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Dear Adjunct Professor Mick Reid and Professor Sabina Knight

**RE: RACS Responses to Working Better for Medicare Review Public consultation survey**

Please find below RACS’ responses to the public consultation survey on the Working Better for Medicare Review.

1. MAIN ISSUES

## In your view/experience, what are the main issues regarding access to primary care, GPs and/or medical specialists, and their distribution across Australia?

The issues underpinning the surgical workforce maldistribution have been an ongoing challenge. RACS has identified the key challenges that stem throughout the surgical career and include:

* Levers used to select junior doctors onto the Surgical Education and Training (SET) program (e.g. selecting more candidates of rural origin and/or with rural medical school experience and early career rural work experience);
* Processes that ensure all Trainees on the SET pathway had at least 12 months positive rural experience, with an aligned rural curriculum, and with some Trainees in general and orthopaedic surgery having most of their training in one rural region;
* Provision of professional support to attract and retain specialist surgeons (Fellows of RACS, FRACS) and Specialist International Medical Graduate (SIMG) surgeons in rural settings (this could include financially viable models of private practice or public hospital employment, safe hours, additional training for extended scope of practice and support from larger centres, including dual appointments, locum relief, continuing professional development);
* Engagement and collaboration in interdisciplinary training including with Rural Generalists with advanced procedural skills and between urban – rural hospitals.

RACS is committed to addressing these challenges as detailed in the RACS’ Rural Health Equity Strategy[[1]](#footnote-1) with recommendations outlined to improve rural health equity.

It is crucial that any surgeon – FRACS, SIMG or otherwise must have ongoing supervision and support. One also needs to be certain of skills in different settings e.g., elective vs emergency that may require a very different skill set. For example, a general surgery elective procedure is often laparoscopic whilst emergency procedure is more likely to be open.

Access to medical specialists in rural areas can also be precluded by the patient’s ability to pay for private practice services where there is no free public hospital outpatient and inpatient surgical services.

1. POSITIVE IMPACTS ON ACCESS

## How do the specific workforce distribution levers being reviewed help or support access to primary care, GPs and/or medical specialists?

General comments in response to this question

RACS considers the workforce distribution levers have a supportive impact in general towards supporting timely access to surgical care close to home. While these distribution levers are a mechanism to identify the current gaps in workforce, it is equally vital that these levers improve the retention of a sustainable surgical workforce.

RACS has recommended in its Rural Health Equity Strategy that all Trainees must have the opportunity for positive rural training. This can be achieved through various approaches such as quarantining SET training posts in rural areas each year for mandatory rural training term; and incentives to attract SET Trainees to a rural location for a period.

Comments specific to section 19AA

RACS supports the section 19AA in its intention to ensure quality surgical standards underpinned through gaining a Fellowship from a specialist medical college.

Comments specific to section 19AB

RACS understands the intent behind section 19AB is to bind SIMG surgeons to work in rural Australia and areas of workforce shortage. RACS recognises SIMGs as an essential, welcome and valued part of rural surgical care, who arrive with limited local knowledge and peer networks. It is important that section 19AB and other legislative instruments ensure that these SIMGs are set up for success in patient care and professional and personal life.

Comments specific to the District of Workforce Shortage (DWS) classification

The DWS classification system is a useful tool to assist the maldistribution of surgical specialists. Currently the only surgical specialty determined as DWS is general surgery. Proposed changes to the DWS were discussed at the DWS Advisory meeting in April 2021 which RACS was a participant. At that meeting, it was raised that “all specialties able to work outside MMM1 areas should be subject to DWS distribution rules”. RACS would welcome expanding the list to include surgical specialties that can work outside MMM1 (with the exclusion of Neurosurgery, Cardiothoracic and Paediatric surgery).

Comments specific to the Modified Monash Model (MMM) classification

The MMM is widely understood geographical classification system. The Department of Health and Aged Care have provided data showing how many surgical procedures per year in each specialty in each MMM area plus how many procedures per year in each specialty in each MMM area were provided within the MMM area the patient lives. RACS is supportive of a transition to the MMM for consistency.

The use of MMM classification is important towards the recognition of rural generalists with extended skills in surgery. A collaborative discussion on defining the scope of practice of rural generalists should outline how they can perform limited scope of procedural practice in response to community need and as part of an interdisciplinary team including FRACS surgeons. Using a urological example, if a rural generalist with extended skills in surgery could undertake cystoscopies and prostate biopsies, it would allow the FRACS surgeon to undertake the more complex work in regional areas.

1. NEGATIVE IMPACTS ON ACCESS

## How do the specific workforce distribution levers being reviewed hinder or limit access to primary care, GPs and/or medical specialists?

General comments in response to this question

As mentioned earlier, these workforce distribution levers should also aim to improve the retention of the surgical workforce that have been recruited to the rural areas. The workforce distribution levers appear to be focused largely on recruiting medical specialists from overseas, and that financial incentives have been primarily targeted at general practice. The over reliance on the SIMG workforce has unintentionally meant that surgical services especially in remote Central and Northern Australia remain fragile and unsustainable.

There is no ability to combine “local knowledge” with existing workforce data. The calculated FTE of a surgeon in one district may look adequate for that district’s population, but there may be much higher workload if there are no surgeons in adjacent districts and workflows to the surgeon in the first district. In addition to that, the age of a surgeon is relevant. There is a need to have money and regulatory levers to recruit before a surgeon retires / in the last 5 years of their career, to enable transition (especially supervision if the new surgeon is an SIMG) without a gap in services.

The Rural Health Equity Strategy foundation papers[[2]](#footnote-2) recommended against compulsion (or bonded placements) as it does not work in high income countries. We recommend an incentive rather than compulsion approach. For example; increased funding awarded to Trainees with rural origin or demonstrated rural commitment to train in the rural area/region of their intended future practice location. A systematic review by Kumar et al[[3]](#footnote-3) provides evidence that incentives work better than compulsion, especially incentives like paying off HECS debt or subsidising/have scholarships to pay training fees. For example, if a SET Trainee agreed to train in rural and practice rurally long term, having their HECS debt paid off and having the SET fees paid could work.

Comments specific to section 19AB

Under the current legislative arrangements, SIMGs who complete their commitment to Section 19AB of the Health Insurance Act (also known as the ten-year moratorium) are subject to the restrictions under Section 19AA. This effectively means that if a SIMG completes their ten-year moratorium, but has not gained fellowship or hold specialist recognition, they will still be subject to the restrictions under Section 19AA. While RACS acknowledges there are certain section 19AB exemptions that SIMGs can apply for (e.g. working in DWS area), this policy largely means SIMGs are often practicing in some clinically challenging and remote settings with limited experience in cultural competency and awareness.

RACS notes that the recent Kruk Report highlights issues surrounding the administrative process for SIMGs and acknowledged that while the report will help alleviate workforce shortages, it is not a long-term solution. While it may appear the recruitment of SIMGs is part of the short-term solution to address workforce shortages, it raises questions on whether recruiting doctors and nurses from underdeveloped countries is moral and ethical.

Comments specific to the District of Workforce Shortage (DWS) classification

The DWS classification process uses population and Medicare billing data. However most surgical services happen in state government hospitals and so are not captured in Medicare billing data. Combining public hospital and Medicare data is needed to get the best picture of where shortages (and oversupply) are.

RACS participated in the DWS Advisory meeting in April 2021. An outstanding query was how the ‘service need’ calculation is not clear. This would have implications on whether an MMM2 location could be included as a DWS.

DWS uses the Australian Statistical Geography Standard -Remoteness Area SA3 area in Australia rather than MMM which is inconsistent with other programs.

There are inconsistencies in the Federal DWS vs State and Territory ‘Area of Need’ classifications. RACS policies that govern SIMG administrative processes currently refer to Area of Need, but not DWS.

Comments specific to the Modified Monash Model (MMM) classification

While the MMM classification system is a refined tool that enables distinction between rural, regional, remote and metropolitan, it has highlighted there are unique challenges faced in each MMM. In the instance of supervisor requirements for SIMGs, RACS observed that it may be difficult to achieve in some MMM3-7 locations. This would require an alternative mechanism to ensure these SIMGs are appropriately supervised.

There is a low level of knowledge about the MMM system in metropolitan areas, including in decision making bodies involved in training. Increasing understanding of this classification system would be helpful.

1. IMPACTS ON AVALABILITY OF TRAINING

## How do the specific workforce distribution levers being reviewed impact the availability of training opportunities for primary care, GPs and/or medical specialists?

RACS utilises the MMM classification as a tool for selection of prevocational doctors onto the SET program, the accreditation of training posts as part of the SET program, and the determination of recipients of rural grants and scholarships. Furthermore MMM is used to define rurality when it comes to selection processes which include

* targeting rural origin students, weighting place of residence
* rewarding rural and Aboriginal and Torres Strait Islander health experience
* increasing rural representation on selection panels

For the past 14 years, the Specialist Training Program (STP) has helped cover the salaries of Trainees in training positions outside the metropolitan teaching hospitals. This Federal Government initiative is designed to improve the quality and distribution of the future specialist workforce. Expansion of STP programs to enable increased and ongoing funding of rural specialist training positions could enable more Australian medical school graduates to undertake surgical training in rural areas.

In locations where there are a high proportion of SIMG surgeons, it could preclude accreditation of hospital training posts which requires FRACS to provide supervision as part of the SET program. This highlights the need for rural specific accreditation criteria to allow for SET Trainee supervision by SIMGs (under level 3 or 4 supervision in Australia) provided there is one FRACS surgeon supervisor on site. Supervision can be supplemented by remote supervision from a second FRACS surgeon from within the training network.

Supervisors in regional, rural and remote areas will require increased support to accommodate additional trainees without straining existing resources and supervision capacity. Funding needs to be dedicated to developing supervision models that support quality remote supervision to Trainees in locations where there is limited specialist availability on-site and a need for that specialty.

1. IMPACTS ON QUALITY OF PRACTICE

## How do the specific workforce distribution levers being reviewed impact the quality of practice for primary care, GPs and/or medical specialists?

We highlight that surgery cannot be considered as one homogenous group in terms of community need in each MMM area. Although rural people have all kinds of problems and need all kinds of surgeons, surgical units are not necessarily viable in some MMM areas. There are nine surgical specialties, in three groups based on surgeon to population ratio. For general and orthopaedic surgery, units in MMM4-7 areas can be viable. For Otolaryngology/Head and Neck, Plastic and Reconstructive, Vascular and Urology, MMM2-3 units can be viable, with outreach to MMM4+ areas and for Neurosurgery, Cardiothoracic Surgery and Paediatric Surgery, the focus is on increasing units in MMM2 areas and providing outreach to MMM3-7 areas. Having DWS specific to each surgical specialty is necessary.

RACS would support the inclusion of rural loading to programs which support medical specialists to work, undertake continuing professional development (CPD) and provide supervision in rural areas, with a view to ensure these rural surgeons are not disproportionately exposed to financial risk. This could include competitive salaries plus incentives/allowances based on distance, isolation, and increased costs of travel for CPD, and expanding practice incentive payments to rural specialist practices. Application of the geographical classification levers to these programs would have an impact on the quality of practice.

RACS notes that there is a need for better transparency and comparability for some countries to improve the SIMG process, as demonstrated in the Kruk Report. RACS has established a work-place based assessment, the External Validation of Professional Practice (EVOPP), as an alternative to the Fellowship Exam for SIMGs. The availability to undertake the EVOPP by rural SIMG surgeons would have an impact on the quality of practice. There might be opportunity to expand the EVOPP in the assessment of SET Trainees to retain fairness. Alternative models for SIMG assessment could be explored such as that in USA. This model includes attaining Fellowship via EVOPP, and then they are given 2-3 years to complete a medical licensing examination but allowing them to practice in a supervised setting until the exam is passed.

Further work also needs to be undertaken to ensure that SIMGs coming into Australia are provided with the necessary cultural safety training and knowledge of the Australian health system. SIMGs must be supported with their integration into Australian practice and life. Currently it is up to the local hospital to arrange all this, but a national online course and maybe online peer support network for the first 12 months would be beneficial.

1. SOLUTIONS

## What are possible solutions to the issues you have highlighted that could improve access to primary care, GPs and/or medical specialists? What needs to change about specific workforce distribution levers being reviewed or how they are used?

General comments in response to this question

As mentioned earlier feedback, RACS is open to collaborative dialogue on defining the scope of practice of rural generalists with extended skills in surgery to perform limited scope of procedural practice in response to community need and as part of an interdisciplinary team including FRACS surgeons. This interdisciplinary team environment is imperative to the sustainability of a rural surgical service.

RACS would support an initiative that would require the state jurisdictions to explicitly quarantine funding for protected teaching supervising time in MMM3-5 areas as part of the national health reform agreement or intergovernmental agreements. Furthermore, we should consider novel ways to incentivise rural surgeons to stay in their local area. There should be clear processes where these rural surgeons are also appointed to urban hospitals where they can perform larger cases in conjunction with urban specialist staff (bidirectional support).

There are some rural areas where there is no free public hospital outpatient and inpatient surgical services. This means patients’ ability to pay for private practice services can be a barrier. Medicare rebates for non-GP specialist item numbers are the same in MMM1 as MMM2-7. A possible solution to increase accessibility is having a rising scale of rebates from MMM3-7, similar to GP rebates. Having specialist private practice incentives (currently only available to GPs) would also help.

Comments specific to section 19AB

RACS strongly recommends that SIMGs working in rural and remote settings must be supported by local professional networks and have access to specialty specific clinical information, for example clinical guidelines, treatment and referral protocols, continuing professional development, examination preparation activities. A national system of remote SIMG supervision and support, to supplement local supervision could be helpful.

Comments specific to the District of Workforce Shortage (DWS) classification

RACS would recommend that Ahpra build capability to capture and utilise data of Full-Time Equivalent for each of the nine surgical specialties, in each MMM area and total for Australia. Alternatively, the distribution of surgeons could be measured as number of surgeons for each of nine surgical specialties, in each MMM area and total ​for Australia, where both primary and secondary practice locations are identified. Secondary practice locations would include outreach services performed by the surgeon outside their primary location.

RACS supportive of the change from Statistical Area Level 3 (SA3) to larger SA4, to more fairly represent the areas that health services are serving, and better reflect the area and population serviced by specialist doctors.

There should be recognition that specialists work in hubs with promotion of these in MMM3-5 areas and beyond, rather than metropolitan areas.

Comments specific to the Modified Monash Model (MMM) classification

RACS appreciates the value of the MMM classification system. Its integrity should be maintained by regular review to ensure it is reflective of the current population.

End of Survey

1. Royal Australasian College of Surgeons. (2020). Rural Health Equity Strategic Action Plan. https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/interest-groups-sections/Rural-Surgery/RPT-Rural-Health-Equity-Public-FINAL.pdf?rev=1709767dffbd48cda7dbfa3c053c6b58&hash=717809CD51D32CE7F4C927E883515ECE [↑](#footnote-ref-1)
2. Royal Australasian College of Surgeons. (2020). Rural Health Equity Foundation papers on Select and Train for Rural. https://www.surgeons.org/Resources/interest-groups-sections/rural-surgery/activities [↑](#footnote-ref-2)
3. Kumar, S., & Clancy, B. (2020). Retention of physicians and surgeons in rural areas—what works? Journal of Public Health. https://doi.org/10.1093/pubmed/fdaa031 [↑](#footnote-ref-3)