alignment of time requirements to obtain Fellowship between AHOMPs and AMDS program need reviewing
Many doctors on the AMDS program are also on the AHOMP program and the requirements for obtaining Fellowship are different—in five years for AHOMP and four years for the AMDS program. To be consistent, these requirements should be aligned.

5.3 Approved Private Emergency Department Program

5.3.1 About the Approved Private Emergency Department Program

The program was established because of a shortage in specialist emergency medical staff. The program allows accredited private emergency departments who require access to the sessional pool of medical staff the ability to apply for access to provider numbers for registrars.[20] This is both a workforce and training program with quality processes and standards being the responsibility of the Australian College of Emergency Medicine. The number of providers of at least one service under this program has increased from 108 in 2004–2005, to 271 in 2009–2010.

The 2005 Biennial Review did not identify any issues with or make any recommendations about this program. In 2010, industry stakeholders report that private emergency departments support the program but would like changes to requirements about how provider numbers are allocated to trainees. The current policy is impacting on retention of registrars and causing gaps in service provision. Hospitals must

20 APED Guidelines, undated

apply for provider numbers every 12 months in line with the Deeds of Agreement that the hospital has in place with the doctor. It appears hospitals are unaware that they can negotiate a longer period with the Commonwealth to eliminate the need to apply for provider numbers every 12 months. This could be readily addressed in consultation with the Department.

Another issue is that the eligibility criteria restricts temporary resident OTDs, and OTDs who are undergoing recognition of standing and credentialing, from qualifying for the program. Program stakeholders report that the application process is more difficult and less clear with answers about eligibility taking some time to get. The AMA report this is a limitation of the program and indicated that once recognised, this group should be able to access Medicare rebates.

5.4 Queensland Country Relieving Doctors Program

5.4.1 About the Queensland Country Relieving Doctors Program

The QCRD program is managed by Queensland Health.

The QCRD program has operated for at least 35 years, with Queensland Resident Medical Officers (RMOs) providing leave relief for annual, conference or study leave to Queensland Health's rural staff and sole or small practices in rural and remote areas. The periods of relief vary but can be as short as one week.

Not all RMO locums are required to be registered on the QCRD program. This is only necessary for RMOs relieving in a Medical Superintendent or Medical Officer with Right to Private Practice position. Positions with rights to private practice are specific to Queensland and do not exist in other jurisdictions. The positions are generally in small rural locations where the hospital doctor also fulfils a general practice role.

The program has more than doubled in size since the 2004–2005 financial year, when 161 providers made claims for at least one service under this program. In 2009–10, 366 providers claimed at least one service.

For Queensland Health, QCRD program is a crucial component to retaining medical practitioners in rural areas because it offers a way of providing leave. The QCRD program provides relief to approximately 70 rural medical practitioners throughout Queensland, covering 1,576 weeks of leave. Relief under this program accounts for 60 per cent of all relief provided to rural practitioners. Many solo medical practitioners would have limited opportunities for relief if they were reliant upon the recruitment of private locums (just two per cent of rural practitioners make private arrangements for relief).

5.4.2 Quality processes

Quality processes for the QCRD program have been strengthened as a result of the Queensland Health review of the program in 2005, and the 2005 Biennial Review of the Medicare Provider Number Legislation.

Even so, experienced medical practitioners agree that there are inherent safety risks for a program that means inexperienced, junior doctors (PGY2) are working in challenging settings—sometimes without access to direct supervision. A coroner's report described a case in September 2006, where a PGY2 doctor working on locum without direct supervision case did not follow the National Heart Foundation Guidelines for the management of acute coronary syndrome. This patient died, and the case illustrates the safety risks of insufficient supervision of junior doctors placed in challenging posts.[21]

21 Coroner's Report of Inquest into the death of Jillian Peta McKenzie, 3 October 2008, page 11

In response to the findings of the coroner, oversight of s3GA processes has been centralised to Rural and Remote Medical Services and there are processes in place to ensure that only people in properly supervised and recognised positions can provide services that attract Medicare benefits. Queensland Health now requires that RMOs attend the Clinical Rural Skills Enhancement Program before taking up locum positions. District Health Services must now develop a job description and also allocate a senior supervisor within a support model for each reliever before they take up the relieving position. Relievers must also take part in an orientation program at the District level with formal report back to Queensland Health.[22] In addition, Queensland Health has developed descriptions of roles and responsibilities for all parties including the supervisor; fact sheets for all relievers, and requires relievers to complete a post placement evaluation. Queensland Health is also developing a Senior Relief pool; a new relief database which is currently at the user acceptance stage and instituting a review and relaunching of the website.

Queensland Health report that the changes to the way the program is managed have resulted in a more reliable recruitment process and that Medical Officers are better prepared and able to access adequate supervision and support. Districts are more aware of their responsibilities to supervise and support locums. The senior relief pool may go some way to addressing safety concerns particularly if this means PGY2 doctors are not placed in sole doctor settings and more experienced registrars cover remote areas.

5.5 Rural Locum Relief Program

5.5.1 About the Rural Locum Relief Program

The RLRP is a workforce measure and not intended as a specific mechanism for education, nor is it a funded program. The program is a key mechanism for recruiting medical practitioners to rural Australia, and providing a means of attracting Medicare rebates. The RLRP is managed by RHWA. The objectives of the program are to:

- attract medical practitioners to general practice in rural and remote Australia
- provide a means by which medical practitioners restricted by s19AA of the Act can access Medicare benefits for general practice services whilst on an approved placements in rural areas.

Across Australia, approximately 94 per cent of doctors on RLRP placements are OTDs with permanent Australian residency or citizenship. The remaining six per cent are Australian medical graduates.[23] Places are taken by OTDs who are permanent residents and who are working toward becoming a VR GP in Australia and Australian graduates, or registrars trying out general practice or completing minimum time requirements for practicing as part of their vocational training.

The program take-up varies across jurisdictions, with New South Wales having the highest number of placements, and South Australia the least (see Table 5.3).

22 Coroner's Report of Inquest into the death of Jillian Peta McKenzie, 3 October 2008, recommended these measures be taken, after the inquest found that the junior doctor who had treated Jillian McKenzie in September 2006 had no access to direct supervision

23 Source: HWA, 29 November 2010

Table 5.3 Placements on the RLRP as at November 2010 by jurisdiction	
Jurisdiction	**No. Drs**
NSW	352
Queensland	80
Victoria	79
WA	60
NT	25
Tasmania	8
SA	4
Total	**608**

The program allows both short and long-term placements. The program is used to fill medical practitioner positions in rural areas. Medical practitioners can be on concurrent s3GA placements, for example, registrars on the AGPT program who want to work in another practice outside their training placement can apply through the RLRP at the same time.

According to the program guidelines, doctors can be on the RLRP for a maximum of four years without obtaining Fellowship. Typically doctors are placed on the RLRP for between one week (for example, if undertaking locum work) and four years. Medical practitioners who leave the program before the four years are up do not need to obtain Fellowship, and indeed it is not appropriate for doctors on short-term placements who intend to leave Australia.

The maximum time period was chosen to reflect the normal amount of time needed to train to be a GP. There is disagreement between stakeholders about whether this timeframe is appropriate. Some general practice stakeholders believe that this timeframe is too short and that the minimum length of time should be up to six years and others think that the time frame is too long.

The numbers of doctors who have provided at least one service under the program have fluctuated between 551 and 767 in the last five years. In November 2010, 608 individual medical practitioners were working in approved positions under the program.

Some stakeholders commented that the name 'RLRP' does not reflect the nature of the program and should be changed; given that most providers are not providing locum services but are working towards vocational recognition.

5.5.2 Quality processes

The 2005 Biennial Review raised issues about the consistency of assessment for the program. The new national assessment process has addressed concerns about inconsistency of approaches across jurisdictions regarding assessment. The RLRP program guidelines were reviewed by RHWA in 2008, and again in March 2010[24].

The adequacy of supervision provided to doctors under this program has remained a concern over the last five years, as does the amount of support for individual doctors. Although the new national registration

24 2010 Guidelines in draft form

system introduced in 2010 will ensure that supervision requirements are consistent, doctors working under this program for over 12 months still face barriers in accessing education and training for vocational recognition.

Assessment: A standard national assessment process was introduced in 2008[25]. The medical practitioners' qualifications and proficiency in English are now verified by the AMC. Doctors then choose a pathway: either through a competent authority; sitting the AMC exam; or through a specialist pathway. The next step is a clinical competence test (either pre-employment structured clinical interview (PESCI) or face to face clinical exam). After passing the exam, doctors then apply for national registration through AHPRA[26]. Receipt of medical registration allows the doctor to apply for a visa.

Once AHPRA has confirmed the identity of the person through a face to face interview the doctor can apply for a s19AB exemption (if required) and then a provider number through an approved placement program, in this case the RLRP.

Supervision: The amount of supervision required is linked to the type of registration conferred on the applicant by AHPRA as part of the registration process, with designated supervisors having the responsibility of implementing supervision.

In the last five years, stakeholders agree that the level of supervision available for doctors on the RLRP is not always adequate, because of a lack of capacity in the system and because the available supervisors are stretched.[27] The consequences are that there are cases where unqualified doctors are working largely unsupervised and doctors working towards Fellowship are finding it more difficult to meet the requirements because they lack access to advice from their supervisor.

Mentoring: The 2005 Biennial Review found that doctors on the RLRP receive insufficient mentoring. The program guidelines were changed, and now require that doctors on RLRP have a mentor. The RLRP is an unfunded program and this review has found that because there are insufficient resources to provide the same level of mentoring for all doctors, resources are prioritised to those in most need.

General practice stakeholders[28] believe that adequate mentoring should be a mandatory component of all authorised workforce programs under s3GA of the Act.

Training: The 2005 Biennial Review found that insufficient support for training was provided to doctors on the RLRP. It recommended implementing a staged program and that all doctors on the RLRP for an extended time should be assessed and participate in training to achieve Fellowship of a recognised specialist college.

Revision of the program guidelines now requires doctors on the program for an extended period of time to pursue Fellowship. These doctors are being provided with support and training to obtain Fellowship (either the FRACGP or FACRRM) by State and Territory rural workforce agencies, through the Additional Assistance Scheme. Established in 2003, the scheme provided $7,000 per person to 200 doctors in 2010–11. In November 2010, there were 105 doctors waiting to receive the funding with the waiting time to access the fund varying across jurisdictions.

25 Australian Medical Board announced a review on 12 November 2010

26 The new national registration system introduced in 2010 is intended to ensure all medical practitioners have equivalent skills to Australian trained graduates.

27 No evidence was provided to the reviewers about the numbers or proportion of doctors who do not get adequate supervision under the RLRP

28 RACGP Submission, 2010

The Additional Assistance Scheme is administered by rural health workforce agencies in different ways according to the situation within their State or Territory. Some jurisdictions provide the funding directly to the doctor; others pool the funding to provide joint training. The program guidelines require doctors who receive Additional Assistance Scheme funding to develop Individual Learning Plans, although the guidelines are currently under review.

Stakeholders suggested ways that doctors on the RLRP could be supported to get training.

- Increase places and individual funding for doctors through the Additional Assistance Scheme.
- Increase investment and allow OTDs to be supported by registered training providers.
- Consider other models; for example tailored training and support for individual doctors needs.

Given the complexity of programs available, it would be desirable for the providers to be case managed to choose the most appropriate education interventions for their situation.

5.6 Special Approved Placements Program

5.6.1 About the Special Approved Placements Program

The program was established as a safety net program to ensure that doctors who are subject to the provisions of s19AA, but due to exceptional circumstances could not undertake a s3GA program or other vocational training, would not have their access to Medicare benefits disrupted.

The program guidelines[29] state that 'exceptional circumstances' that would be considered are:

(a) Where it can be demonstrated that there is substantial hardship because of particular family circumstances for the medical practitioner directly related to not being able to access Medicare benefits in a metropolitan area.

(b) Where serious illness to the medical practitioner or his or her immediate family can be demonstrated and where treatment for the illness is limited to particular locations.

(c) Other exceptional circumstances peculiar to the individual case.

While the Guidelines specify particular issues considered in making decisions regarding placing a doctor on this program, all applications are decided on individual merit.

The period of participation in the program may be up to five years in the first place and may be renewed at the discretion of the Minister on receipt of evidence demonstrating that the circumstances leading to the original approval remain current.

In 2009–2010, there were 61 doctors on the program; a fivefold increase since 2005–2006[30].

29 SAPP Guidelines dated December 2003

30 Note that these data are different than that shown in Table 4.1, covering slightly different time periods and using a different definition of participants. In Table 4.1, participants are defined as having made at least one claim and in Table 5.4, the count is of approved placements.

Table 5.4: SAPP Placements granted over the past five financial years					
Indicator	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10**
Number of placements granted	11	13	48	44	45
Number of new placements	8	8	36	37	23
Number of extensions	3	5	12	7	22
Number of new doctors on SAPP	8	8	33	24	22
Total number of doctors on SAPP	11	15	43	53	61

5.6.2 Quality processes

There are a number of conditions placed on a SAPP placement including having adequate supervision, and that doctors be working towards vocational recognition or be seeking a placement on a vocational training program. SAPP doctors are responsible for arranging their own supervision and mentoring and are closely monitored by DoHA with regards to their progress towards Fellowship.

We have no evidence about whether doctors on SAPP are in need of additional support for education as is the case for doctors on other workforce programs.

5.7 Temporary Resident Other Medical Practitioner Program

5.7.1 About the Temporary Resident Other Medical Practitioner Program

This program provides access to the Medicare benefits arrangements (at the lower A2 rate) for eligible pre-1996 non VR medical practitioners (non specialists in general practice). As such it is not considered a workforce or training program. Although the program does not have workforce components, the provider numbers are linked to other workforce programs such as the AHOMP program.

The TROMP program was created to overcome an unintended consequence of amendments to the 1996 Medicare Provider Number Legislation, which would have seen a number of long-term temporary resident medical practitioners lose access to the Medicare benefits arrangements. This affected temporary resident non VR medical practitioners who had entered medical practice in Australia prior to 1 January 1997, and who were not vocationally recognised.

Registration on the program was initially quite steady, but in recent years only a handful of doctors are registering. As at 20 October 2010, there are 164 medical practitioners registered on the TROMP program. Seven medical practitioners have come off the program due to either gaining permanent residency or FRACGP. Of the other program participants, seven are New Zealand citizens; 118 are temporary residents from countries other than New Zealand and the doctor's background unknown for 39 participants.[31]

31 Under the Health Insurance Act, the Migration Act is used to define temporary and permanent residency, which means that New Zealand Citizens are considered to be temporary residents. From 1 April 2010, an amendment of the 19AB legislation means that NZ citizens with permanent residency are able to seek vocational reciprocal vocational recognition or be granted a vocational place

5.7.2 Quality processes

Due to the intent of the program, it was not considered appropriate to enforce a pathway towards Fellowship for this cohort of doctors. Nevertheless, doctors on this program are encouraged to pursue vocational training and are given a list of appropriate contacts to do so. Under the new national registration system, participants will have to comply with the Australian Medical Board's continuing professional development requirements in order to maintain medical registration.

The 2005 Biennial Review did not identify any issues with or make any recommendations about this program. In 2010, general practice stakeholders raised concerns about the amount of time (ten years) allowed for doctors on the TROMP program to achieve Fellowship.

DoHA is planning a review of the guidelines for TROMP and Other Medical Practitioner (OMP) programs with the objective of aligning assessment, competencies and requirements for obtaining Fellowships across all OMP Programs.

5.8 2010 Recommendations for section 3GA workforce programs

Recommendation 11

DoHA to invest in support for doctors on workforce programs.

Recommendation 12

DoHA to fund a research project that assesses the extent that doctors on s3GA programs access the required level of supervision, and act on the findings of this research project. The research project could include an anonymous survey of doctors' experiences of the quality of supervision.

Recommendation 13

Relevant program areas in DoHA (or relevant authority) to establish a mechanism that allows regular industry input into operational issues in order to identify and address any problems in delivering services under the programs, rather than wait for the five year review of the Medicare Provider Number Legislation.

Recommendation 14

DoHA to add the ACRRM Independent Pathway (a fully accredited independent general practice training pathway) to Schedule 5 of the Regulations to facilitate access to Medicare provider numbers for registrars on this pathway.

Recommendation 15

15.1: DoHA to add Fellowships of the RACGP, ACRRM, the Australasian College of Sports Physicians and the College of Intensive Care Medicine of Australia and New Zealand to Schedule 5 of the Regulations, which lists organisations and courses for s3GA of the Act.

15.2: DoHA to routinely update Schedule 5 of the Regulations as Fellowship courses are certified by the AMC.

2010 Program specific recommendations for section 3GA workforce programs

Approved Medical Deputising Service Program

Recommendation 16

DoHA to actively monitor the impact of health reforms on the provision of after-hours care by AMDSs and revise the AMDS Program Guidelines as needed.

Queensland Country Relieving Doctors Program

Recommendation 17

17.1: Queensland Health to ensure that all junior doctors on a relief placement have access to direct supervision and endeavour to place more senior doctors in remote relief placements.

17.2: Queensland Health to monitor the achievement of this recommendation and report on its success at the next review of the Medicare Provider Number Legislation in 2015.

Rural Locum Relief Program

Recommendation 18

DoHA to fund rural health workforce agencies to provide support for doctors working under the RLRP.

Chapter Six — Section 3GA Training Programs

6.1 Overall findings for training programs

Training programs are associated with specialist colleges and are managed either by the College or by designated organisations. This review found that support for doctors on training programs is relatively well funded and supervision is an inherent part of training, although there are differences in how organisations are remunerated for supervision.

Professional bodies highlighted the need to monitor training capacity as well as the demand for and supply of training places.

6.1.1 Stresses on the medical training system highlight a need for good monitoring data on training capacity, and a coordinated approach to medical workforce planning and training

The 2005 Biennial Review emphasised the need for adequate and cohesive planning for medical training: the issue is in sharper focus in 2010. Not only has there been an increase in the number of medical graduates, but the number of doctors seeking vocational training places has more than doubled. Stakeholders suggest that the system has been able to absorb the increased number of medical school graduates because the increase in graduate medical student places has occurred in a staggered way across the States and Territories.

Nevertheless, the increase in university medical places is expected to place stresses on the postgraduate training system in the future, which highlights the need to reform the way planning for workforce and training is conducted. Industry stakeholders said that training and workforce issues have not been addressed in a coordinated way in the last decade.

Managing demand for vocational training places has also required concerted effort, and the Government has established and funded training places on three programs: the Specialist Training Program; the AGPT Program and PGPPP. Two other training programs, the SCTP and the APEDP, enable trainees to work and access Medicare rebates in private hospitals and other non-traditional teaching settings.

For this review, stakeholders expressed concerns about the structural limitations of the training system as a whole, and the limited capacity for providing supervision. Industry stakeholders are calling for deregulation of training to allow greater involvement of the private sector; general practice; international partners; and research institutes. They are also calling for alternative funding options to be considered, such as allowing specialist trainees to bill Medicare for services as already occurs for those undertaking general practice training.

Another broader issue raised by some industry stakeholders is the need for generalist services, especially in regional Australia. Ensuring that more postgraduate training places for generalist pathways are made available may assist in preventing doctors sub-specialising too soon.

It is anticipated that HWA, which was established in 2010 by the Australian Government, will also contribute to workforce planning. The HWA mandate is 'to meet the future challenges of providing a health workforce that responds to the needs of the Australian Community. [It] will develop policy and deliver programs across four main areas—workforce planning, policy and research; clinical education;

innovation and reform of the health workforce; and the recruitment and retention of international health professionals. HWA will also consider the adequacy and availability of workforce data.'[32] Another area of effort is research: HWA is leading a collaboration to undertake a substantial program of national health workforce planning and research projects over a three-year period.

A broad range of medical stakeholders, including medical students; doctors in training and their supervisors; medical schools; hospitals; and key health organisations recently issued a joint consensus statement, which echoes the viewpoints of stakeholders consulted for this review. The consensus statement calls for more medical workforce training resources, and lays out a framework for delivering the right number of medical practitioners in the right places. The framework specifies responsibilities and short and medium term tasks for managing the demand for and supply of the medical workforce[33]. The statement suggests a moratorium on new medical schools and no significant increase in medical student numbers before an analysis of demand for medical workforce and associated training infrastructure is completed.

Also included in the consensus statement is a call for a nationally consistent process for allocating intern places; providing places for all currently enrolled international full fee paying medical students and for agreements about providing intern placements for international medical students in the future. The statement is also concerned with improving and specifying training arrangements within the context of the hospital funding reform process.

6.1.2 Capacity to provide general practice training placements

In Australia, an estimated 1,400 of 7,000 general practices are involved in GP training[34]—an estimated one in five general practices. It's estimated that by 2012, there will be approximately 900 junior doctors and over 1000 general practitioner registrars requiring placement in general practice each year[35]. The number and type of training places that the practice can take on depends on the practice infrastructure, the practice size and their commitment to GP training. Practices might host medical students, junior doctors or GP registrars depending on factors including practice infrastructure and supervisory capacity.

This review has heard specific concerns about the capacity of the system to provide general practice training. Even though there is currently theoretical capacity in the system, industry stakeholders are concerned that training positions will fall well short of requirements unless more teaching sites are recruited or larger numbers of trainees are placed at each site.

Some of the barriers to engaging more general practices in taking on clinical placements are listed below.

- The financial costs of training medical students. Even though practices are financially compensated for having a trainee, a recent study by Laurence (2010) found that there are net financial losses for teaching medical students, but there can be small (but inconsistent) financial gains from teaching junior doctors[36]
- The way the teaching practice incentive is paid. Payment is made in arrears and to general practices as a whole, not to individual supervisors. The payment mode does not recognise the individual doctor's contribution, which disadvantages contractors.

32 HWA Website

33 Joint Statement AMA Medical Training Summit, Sept 2010. *Action on Medical Training*

34 Source: RACGP

35 Source: DoHA

36 Laurence C (2010) To teach or not to teach? A cost-benefit analysis of teaching in private general practice. *Medical Journal of Australia,* 193(10)

- The time burden of teaching student doctors. Having a medical student or junior doctor reduces patient throughputs and clinical sessions, and increases time demands on other practice staff.
- The GPs confidence in their own teaching skills.
- The difficulty coordinating placements with educational facilities for medical students.

These barriers will need to be addressed to encourage more general practices to take on clinical training places.

6.2 Australian General Practice Training Program

This program aims to provide doctors with the knowledge, skills and attitudes necessary to work in unsupervised general practice and meet community health needs. It allows participants to gain valuable practical experience in teaching hospitals, rural and urban practices, and in specialised medical centres that provide healthcare for local communities, Indigenous Australians and people from socially disadvantaged groups.

The AGPT program is a postgraduate vocational training program for doctors who wish to pursue a career in general practice in Australia and is administered by GPET. The program is for three years, full time (four years for rural and remote registrars), and the number of places on the program is capped. In 2010, the cap was 900 placements. The training must be conducted within accredited medical practices, and is supervised and assessed by experienced medical educators associated with a regional training provider (RTP). The training includes a mentoring element and self-directed learning, as well as regular face-to-face educational activities. OTDs who are permanent residents or Australian citizens are eligible for the program.

Towards the end of their training on the program, participants become eligible to sit the RACGP or ACRRM Fellowship exams.

General practice stakeholders have welcomed the expansion of the AGPT. Although there is theoretically capacity in the system to meet the demand for placements, industry stakeholders are concerned that training positions will fall well short of requirements unless more teaching sites are recruited or larger numbers of trainees are placed at each site.

6.3 Prevocational General Practice Placements Program

This objective of PGPPP is to provide professional, well supervised and educational general practice placements for junior doctors as part of their training. The target group are junior doctors undertaking hospital training but not yet enrolled in a specialty program. OTDs were recently added to the program's target group.

The PGPPP has been managed by GPET since early 2010. GPET has established a prevocational training committee to address issues such as setting suitable standards for prevocational training and supervision. General practices must be accredited to provide placements.

The emphasis of the program is different depending on the level of the doctor. For interns, the program provides work experience and exposure to general practice as a professional career. Junior doctors in PGY2 or 3 can work at a higher level, and might provide additional service capacity for the general practice they are placed in. Depending on the capacity and infrastructure of the training collaborations more than one general practice placement can be undertaken by junior doctors throughout the year.

Between January and July 2010, 40 per cent of PGPPP participants were interns (PGY1), 47 per cent were in PGY2 and the remaining 13 per cent were in at least PGY3. Junior doctors in PGY2 and 3 undertake placements for an average of 12 weeks and can bill Medicare at the A1 rate.

At first, the program was seen as strategy to bring junior doctors to outer metropolitan, regional, rural and remote areas. Placements were available in rural and remote areas classified using the Rural, Remote and Metropolitan Areas 3–7, as well as designated urban areas, such as outer metropolitan areas and DWS. With expansion, the program now allows placements in metropolitan practices. Industry stakeholders have welcomed the reduction of location restrictions and would like to see more metropolitan practices participating in the program.

The program has expanded substantially in the past five years. In 2005–06, there were 21 doctors who provided at least one service under the PGPPP; by 2009–10 237 doctors had provided at least one service under the PGPPP. In 2005, there were 280 placements in areas where it is difficult to attract students and junior doctors from New South Wales did not participate[37]. By 2010 there were a minimum of 350 placements available in a range of locations including New South Wales, with part time placements part of the mix. The Government plans to offer 975 placements on the program by 2012.

General practice stakeholders are satisfied with, and strongly support, the continuing expansion of this program. One benefit has been the increase in capacity to integrate training between local hospitals and general practices and the opportunity to forge better links between GPET and regional training providers.

Even so, stakeholders raised some issues, which have the potential for discouraging practices and hospitals from participating in the program.

- Some hospitals are reportedly less willing to take on trainees under the program because the method for allocating the PGPPP training budget takes insufficient account of local conditions.
- Negotiating placements with individual facilities in Queensland is an issue for these facilities because the Postgraduate Medical Education Council of Queensland Health is responsible for practice accreditation.
- There is lack of transparency about planning for placements, which reportedly makes it hard for general practices and/or health services to determine how many places are available and where these are located.
- There are barriers to placing OTDs in inner metropolitan locations as they are subject to s19AB of the Act, which restricts them to working in DWS.
- The costs to general practices of training junior doctors can be high. A recent study by Laurence (2010) concluded there is a marginal net financial gain to general practices involved in prevocational and vocational training but not for those involved in undergraduate medical student training[38].

37 Due to concerns about adequacy of Medical Indemnity Insurance, now addressed

38 Laurence C (2010) To teach or not to teach? A cost-benefit analysis of teaching in private general practice. *Medical Journal of Australia,* 193(10)

6.4 Remote Vocational Training Scheme

The RVTS is a four year program that has been designed to deliver structured distance education and supervision to doctors while they continue to provide general medical services to a remote and/or isolated community. These doctors would otherwise have to leave their current location in order to undertake training.

The RVTS targets medical practitioners living in remote and isolated communities throughout Australia. The training provided meets the requirements for Fellowship of both ACRRM and RACGP. The program has been delivered by RVTS Ltd since 2006.

RVTS has recently allowed temporary resident OTDs, including those who are yet to attain AMC certification, to enrol on the program. The change was made to meet a need for training long-term temporary resident OTDs who are not eligible for other general practice training programs. Many of this group are well established in Australia, have provided services over many years and have made substantial investments in practices.

The program has grown over the last five years. In 2005–06 there were 10 doctors who provided at least one service, to 30 providers in 2009–10.[39] There are 52 registrars currently enrolled in the training program with around half of the participants being OTDs without AMC certification. Given the profile of doctors working in rural and remote Australia, the demand for places is expected to increase now that temporary resident OTDs are eligible.

More information is needed to understand the quantum of demand for places in the program so that appropriate funding can be provided to meet the demand for places.

6.5 Specialist College Trainee Program

This program is administered by relevant specialist medical colleges. Applications for trainees to be listed on the Register of Approved Placements for s3GA programs are processed by Medicare Australia.

The program is a mechanism for allowing registrars working in private hospitals and non-government health settings to access Medicare rebates (A2 level). It is not a funded program and is linked to, but not the same as, the Specialist Training Program managed by DoHA.[40]

Specialist College Trainee placements are considered where

- trainees are in an accredited advanced training position that counts fully to training time and formal requirements
- rotations from public sector to private hospitals are part of a structured training program and placements will provide experience that is relevant to the course of training
- appropriate supervision will be provided
- the required number of training positions, and trainees in public hospitals, is maintained. The first priority is given to filling trainee positions in public hospitals.

39 Discrepancy between DoHA data indicating 30 registrars accessing Medicare rebates under the program and RVTS data, 52 registrars currently involved may be explained by registrars using provider numbers under a workforce program such as RLRP through the ROMPS

40 Note that we received limited feedback about this program and there appeared to be some confusion about how the program relates to the Specialist Training Program

Guidelines for this program have not been obtainable for this review. The Royal Australian and New Zealand College of Psychiatrists reported that they have been unable to ascertain adequate information about the program and as a consequence, medical practitioners are finding it difficult to understand whether a placement is eligible for the program, how to apply for provider numbers under the program, and what items can be billed against the provider numbers. The consequences to this are that improper claims could be made.

In addition, the Royal Australian and New Zealand College of Psychiatrists indicated that Group A2 Medicare item numbers are very general across in-patient settings and may not adequately recompense the skills and types of services provided by specialist registrars of their College, and pose a barrier to mental health service delivery.

Stakeholders are calling for information about the program and for its application processes to be clarified.

6.6 2010 Recommendations for section 3GA training programs

Prevocational General Practice Placement Program

Recommendation 19

GPET to ensure that all junior doctors have access to direct supervision and endeavour to place more senior trainees in remote placements.

Specialist College Trainee Program

Recommendation 20

Medicare Australia, in consultation with the specialist colleges, to prepare new guidelines about the parameters of the SCTP including who is eligible and under what circumstances rebates under the program can be claimed. The guidelines should also describe how the program relates to the Specialist Training Program managed by DoHA.

Recommendation 21

DoHA to clarify the items that can be claimed by registrars under the program and expand eligibility to item numbers to more accurately reflect the differing practices of each specialty.

Recommendation 22

DoHA to review the level of rebates (A2) that can be claimed under the program with a view to making these in line with VR (A1) items.

Chapter Seven — Section 3GC, the Medical Training Review Panel

7.1 Findings for the MTRP

The MTRP was established under s3GC of the Act. The Panel is required to compile information about s3GA training and workforce programs, including participation in these programs. The Panel prepares an annual report to the Minister, which is tabled in Parliament.

The MTRP is currently chaired by a senior executive of DoHA. The membership of the Panel includes a wide range of representatives of medical education and training organisations including medical schools, specialist colleges, medical students and doctors in training, and jurisdictions.

The scope of the 2010 review is the effectiveness of the MTRP in meeting its statutory requirements. In 2008–09, the MTRP underwent an independent review of its workplan and governance arrangements and hence these arrangements are not being covered in this review.

The review has found that the MTRP is successfully meeting statutory requirements to monitor and collect information on s3GA programs, and the medical practitioners who are enrolled in these courses and programs.

Stakeholders use the data provided in the annual reports to monitor trends in: training places; in workforce planning processes to plan for expected trainees in specialist colleges, and in the public and private sector; and for comparison purposes across the specialist colleges. The data is generally viewed as being valuable and stakeholders say the report is useful as it is the only place where the information about medical training is consolidated and trends can be followed.

Most stakeholders who refer to the data indicated that the quality of data has improved over time. They also agree that the Panel is providing valuable advice to Government about the availability and quality of medical care in Australia. A few stakeholders commented on the time lag in the data and would like to see the data produced more quickly or better and more rapid data collection systems developed. Stakeholders also suggest the MTRP provide more analysis of data and for qualitative data to be collected to inform the interpretation.

A number of stakeholders commented that the MTRP data are less useful in monitoring demand for training than they are at monitoring the supply of training places. For example, general practice stakeholders said they lack a broad map of demand for, and availability of, clinical training capacity in general practice—such as the number of supervisors available and the number of medical students, junior doctors and registrars expected each year. Industry stakeholders are also seeking better information about the number of prevocational and vocational training placements available. These stakeholders anticipate that HWA may fill this gap.

The AMA is calling for the MTRP to monitor the accuracy of HWA medical training modelling and training plan. A biennial review by MTRP of clinical training places could identify any gap between actual need for places and the number of places identified through HWA processes.

General practice stakeholders also emphasised the role that the MTRP could play in providing advice about what internships should be available so that training places are not too specialised, and that there are appropriate positions available for junior doctors who want to take a generalist pathway.

Specialist college stakeholders are asking for data collection to be standardised from year to year to allow them to proactively collect data.

GPET is actively seeking routine and regular access to information about the impact of the AGPT program from DoHA. They are also seeking monitoring data about the location, types of activities and billing items being used by medical practitioners in this program; and better access to data about retention of medical practitioners on the AGPT in rural and remote areas. These data will provide information about the achievements of outcomes for the approximate 3,000 placements on these programs and assist in planning. Currently, requests to DoHA must be made quarterly, the process can be slow and information provided is not comprehensive.

Information on outcomes of training and workforce programs would also be useful to the MTRP to meet the requirement to monitor the impact of Medicare provider arrangements.

Many of the additional activities identified by stakeholders as outlined above are outside the scope of what the MTRP is legislated to undertake.

HWA is a relatively new body with a role in coordinating planning for medical workforce training[41]. In 2010, HWA has observer status on the MTRP and the Panel has been invited to contribute to the national medical workforce planning and research collaboration being coordinated by the HWA.

HWA's remit covers 30 health professions and the organisation has funding for a substantial work program. The MTRP has a broad and representative membership, including all major organisations involved in training medical graduates. The MTRP has no resources or funding for work programs.

Given the overlapping interests but clear differences in the roles and resources, a common view is that the MTRP and HWA should have formal links and that the HWA should draw on the Panel for specific advice and direction regarding medical training.

Stakeholders agree that the membership of the Panel is appropriate and that most key medical training bodies and stakeholders are represented on it. However, three groups involved in medical training and workforce programs are requesting membership of the Panel. These are the RVTS, NAMDS, and RHWA.

41 HWA is developing a national training plan for doctors, nurses and mid-wives; the National Health Workforce Planning and Research Collaboration. The Collaboration has a five year work-plan and will develop future scenarios based on information about supply and demand for training at the national, regional and local levels. The goal is for Australia to produce sufficient graduates to meet our workforce needs by 2025.

7.2 2010 Recommendations for section 3GC

Recommendation 23

The Government consider amending the legislation to allow the MTRP to undertake additional activities to monitor health services capacity in providing training places for prevocational and vocational doctors and provide advice to DoHA and/or HWA on these issues.

Recommendation 24

The Government consider amending the legislation to allow the MTRP to monitor the effectiveness of training programs in meeting workforce needs and demands.

Recommendation 25

The Government consider amending the legislation to allow the MTRP to provide advice about medical training and to develop formal links with HWA.

APPENDICES

Appendix 1: List of stakeholders who contributed to the review

Participated in interviews or group discussions

Organisation	Contact
Australian College of Rural and Remote Medicine	Marita Cowie
Australian General Practice Network	Leanne Wells, Rachel Yates and David Butt
Australian Health Practitioner Regulation Agency	Joanne Katsoris
Australian Medical Association	Dr Michael Bonning, Perry Stirling and Dr Steve Hambleton
Committee of Presidents of Medical Colleges	All CEOs
Confederation of Postgraduate Medical Education/ Junior Medical Office Forum	Dr Jagdishwar Singh and Caitlin O'Mahoney
General Practice Education and Training Ltd	Rebecca Richardson and Rodger Coote
General Practitioners Registrars Association	Dr Belinda Guest and Amit Vohra
Health Workforce Australia	Mark Cormack
Medicare Australia	Philip Freestone
Melbourne Medical Deputising Service	Patricia Coles and Adam Wilson
National Association Medical Deputising Australia Ltd	Dr Stuart Tait and Dr Nic Richardson
Queensland Health	Janette Jones, Jacqui May, Nick Lord, Ron Wynn and Lynette Ferguson, Dr Denis Lennox
Remote Vocational Training Scheme Ltd	Dr Pat Giddings and Dr Cameron Loy
Royal Hobart Hospital, Department of Anaesthesia and Perioperative Medicine	A/Professor Marcus Skinner
Royal Australian College of General Practitioners	Professor Claire Jackson, Dr Elizabeth Marles, Dr Morton Rawlin, Dr Zena Burgess and Roald Versteeg
Royal Australian and New Zealand College of Psychiatrists	Dr Andrew Gosbell, A/Professor Stephen Jurd, Lois Lowe, Sharon Holloway, Emma Walls, Richard Turkentine, and Fatima Mehmedbegovic
Royal Australasian College of Surgeons	Glenn Petrusch
Rural Doctors Association of Australia	Dr Paul Mara
Rural Health Workforce Australia	Dr Kim Webber, Margie Mahon
Rural Health Workforce Agencies	Louise Mason and Peter Barns (Tasmania); Karen Argall and Pam Audrins (Victoria); Tony Miles and Marie Nelson (NSW); Charlie Duncan (Queensland); Ken O'Brien (NT); Laura Harnett and Cheryl Grigsby (WA)
SA Health	Professor Paddy Phillips
University of South Australia	Professor Michael Kidd
Vic Health	Cameron Rowe, Dean Ravens, Tanya Surward, Rob Grenfell and Burnie Street
WA Health	Emeritus Professor Louis Landau

Written and electronic submissions

Organisation
Australian College of Rural and Remote Medicine
Australian Locum Medical Service/ National Association of Medical Deputising Australia Ltd
Australian Medical Association—Council of Doctors in Training
Australian Medical Council
Australian and New Zealand College of Anaesthetists
Australasian College of Emergency Medicine
CEOs, Chairs and Directors of Medical Services in Victorian Health services
Epworth Hospital
Knox Private Hospital
Melbourne Medical Deputising Service
National Association Medical Deputising Australia Ltd
NSW Doctors' Health Advisory Service/ University of Sydney/ GPET
Queensland Health
Royal Australian College of General Practitioners
Royal Australasian College of Physicians
Royal Australasian College of Surgeons
Rural Doctors Association of Australia (TRP representative)
Rural Health Workforce Australia
SA Health
Tasmanian Department of Health
University of South Australia
Upper Murray Health and Community Services (DHS, Victoria)
Vic Health
WA Health

Department of Health and Ageing Officers who contributed to the review

Section/ Department	Officer
Office of Rural Health, Workforce Distribution Branch, Department of Health and Ageing	Virginia Shaw
Medical Education and Training Branch, Department of Health and Ageing	Melanie Cullen and Pauline Hetherington
Medical Education and Training Branch, Department of Health and Ageing	Deborah Gaudie
Medical Education and Training Branch, Department of Health and Ageing	Sue Woolfe
Medical Education and Training Branch, Department of Health and Ageing	Padmaja Jha
Medicare Australia	Philip Freestone
Service Access Programs Branch, Department of Health and Ageing	Swain Jeffery and Jo Doble
Workforce Distribution Branch, Department of Health and Ageing	Stephen McAlister and Kathryn Yuile
Workforce Distribution Branch, Department of Health and Ageing	Elizabeth Murray

Appendix 2: List of Acronyms

ACRRM	Australian College of Rural and Remote Medicine
AGPT program	Australian General Practice Training Program
AHOMP program	After Hours Other Medical Practitioner Program
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMC	Australian Medical Council
AMDS program	Approved Medical Deputising Service program
APEDP	Approved Private Emergency Department Program
CMO	Career Medical Officer
DoHA	Department of Health and Ageing
DWS	District of Workforce Shortage
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FGAM	Foreign Graduates of Approved Medical Schools
FRACGP	Fellowship of the Royal Australian College of General Practitioners
GPET	General Practice Education and Training Ltd
GP	General Practitioner
HWA	Health Workforce Australia
MDS	Medical Deputising Service
MOMP	Medicare Plus for Other Medical Practitioners Program
MTRP	Medical Training and Review Panel
NAMDS	National Association of Medical Deputising Services
OTD	Overseas Trained Doctor
PGPPP	Prevocational General Practice Placements Program
PGY	Postgraduate Year
PIP	Practice Incentive Payment
QCRD program	Queensland Country Relieving Doctors Program
QI&CPD	Quality Improvement and Continuing Professional Development
RACGP	Royal Australian College of General Practitioners
RLRP	Rural Locum Relief Program
RMO	Resident Medical Officer
RHWA	Rural Health Workforce Australia
RVTS	Remote Vocational Training Scheme Ltd
SAPP	Special Approved Placements Program
SCTP	Specialist College Trainee Program
STP	Specialist Training Program
TROMP	Temporary Resident Other Medical Practitioner Program
VR	Vocationally Recognised

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All information in this publication is correct as of December 2010

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