Australian Government
Department of Health and Ageing

Biennial Review of the Medicare Provider Number Legislation

December 2005

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The Hon Tony Abbott MP
Minister for Health and Ageing
Parliament House
Canberra ACT 2600

28th November 2005

Dear Minister

I am pleased to submit the 2005 Biennial Review of the Medicare Provider Number Legislation, as required under Section 19AD of the *Health Insurance Act 1973.*

This 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 Government departments, both State and Federal and the many relevant organisations that made themselves readily available for this review. Of particular assistance were the members of the Reference Group whose valuable input gave me a deeper insight to the issues and enabled me to explore the practicality of any recommendations that were being considered.

I want to give special recognition to the project officers Ms Gigi O'Sullivan and Ms Joanne Hall whose competence and commitment to the task made it possible to complete the review within the scheduled timetable.

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

Yours sincerely

Ron Phillips
Managing Director
Rapcor Pty Limited

Executive Summary

The 2005 Biennial Review of the Medicare Provider Number Legislation has been undertaken as a requirement of section 19AD(1) of the *Health Insurance Act 1973* (the Act). This section of the Act states that the Minister must cause a report setting out details of the operation of sections 19AA, 3GA and 3GC to be laid before each House of Parliament by 31 December 2005 (refer Appendix A).

To undertake this review the Minister for Health and Ageing, the Hon Tony Abbott MP, through the Department of Health and Ageing appointed an independent consultant with the assistance of a Reference Group (refer Appendix C) made up of key stakeholder organisations to undertake this Review.

The Review found that:

- There continues to be overwhelming agreement with the objective of the legislation that all graduates without further training should not be practising unsupervised, and that General Practice be a vocational specialty.
- Although difficult to quantify, it is still generally agreed that the legislation is having a positive impact on raising the quality of general practice services to the community.
- There is broad agreement that compared to other issues, the operation of this section of the Act has had very little to do with the medical workforce shortage that is facing Australia and the world.
- This legislation is underpinning a range of quality and workforce packages that have been put in place and therefore should be retained.
- There continues to be strong support in the medical profession for the work carried out by the Medical Training Review Panel (MTRP) and for it to continue maintaining its focus on training issues.

The Review also found that the majority of the 16 recommendations of the previous review, which concentrated upon ensuring the quality intent of section 19AA was not jeopardised by workforce programs under section 3GA, have been implemented or were in the process of being implemented.

Of particular note were:

a) The Prevocational General Practice Placements Program (previous recommendation 14), aimed at allowing prevocational doctors to experience general practice outside the hospital setting, has been well received by the profession.

b) The Rural Locum Relief Program (RLRP) guidelines were in the process of being amended at the time of this Review. Many of the recommendations made in the previous review are still under discussion. These include national standards for assessing qualification and experience of entrants, supervision and mentoring requirements, and the undertaking from doctors on the RLRP to complete the necessary education and training to obtain appropriate qualifications. This Review

reiterates the importance of completing and implementing the review of the RLRP guidelines within a timely manner so as to maintain quality standards and to support the work of doctors on this Program.

c) Changes to the composition of the MTRP have been well received by the profession.

During the bilateral consultations, held as part of the Review, the projected increase in medical graduates was consistently raised as an issue. The Review received representations that there needs to be adequate and cohesive planning in place for capacity building and funding to strengthen the resources and infrastructure for the medical graduates of the future.

Federal, State and Territory governments recognise that significant planning is required to ensure that junior medical doctors have appropriate supervision, training and support across a range of training environments, including community, ambulatory and rural settings.

Constant monitoring will be required over the next few years to ensure these new medical graduates are properly trained and absorbed into the Australian medical workforce.

This report and the recommendations are tendered to the Minister and the Parliament for their consideration.

Chapter One — Background and methodology

Background

The 1996 Commonwealth Budget saw the introduction of major changes to the training arrangements of new medical practitioners. As of 1 November 1996, changes to the *Health Insurance Act 1973* (the Act) required all new medical practitioners seeking access to Medicare benefits to have completed, or be undertaking, an approved vocational training program or to be otherwise vocationally recognised.

Sections 19AA, 3GA and 3GC of the Act are collectively known as the Medicare provider number legislation. Extracts of sections 19AA, 3GA and 3GC of the Act are provided at Appendix A.

The intention of limiting Medicare provider numbers to only those doctors who have received vocational training is to ensure that all medical practitioners are appropriately skilled to enter into unsupervised general practice. Vocational training ensures that registrars continue to receive high quality training to enable them to provide better patient care for all Australians.

A sunset clause was included when the changes to the Act were first introduced in 1996. The Government agreed to include the clause as a safeguard which ensured that the legislation would be revoked automatically unless it was demonstrated to Parliament that there were no significant adverse impacts on affected doctors.

In order to secure passage of the legislation necessary to achieve these new arrangements through the Senate, a number of measures were agreed to by the Government. In particular, section 19AD (extract at Appendix A) was inserted into the Act as a means of measuring the effect of the new restrictions on provider numbers, as well as its success in encouraging postgraduate education and training.

The 1999 Mid-Term Review of Provider Number Legislation

The 1999 Mid-Term Review of Provider Number Legislation was conducted by the Hon Ron Phillips of Rapcor Pty Limited. The Mid-Term Review found overwhelming agreement that medical graduates without postgraduate training should not be practising unsupervised and that General Practice be recognised as a vocational specialty.

The Mid-Term Review made several recommendations to ensure that the quality focus of section 19AA was not undermined by the pressure of workforce needs. The review also found an increase in vocational training opportunities for doctors and no evidence of unemployment among doctors as a result of the legislation. As no adverse impact of the legislation could be identified, the review recommended the removal of the sunset clause.

The sunset clause in section 19AA was repealed in 2001.The deletion of the clause allowed the Medicare provider number restrictions for new medical practitioners to continue beyond 1 January 2002. At the time of amending the Act, a requirement for a biennial report on the operations of the legislation was also introduced.

The 2003 Biennial Review of the Medicare Provider Number Legislation

The Hon Ron Phillips was appointed by the then Minister for Health and Ageing, Senator the Hon Kay Patterson, to conduct the 2003 Biennial Review of the Medicare Provider Number Legislation. In summary, the 2003 Biennial Review found that:

1. Section 19AA

- There continues to be overwhelming agreement with the objective of the legislation that all graduates without further training should not be practicing unsupervised and that General Practice be a vocational specialty.
- Although difficult to quantify, it is generally agreed that the legislation is having a positive impact on raising the quality of general practice services to the community.
- There is broad agreement that compared with other issues the operation of this section of the Act has had very little to do with the medical workforce shortage that is facing Australia and the world.
- This legislation is underpinning a range of quality and workforce packages that have been put in place and therefore should be retained.

2. Section 3GA

- This section is being used effectively to approve training courses and to assist in addressing workforce shortages. However, the following issues need to be resolved:
- There is a need to ensure that the drive to address the growing workforce shortage does not lead to a weakening of the quality and training objectives of this legislation.
- There is a need to give prevocational doctors in their early postgraduate years an opportunity to experience general practice.

3. Section 3GC

- There continues to be strong support in the medical profession for the work carried out by the Medical Training Review Panel and for it to continue maintaining its focus on training issues. However, there is a need to regularly review the composition of the Panel to ensure it maintains its vitality and relevance to the issues it is addressing.

The 2005 Biennial Review of the Medicare Provider Number Legislation

Methodology

The Department of Health and Ageing contracted the Hon Ron Phillips to undertake the 2005 Biennial Review of the Medicare Provider Number Legislation. Ms Gigi O'Sullivan and Ms Joanne Hall of the Department's Health Workforce Branch provided secretariat support to Mr Phillips. The Review commenced in August 2005 and the final report was submitted to the Minister, the Hon Tony Abbott MP, on 28 November 2005. The Minister approved the tabling of the report on 14 December 2005.

The Terms of Reference of the 2005 Review is at Appendix B.

A Reference Group was established to provide advice as required to Mr Phillips on the issues to be covered by the Review. A total of 11 organisations were represented in the Reference Group (listed at Appendix C). The Committee of Presidents of Medical Colleges consisted of two representatives, one from the Royal Australian College of General Practitioners and one from the Australasian College for Emergency Medicine.

The review process commenced with the circulation of a letter on 5 August 2005 to all key stakeholders (listed in Appendix D) advising them of the arrangements being put in place for the Review and the membership of the Reference Group. The letter also invited submissions to the Review and outlined Mr Phillips' schedule of visits around Australia for consultations with key stakeholders.

A public notice calling for submissions to the Review was placed with the *Australian Doctor* and the *Medical Observer* on Friday 26 August 2005 and the *Weekend Australian* on Saturday 27 August 2005 (reproduced at Appendix E). The deadline for submissions was 30 September 2005.

The Department's Health Workforce website at www.health.gov.au/internet/wcms/publishing.nsf/Content/Health%20Workforce-1 was updated with a web page for the 2005 Biennial Review (Appendix F).

The bilateral consultation meetings were conducted with key stakeholders in an interview format using the same structured questions for each meeting. These questions were designed to provide a framework for discussions on the legislation's effect on access to and quality of medical training, and on the supply, demand and distribution of the medical workforce, as perceived by stakeholder organisations. Representatives who consulted with Mr Phillips had a choice between addressing each indicative question or raising issues directly with Mr Phillips. Views were also sought on the impact of the recommendations of the 2003 Biennial Review report and any unintended consequences of the legislation. The list of indicative questions asked during the interviews is set out in Appendix G.

Locations and dates of stakeholder consultation meetings were as follows:

Adelaide	1 September 2005
Sydney	5 and 6 September 2005
Perth	9 September 2005
Melbourne	15 September 2005
Brisbane	20 and 21 September 2005
Canberra	27 and 28 September 2005

Mr Phillips met with the Reference Group three times during the course of the Review:

- 30 August 2005 — to discuss the Terms of Reference and issues to be covered by the Review prior to commencement of the bilateral discussions with interested stakeholders;
- 29 September 2005 — to present and discuss his initial findings arising from bilateral discussions with stakeholders; and
- 18 October 2005 — to discuss possible recommendations.

Mr Phillips also consulted various areas within the Department of Health and Ageing, including the:

- Health Workforce Branch;
- Primary Care Programs Branch;
- General Practice Programs Branch; and
- Chair of the Medical Training Review Panel.

A total of 24 submissions were received by the Review. A list of the individuals and organisations that tendered submissions is at Appendix H. In addition to submissions and consultations with key stakeholders, the Review was required to analyse a number of literature sources and data. These are listed in the Bibliography.

Chapter Two — Results of the recommendations made by the 2003 Biennial Review of the Medicare Provider Number Legislation

Background

Overall, the 2003 Biennial Review found that the provider number legislation was working well. The Fellowship requirements for access to a Medicare provider number were strongly endorsed and the workforce measures were generally supported. There was strong support for the work of the Medical Training Review Panel (MTRP) in examining medical training programs and opportunities.

The Review made 16 recommendations aimed at improving the operation of sections 19AA, 3GA and 3GC of the *Health Insurance Act 1973* (the Act). To ensure that the quality intent of section 19AA was not jeopardised by workforce programs established under section 3GA, a review of certain 3GA program guidelines was recommended. The aim of this review was to place greater emphasis on supervision and educational support for doctors on these workforce programs so that they could achieve their vocational specialty within a reasonable timeframe.

Strong representations were made to the Review for the introduction of elective supervised terms in general practice for prevocational doctors, both as a training and workforce initiative. This led to the establishment of the Prevocational General Practice Placements Program (recommendation 14).

Several recommendations were also made in relation to the membership of the MTRP, a legislative body established under section 3GC of the Act.

The Minister for Health and Ageing, the Hon Tony Abbott MP, approved the tabling of the Biennial Review report on 23 December 2003. The report was presented out-of-session to Parliament on 24 December 2003.

The 16 recommendations of the 2003 Biennial Review are set out below, with an update on action taken to address each recommendation.

2003 Biennial Review recommendations and outcomes

Rural Locum Relief Program

Recommendation 1

The title "Rural Locum Relief Program" (RLRP) be replaced with a name that more accurately reflects its purpose. Some suggested names include: *Rural General Practitioner Recruitment Program* or *Rural General Practitioner Placement Program*

Recommendation 2

Review the guidelines of the RLRP including consideration of the following items:

2.1 — Maintain application to Rural, Remote and Metropolitan Area (RRMA) classifications 4–7 with the flexibility to extend to RRMA classification 3 under special circumstances.

2.2 — Provide for flexibility in the application of the guidelines at a State level giving each State the capacity to assess the needs of their communities while not compromising quality standards.

2.3 — Set appropriate national assessment standards of qualifications and experience for doctors entering the program.

2.4 — Require supervision and mentoring appropriate to the doctor's qualifications and experience.

2.5 — Require appropriate monitoring and quality control of placements by the delegated agencies.

2.6 — Require an undertaking from the doctor to complete the necessary education and training to obtain the appropriate Australian Medical Council (AMC) and/or Royal Australian College of General Practitioners (RACGP) Fellowship qualifications.

2.7 — Enforce a time limit on the duration of placements provided the time frame was sufficient for enrolled doctors to obtain their Fellowship of the Royal Australian College of General Practitioners through (FRACGP) or the Practice Eligible Route, and provided some scope for flexibility in individual cases.

Outcomes

Implementation of recommendations 1 and 2 are in progress. A working group met in April 2005 to revise the Program guidelines in response to the Biennial Review. The group comprised representatives from the Department of Health and Ageing, NSW Rural Doctors Network and Health Workforce Queensland.

The draft revised guidelines will be sent for comments to the Australian Rural and Remote Workforce Agencies Group, the RACGP, the Australian College of Rural and Remote Medicine, the Rural Doctors Association of Australia, the Australian Divisions of General Practice and the Australian Medical Association.

Further recommendations in relation to this issue are included in the 2005 Biennial Review of the Medicare Provider Number Legislation.

Recommendation 3

Provide specific funding for structured training, support and mentoring to assist doctors in the RLRP as a pathway to Fellowship.

Outcome

Recommendation 3 has been implemented. The Department of Health and Ageing (through the Health Services Improvement Division) now provides funding to support doctors on the RLRP to achieve FRACGP.

Recommendation 4

Actively market the RLRP to Australian graduates in their intern year and second postgraduate year.

Outcomes

This recommendation has been implemented. Rural Workforce Agencies are encouraged to market rural general practice to both Australian graduates and undergraduates. This includes marketing the RLRP.

Recommendation 5

Amend the Rural Other Medical Practitioners (OMPs) guidelines to allow the benefits for Rural OMPs to be paid on a case-by-case basis to doctors allocated to RRMA classification 3 locations under the RLRP.

Outcome

Recommendation 5 has been implemented. The Government has extended certain GP workforce programs, including the Rural OMPs Program to 'areas of consideration', which are areas that are not classified as RRMA 4–7 but exhibit the characteristics of rural areas.

Medical Training Review Panel

Recommendation 6

Review the membership of the MTRP taking into account the following issues:

6.1 — Australian Divisions of General Practice: Restructuring of the Divisions Network resulted in them being excluded from the MTRP due to technical legislative reasons. Their significant involvement in workforce and training issues for general practitioners means they should be represented.

6.2 — Australian Medical Council: Their role has expanded since the MTRP commenced their work, such as accrediting specialist training, determining specialist colleges and overseas trained doctor specialist issues.

6.3 — General Practice Education and Training: They were formed after the MTRP and have a significant role in the placement and training of general practitioners.

6.4 — Public Service Association of NSW: There is concern over whether this is still an appropriate organisation to be represented on the MTRP.

6.5 — Australian College of Rural and Remote Medicine: They have a significant role in providing continuing professional development for rural doctors.

6.6 — Introduce a rotation system for specialist colleges, for example, four to six colleges at any one time represented for say a two-year period.

Outcomes

Recommendations 6.1, 6.2, 6.3, 6.4 and 6.5 have been implemented. The Minister approved expansion of the MTRP membership to include the:

- Australian Divisions of General Practice
- Australian Medical Council
- General Practice Education and Training
- Australian College of Rural and Remote Medicine
- Australasian College of Dermatologists
- Royal Australasian College of Medical Administrators
- Royal Australian and New Zealand College of Ophthalmologists

The Minister agreed to all specialist colleges being represented on the MTRP. Accordingly, there was no longer a need for the Committee of Presidents of Medical Colleges to present previously unrepresented specialist medical colleges on the Panel and there was no need to proceed with the rotational system recommended in 6.6.

The Minister agreed to the removal of the Public Service Association of NSW from the Panel.

Recommendation 7

Establish a fixed term of appointment of between three and five years for a person representing their organisation on the MTRP, with a possibility of renewal.

Outcome

Recommendation 7 has not been implemented. Establishing a fixed term for Panel members was not supported by stakeholders at the MTRP special meeting of 27 February 2004 as it was felt to be unnecessary. It is unlikely that a number of organisations would have the same representative for a period of three to five years due to factors such as staff turnover. Member organisations are also aware of the importance of ensuring their representation on the Panel is appropriate, and revise their representation as required.

No further action is proposed.

Recommendation 8

Provide the Chairman of the MTRP with the ability to co-opt representatives of up to two organisations.

Outcome

Recommendation 8 has not been implemented. Co-opting was not supported by stakeholders at the MTRP special meeting of 27 February 2004 as it was felt to be unnecessary. Invitations to MTRP meetings are already extended to additional organisations on a meeting-by-meeting basis.

No further action is proposed.

Recommendation 9

That the MTRP, in addition to its current comprehensive collection of data on vocational medical training, should collect data on Postgraduate Year 1 (interns) and Postgraduate Year 2 relating to the number of positions available, the number filled in each State and Territory, and the gender of trainees.

Outcome

Recommendation 9 has been implemented. Work has commenced on the collection of this data, which will be included in the 2005 MTRP Annual Report.

Recommendation 10

Noting the significant increase in medical school places established by the Australian Government from 2004, it is essential that steps be taken to ensure the States and Territories provide adequate intern (Postgraduate Year 1) positions for all medical school graduates.

Outcome

Implementation of recommendation 10 is in progress. State and Territory health departments are aware of this issue and work has commenced in jurisdictions to ensure that intern positions will be available when required.

This issue is being considered by the Joint Jurisdictions Junior Medical Officer (JMO) Workforce Working Group, which includes workforce planning representatives from each State and Territory health department and the Australian Government Department of Health and Ageing.

It is also being considered by the Medical Specialist Training Taskforce set up by the Australian Health Ministers' Advisory Council to consider the scope for expanding vocational training opportunities in the private sector.

The MTRP will include the PGY 1 and PGY 2 data being collected by the Joint Jurisdictions JMO Workforce Working Group in their 2005 Annual Report.

Further recommendations are included in the 2005 Biennial Review of the Medicare Provider Number Legislation.

Aligning the definitions of 'district of workforce shortage' and 'area of need'

Recommendation 11

During the deliberations of the Overseas Trained Doctor Taskforce they should examine further ways to better align the definitions of 'district of workforce shortage' and 'area of need'.

Outcomes

Recommendation 11 has been implemented. Improved information sharing arrangements between Australian Government and State and Territory health officials are now in place.

Under these arrangements, most jurisdictions seek evidence of district of workforce shortage status as part of the Area of Need application process for doctors wishing to work in general practice or private specialist positions requiring Medicare access.

In addition, the Department of Health and Ageing has introduced a District of Workforce Shortage database on its website. The website enables a user to determine whether a particular locality within Australia is currently classified as a district of workforce shortage with respect to general practice by searching a database of localities.

Australasian College of Sports Physicians Training Program

Recommendation 12

That the Minister notes the situation of sports medicine trainees who are subject to section 19AA and consider how this issue may be resolved in light of the fact that sports medicine is currently awaiting assessment of its application for recognition as a specialty.

Outcome

Recommendation 12 has been implemented. The Approved Placements for Sports Physicians Program was established in April 2004 as an interim measure until such time as a decision is made on the College's application.

Sports medicine is not currently recognised as a medical specialty under the *Health Insurance Act 1973*. The Australasian College of Sports Physicians has submitted an application to the Australian Medical Council's Recognition of Medical Specialties Advisory Committee seeking recognition of sports medicine as a specialty. A review team is currently being established and an assessment of the sports medicine application will commence shortly.

The Program is administered by the Department of Health and Ageing. Four practitioners have applied to the approved placement program to date.

Further recommendations are included in the 2005 Biennial Review of the Medicare Provider Number Legislation.

Queensland Country Relieving Doctors Program

Recommendation 13

Develop clear guidelines for the operation of the Queensland Country Relieving Doctors (QCRD) Program to address the issues of supervision, training and support consistent with the guidelines for other "Approved Placement Programs".

Outcome

Implementation of recommendation 13 is in progress. Queensland Health is undertaking a review of the QCRD Program and one of the purposes of the review is to develop standard State-wide guidelines for the operation of the QCRD Program.

The draft guidelines for the Program are in the final stages of development and include:

- an effective training and preparation module that can be delivered State-wide to Resident Medical Officers (RMOs) participating in the QCRD Program;

- roles and responsibilities of RMOs providing relief to rural and remote communities;
- explicit standards for orientation, support and professional supervision available to RMOs when relieving in rural and remote communities;
- a robust ongoing evaluation of the whole operation of the scheme;
- alternate relief arrangements that may be used by Health Service Districts to meet the relief requirements for rural practitioners within the District; and
- conditions and entitlements for RMOs when relieving.

Further recommendations are included in the 2005 Biennial Review of the Medicare Provider Number Legislation.

Community and General Practice Terms for Prevocational Doctors

Recommendation 14

Introduce a new "Approved Placement Program" under section 3GA to allow prevocational doctors to undertake supervised terms in general practice in urban and rural areas to meet both training and workforce needs. The following guidelines to be considered:

14.1 — Participation to be limited to doctors in Postgraduate Year 2 and beyond.

14.2 — Participation should be by applications, assessed by the Postgraduate Medical Education Councils as part of the doctor's prevocational medical education and training.

14.3 — Doctors in the program are to work under the supervision of a vocationally registered general practitioner recognised under the *Health Insurance Act 1973*.

14.4 — Design and supervision of the placements will be in accordance with criteria established with input from the postgraduate medical education body in the relevant State or Territory.

14.5 — Participation to be limited to three months Full Time Equivalent for any individual doctor with provision for part-time involvement.

14.6 — Placements are to be available in a range of rural and urban localities with outer urban areas to be given priority.

14.7 — The Medicare rebate available to patients treated by a doctor are to be at Group A1 of the Medicare Benefits Schedule.

14.8 — Junior doctors are to undertake the necessary liaison with appropriate practices and authorities to obtain the necessary approvals, including obtaining leave from their public hospital placement.

14.9 — General Practice Education and Training (GPET) to assist in the identification of practices that offer the appropriate level of supervision.

14.10 — The Australian Government may need to provide additional funding to Postgraduate Medical Education Councils, GPET and participating practices to assist in meeting the cost of supervising the scheme and the participating doctors.

14.11 — The implementation of this Program be done in close consultation with the States and Territories.

Outcomes

Recommendations 14.1–14.11 have been implemented. The Prevocational General Practice Placements Program commenced on 1 July 2004 with prevocational doctors able to undertake a general practice placement in outer metropolitan, regional, rural and remote areas from January 2005.

The target group for the Program is Postgraduate Years 2 (PGY 2) and 3 (PGY 3). In some States, interns can participate in the Program providing the relevant State/Territory Postgraduate Medical Education Council supports their inclusion.

The Confederation of Postgraduate Medical Education Councils is represented on the National Advisory Committee (NAC) to the Program. Approximately 60 general practice placements were underway or had been completed by 30 June 2005. It is expected that approximately 200 placements will take place in 2005–06. A significant increase in uptake of the 280 available placements is expected in 2006–07.

Doctors participating in the Program are supervised by an accredited general practice supervisor.

Program guidelines have been developed to ensure that design and supervision of the general practice placements is appropriate.

The average length of a general practice placement is 12 weeks full-time. However, the Program is flexible so placement arrangements are suitable for local environments and hospital terms.

The general practice placements will be available in rural, remote, regional and outer metropolitan areas. Placements will also be considered in defined Areas of Workforce Shortage and RRMA 2 locations on a case-by-case basis.

Postgraduate doctors in PGY 2 or PGY 3 are able to bill Medicare at Group A1 of the Medicare Benefits Schedule.

General practice placements are provided through two managing organisations – the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners. The managing organisations identify appropriate practices and ensure junior doctors obtain the necessary approvals.

A representative from GPET is on the NAC.

Supervision is recognised as an important aspect of this Program and significant funding is provided to cover the cost of supervision and educational resources to support the educational experience of junior doctors in a general practice setting.

As part of designing the Program, the Department undertook an extensive consultation process involving the States and Territories on relevant issues such as accreditation of training, medical indemnity and the supply of junior doctors.

Further recommendations are included in the 2005 Biennial Review of the Medicare Provider Number Legislation.

Approved Medical Deputising Service Program

Recommendation 15

Review the guidelines of the Approved Medical Deputising Service (AMDS) Program with a view to:

15.1 — Encompassing in-hours care of patients in Residential Aged Care Facilities (RACFs).

15.2 — Ensuring full accreditation as an Approved Medical Deputising Service against the Royal Australian College of General Practitioners' (RACGP) Medical Deputising Service standards is a mandatory pre-condition for the purposes of obtaining approval to join the AMDS Program.

15.3 — Ensuring all Approved Medical Deputising Services are fully accredited against the RACGP's Medical Deputising Service standards by a Commonwealth-recognised accreditation body and offer full overnight home visit service for the complete after hours period.

15.4 — Ensuring all after hours only clinics approved for the AMDS Program are part of an Approved Medical Deputising Service providing home visit service coverage for the full after hours period.

15.5 — Providing clear standards for supervision, mentoring and training.

Outcomes

Implementation of recommendations 15.2–15.5 are in progress. An AMDS Program Guidelines Stakeholder Reference Group consisting of representatives from the RACGP, the Australian Medical Association and the National Association for Medical Deputising Australia was set up to provide advice and expertise on amending the guidelines in line with the 2003 Biennial Review recommendations. It has proposed new guidelines which are expected to be considered by the Minister.

The Stakeholder Reference Group noted that the outcome of the initiative under Strengthening Medicare to improve primary medical care for residents of aged care homes should be considered before implementing the Review recommendation in relation to in-hours care of patients in RACFs (Recommendation 15.1).

The Stakeholder Reference Group recommended a two-tier assessment process be introduced to the AMDS Program guidelines to determine eligibility to participate in the Program. The two-tier method enforces the Program requirement for full accreditation and also ensures that medical deputising services provide coverage, including home visits, during the entire after hours period, before being approved.

Quality assurance issues around mentoring, supervision and training are also under consideration in the proposed guidelines.

Further recommendations are included in the 2005 Biennial Review of the Medicare Provider Number Legislation.

Streamlining the process for doctors in Approved Placement Programs

Recommendation 16

The Government consider appropriate methods of improving and streamlining the process for doctors in "Approved Placement Programs".

16.1 — Support the Health Insurance Commission to establish arrangements so that a delegated agency sponsoring and supporting a doctor can access information regarding that doctor's registration for a provider number, which does not contravene existing legislative arrangements.

16.2 — Overcoming the need for doctors in the RLRP requiring multiple applications and provider numbers covering each practice they work in.

16.3 — Supporting the Health Insurance Commission and the Department of Health and Ageing to overcome the problem of doctors in "Approved Placement Programs" having their provider number expire reducing the rebate and adversely impacting upon general practices and their patients.

Outcomes

Implementation of recommendations 16.1–16.3 are in progress. The Department has consulted GP groups and Medicare Australia regarding streamlining the application process.

The provider number has links to many programs and incentives and a major change in the application process would potentially affect these links. Accordingly, a departure from the current provider number model will need wider consultations to include specialists, private health insurers, allied health professionals and consumers. Other Government agencies such as the Department of Veterans' Affairs and Centrelink will also need to be consulted.

Medicare Australia (formerly the Health Insurance Commission) has introduced a Provider Directory System (PDS) on their website which allows health professionals to view and update certain provider and practice information recorded by Medicare Australia. By using the PDS, a provider can update information about his/herself or their practices as well as provide practitioners with information relating to practice addresses which are time and location specific.

Other streamlining arrangements introduced since the last 2003 Biennial Review include:

- the *DoctorConnect* website which contains information regarding Medicare provider numbers and enables downloading of an application form; and
- the Department of Health and Ageing's online Districts of Workforce Shortage database which enables a user to determine whether a particular locality within Australia is currently classified as a district of workforce shortage with respect to general practice.

The Australian Government is continuing to investigate ways to streamline the process, including online submission of forms and, where possible, reducing the number of forms that doctors are required to complete.

Further recommendations are included in the 2005 Biennial Review of the Medicare Provider Number Legislation.

MTRP Special Meeting to discuss the recommendations of the 2003 Biennial Review report

Section 19AD (4) of the *Health Insurance Act 1973* provides that following the tabling of the biennial review report, the MTRP must convene a meeting to discuss the report. The Minister must then table a record of the meeting in Parliament within 20 sitting days after the meeting.

A record of the proceedings of the MTRP special meeting, which was held on 27 February 2004, was tabled in Parliament in May 2004 and can be downloaded from the Department of Health and Ageing's Health Workforce website at the link below:

www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-workforce-new-biennial.htm/$FILE/transcript04.pdf

Chapter Three — Sections 19AA, 3GA and 3GC of the *Health Insurance Act 1973* — Analysis of key issues

Section 19AA

Vocational recognition

The Government introduced vocational recognition in 1989 to recognise general practice as a discipline in its own right, and to acknowledge that training and ongoing education specific to general practice are important elements of maintaining high quality standards in general practice.

When vocational recognition was introduced, the two ways by which a medical practitioner could achieve vocational recognition were to either be accepted on to the Vocational Register or to attain Fellowship of the Royal Australian College of General Practitioners (FRACGP).

Certification for access to the Vocational Register was granted by the Royal Australian College of General Practitioners (RACGP), a Vocational Registration Eligibility Committee, or the Vocational Registration Appeal Committee. The criteria for entry into the Vocational Register included certification that the practitioner's medical service was predominantly in general practice and that the practitioner had appropriate training and experience in general practice.

Continued access to the Vocational Register is dependent on the GP's participation in appropriate quality assurance programs and continuing professional development activities approved by the RACGP or the Australian College of Rural and Remote Medicine (ACRRM), and on the practitioner's service being predominantly in general practice.

In 1995–96, the number of practitioners accessing the Vocational Register peaked at 68.8%. The number has declined since the closing of the Register in 1996. By contrast, the number of GPs with FRACGP has gradually increased in the last decade.[1] Table I.1 of Appendix I demonstrates these trends and also shows that the number of Other Medical Practitioners (OMPs)[2] has decreased to 16.6% in 2004–05.

With the closing of the Vocational Register, the only way for doctors to become vocationally recognised is to attain FRACGP.

1 Biennial Review of the Medicare Provider Number Legislation, December 2003

2 OMPs are GPs who are neither Vocationally Registered, FRACGP, nor undertaking RACGP training

The MedicarePlus for OMPs Program

At the time of the establishment of vocational recognition, a fee differential between Medicare rebates for non-vocationally recognised medical practitioners and vocationally recognised medical practitioners was also introduced.

Under this fee differential, vocationally recognised medical practitioners are able to access the higher A1 Medicare rebate, while non-vocationally recognised medical practitioners can only access the lower A2 Medicare rebate unless the services are provided through certain Government incentive programs.

One of these programs is the MedicarePlus for OMPs Program which the Australian Government introduced in February 2004 as part of the Strengthening Medicare package. The Program provides eligible pre-1996 non-vocationally recognised medical practitioners access to the higher Medicare rebate for services provided in areas of workforce shortage.

After five years in an area of workforce shortage, the services of these medical practitioners will continue to attract the higher rebate regardless of where they are subsequently located.

To maintain eligibility for the Program, medical practitioners are required to undertake continuing professional development activities through either the RACGP or ACRRM.

Grandfathering

The introduction of vocational recognition was accompanied by a grandfathering period that allowed established GPs access to the Vocational Register on the basis of general practice experience alone. The grandfathering period ended in November 1996.

The Biennial Review found strong support for a final round of grandfathering onto the Vocational Register for those non-vocationally recognised doctors who generally met the requirements for vocational registration and have continued to work in general practice for the majority of their practice time since 1996.

A final round of grandfathering is considered a way to remove the inequity between GPs with vocational recognition and those who meet certain criteria but are not vocationally recognised. Grandfathering would also remove the discrimination against patients of non-vocationally recognised doctors who are only able to claim the lower Medicare rebate, thus improving patients' affordability of these doctors.

The Department of Health and Ageing reports that there are approximately 2500 non-vocationally recognised medical practitioners in Australia, and around 1500 of these are currently accessing the higher Medicare rebate through various incentive programs. Grandfathering would eliminate the administrative burden of managing these programs, such as the MedicarePlus for OMPs Program.

Opening up a final round of grandfathering for non-vocationally recognised doctors would also be a quality measure as it would become compulsory for these doctors to undertake continuing professional development in order to maintain vocational recognition status.

There are some concerns, however, that the current incentive programs would lose their usefulness as a workforce distribution tool if grandfathering was introduced.

The Review needed to take into account the balance between issues of fairness and quality for doctors and patients versus the impact on workforce distribution.

> **Recommendation 1**
>
> Provide one more opportunity for doctors who meet the necessary criteria to be grandfathered onto the Vocational Register.

Increase in the number of medical school places and medical schools

The Australian Government's Strengthening Medicare package introduced in 2004 announced a range of initiatives to address the medical workforce shortage. This included an increase of 246 medical school places each year from 2005, representing a 30% growth in publicly-funded medical school places since 2000.

Figure 1 provides a graph on the number of medical students who have and will have commenced medical studies between 1992 and 2010. The graph does not include the extra domestic fee-paying students that are being allocated places in medicine, nevertheless, it demonstrates an upward trend.

In addition to the increase in the number of medical school places, eight new medical schools will have been established between 2000 and 2008, most with significant funding from the Australian Government. These medical schools are:

- James Cook University, North Queensland
- The Australian National University, Canberra
- Griffith University, Queensland
- The University of Notre Dame Australia, Western Australia
- Bond University, Queensland
- The University of Western Sydney (opening in 2007)
- The University of Notre Dame Australia's new Sydney campus (opening in 2008)
- The University of Wollongong, also opening in 2007.

Impact of the increase in medical school graduates

At present, there are generally more vocational training places available than there are doctors to fill them. Feedback provided to the Review confirms this to be the case. Accordingly, junior doctors should not have a problem accessing a vocational training program, albeit the training program they enter into may not always be their first choice.

Tables J.1 and J.2 of Appendix J provide the number of vocational training positions/trainees in programs and likely number of first year vocational training places to be offered for commencement for 2004–05 and 2005–06 respectively.

The number of Australian students completing university medical studies is expected to grow from approximately 1,300 in 2005 to 2,100 by 2011. This equates to an increase in medical graduates of more than 60%, which requires a corresponding increase in prevocational hospital training and vocational training for junior doctors as a result of the requirements under section 19AA of the *Health Insurance Act 1973*.

The Medical Training Review Panel (MTRP) defines 'vocational training' as the training that is undertaken in a training program in pursuit of a specific career option, either in general or other specialist practice, and which is supervised by either a medical college or General Practice Education and Training. The funding for the training is provided from a variety of sources, the principal source being governments, usually State/Territory, through public hospitals. In the case of general practice, however, funding is provided by the Australian Government. Some disciplines have a number of training places in the private sector.[3]

The projected increase in medical graduates is an issue that was consistently raised during bilateral consultations. Some stakeholders expressed concern about whether the current level of planning and preparation was sufficient to ensure that the future demand for intern and training places is met.

The Review received representations arguing there needs to be adequate and cohesive planning in place for capacity building and funding to strengthen the resources and infrastructure for medical graduates of the future.

Many were aware of the activities around the expansion of vocational training from within traditional public hospital settings to the private sector. Most raised concerns regarding the supervision, mentoring and education that would need to be accessible to a larger contingent of junior doctors. Small hospitals and rural and remote community sectors would also require support to enable them to provide adequate training for future medical graduates.

The need for a comprehensive and coordinated approach to address the future supply of training placements

State and Territory governments recognise that significant planning is required to ensure that junior medical doctors have appropriate supervision, training and support across a range of training environments, including community, ambulatory and rural settings. Many jurisdictions are actively planning for the additional infrastructure and resources that will be required to meet the expected increase in medical school graduates.

The Australian Health Workforce Officials' Committee established a Joint Jurisdictional Junior Medical Officer Workforce Working Group to consider issues relating to the junior medical workforce. This committee, comprising representation from State and Territory health authorities, has also been discussing ways to address the support and supervision requirements for the increase in medical school and Australian Medical Council graduates in coming years.

In relation to vocational training, the Australian Health Ministers' Advisory Council's Medical Specialist Training Steering Committee is exploring the formal diversification

3 Medical Training Review Panel — Eighth Report, November 2004

of vocational training into a range of new training settings, including the private sector, to better align training with service delivery arrangements.

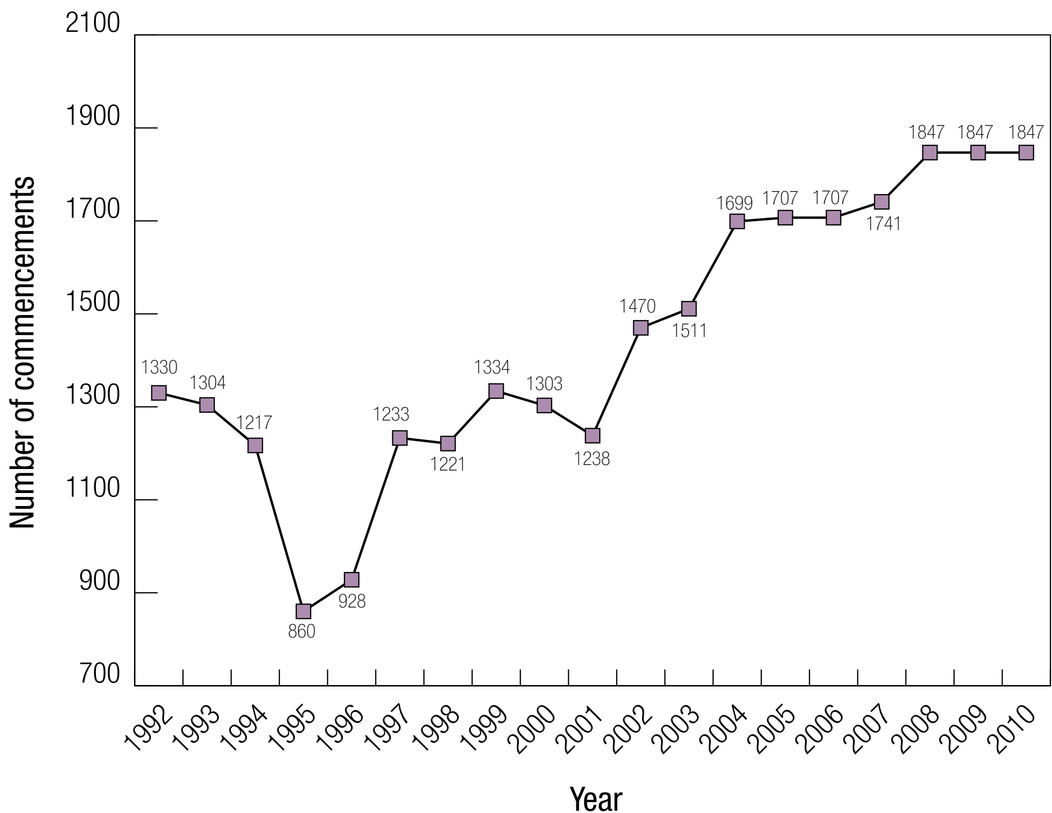
With appropriate support mechanisms, the introduction of the private sector into the training system will increase the health system's capacity for training. Further, there is likely to be opportunities for prevocational interns to follow vocational trainees into the private sector, as vocational trainees often provide the supervision for interns. Preliminary work undertaken by the Steering Committee indicates that the expansion of training settings should coincide with increasing numbers of graduates.

These issues will be incorporated into the Steering Committee's report to the Australian Health Ministers' Advisory Council in 2006.

Recommendation 2

The MTRP be directed to monitor and report regularly on the activities and progress being made to ensure adequate intern and training positions are in place to meet the increasing numbers of new medical graduates.

Figure 1: Medical students, commencements, Australian citizens and permanent residents, 1992–2010



Source: AIHW, DEST, Australian Medical Schools. Note data after 2004 are estimates from medical schools.

Section 3GA

Balance between workforce quality and workforce distribution

There continues to be ongoing tension between the requirements of workforce quality and workforce distribution. The Review acknowledges that as long as Australia continues to experience workforce shortages, there will always be a reliance on workforce distribution programs to deliver medical practitioners to those communities in most need. However, the Review also acknowledges the need to ensure these workforce distribution programs do not undermine the training and quality objectives of the legislation.

A list of all the training and workforce programs established under section 3GA of the *Health Insurance Act 1973* (the Act), and as specified in the *Health Insurance Regulations 1975, Schedule 5* (Regulation 6E) is at Appendix K.

Both training and workforce programs established under section 3GA of the Act are recognised as being major factors in improving the doctor numbers in rural and remote areas of Australia.[4] Table 1 demonstrates a 26.3% increase in headcount in general practice numbers in rural and remote areas since 1995–96.

The Rural Locum Relief Program (RLRP) continues to be a major workforce program for which 3GA placements are granted. Table L.1 of Appendix L indicates that 764 doctors were approved to participate in the RLRP during 2003–04 and 671 during 2004–05. Table L.3 shows a State/Territory breakdown of RLRP doctors for 2003–04 and 2004–05.

Of all the 3GA training and workforce programs, the Australian General Practice Training Program (AGPTP) has the highest intake of trainees. During the first half of the 2005 training year, a total of 1,557 GP registrars were enrolled in the training program, of which 983 were on the General Pathway and 574 were on the Rural Pathway (Table L.5 of Appendix L). General Pathway trainees are also required to undertake at least one placement in a rural area as part of this training.

Both the RLRP and the AGPTP are discussed in more detail further in this chapter.

Continuing the emphasis on quality without impacting negatively on workforce distribution

The Review received feedback on a number of occasions that, while efforts to increase the number of doctors in rural and remote communities are highly commended, safeguards need to be put in place to ensure that workforce programs are not used as a long term avenue for circumventing the intent of section 19AA of the Act.

The General Practice Representative Group (GPRG), consisting of the Royal Australian College of General Practitioners, the Australian Medical Association, the Australian Divisions of General Practice and the Rural Doctors Association of Australia, maintains the view that "doctors who have yet to meet the equivalent of FRACGP must be assessed for entry into general practice, and be supervised, mentored and supported in their education to the national standards of the RACGP."[5]

4 Biennial Review of the Medicare Provider Number Legislation, December 2003

5 General Practice Representative Group communiqué, 11 March 2004

The RACGP, supported by the other members of the GPRG, have submitted to the Review that changes to the requirements for 3GA programs should be made in accordance with the views of the GPRG.

Others stakeholders had different views on the validity of including such requirements in programs that focus primarily on placing doctors in areas that have difficulty in recruiting.

There was general agreement that the quality and training aspects of the RLRP and the Approved Medical Deputising Service (AMDS) Program (discussed further in this chapter) and other workforce programs should be encouraged. However, care needed to be taken to ensure this quality focus did not impact negatively on the rural, remote and urban after hours workforce.

Consistent national approach to assessment and approval standards by medical boards

A recurring comment among stakeholders is the lack of consistency between medical boards in their assessment standards.

Programs that are affected as a result of medical boards' lack of consistency include the RLRP. This is discussed in more detail later in this chapter under Rural Locum Relief Program.

The Review was made aware that the State and Territory medical registration boards have acknowledged the need to work towards a nationally consistent approach which clearly meets the needs of the Australian population.

Recommendation 3

3.1 The Review concludes that there is a need to maintain the current list of 3GA training and workforce programs and sees no need for any additional programs.

3.2 There should be increasing emphasis on standardised assessments, structured education, supervision and mentorship in all workforce programs.

3.3 The Australian Government should consider further investment to support the quality and training aspects of the RLRP, the AMDS Program and other 3GA workforce programs because of their value in providing quality care to the rural and remote regions of Australia and after hour services in urban areas.

3.4 The Australian Government should continue to stress the need for medical boards to have a consistent national approach to their assessment and approval process.

Table 1: Growth in General Practice numbers in rural and remote[1] areas			
Year	**Headcount[2]**	**FTE[3]**	**FWE[4]**
Number			
1995–96	5,417	3,120	3,551
1996–97	5,589	3,164	3,596
1997–98	5,706	3,216	3,641
1998–99	5,968	3,232	3,635
1999–00	6,210	3,287	3,672
2000–01	6,363	3,417	3,825
2001–02	6,588	3,555	4,005
2002–03	6,739	3,660	4,118
2003–04	6,841	3,778	4,263
% change on previous year			
1996–97	3.2%	1.4%	1.3%
1997–98	2.1%	1.6%	1.2%
1998–99	4.6%	0.5%	-0.2%
1999–00	4.1%	1.7%	1.0%
2000–01	2.5%	4.0%	4.2%
2001–02	3.5%	4.0%	4.7%
2002–03	2.3%	3.0%	2.8%
2003–04	1.5%	3.2%	3.5%
% change on 1995–96			
2003–04	26.3%	21.1%	20.1%

Source: Australian Government Department of Health and Ageing Submission to the Productivity Commission, August 2005

1 Rural and Remote	Defined as RRMA 3 (Large rural centre — Statistical Local Areas (SLAs) where most of the population resides in urban centres with a population of 25,000 or more); RRMA 4 (Small rural centre — SLAs in rural zones containing urban centres with populations between 10,000 and 24,999); RRMA 5 (other rural area — All remaining SLAs in the rural zone); RRMA 6 (Remote centre – SLAs in the remote zone containing populations of 5,000 or more); and RRMA 7 (Other remote area — all remaining SLAs in the remote zone).
2 GP headcount	A count of all GPs who have provided at least one Medicare Service during the reference period.
3 FTE (Full-time Equivalent)	FTE is an alternative measure to head count as it measures the number of doctors working full-time and the partial contribution of part time doctors. FTE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period. Where the doctor's Medicare billing is greater than or equal to the mean billing of full-time doctors, then the FTE is capped at one.
4 FWE (Full-time Workload Equivalent)	FWE is a measure of service provision because it takes into account doctors' varying workloads. FWE is calculated by dividing each doctor's Medicare billing by the average billing of full-time doctors for the reference period. Where the doctor's Medicare billing is greater than or equal to the mean billing of full-time doctors, then the FTE is capped at one but the FWE is not.

Queensland Country Relieving Doctors Program

Queensland Health regards the Queensland Country Relieving Doctors (QCRD) Program as a valuable asset in the retention of medical practitioners servicing rural and remote communities of Queensland.

The QCRD Program provides relief to approximately 160 medical practitioners throughout Queensland, with approximately 78 of these doctors requiring a Medicare provider number in order to provide medical services. In these instances, the relievers provide a service to the hospital as well as a locum service in the private practice of a Medical Superintendent Full-time or Medical Officer with Right of Private Practice. This component of the placement requires a Medicare provider number that will attract Medicare benefits.[6]

A total of 158 doctors required 3GA placements to access Medicare benefits under the Program in 2004–05 (Table L.1 of Appendix L). A description of the QCRD Program is at Appendix M.

Queensland Health reports that a total of 2,096 weeks of relief is required per year to meet the minimum leave entitlements of Queensland Health's rural practitioners.[7]

Approximately 450 relievers are sourced each year from Queensland Health hospitals as far north as Townsville, as west as Mt Isa, and as south as the Gold Coast. In total, there are 18 hospitals in Queensland that are involved in the QCRD Program. In 2003, the Program provided in excess of 10,000 days of leave to rural practitioners.[8]

Review of the QCRD Program

The 2003 Biennial Review recommended that clear guidelines be developed for the operation of the QCRD Program to address the issues of supervision, training and support for those junior doctors providing relief in communities where access to Medicare benefits is required (recommendation 13).

At the time of preparation of this report Queensland Health was in the final stages of their review of the QCRD Program. The review is aimed at providing "an improved framework to facilitate publicly employed junior doctors to provide relief to Queensland Health medical practitioners in rural and remote areas of Queensland."[9]

In addition to implementing the 2003 Review recommendation, Queensland Health has used this opportunity to review and reform the operation of the entire QCRD Program by addressing those areas not covered by the Biennial Review recommendation.

Feedback from Queensland stakeholders indicate that the Program has progressed considerably since the commencement of the review of the QCRD Program.

The QCRD Program review is expected to be completed by the end of 2005.

6 Queensland Country Relieving Doctors Review — Update Report: September 2005, Queensland Health

7 Queensland Country Relieving Doctors Review — Update Report: September 2005, Queensland Health

8 Queensland Country Relieving Doctors Review — Update Report: September 2005, Queensland Health

9 Queensland Country Relieving Doctors Review — Update Report: September 2005, Queensland Health

Recommendation 4

The Department of Health and Ageing to monitor the progress of Queensland Health's review of the 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 the other 3GA workforce programs.

Rural Locum Relief Program

The Rural Locum Relief Program (RLRP) was introduced in 1998 to help address the shortage of GPs providing services in rural and remote Australia. It continues to maintain its workforce redistribution focus through placements in small rural and remote areas and large remote centres (Rural, Remote and Metropolitan Area classification (RRMA) 4–7), large rural centres (RRMA 3) and all Aboriginal Medical Services (including those in RRMA 1 or 2 locations). A description of the RMMA classifications is at Appendix N. More recently, placements have been approved in areas of consideration[10] as determined by the Minister for Health and Ageing.

The number of doctors participating in the RLRP is provided in Appendix L and a description of the Program, including its aim and eligibility criteria, is at Appendix M.

Outcomes of the 2003 Biennial Review recommendations

The 2003 Biennial Review made several recommendations for the RLRP aimed at ensuring the Program did not jeopardise the quality intent of the Medicare provider number legislation. In particular, it recommended that the RLRP guidelines be amended to include appropriate standards to ensure the quality standards of doctors on the Program. The outcomes of these recommendations are detailed in *Chapter Two — Results of the recommendations made by the 2003 Biennial Review of the Medicare Provider Number Legislation.*

The Department of Health and Ageing initiated the review of the RLRP guidelines and a working party consisting of two Rural Workforce Agencies (RWAs) was convened to look into implementing the recommendations of the 2003 Biennial Review.

The RLRP guidelines were in the process of being amended at the time of this Review. Many of the recommendations made in the previous review are still under discussion. These include national standards for assessing qualification and experience of entrants, supervision and mentoring requirements, and the undertaking from doctors on the RLRP to complete the necessary education and training to obtain appropriate qualifications.

One positive outcome of the 2003 recommendations relates to the funding for structured training, support and mentoring to assist doctors in the RLRP as a pathway to Fellowship (recommendation 3). The Australian Government is providing additional financial assistance ($6,000 per doctor, excluding GST) to RWAs for training and/or support of RLRP doctors,

10 Areas of consideration are areas that are not classified as RRMA 4-7 locations but exhibit the characteristics of rural areas. In 2004, the Minister for Health and Ageing approved "areas of consideration" which can include RRMA 2 and 3 locations as well as Darwin.

both overseas trained doctors and Australian graduates, who may require assistance in order to gain Fellowship of the Royal Australian College of General Practitioners (FRACGP)[11].

This support provided through the RWAs is regarded as significant assistance in encouraging RLRP doctors to progress towards Fellowship. A total of 331 doctors were provided this assistance during 2004–05, according to the Department of Health and Ageing.

National assessment standards

The RLRP was intended originally to allow locum relief of rural and remote GPs. Over the years, the Program has evolved into a medium-term workforce measure and has attracted more overseas trained doctors than Australian graduates. Under the amended guidelines, it is proposed that the maximum time allowed on the Program be increased to four years and that the Program's name be changed to "Rural General Practitioner Temporary Placement Scheme" to more accurately reflect its purpose.

There continues to be concern regarding the varying eligibility criteria around Australia for doctors entering the RLRP. The Review is aware that the State and Territory medical boards assess these doctors prior to granting registration, nevertheless, there is still a question as to whether minimum assessment standards for entry into the Program should be introduced.

In exploring this matter further, the Review found the lack of consistency between medical boards to be a major issue.

Stakeholders hold mixed views on the introduction of national assessment standards for the RLRP. Many view national assessment standards as being difficult to put in place while others support their introduction on safety and quality grounds.

Training requirements under the RLRP

The RLRP is an important tool for placing doctors in difficult-to-recruit-for locations. The Australian Rural and Remote Workforce Agencies Group (ARRWAG) submitted to the Review that it supports the need for quality training and ongoing educational support for doctors working on the RLRP, but that changes made to the program to enforce such requirements should not impact negatively on the Program's capacity to place people in difficult to recruit for locations.[12]

As a way forward, ARRWAG proposed some avenues for adding to the quality of the training and support provided to doctors on the RLRP. These include considering

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11 The ongoing support provided by the RWAs includes:

(i) Providing accurate, realistic and timely information about all aspects of the proposed location, position and community;

(ii) Adopting a "case management" approach in managing and supporting the doctor and the family through the appointment, relocation and adjustment process in the community;

(iii) Developing an Individual Learning Plan (ILP) for each doctor who has not yet achieved FRACGP;

(iv) Case management and support from the RWA to assist each doctor to meet the needs identified in their ILP;

(v) Introducing each new RLRP doctor and those who are yet to achieve Fellowship to medical and community based support groups (eg. a doctors network); and

(vi) Facilitating access to electronic linkages such as newsletters, internet list servers and websites that provide for effective two-way communication with other doctors on the RLRP, as well as being a source of up-to-date and relevant news.

12 ARRWAG submission to the 2005 Biennial Review of the Medicare Provider Number Legislation, October 2005

a number of approaches already being used successfully by RWAs to develop an improved model, and developing guidelines that enable reassessment of a doctor after four years of participation in the RLRP.

The Review was made aware that doctors on the RLRP will remain ineligible to sit the FRACGP examination until they have completed four years general practice experience, including one year in Australian general practice. This was the rationale behind increasing the maximum duration of RLRP placements to four years, which is an outcome of a 2003 recommendation.

Supervision of RLRP doctors

The level of mentoring and supervision provided to RLRP doctors also varies between jurisdictions. ARRWAG agrees with the 2003 recommendation relating to supervision and mentoring for RLRP doctors. This is one of the recommendations that is still under consideration. At present, the situation is unchanged with most RWAs not having the funds or resources to provide or monitor the supervision and mentoring of RLRP doctors to the extent required.

Some RWAs arrange voluntary supervision and mentoring, but this is limited. In some States, medical boards stipulate supervision requirements for doctors with conditional registration, but ARRWAG reports that this is not monitored adequately.

The Rural Workforce Agency, Victoria reports that with the expansion of the GP Regional Training Program and Rural Clinical Schools and increased numbers of medical students and registrars in rural practices, existing supervisors and educators are already stretched in their capacity to provide mentoring and supervision to RLRP doctors.

There is agreement among stakeholders that RLRP doctors should be placed in areas that have the capacity to support them in terms of supervision and infrastructure.

Recommendation 5

5.1 The Department of Health and Ageing are to establish a formal and representative committee, including non-RWA organisations (eg. groups associated with quality and training), to review the guidelines of the RLRP.

5.2 The review of the RLRP guidelines should take into account the recommendations of the 2003 Biennial Review not already implemented, with particular emphasis on addressing quality assurance issues around assessment, mentoring, supervision and training.

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 (eg. more than 12 months) receive the appropriate assessment and training to achieve Fellowship of a recognised college.

Approved Medical Deputising Service Program

The Approved Medical Deputising Service (AMDS) Program was introduced in November 1999 to address the shortage of doctors providing after hours home visits. In 2001, after a review by an independent consultant, the Program was extended to also include after hours only clinics operated by Medical Deputising Services (MDSs).

A total of 91 and 108 doctors were approved to participate in the AMDS Program during 2003-04 and 2004-05 respectively (Table L.1 of Appendix L). A brief description of the Program is at Appendix M.

There are currently 21 MDSs that have been approved to participate in the AMDS Program. The AMDS service providers (AMDSs) are located in all six States and are listed in Appendix O.

Outcomes of the 2003 Biennial Review

The 2003 Biennial Review made several recommendations for the AMDS Program with the aim of continuing the quality focus of the Medicare provider number legislation (recommendation 15). These recommendations are still in progress (refer to *Chapter Two — Results of the recommendations made by the 2003 Biennial Review of the Medicare Provider Number Legislation*).

The Department of Health and Ageing initiated a Stakeholder Reference Group (the Group) consisting of representatives from the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association and the National Association for Medical Deputising Australia (NAMDS) to provide advice and expertise on amending the guidelines in line with the 2003 Biennial Review recommendations.

The Program guidelines were at the final stage of amendment at the time of preparing this report. The recommendations covering accreditation, home visits and coverage during the entire after hours period have been taken into account during the redrafting of the guidelines. Specific standards for supervision, mentoring and training for AMDS doctors are also under consideration.

In-hours services to Residential Aged Care Facilities

In considering the recommendation to expand the AMDS Program to allow AMDSs in-hours access to Residential Aged Care Facilities (RACFs), the Group agreed to defer action on this recommendation until the impact of the Aged Care Panels Initiative under Strengthening Medicare could be determined.

Aged Care Panels Initiative

The Medicare Aged Care GP Panels Initiative commenced on 1 July 2004 with the aim of ensuring better access to primary medical care for residents of RACFs and enabling GPs to work with homes on quality improvement strategies for the care of all residents.

A Panel is a group of GPs who agree to undertake particular activities that have been identified as priorities for RACFs in a Division of General Practice. Divisions of General

Practice play a key role in establishing and operating the Panels and undertaking related activities to improve access to GP service by residents of RACFs, and to support GPs to provide high quality primary care services within the RACFs.

Anecdotal evidence provided to the Review during stakeholder consultations indicates that on the whole, the Aged Care Panels Initiative has not improved RACF residents' access to primary health care during the in-hours period. However, as the Panels are a recent introduction, it may take some time before improvement in access will become apparent.

During the Review process, the Australian Divisions of General Practice and NAMDS agreed to open up discussions to identify the role of MDSs in supporting the aims of the Panels Initiative, with the possible use of MDSs in providing in-hours care to RACFs.

Streamlining the application process

AMDSs provided feedback to the Review on the amount of time spent by doctors and service providers applying for Medicare provider numbers, 3GA placements, section 19AB exemptions (where applicable) and deeds of agreement.

Many raised concern regarding the compliance burden associated with renewing these requirements and the paperwork required to be submitted during the annual renewal period.

The Department of Health and Ageing has been aware of this issue and is exploring ways to reduce the frequency of applications and paperwork associated with the Program. This includes the possibility of extending the duration of deeds of agreements for AMDSs and 3GA placements and provider numbers for doctors on the Program.

Recommendation 6

6.1 The Department of Health and Ageing are to complete and implement the revised guidelines for the AMDS Program in line with the recommendations of the 2003 review.

6.2 The Divisions of General Practice and local MDSs are to develop closer co-operation to promote co-ordination between general practice and MDSs with particular emphasis on:

- participation of MDSs in Division Aged Care GP panels to assist in providing after hours services to RACFs; and
- the possible use of MDSs in providing in-hours care to RACFs.

6.3 To streamline the administration of the Program, the Department of Health and Ageing are to extend the duration of both the deeds for MDSs and provider numbers for the doctors.

Rural and Remote Area Placement Program

The Rural and Remote Area Placement Program (RRAPP) was introduced in response to a Medical Training Review Panel recommendation that at least one rural term be included for medical officers in their first two postgraduate years. The pilot RRAPP commenced in April 2000 with approval to operate until December 2004.

Many of the participants of the RRAPP were interns and, according to RRAPP reports, provided positive feedback on their experience in general practice placements.

With the cessation of the RRAPP in December 2004, general practice placements were provided under the Prevocational General Practice Placements Program (PGPPP).

A total of 50 placements were approved under the RRAPP during 1 January to 31 December 2004 (Table L.6 of Appendix L). A description of the Program is provided at Appendix M.

Prevocational General Practice Placements Program

The 2003 Biennial Review found widespread support among stakeholders for the introduction of a 3GA program that would allow prevocational doctors to experience general practice outside the hospital system. The MTRP had also highlighted the need for community and general practice terms for junior doctors in its reports.

At the time of the 2003 Review, there were few opportunities outside of the RRAPP for junior doctors to experience supervised prevocational general practice training before deciding on their career path.

By contrast, prevocational supervised terms are standard features in other specialties, such as anaesthesia, paediatrics, surgery and other hospital medical disciplines. The importance of supervised prevocational exposure to general practice for junior doctors is well recognised, even for those intending to enter other specialty areas.[13]

Accordingly, the 2003 Biennial Review recommended the introduction of a new Approved Placement Program to allow prevocational doctors to undertake supervised terms in general practice in urban areas to meet both training and workforce needs (recommendation 14).

During the final stages of the preparation of the 2003 Biennial Review report, the Government announced its Strengthening Medicare package on 18 November 2003 which included an initiative *Bringing more graduate doctors to outer metropolitan, regional, rural and remote areas*. Under this initiative, up to 280 general practice placements per year (equal to 70 full-time equivalent doctors) would be provided for prevocational doctors.

The measure *Bringing more graduate doctors to outer metropolitan, regional, rural and remote areas* was implemented as the Prevocational General Practice Placements Program (PGPPP). General practice placements on the Program commenced in January 2005. A total of 59 general practice placements were underway or had been completed by 30 June 2005 (Table L.7 of Appendix L). A description of the PGPPP is at Appendix M.

It is expected that approximately 200 placements will take place in 2005–06. A significant increase in uptake of the 280 available placements is expected in 2006–07.

13 Biennial Review of the Medicare Provider Number Legislation, December 2003

Interns as part of the target group

The 2005 Biennial Review found great support for the PGPPP. Stakeholders consider the Program to be a valuable tool for those prevocational doctors who wish to "try before they buy", who would not normally be exposed to general practice during their training in the hospital environment. Even though the Program is relatively new, feedback provided to the Review indicates that junior doctors regard the PGPPP as a very worthwhile Program.

Junior doctors who are undertaking hospital training, but not yet enrolled in a specialty, are the target group for the PGPPP. Generally, the target group is Postgraduate Years (PGY) 2 and 3. There is flexibility to include later postgraduate years and interns, subject to the agreement of the Postgraduate Medical Education Council in each State and Territory.

The intern year is considered to be influential in career decisions and a positive general practice experience during the intern year may encourage junior doctors to take up general practice as a career. Additionally, allowing interns to participate in the Program helps develop a pool of doctors with early general practice experience.

Accordingly, stakeholders suggested that the current restriction of the PGPPP to PGY 2 and 3 be removed and for the Program to be opened up to interns. According to the Department of Health and Ageing, this is already occurring in South Australia and Queensland through the respective Postgraduate Medical Education Councils.

Medical indemnity

The 2005 Review found indemnity to be an issue in New South Wales. The main issue raised in relation to medical indemnity is the insurance cover for junior doctors, particularly PGY 2 and 3, undertaking general practice placements outside hospital premises.

The Department of Health and Ageing reported to the Review that it is pursuing the medical indemnity issue with NSW Health. The Australian Government has developed interim arrangements, however, NSW Health is seeking further advice.

Expansion of PGPPP locations

Placements on the PGPPP are available in rural, remote, regional and outer metropolitan areas. Placements are also considered in defined Areas of Workforce Shortage and RRMA 2 locations on a case-by-case basis. Due to these arrangements, stakeholders perceive the Program as being a workforce distribution initiative. An explanation of the RRMA classifications is at Appendix N.

As the PGPPP is still in its infancy, there is currently insufficient information to evaluate its effectiveness. Feedback provided to the Review indicates that the Program's workforce focus prevents many doctors from participating in the Program due to family and personal commitments, and precludes placements in city-based practices which have the capacity to take on the junior doctors.[14]

Noting the Program's important role in exposing postgraduate doctors to general practice, stakeholders called on more flexibility in the administration of the Program to allow for placements in city-based practices.

This issue is very relevant to the move to expand vocational training to private settings due to the increase in medical school graduates, which was discussed earlier in this chapter. The Review is aware that there are committees exploring the expansion of specialist vocational training to private sectors. Consideration could also be given to expand the role of the PGPPP as one of many options available for future junior doctors, especially those seeking a career in general practice.

Part-time placements on the PGPPP

The PGPPP provides funding to hospitals for salary and recruitment costs for backfilling the vacancy created in the hospital when doctors are released for general practice placements. However, despite the funding provided for backfilling, the Review identified issues such as difficulties in filling rosters and obtaining time off from hospitals as obstacles undermining the success of the Program. Feedback provided to the Review indicates that junior doctors are only able to participate in the Program during 'down times' and this raised concerns regarding safe working hours.

A National Advisory Committee (NAC) which includes representation from the Confederation of Postgraduate Medical Education Councils, Committee of Presidents of Medical Colleges, the Royal Australian College of General Practitioners, the Rural Doctors Association of Australia and the Department of Health and Ageing sets the direction for the Program.

As a solution, the NAC might consider more flexible working arrangements for doctors undertaking placements on the Program. A suggestion was made to the Review to establish 'demonstration sites' to trial the feasibility of part-time positions on the PGPPP.

Recommendation 7

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.

7.2 The NAC examine the feasibility of establishing some demonstration sites to test the feasibility of part-time placements.

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Australian General Practice Training Program

The Australian General Practice Training Program (AGPTP) is a postgraduate vocational training program for medical graduates who wish to pursue a career in general practice in Australia. The AGPTP is administered by General Practice Education and Training Limited (GPET). The number of participants of the AGPTP is provided at Appendix L and a description of the Program is provided at Appendix M.

Overseas trained doctors and former overseas medical students subject to section 19AB of the *Health Insurance Act 1973* may only access a Medicare provider number for placements on the Rural Pathway. Unrestricted doctors are able to access both the General and the Rural Pathways.

The Australian Medical Council examinations as a prerequisite for overseas trained applicants

The Australian Medical Council (AMC) examinations are designed to assess, for registration purposes, the medical knowledge and clinical skills of overseas trained doctors whose basic medical qualifications are not recognised in Australia.

The standard of the AMC examinations is defined as the level of attainment of medical knowledge, clinical skills and attitudes required of newly qualified graduates of Australian medical schools who are about to commence intern training.[15] The AMC examinations consist of a multiple choice examination and a clinical examination.

The AGPTP requires overseas graduate applicants to have sat and passed the AMC examinations prior to participating in the Program. Some stakeholders questioned whether this prerequisite was necessary. Requiring overseas graduates to sit and pass the AMC exams can increase their training requirements by two to three years, and as a result, delay their entry into the workforce.

On the other hand, many stakeholders expressed the view that the known standard of quality among Australian graduates may not necessarily be present in overseas graduates. By completing the AMC assessment process, there is some assurance that the doctors entering the APGTP have a comparable level of knowledge and competencies to their Australian counterparts. There is general agreement among stakeholders that overseas trained doctors should meet certain quality standards before being allowed to practice in Australia.

It was suggested that the AGPTP move towards a competency-based assessment to allow overseas graduates with suitable qualifications and experience to enter the Program in a more timely manner. However, until a suitable alternative is introduced, many believe that the AMC prerequisite should be retained.

It was noted that there is a separate pathway to the AMC assessment process applicable to overseas graduates. This is the specialist assessment procedure for overseas trained specialists seeking a determination of equivalency of training and qualifications with Australian trained specialists. The process is administered by the AMC and the actual assessment of the applicant's training and experience is undertaken by the relevant specialist medical college.

15 Extract from *Assessment of overseas medical qualifications in Australia*, AMC website at www.amc.org.au

In addition, up to seven specialist medical colleges are being funded by the Australian Government to establish pilot rapid assessment units in order to meet the recommended standards and processes arising from the Australian Competition and Consumer Commission reviews of specialist medical colleges.

Recommendation 8

GPET, the AMC and the relevant medical colleges to review the entry criteria for the AGPTP to enable overseas trained doctors with suitable qualifications (other than passing the AMC exam) and experience to enter the Program.

Approved Placements for Sports Physicians Program

At the time of undertaking this Review, the Australasian College of Sports Physicians (ACSP) was undergoing the Australian Medical Council (AMC) process for recognition of sports medicine as a medical specialty.

The 2003 Biennial Review recommended that the situation of sports medicine trainees who are subject to section 19AA be resolved in light of the ACSP's application for recognition as a medical specialty (recommendation 12). This recommendation led to the establishment of the Approved Placements for Sports Physicians Program in April 2004 (refer to *Chapter Two — Results of the recommendations made by the 2003 Biennial Review of the Medicare Provider Number Legislation*).

The Approved Placements for Sports Physicians Program allows affected doctors access to Medicare while the ACSP awaits the results of their AMC application for recognition as a specialty. Participants of the Program can access Al equivalent rebates for limited items on the Medicare Benefits Schedule. A description of the Program is provided at Appendix M.

While the Approved Placements for Sports Physicians Program itself is not time limited, Medicare provider numbers issued under the Program expire on 30 June 2006. This is the originally anticipated date of completion of the AMC's decision on whether or no to recognise the ACSP as a medical college and sports medicine as a speciality.

The AMC will require an estimated 12 months to process the ACSP's application and the ACSP will require an additional 12 months to implement the decision. Concern was expressed by the ACSP that the entire process may not be completed by 30 June 2006. This time limit has resulted in uncertainty among participants of the Approved Placements for Sports Physicians Program.

Recommendation 9

The Department of Health and Ageing 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 specialty and training program.

Streamlining the Medicare provider number application process

The 2003 Biennial Review made recommendations aimed at improving and streamlining the process for doctors in "Approved Placement Programs" (recommendation 16). The three areas of contention were:

1. the secrecy provisions under section 130 of the *Health Insurance Act 1973* (the Act) which prohibit administering bodies from accessing the provider number information of doctors on their 3GA program;
2. the current system that requires multiple Medicare provider numbers for each practice location; and
3. expiration of provider numbers resulting in the doctor's inability to attract Medicare benefits.

The current multiple provider number system

The Review found that, of the three areas listed above, the issue of multiple provider numbers continues to be a problem for some stakeholders. There continues to be broad concern regarding the amount of time, paperwork, confusion and the delays associated with the allocation of Medicare provider numbers.

Streamlining the application process is acknowledged to be difficult. Implementing the Medicare provider number legislation is complex and there are a number of authorities involved in the process. These include State and Territory health departments, medical boards, the various agencies delegated to administer the 3GA programs, Medicare Australia, and the Department of Health and Ageing, if the applicant is an overseas trained doctor subject to section 19AB of the Act.

The compliance burden can affect medical practitioners, patients, and communities, especially those in districts of workforce shortage who are trying to engage locums to cover absences or illnesses of their doctors.

Medicare provider numbers are issued to medical practitioners for the purpose of claiming Medicare benefits and are used to facilitate the payment of patient claims. Provider numbers uniquely identify practitioners who rendered services, and the locations from which services were rendered. They are used by Government to collect information regarding Medicare-related services rendered in a locality.

Representations were made to the Review to streamline the system so that doctors are not required to have an excessive number of location specific provider numbers. Stakeholders called for the relevant bodies to get together to discuss ways to improve the process.

With the projected increase in the number of vocational training placements required to cater for the medical graduates coming through the system in the near future, this issue has become even more pressing. It will also be an issue in any plan to expand training places to private clinical settings.

Recent improvements

The DoctorConnect website was launched by the Australian Government in May 2005. The website provides appropriately qualified overseas trained doctors online assistance to enter the Australian medical workforce. It contains information regarding Medicare provider numbers and enables downloading of a Medicare provider number application form. The website is supported by an email contact and call centre facility.

Medicare Australia (formerly the Health Insurance Commission) has introduced a Provider Directory System (PDS) on their website which allows health professionals to view and update certain provider and practice information recorded by Medicare Australia. By using the PDS, a provider can update information about his/herself or their practices as well as provide practitioners with information relating to practice addresses which are time and location specific.

The Department of Health and Ageing's online Districts of Workforce Shortage database enables a user to determine whether a particular locality within Australia is currently classified as a district of workforce shortage with respect to general practice.

The Australian Government is investigating other ways to streamline the process, including online submission of forms and, where possible, reducing the number of forms doctors are required to complete.

Recommendation 10

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".

10.2 The committee should comprise amongst others the Australian Medical Association, General Practice Education and Training, the Australian Rural and Remote Workforce Agencies Group, the National Association for Medical Deputising Australia, Medicare Australia and the Department of Health and Ageing.

Section 3GC

Medical Training Review Panel

The Medical Training Review Panel (MTRP) was established in 1996 and provides comprehensive advice on a wide range of medical issues, including medical workforce trends and the quality and availability of prevocational training and vocational training. The organisations that make up the Panel are listed at Appendix P.

Under section 3GC of the *Health Insurance Act 1973* (the Act), the Panel is required to compile information relating to 3GA training and workforce programs and the number of medical practitioners enrolled in these programs. The full text for section 3GC of the Act is at Appendix A.

The 2003 Biennial Review made a range of recommendations for the MTRP in relation to its membership, data collection and adequate intern positions for medical graduates. Most of these recommendations have been implemented (refer to *Chapter Two — Results of the recommendations made by the 2003 Biennial Review of the Medicare Provider Number Legislation*).

This Review found unanimous support for the continued operation of the Panel and its work in collecting data on medical training. MTRP members regard the Panel as a useful forum for a wide range of relevant organisations to discuss medical training issues, including the number of places available for junior doctors. Panel members generally regard the increased representation on the MTRP resulting from the 2003 Biennial Review recommendations as a positive outcome.

National Projects

The MTRP provides advice and support to improve the quality of training for junior doctors in their first two postgraduate years; that is, the years following the completion of their medical degree and before they enter specialty training programs. This work is primarily undertaken through the MTRP National Projects. Funding has been made available by the Department of Health and Ageing for these projects since 1998. To date, 31 projects have been funded.

A summary of the main projects funded to date can be found on the Confederation of Postgraduate Medical Education Councils' website at: www.cpmec.org.au/mtrpprojects/index.cfm

The Biennial Review received feedback during stakeholder consultations that the research grants funded through the National Projects lack monitoring and transparency. The Australian Medical Association suggested that the MTRP National Projects funding be utilised more effectively to address a range of issues including the projected increase in medical graduates. It also called for a more open and contestable process for project funding.[16]

Some stakeholders commented that many of the research projects undertaken under the National Projects have been State-based, with most projects not being made available nationally.

16 2005 Biennial Review of the Medicare Provider Number Legislation — AMA Submission, September 2005

The MTRP has been aware of these issues and, in February 2005, agreed to the engagement of an independent consultant to undertake an evaluation of the National Projects, with the aim of assessing and advising on their sustainability and national applicability.

The consultant's report was presented at the August 2005 meeting of the MTRP. During this meeting, the MTRP considered the consultant's report and agreed to establish a working party to develop an options paper regarding the future of the National Projects.

The working group held its first meeting in November 2005 and will report back to the MTRP at its next meeting in February 2006.

Augmenting the work of the MTRP

While most stakeholders support the work and data collection activities of the MTRP, many believe the Panel should report on other issues. With the availability of medical training opportunities being a strong driver of national workforce policy and planning, it would be useful if the MTRP reported on activities associated with capacity building and increasing the supply of training placements for new medical graduates.

This issue is discussed in more detail in the beginning of this chapter under *Increase in the number of medical school places and medical schools.*

Recommendation 11

11.1 The Review concludes that there is a need to maintain the role of the MTRP.

11.2 The MTRP should improve the process for the more effective use of funding provided under the National Projects.

Other issues

Anomaly in the legislation

The Review received representations regarding the impact of section 19AA of the *Health Insurance Act 1973* (the Act) on those overseas trained doctors who gain permanent residency in Australia before Fellowship. As temporary resident doctors, these practitioners are not subject to the Fellowship requirements of section 19AA of the Act as it only applies to permanent resident and Australian citizen overseas trained doctors and Australian graduates.

However, once these temporary resident doctors gain permanent residency in Australia, they are 'caught out' by section 19AA which requires them to be on either a workforce or training program established under section 3GA in order to continue accessing Medicare benefits. Stakeholders raised concerns regarding the inequalities between these two groups of overseas trained doctors.

On the other hand, the anomaly in the legislation means a temporary resident doctor can work in Australia for a number of years without being in a structured training pathway. Feedback provided to the Review suggests that the quality focus of section 19AA be applied to temporary resident doctors, not just to their permanent resident and Australian citizen counterparts. The RACGP submitted to the Review that temporary resident doctors who work in general practice for longer than six months should undergo compulsory assessment for suitability and competence, be provided with structured educational support, and be required to move to the Fellowship of the RACGP.[17] This would require legislative change to section 19AA of the Act.

There appears to be no national data available on the duration for which Medicare provider numbers are allocated to overseas trained doctors. The Review believes it is necessary to examine data on the number of temporary resident doctors who have been granted a provider number for six months or more to determine the impact of such a change.

The Department of Health and Ageing reports that it has been working with State and Territory health departments, medical registration boards, and major medical stakeholders to develop a nationally consistent model for the assessment and supervision of temporary resident overseas trained doctors who wish to enter general practice. The model is expected to be finalised in 2006.

Recommendation 12

The Department of Health and Ageing are to consider and if necessary meet with the appropriate agencies to determine the best method of collecting data on the number of temporary resident doctors who have been granted a provider number for six months or more. This data is to be available for the next Biennial Review.

17 RACGP submission to the 2005 Biennial Review of the Medicare Provider Number Legislation, 10 October 2005

Frequency of the Biennial Review

The Review found unanimous support for the continuation of the Biennial Review process. The process is seen as a useful means of monitoring the operation and impact of the Medicare provider number legislation and a significant forum for advancing the quality objectives of section 19AA of the *Health Insurance Act 1973* (the Act).

However, there were mixed views on the frequency of the reviews. Some stakeholders consider that the reviews come too soon with not enough time in between to implement recommendations. Those recommendations that have been implemented tend to be at their introductory stage at the time of the following review, making a proper evaluation premature. For these reasons, some stakeholders consider a three year period to be more appropriate. Such a change would require legislative amendment to section 19AD of the Act.

Others, on the other hand, indicate that the longer the time in between reviews, the slower it will take to implement the changes. For this reason, the review should retain its biennial frequency.

All agreed that with the projected increase in medical graduates from 2008, the Biennial Review would become even more relevant in 2007 and 2009.

Chapter Four — Summary of Recommendations

Section 19AA

Recommendation 1

Provide one more opportunity for doctors who meet the necessary criteria to be grandfathered onto the Vocational Register.

Medical graduates

Recommendation 2

The Medical Training Review Panel be directed to monitor and report regularly on the activities and progress being made to ensure adequate intern and training positions are in place to meet the increasing numbers of new medical graduates.

Section 3GA

Recommendation 3

3.1 The Review concludes that there is a need to maintain the current list of 3GA training and workforce programs and sees no need for any additional programs.

3.2 There should be increasing emphasis on standardised assessments, structured education, supervision and mentorship in all the workforce programs.

3.3 The Australian Government should consider further investment to support the quality and training aspects of the Rural Locum Relief Program, the Approved Medical Deputising Service Program and other 3GA workforce programs because of their value in providing quality care to the rural and remote regions of Australia and after hour services in urban areas.

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 process.

Queensland Country Relieving Doctors Program

Recommendation 4

The Department of Health and Ageing to monitor the progress of Queensland Health's review of the Queensland Country Relieving Doctors 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 the other 3GA workforce programs.

Rural Locum Relief Program

Recommendation 5

5.1 The Department of Health and Ageing are to establish a formal and representative committee, including non-RWA organisations (eg. groups associated with quality and training), to review the guidelines of the Rural Locum Relief Program (RLRP).

5.2 The review of the RLRP guidelines should take into account the recommendations of the 2003 Biennial Review not already implemented with particular emphasis on addressing quality assurance issues around assessment, mentoring, supervision and training.

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 (eg. more than 12 months) receive the appropriate assessment and training to achieve Fellowship of a recognised college.

Approved Medical Deputising Service Program

Recommendation 6

6.1 The Department of Health and Ageing are to complete and implement the revised guidelines for the AMDS Program in line with the recommendations of the 2003 review.

6.2 The Divisions of General Practice and local Medical Deputising Services (MDSs) are to develop closer co-operation to promote co-ordination between general practice and MDSs with particular emphasis on:

- participation of MDSs in Division Aged Care GP panels to assist in providing after hours services to residential aged care facilities (RACFs); and
- the possible use of MDSs in providing in-hours care to RACFs.

6.3 To streamline the administration of the Program, the Department of Health and Ageing are to extend the duration of both the deeds for MDSs and provider numbers for the doctors.

Prevocational General Practice Placements Program

Recommendation 7

7.1 The Australian Government monitor and plan to ensure there are adequate positions available to cover the increase in demand that will result from an increase in the number of medical graduates.

7.2 The National Advisory Committee examine the feasibility of establishing some demonstration sites to test the feasibility of part-time placements.

Australian General Practice Training Program

Recommendation 8

General Practice Education and Training, the Australian Medical Council (AMC) and the relevant medical colleges to review the entry criteria for the Australian General Practice Training Program to enable overseas trained doctors with suitable qualifications (other than passing the AMC exam) and experience to enter the Program.

Approved Placements for Sports Physicians Program

Recommendation 9

The Department of Health and Ageing 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 specialty and training program.

Streamlining the application process

Recommendation 10

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".

10.2 The committee should comprise amongst others the Australian Medical Association, General Practice Education and Training, the Australian Rural and Remote Workforce Agencies Group, the National Association for Medical Deputising Australia, Medicare Australia and the Department of Health and Ageing.

Medical Training Review Panel

Recommendation 11

11.1 The Review concludes that there is a need to maintain the role of the Medical Training Review Panel (MTRP).

11.2 The MTRP should improve the process for the more effective use of funding provided under the National Projects.

Anomaly in the legislation

Recommendation 12

The Department of Health and Ageing are to consider and if necessary meet with the appropriate agencies to determine the best method of collecting data on the number of temporary resident doctors who have been granted a provider number for six months or more. This data is to be available for the next Biennial Review.

Appendices

Appendix A — Extracts from the *Health Insurance Act 1973*

SECTION 19AA

Medicare benefits not payable in respect of services rendered by certain medical practitioners

(1) A Medicare benefit is not payable in respect of a professional service, rendered after the commencement of this section, if the person who rendered the service:

(a) first became a medical practitioner on or after 1 November 1996; and

(b) was not, at the time the service was rendered:

(i) a specialist (whether or not the service was rendered in the performance of the specialist's specialty); or

(i) a consultant physician (whether or not the service was rendered in the performance of the consultant physician's specialty); or

(i) a general practitioner; or

Note: For ***general practitioner***, see subsection 3(1).

(iv) subject to subsection (3), a person registered under section 3GA; or

(v) a person who is covered by an exemption under subsection 19AB(3), being a person who is neither an Australian citizen nor a permanent resident within the meaning of the Migration Act 1958.

Note: Subsection (5) gives a restricted meaning to the term ***professional service*** for the purposes of this section.

(2) A medicare benefit is not payable in respect of a professional service, rendered after the commencement of this section, if the medical practitioner on whose behalf the service was rendered:

(a) first became a medical practitioner on or after 1 November 1996; and

(b) was not, at the time the service was rendered:

(i) a specialist (whether or not the service was rendered in the performance of the specialist's specialty); or

(ii) a consultant physician (whether or not the service was rendered in the performance of the consultant physician's specialty); or

(iii) a general practitioner; or

Note: For ***general practitioner,*** see subsection 3(1).

(iv) subject to subsection (3), a person registered under section 3GA; or

(v) a person who is covered by an exemption under subsection 19AB(3), being a person who is neither an Australian citizen nor a permanent resident within the meaning of the *Migration Act 1958.*

Note 1: An effect of subsection 3(17) is that a service cannot be taken to be rendered on behalf of a medical practitioner if it is rendered by another medical practitioner.

Note 2: Subsection (5) gives a restricted meaning to the term ***professional service*** for the purposes of this section.

(3) Subparagraphs (1)(b)(iv) and (2)(b)(iv) only apply in relation to a professional service that was rendered:

(a) during the period in respect of which, and in the location in respect of which, the person is registered under section 3GA; or

(b) in such other circumstances (which may include circumstances relating to the period during which, or the location in which, services are rendered) as are specified in the regulations.

(4) For the purposes of this section, a medical practitioner who, on 1 November 1996:

(a) was a medical practitioner who had not commenced, or who had not completed, training as an intern; or

(b) was not an Australian citizen or a permanent resident within the meaning of the *Migration Act 1958;*

is taken to have first become a medical practitioner on 1 November 1996.

In this section:

intern means a medical practitioner who is undertaking:

(a) a period of internship (by whatever name called); or

(b) a period of supervised training (by whatever name called);
under a law of a State or Territory specified in the regulations (whether or not the medical practitioner is a resident in a hospital for some or all of that period).

professional service does not include:

(a) a service of a kind referred to in paragraph (b), (ba) or (c) of the definition of professional service in subsection 3(1); or

(b) a ***professional service*** (as defined in subsection 3(1)) that is constituted by assistance at an operation.

SECTION 3GA
Register of Approved Placements

(1) The purpose of this section is to provide for registration of certain medical practitioners in approved placements.

(2) The Commission is to establish and maintain a Register of Approved Placements.

(3) The Register may be maintained in any form, including as a computer record.

(4) A medical practitioner may apply to the Commission for registration under this section.

(5) If a medical practitioner makes an application and:

(a) a body specified in the regulations gives the Managing Director of the Commission written notice stating:

(i) that the applicant is enrolled in, or undertaking, a course or program of a kind specified in the regulations; and

(ii) the period over which, and the location in which, the applicant will be undertaking the course or program; or

(b) the applicant is, in accordance with the regulations, eligible for registration under this section;

the Managing Director must, within the required period under subsection (6), enter the applicant's name in the Register, together with the period in respect of which and the location in respect of which the applicant is registered.

(6) The ***required period*** for the purposes of subsection (5) is:

(a) if a notice was given to the Managing Director of the Commission under paragraph (5)(a) in connection with the application:

(i) the period of 14 days after the notice was received by the Commission; or

(ii) if the application was made after the notice was received—the period of 14 days after the application was received by the Commission; or

(b) if no such notice was given—the period of 14 days after the application was received by the Commission.

(7) The Managing Director must give the applicant written notice of the day on which the applicant's name is to be entered in the Register.

(8) The Commission may give a body specified in regulations made for the purposes of paragraph (5)(a) information about the following matters, to the extent that those matters relate to persons about whom the body has given a notice under paragraph (5)(a):

(a) the current state of the Register;

(b) additions to the Register;

(c) deletions from the Register.

SECTION 3GC
Medical Training Review Panel

(1) The Minister must, by instrument in writing, establish a Medical Training Review Panel.

(2) The functions of the Panel are:

(a) to compile such information relating to:

(i) courses and programs of a kind specified in regulations made for the purposes of subparagraph 3GA(5)(a)(i); and

(ii) medical practitioners who are enrolled in or undertaking, or who are available to enrol in or undertake, those courses and programs;

as the Minister determines in writing; and

(b) to publish the information in such a manner as the Minister determines in writing; and

(c) to establish and maintain a register of employment opportunities for medical practitioners, in such a form and containing such information as the Minister determines; and

(d) to compile information in relation to each medical college on the number of people who sit, and the number of people who pass, each examination held by the medical college for people seeking:

(i) admission to advanced training; or

(ii) admission to Fellowship of the college.

(3) The Minister may make written determinations relating to:

(a) appointment of persons as members of the Panel; and

(b) nomination of persons for such appointment.

(4) The Panel must, as soon as practicable after 30 June in each year, prepare and give to the Minister a report on its operations during the financial year that ended on that day.

(4A) The report prepared under subsection (4) must include the information compiled by the Panel under paragraph (2)(d) during the year concerned.

(5) The Minister must cause a copy of each report to be laid before each House of the Parliament within 15 sitting days of that House after the Minister receives the report.

(6) Determinations under this section are disallowable instruments for the purposes of section 46A of the *Acts Interpretation Act 1901*.

(6A) In this section, ***medical college*** means:

(a) an organisation declared by the regulations to be a professional organisation in relation to a particular specialty for the purposes of paragraph 3D(1)(a); or

(b) the Royal Australian College of General Practitioners.

SECTION 19AD
Reports by Minister

1. The Minister must cause a report setting out details of the operation of sections 3GA, 3GC and 19AA to be laid before each House of the Parliament:

   (a) on or before 31 December 1999; and

   (b) thereafter, at the end of each 2 year period commencing on a biennial anniversary of 31 December 1999.

2. Within 3 months after a report mentioned in paragraph (1)(b) is tabled, the Medical Training Review Panel must convene a meeting to discuss the report.

3. The Medical Training Review Panel must invite representatives of the following to attend a meeting mentioned in subsection (2):

   (a) a student or students representing those people enrolled at each university medical school in Australia; and

   (b) a representative of the National Rural Health Network.

4. The Minister must cause a record of the proceedings of a meeting mentioned in subsection (2) to be laid before each House of the Parliament within 20 sitting days after the meeting.

Appendix B — Terms of Reference

2005 Biennial Review of the Medicare Provider Number Legislation

1. In accordance with Section 19AD(1) of the *Health Insurance Act 1973* (the Act) the Minister for Health and Ageing is to table a report in Parliament on or before 31 December 2005 which examines the details of the operation of the Medicare provider number legislation contained under Sections 19AA, 3GA and 3GC of the Act.

   - Section 19AA of the Act restricts access to Medicare by Australian citizen or permanent resident doctors who were first recognised as medical practitioners after 1 November 1996 unless they hold Fellowship of a recognised medical college.
   - Section 3GA of the Act permits medical practitioners who are subject to Section 19AA of the Act to provide professional services that attract Medicare benefits through placements on approved training or workforce programs.
   - Section 3GC of the Act established the Medical Training Review Panel to examine the demand for and supply of medical training opportunities and to monitor the impact of the Medicare provider number arrangements.

2. The Minister has appointed The Hon Ron Phillips to review and report to him on these issues. Mr Phillips will hold bilateral discussions with all interested stakeholders concerning the issues covered in the Review, and an opportunity will be provided for public submissions to be made to the Review.

3. A Reference Group will be established to provide advice as required to Mr Phillips on the issues covered by the Review. The Reference Group is to include a representative or representatives from the following organisations:

   - Australian College of Rural and Remote Medicine
   - Australian Divisions of General Practice
   - Australian Health Workforce Officials Committee
   - Australian Medical Association Council of Doctors-in-training
   - Australian Medical Students' Association
   - Australian Medical Workforce Advisory Committee
   - Australian Rural and Remote Workforce Agencies Group Ltd
   - Committee of Presidents of Medical Colleges

- Confederation of Postgraduate Medical Education Councils
- General Practice Education and Training Ltd
- National Association for Medical Deputising Australia Ltd

4. The Reference Group will meet up to three times with Mr Phillips in the course of the Review as follows:
    - once in August to discuss issues to be covered by the Review prior to commencement of the bilateral discussions with interested stakeholders;
    - once in September to discuss issues raised by interested stakeholders; and
    - once in October to discuss issues raised in submissions to the Review and proposed recommendations drafted by the reviewer.

Appendix C — Organisations represented on the Reference Group

The Reference Group for the 2005 Biennial Review of the Medicare Provider Number Legislation comprised representatives from the following organisations:

- Australian College of Rural and Remote Medicine
- Australian Divisions of General Practice
- Australian Health Workforce Officials Committee
- Australian Medical Association Council of Doctors-in-training
- Australian Medical Students' Association
- Australian Medical Workforce Advisory Committee
- Australian Rural and Remote Workforce Agencies Group Ltd
- Committee of Presidents of Medical Colleges
- Confederation of Postgraduate Medical Education Councils
- General Practice Education and Training Ltd
- National Association for Medical Deputising Services Australia Ltd

Appendix D — Organisations and individuals consulted

Health Departments

Australian Department of Health and Ageing
ACT Health
Department of Health and Human Services, Tasmania
Department of Human Services, Victoria
NSW Health
NT Department of Health and Community Services
Queensland Health
SA Department of Human Services
WA Department of Health

State and Territories Medical Boards

Medical Board of NSW
Medical Board of Queensland
Medical Board of South Australia
Medical Board of the ACT
Medical Board of the Northern Territory
Medical Board of Western Australia
Medical Council of Tasmania
Medical Practitioners Board of Victoria

Rural Workforce Agencies

Australian Rural and Remote Workforce Agencies Group
Northern Territory Remote Health Workforce Agency
NSW Rural Doctors Network
Health Workforce Queensland
Rural Doctors Workforce Agency, South Australia
Rural Workforce Agency, Victoria
Tasmanian General Practice Divisions Ltd
Western Australian Centre for Remote and Rural Medicine

Recognised Specialist Colleges

Committee of Presidents of Medical Colleges
Australasian College for Emergency Medicine
Australasian College of Dermatologists
Australian and New Zealand College of Anaesthetists
The Royal Australasian College of Physicians

The Royal Australasian College of Surgeons
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
The Royal Australian and New Zealand College of Ophthalmologists
The Royal Australian and New Zealand College of Psychiatrists
The Royal Australian and New Zealand College of Radiologists
The Royal Australian College of General Practitioners
The Royal Australian College of Medical Administrators
The Royal College of Pathologists of Australasia

Other Stakeholders

Medical Training Review Panel
Australasian College of Sports Physicians
Australian College of Rural and Remote Medicine
Australian Divisions of General Practice Ltd
Australian Health Workforce Officials Committee
Australian Medical Association
Australian Medical Association Council of Doctors-in-training
Australian Medical Council
Australian Medical Students' Association
Australian Medical Workforce Advisory Committee
Confederation of Postgraduate Medical Education Councils
Consumers' Health Forum of Australia
Department of Immigration and Multicultural and Indigenous Affairs
General Practice Education and Training
Medicare Australia
National Aboriginal Community Controlled Health Organisation
National Health Workforce Secretariat
National Rural Health Alliance
Metro Medic
Rural Doctors Association of Australia

Approved Medical Deputising Service Program Stakeholders

National Association for Medical Deputising Australia Ltd
After Hours (Newcastle) Medical Service
After Hours (Northside) Medical Service
After Hours Doctor Pty Ltd
Australian Locum Medical Service
Chevron After Hours Medical Service
Eastern Suburbs Medical Service
Family Care Medical Service
GP After Hours Armadale
GP Solutions
Medcall
Medeco After Hours

Melbourne Medical Locum Service
Millennium Medical Deputising Service
Sydney Medical Service Co-op
WA Deputising Medical Service

Approved Private Emergency Department Program Stakeholders

Australian Private Hospitals Association
Epworth Hospital
Greenslopes Private Hospital
Holy Spirit Northside Private Emergency Service

Appendix E — Copy of advertisement calling for submissions

2005 Biennial Review of the Medicare Provider Number Legislation

The Hon Ron Phillips has been appointed by the Minister for Health, the Hon Tony Abbott MP, to review and report on the operation and impact of Sections 19AA, 3GA and 3GC of the *Health Insurance Act 1973* (the Act). The report is required to be tabled in Parliament by 31 December 2005.

- Section 19AA of the Act restricts access to Medicare by Australian citizen or permanent resident doctors who were first recognised as medical practitioners after 1 November 1996 and do not hold Fellowship of a recognised medical college.
- Section 3GA of the Act permits medical practitioners who are subject to Section 19AA of the Act to provide professional services that attract Medicare benefits through placements on approved training or workforce programs.
- Section 3GC of the Act established the Medical Training Review Panel to examine the demand for, and supply of, medical training opportunities and to monitor the impact of provider number arrangements.

Interested parties are welcome to forward written submissions to the Review and should do so no later than COB, Friday 30 September 2005.

Mr Phillips will be holding bilateral stakeholder consultations in a number of cities during August and September 2005. It is recommended that interested parties visit the Health Workforce web page at www.health.gov.au/workforce/index.htm for further information on the Review, including Mr Phillips' travel schedule.

Interested parties who wish to tender a submission, attend consultation meetings or require further information should contact the Review Secretariat at:

The Secretariat
2005 Biennial Review of the Medicare Provider Number Legislation
MDP 50
GPO Box 9848
CANBERRA ACT 2601
Email to: biennial.review@health.gov.au
Telephone: (02) 6289 7918

Appendix F — Copy of web page provided on Department of Health and Ageing website

2005 Biennial Review of the Medicare Provider Number Legislation

Overview

There is a requirement under the *Health Insurance Act 1973* (the Act) for the impact of the Medicare provider number legislation to be reviewed on a biennial basis. This legislation prevents Australian citizen or permanent resident doctors who were first recognised as medical practitioners after 1 November 1996 and who have not achieved Fellowship from a recognised medical college from accessing Medicare. An exception may be made where the medical practitioner is participating in an approved training or workforce program.

The 2005 Biennial Review of the Medicare Provider Number Legislation will commence in late August 2005. Utilising information from submissions, consultations with key stakeholders and literature and data analysis, the Review report will provide advice and recommendations to the Minister on how the operations of Sections 19AA, 3GA and 3GC of the Act may be improved. In accordance with legislative requirements, the Review report will be tabled in Parliament by 31 December 2005.

2005 Biennial Review Arrangements

Terms of Reference for the Review

In accordance with Section 19AD(1) of the *Health Insurance Act 1973* (the Act) the Minister for Health and Ageing is to table a report in Parliament on or before 31 December 2005 which examines the details of the operation of the Medicare provider number legislation contained under Sections 19AA, 3GA and 3GC of the Act.

- Section 19AA of the Act restricts access to Medicare by Australian citizen or permanent resident doctors who were first recognised as medical practitioners after 1 November 1996 unless they hold Fellowship of a recognised medical college.
- Section 3GA of the Act permits medical practitioners who are subject to Section 19AA of the Act to provide professional services that attract Medicare benefits through placements on approved training or workforce programs.

- Section 3GC of the Act established the Medical Training Review Panel to examine the demand for and supply of medical training opportunities and to monitor the impact of the Medicare provider number arrangements.

The Minister has appointed the Hon Ron Phillips to review and report to him on these issues. Mr Phillips will hold bilateral discussions with all interested stakeholders concerning the issues covered in the Review, and an opportunity will be provided for public submissions to be made to the Review.

A Reference Group will be established to provide advice as required to Mr Phillips on the issues covered by the Review. The Reference Group is to include a representative or representatives from the following organisations:

- Australian College of Rural and Remote Medicine
- Australian Divisions of General Practice
- Australian Health Workforce Officials Committee
- Australian Medical Association Council of Doctors-in-training
- Australian Medical Students' Association
- Australian Medical Workforce Advisory Committee
- Australian Rural and Remote Workforce Agencies Group Ltd
- Committee of Presidents of Medical Colleges
- Confederation of Postgraduate Medical Education Councils
- General Practice Education and Training Ltd
- National Association for Medical Deputising Australia Ltd

The Reference Group will meet up to three times with Mr Phillips in the course of the Review as follows:

- once in August to discuss issues to be covered by the Review prior to commencement of the bilateral discussions with interested stakeholders;
- once in September to discuss issues raised by interested stakeholders; and
- once in October to discuss issues raised in submissions to the Review and proposed recommendations drafted by the reviewer.

Public Submissions

Key stakeholder bodies and interested members of the public are invited to provide submissions to the Review. A public notice calling for submissions to the Review will be placed with the Australian Doctor and the Medical Observer on Friday 26 August 2005 and the Weekend Australian on Saturday 27 August 2005. The deadline for submissions is close of business 30 September 2005. Submissions to the Review should be forwarded to the Review Secretariat. Contact details of the Review Secretariat.

Interested parties providing submissions which contain confidential information should indicate clearly which parts of the document are subject to confidentiality.

However, it should be noted that submissions received for the Review are subject to the Commonwealth *Freedom of Information Act 1982* (the FOI Act). The FOI Act extends, as far as practicable, the right of the Australian community to access information (generally documents) in the possession of the Australian Government. This right is limited only by exceptions and exemptions which may be applied to documents to protect the public interest and the private and business affairs of persons in respect of whom information is collected and held by departments and public authorities. This means that organisations or other people may request that a copy of the submission be made available to them under the FOI Act, and such requests would have to be given proper consideration.

Public Consultations

Mr Phillips will be conducting bilateral stakeholder consultations in all capital cities around Australia to discuss issues covered by the Review. Mr Phillips' travel schedule is as follows:

Adelaide	31 August and 1 September
Sydney	5 and 6 September
Perth	8 and 9 September
Melbourne	14 and 15 September
Hobart	16 September
Brisbane	20 and 21 September
Darwin	22 September
Canberra	27 and 28 September

Interested parties who would like to arrange meetings should contact the Review Secretariat in the first instance to set up a booking with Mr Phillips. Contact details of the Review Secretariat.

Background

The Biennial Review of the Medicare Provider Number Legislation is a requirement under Section 19AD(1) of the *Health Insurance Act 1973* (the Act). This Section of the Act states that the Minister must cause a report setting out details of the operation of Sections 19AA, 3GA and 3GC to be laid before each House of Parliament by 31 December.

Sections 19AA, 3GA and 3GC were included in the Act in 1996 and form key elements of what are collectively known as the Medicare provider number legislation. They ensure that all medical practitioners are appropriately skilled to enter into unsupervised medical practice.

A copy of the second reading speech for the 1996 amendment to the Act to change the provider number eligibility requirements is on pages 5799 to 5801 of Hansard, Thursday 17 October 1996.

The Review will not cover the provider number restrictions under Section 19AB of the Act which apply to overseas trained doctors. However, the impact of Sections 19AA and 3GA on permanent resident and Australian citizen overseas trained doctors is part of this Review.

Section 19AA

Section 19AA of the Act restricts access to Medicare benefits by Australian citizen or permanent resident doctors who were first recognised as medical practitioners after 1 November 1996 and do not hold Fellowship of a recognised medical college.

Section 3GA

Section 3GA of the Act permits medical practitioners who are subject to Section 19AA of the Act to provide professional services that attract Medicare benefits through placements on approved training or workforce programs. Programs approved under this Section include:

- most specialist college training programs;
- the Australian General Practice Training Program; and
- a number of workforce programs such as the Rural Locum Relief Program, the Approved Medical Deputising Service Program for after hours medical deputising services, and the Approved Private Emergency Department Program.

A complete list of Section 3GA programs is at Annex A.

Section 3GC

Section 3GC of the Act established the Medical Training Review Panel (MTRP) to examine the demand for, and supply of, medical training opportunities and to monitor the impact of provider number arrangements.

2003 Biennial Review

The 2003 Biennial Review of the Medicare Provider Number Legislation was undertaken by the Hon Ron Phillips. The Minister for Health, the Hon Tony Abbott MP, approved the tabling of the report on 23 December 2003. The report was presented out-of-session to Parliament on 24 December 2003.

Overall, the 2003 Biennial Review found that the provider number legislation is working well. The Fellowship requirements for access to a Medicare provider number were strongly endorsed and the workforce measures were generally supported. There was strong support for the work of the MTRP in examining medical training programs and opportunities. However, Mr Phillips made 16 recommendations aimed at improving the operation of Sections 19AA, 3GA and 3GC of Act.

Background information on the 2003 Biennial Review, including a list of the 16 recommendations, can be found at the link below:

2003 Biennial Review

The 1999 Mid-Term Review was also undertaken by the Hon Ron Phillips. The Review report can be found at the link below:

1999 Mid-Term Review

Contact Details for the Review

For further information on the Biennial Review, please contact the Biennial Review Secretariat on telephone (02) 6289 7918 or via email. Written correspondence may be forwarded to:

The Secretariat
2005 Biennial Review of Provider Number Legislation
MDP 50
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2600

Appendix G — Indicative questions asked during the stakeholder consultations

Operation of Section 19AA

Q: What impact has the operation of Section 19AA had upon the quality of training of the medical workforce (including hospital doctors)?

Operation of Section 3GA

Q: What impact has the operation of Section 3GA had upon the quality of training of the medical workforce?

Q: Is there adequate access to the courses and programs available under Section 3GA?

Q: What impact has the operation of Section 3GA had upon the supply and distribution of the medical workforce?

Q: In what ways can training and employment alternatives available under Section 3GA be improved?

Operation of Section 3GC

Q: Has the MTRP been successful in fulfilling its requirements to compile and publish information relevant to the administration of courses and programs under Section 3GA?

Q: Has the MTRP effectively examined and monitored the demand for and supply of medical training opportunities and the impact of the legislation?

Q: Does the composition and membership of the MTRP provide effective representation of relevant client groups?

Other issues

Q: Can you identify any unintended consequences of this legislation?

Q: What impact has the information and recommendations contained in the 2003 Biennial Report had upon the operation of the legislation?

Appendix H — List of submissions received

Organisations

ACT Division of General Practice Ltd
After Hours (Newcastle) Medical Service
After Hours Doctor (Hobart)
Australasian College of Sports Physicians
Australian and New Zealand College of Anaesthetists
Australian Divisions of General Practice
Australian Locum Medical Service
Australian Medical Association
Australian Private Hospitals Association
Australian Rural and Remote Workforce Agencies Group
Department of Human Services, Victoria
Epworth Hospital
Medcall Pty Ltd
Medeco Pty Ltd
Melbourne Medical Locum Service
Queensland Health
Rural Workforce Agency Victoria
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
The Royal Australian College of General Practitioners
The Royal College of Pathologists of Australasia
Western Australian Centre for Remote and Rural Medicine

Individuals

Dr Erich Heinzle
Dr Sabita Banik
Mr Ray Thallur

Total 24 submissions received

Appendix I — Number of general practitioners

Table I.1: Number of GPs since 2002 by OMP[a], FRACGP, RACGP trainee and Vocationally Registered (VR) GP by financial year

Year[b]	OMP		RACGP Trainee		VR GP		FRACGP		Total
	Number	%	Number	%	Number	%	Number	%	GPs
2002–03	4,426	18.2	1,111	4.6	12,641	52.1	6,082	25.1	24,260
2003–04	4,109	16.9	1,140	4.7	12,315	50.6	6,759	27.8	24,323
2004–05	4,098	16.6	1,230	5.0	12,044	48.8	7,297	29.6	24,669

Figures based on date-of-processing and derived major speciality[c], for reference period for medical practitioners billing Medicare.

GP — General Practitioner

OMP — Other Medical Practitioner

FRACGP — Fellow of the Royal Australian College of General Practitioners

RACGP Trainee — Registrar on the Australian General Practice Training Program

VR[d] GP — Vocationally Registered General Practitioner

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a If the doctor's derived major specialty in the last quarter of the reference period is included in the Other Medical Practitioners (OMPs) classification listed below, then the doctor is tagged as an OMP.

104 Other non specialist, pre-November 1996
110 Othe r non specialist, from November 1996
202 Procedural GP, non recognised
203 Procedural sports physician
186 Remote OMP
187 Fellow of the Australasian College of Sports Physicians
196 Rural and Remote Area Placement Program
198 Temporary resident OMP
188 Medicare Plus pre 1996 OMP (restricted) — from February 2004
189 Medicare Plus pre 1996 OMP (un-restricted) — from February 2004
199 MDS After Hours OMP — from August 2004
178 Pre vocational GP Placement Program — from January 2005
615 Outer metropolitan OMP

b Yearly figures are based on the last quarter of the reference period. A doctor may have been an active RACGP trainee for the first half of the year, completed his or her training and billed as FRACGP for the rest of the year. In this case, the doctor will not be included as an RACGP trainee in the above table. Figures in this table for RACGP trainees will not therefore match those in Appendix L due to the different methods of extracting data.

c The classification for major specialty is derived from a combination of the doctor's registered specialty and the types of claims processed.

d Vocational Registration was available for GPs from 1989 to 1996. Refer to *Chapter Three — Section 19AA — Vocational Recognition* for more information.

Appendix J — Number of training positions/programs

Table J.1: Number of vocational training positions/trainees in programs in 2004 and the likely number of first year vocational training places to be offered for commencement in 2005, by medical college/faculty/vocational training organisation[a]

College / Faculty	Total number of vocational training placements 2004	% Total	First year advanced vocational training placements likely to be available in 2005	% Total first year
Australian and New Zealand College of Anaesthetists [a,b,c]	465	7.3	153	8.6
Australasian College of Dermatologists[c]	61	0.9	3	0.2
Australasian College for Emergency Medicine [a,c,d]	471	7.4	108	6.1
General Practice Education and Training[c]	1,569	24.6	624	35.0
Joint Faculty of Intensive Care Medicine — Australia and NZ College of Anaesthetists and Royal Australasian College of Physicians [c,e]	146	2.3	[f]	[f]
Royal Australasian College of Medical Administrators [c]	96	1.5	27	1.5
Royal Australian and New Zealand College of Obstetricians and Gynaecologists [c]	292	4.6	48	2.7
Royal Australian and New Zealand College of Ophthalmologists [a]	105	1.6	25	1.4
Royal College of Pathologists of Australasia [c,h]	273	4.3	46	2.6
Royal Australasian College of Physicians — Adult Medicine Division [a,c,i]	663	10.4	257	14.4
Royal Australasian College of Physicians — Paediatrics and Child Health [a,c,j]	258	4.0	97	5.4
Royal Australasian College of Physicians — Australasian Faculty of Occupational Medicine [c]	62	0.9		
Royal Australasian College of Physicians — Australasian Faculty of Public Health Medicine [c,k]	65	1.0	18	1.0
Royal Australasian College of Physicians — Australasian Faculty of Rehabilitation Medicine [c]	118	1.8	29	1.6
Royal Australian and New Zealand College of Psychiatrists	725	11.4	115	6.4
Royal Australian and New Zealand College of Radiologists — Radiodiagnosis[c]	241	3.8	21	1.2
Royal Australian and New Zealand College of Radiologists — Faculty of Radiation Oncology [c]	68	1.1	14	0.8
Royal Australasian College of Surgeons [a]	709	11.1	197	11.1
TOTAL	**6387**	**100.0**	**1782**	**100.0**

a For those colleges that require a period of recognised basic training prior to commencing advanced training, the details on basic training positions/programs have been summarised in table 10 of the Medical Training Review Panel Eighth Report, November 2004.

b The data provided are the number of registered, financial trainees. From 2004, the Australian and New Zealand College of Anaesthetists training program has changed to include a basic component (years 1–2) and an advanced component (years 3–5) so the data presented in this table are different from that presented in previous MTRP reports (1997 to 2003) as it only relates to advanced trainees in years 3 to 5 of the program.

c The data provided are for advanced trainees in a training program, not accredited training positions.

d The Australasian College for Emergency Medicine does not limit entry to advanced training. Once provisional trainees have completed all provisional training requirements, they move into advanced training. Accordingly, the number of first year advanced trainees is dependent upon the number of provisional trainees who complete all requirements.

e The Australian and New Zealand College of Anaesthetics and the Royal Australasian College of Physicians (RACP) offer a joint training program in intensive care through the Joint Faculty of Intensive Care Medicine. There were 18 trainees registered in this program. To avoid any double counting the trainees have been included in the HFICM total and removed from the RACP total.

f The nature of the intensive care training program means that the great majority of trainees are in the third, fourth or fifth year of the training program. This is because training years 1, 2 and 3 often are undertaken in a primary specialty such as anaesthesia, medicine or related disciplines. Therefore, it is not possible to accurately estimate the number of trainees in intensive care in their first year of training (which is only likely to be a small number of trainees).

g Total number of training placements available, the actual number of trainees may differ depending upon the final number of suitable applicants.

h The Royal College of Pathologists of Australasia (RCPA) and the RACP offer joint training program in the subspecialties of haematology and immunology. Currently there are 70 trainees registered in these programs, and so as to avoid any double counting the numbers have been included in the RCPA total and removed from the RACP total.

i The 88 RACP Adult Medicine Division advanced trainees in joint training program (18 intensive care, 2 chemical pathology/ endocrinology, 58 haematology and 10 immunology) have not been included in the RACP total to avoid any possibility of double counting; as joint training relates to advanced trainees only, the number of basis trainees noted in table 10 is not affected.

j Paediatric advanced trainees in joint training programs have been excluded from this table to avoid any possibility of double counting; the relevant number is 3 in haematology, 3 in immunology and allergy and 3 in intensive care. As joint training relates to advanced trainees only, the number of basics trainees noted in table 10 of the Medical Training Review Panel Eighth Report is not affected.

k Includes 8 trainees currently training overseas.

Source: Medical Training Review Panel Eighth Report, November 2004, pages 11–12

Table J.2: Number of advanced vocational training positions/trainees in programs in 2005 and the likely number of first year vocational training places to be offered for commencement in 2006, by medical college/faculty/vocational training organisation

College / Faculty	Total number of vocational training placements 2005[a]	% Total	Total college trainee numbers	First year advanced vocational training placements likely to be available in 2006	% Total first year
Australian and New Zealand College of Anaesthetists [a,c,d]	477	7.9	795	159	8.4
Australasian College of Dermatologists[d]	60	1.0	17	0.9	
Australasian College for Emergency Medicine [a,c,e]	458	7.6	689	122	6.4
General Practice Education and Training [d]	1905	31.4	626[f]	33.0	
Joint Faculty of Intensive Care Medicine — Australia and NZ College of Anaesthetists and Royal Australasian College of Physicians [d,g]	187	3.1	[h]	-	
Royal Australasian College of Medical Administrators [d]	81	1.3	27	1.4	
Royal Australian and New Zealand College of Obstetricians and Gynaecologists [d]	299	4.9	56	3.0	
Royal Australian and New Zealand College of Ophthalmologists [a]	53	0.9	101	22	1.2
Royal College of Pathologists of Australasia [d,i]	282	4.7	58	3.1	
Royal Australasian College of Physicians — Adult Medicine Division [a,d,j]	672	11.1	1398	274	14.4
Royal Australasian College of Physicians — Paediatrics and Child Health [a,d,k]	234	3.9	433	89	4.7
Royal Australasian College of Physicians — Australasian Faculty of Occupational Medicine [d]	72	1.2	0	0	
Royal Australasian College of Physicians — Australasian Faculty of Public Health Medicine [c,l]	71	1.2	12	0.6	
Royal Australasian College of Physicians — Australasian Faculty of Rehabilitation Medicine [d]	118	1.9	30	1.6	
Royal Australian and New Zealand College of Psychiatrists [a n]	87	1.4	725	142	7.5
Royal Australian and New Zealand College of Radiologists — Radiodiagnosis [c]	263	4.3	9	0.5	
Royal Australian and New Zealand College of Radiologists — Faculty of Radiation Oncology [c]	77	1.3	15m	0.8	
Royal Australasian College of Surgeons [a, o]	663	10.9	1156	240	12.6
TOTAL	6059	100.0		1898	100.0

a For those colleges that require a period of recognised basic training prior to commencing advanced training, the details on basic training positions/programs have been summarised in Table 3.11 of the Medical Training Review Panel Ninth Report, December 2005.

b These data represent an aggregation of both advanced and basic trainees for medical college training programs for which this is applicable.

c The data provided are the number of registered, financial trainees.

d The data provided are for trainees in a training program, not accredited training positions.

e The Australasian College for Emergency Medicine does not limit entry to advanced training. Once provisional trainees have completed all provisional training requirements they move into advanced training. Accordingly, the number of first year advanced trainees is dependent upon the number of provisional trainees who complete all requirements.

f Total number of training placements available, the actual number of trainees may differ depending upon the final number of suitable applicants.

g The Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians (RACP) offer a joint training program in intensive care through the Joint Faculty of Intensive Care Medicine (JFICM). There were 18 trainees registered in this program. To avoid any double counting the trainees have been included in the JFICM total and removed from the RACP total.

h The nature of the intensive care training program means that the great majority of trainees are in the third, fourth or fifth year of the training program. This is because training years 1, 2 and 3 often are undertaken in a primary specialty such as anaesthesia, medicine or related disciplines. Therefore, it is not possible to accurately estimate the number of trainees in intensive care in their first year of training (which is only likely to be a small number of trainees).

i The Royal College of Pathologists of Australasia (RCPA) and the RACP offer joint training programs in the subspecialties of haematology, immunology, chemical pathology/endocrinology and microbiology/infectious diseases; currently there are 82 trainees registered in these programs and so as to avoid any double counting the numbers have been included in the RCPA total and removed from the RACP total.

j The 85 RACP Adult Medicine Division advanced trainees in joint training programs (6 intensive care, 3 chemical pathology/endocrinology, 63 haematology and 12 immunology) have not been included in the RACP totals to avoid any possibility of double counting. As joint training relates to advanced trainees only, the number of basic trainees noted in table 10 is not affected.

k Paediatric advanced trainees in joint training programs have been excluded from this table to avoid any possibility of double counting; the relevant number is 2 in haematology and 3 in immunology; as joint training relates to advanced training only, the number of basic trainees noted in table 10 is not affected.

l Includes 2 trainees currently training overseas.

m This number includes trainees who are eligible and elect to sit the Part II exams in August 2005. The number has also been determined using the 2004 Part II Exam pass rate.

n From 2004 the Royal Australian and New Zealand College of Psychiatrists Fellowship training has changed whereby the program now includes a minimum of 3 years basic training, followed by a minimum of 2 years advanced training. In 2004, numbers of trainees were reported as an aggregate; that is, the number of vocational trainees included both advanced and basic.

o Figures are 2004 data obtained from the Royal Australasian College of Surgeons College Activities Report, 31 December 2004. Actual 2005 figures will be published in the College Activity Report in early 2006.

Source: Medical Training Review Panel Ninth Report, December 2005

Appendix K —
Training courses and workforce programs approved under section 3GA of the *Health Insurance Act 1973*

Schedule 5 Matters specified for Register of Approved Placements (regulations 6E and 6EA)

Table K.1 Part 1 Specialist Training Programs		
Item	**Body**	**Qualification**
1	Australasian College of Dermatologists	FACD
2	Australasian College for Emergency Medicine	FACEM
3	Royal Australian College of Obstetricians & Gynaecologists	FRACOG
4	Australasian Faculty of Occupational Medicine	FACOM
5	Royal Australian College of Ophthalmologists	FRACO
6	Royal College of Pathologists of Australasia	FRCPA
7	Royal Australasian College of Physicians	FRACP FAFOM
8	Royal Australian and New Zealand College of Psychiatrists	FRANZCP
9	Australasian Faculty of Public Health Medicine	FAFPHM
10	Royal Australasian College of Radiologists	FRACR DRACR
11	Australasian Faculty of Rehabilitation Medicine	FAFRM
12	Royal Australasian College of Surgeons	FRACS

Table K.2 Part 2 Workforce Programs		
Item	**Body**	**Program**
1	Queensland Department of Health	Queensland Country Relieving Program
2	RACGP	RACGP Training Program
3	Commonwealth Department of Health and Ageing	Rural Locum Relief Program
4	NSW Rural Doctors Network Ltd.	Rural Locum Relief Program
5	Rural Workforce Agency Victoria Ltd.	Rural Locum Relief Program
6	Queensland Rural Divisions Coordinating Unit Inc.	Rural Locum Relief Program
7	South Australian Rural and Remote Medical Support Agency Inc.	Rural Locum Relief Program
8	University of Western Australia — West Australian Centre for Remote and Rural Medicine	Rural Locum Relief Program
9	Tasmanian General Practice Divisions Inc.	Rural Locum Relief Program
10	NT Remote Workforce Agency Inc.	Rural Locum Relief Program
12	Commonwealth Department of Health and Ageing	Assistance at Operations Program
13	Australasian College of Sports Physicians	Australasian College of Sports Physicians Training Program
14	Commonwealth Department of Health and Ageing	Approved Medical Deputising Service Program
15	Australian College of Rural and Remote Medicine	Rural and Remote Area Placement Program
16	Commonwealth Department of Health and Ageing	Approved Private Emergency Department Program
17	Commonwealth Department of Health and Ageing	Temporary Resident Other Medical Practitioner Program
18	General Practice Education and Training Limited (ACN 095 433 140)	Australian General Practice Training Program
19	Commonwealth Department of Health and Ageing	Metropolitan Workforce Support Program
20	Commonwealth Department of Health and Ageing	Special Approved Placements Program
21	Commonwealth Department of Health and Ageing	Approved Placements for Sports Physicians Program
22	Australian College of Rural and Remote Medicine	Prevocational General Practice Placements Program
23	Royal Australian College of General Practitioners	Prevocational General Practice Placements Program
24	General Practice Education and Training Limited (ACN 095 433 140)	Prevocational General Practice Placements Program

Part 3 Participatory eligibility programs

1 Specific Workforce Shortage Program

(1) This item relates to:

(a) the Specific Workforce Shortage Program established by the Minister for the placement of medical practitioners in locations otherwise underprovided with medical practitioners qualified to provide services in demand; and

(b) the associated registration of medical practitioners, under section 3GA of the Act, in the Register of Approved Placements.

(2) A medical practitioner who is an applicant under subsection 3GA (5) of the Act is eligible for registration if he or she:

(a) is awaiting:

(i) recognition, by the appropriate Australian medical college, of an acquired overseas specialist qualification; or

(ii) if he or she is an overseas trained doctor or former overseas medical student, within the meaning of section 19AB of the Act, who has an exemption under subsection 19AB (3) of the Act — recognition, by the Royal Australian College of General Practitioners, of his or her post-graduate general practice qualifications; and

(b) because of the circumstance mentioned in paragraph (a), has been accepted for participation in the Program to provide professional services.

Appendix L — Number of doctors on approved 3GA workforce programs

Section 3GA of the *Health Insurance Act 1973* (the Act) allows medical practitioners undertaking postgraduate education or placements on approved workforce programs to provide professional services that attract Medicare benefits. Workforce programs allow doctors who are otherwise restricted from accessing Medicare benefits due to section 19AA of the Act to be granted a Medicare provider number while undertaking placements in communities experiencing workforce shortage.

The tables below provide data on the number of participants in the 3GA workforce programs during 2003-04 and 2004-05. The descriptions of these workforce programs are provided at Appendix M.

Table L.1: Number of doctors[a] on 3GA placements for financial years 2003–04 and 2004–05

	Number of doctors				Australian trained		Overseas Trained Doctors[b]			
Program Name	Total Count		FWE[c]		Count		Total Count		Count	
	2003–04	2004–05	2003–04	2004–05	2003–04	2004–05	2003–04	2004–05	Subject to section 19AB	
AMDS Program	91	108	35	51	27	27	64	81	64	81
AGPTP	1495	1572	883	904	1113	1146	382	426	380	426
QCRD Program[d, e]	n/a	158	n/a	10	n/a	135	n/a	23	n/a	22
RLRP[d, f, g]	764	671	330	330	288	176	476	495	472	490
TROMPs[h]	73	68	28	29	0	0	73	68	0	0

Table L.2: Approved Medical Deputising Service Program — number of doctors by State/Territory[a] for financial years 2003–04 and 2004–05

	State/Territory								
Financial Year	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
2003-04	25	38	18	7	nfp	nfp	0	0	91
2004-05	22	64	14	nfp	nfp	0	0	0	108

Table L.3: Rural Locum Relief Program — number of doctors by State / Territory[a] for financial years 2003–04 and 2004–05

	State/Territory								
Financial Year	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
2003-04	176	126	356	36	27	nfp	28	nfp	764
2004-05	191	126	233	38	29	nfp	39	nfp	671

nfp = not for publication (cells have been suppressed for confidentiality concerns relating to small sample)

AMDS Program	Approved Medical Deputising Service Program
AGPTP	Australian General Practice Training Program
QCRD Program	Queensland Country Relieving Doctors Program
RLRP	Rural Locum Relief Program
TROMPs=	Temporary Resident Other Medical Practitioners Program

Source for Tables L.1–L.3: Department of Health and Ageing (GP Divisions and Information Branch)

The above figures are based on program specific specialty codes and eligibility start and end dates and on data processed to the end of September 2005.

Note that the above figures have been extracted using Medicare billing data. Some workforce programs have a large component of non-Medicare billing providers and have been annotated as such in the above tables (QCRD Program and TROMPs), or separated out in tables below (the Rural and Remote Area Placement Program and the Prevocational General Practice Placements Program).

The Approved Private Emergency Department Program, the Approved Placements for Sports Physicians Program, the Metropolitan Workforce Support Program and the Special Approved Placements Program have not been included in the above tables. The small numbers of participants on these programs and their corresponding FWEs make it impractical for inclusion in the tables.

a A single practitioner can actively participate in more than one 3GA program during the year, and may therefore be counted against multiple programs.

b Overseas trained doctors include 'former overseas medical students' i.e. persons who were not Australian citizens or permanent residents when they commenced study for their medical degree in Australia. It also includes doctors whose basic medical qualifications were obtained overseas but who were recognised medical practitioners in Australia prior to 1 January 1997 and are therefore not subject to section 19AB of the *Health Insurance Act 1973.*

c The average schedule fee of GP trainees was used for the calculation of FWE (Full-time Workload Equivalent) for the Australian General Practice Training Program. The average schedule fee for all other programs was based on Other Medical Practitioners as there was insufficient data to produce an average for each program.

d The Queensland Country Relieving Doctors (QCRD) Program did not have a separate specialty code allocated to it until September 2004. Prior to this, providers on the QCRD Program were assigned the same specialty code as the Rural Locum Relief Program (RLRP) providers.

e The data for the QCRD Program for 2004-05 captures only those Medicare-billing doctors who provided a locum service in the private practice of a Medical Superintendent Full-time or Medical Officer with Right of Private Practice. Approximately 450 relievers in total are sourced each year from Queensland Health hospitals (refer to the QCRD Program section in Chapter Three for more details).

f The Australasian College of Sports Physician (ACSP) Training Program did not have a separate specialty code allocated to it until July 2005. Prior to this, trainees of the ACSP Training Program were assigned the same specialty code as the RLRP providers. Table L.4 provides a more accurate head count for providers on the RLRP, however, the data in Table L.4 is a 'snapshot' of the number of RLRP doctors as at 30 June 2005, rather than the total numbers who were on the Program during the financial year.

g In 2003–04, 86% of providers enrolled in the RLRP were also enrolled in the Rural OMPs Program at some time during the reference period, entitling them to A1 rates. In 2004-05, 83% of providers enrolled in the RLRP were also enrolled in the Rural OMPs, also entitling them to A1 Medicare rebates.

h Doctors who were licensed or registered as a medical practitioner in Australia before 1 January 1997 and who do not have Fellowship of a recognised medical college were automatically placed on the Temporary Resident Other Medical Practitioners Program (TROMPs) in 2001 in order to preserve their access to Medicare. The data for the TROMPs in this table captures only those doctors on the Program who are actively billing Medicare. At the time of printing this report, 206 doctors have been placed on the TROMPs which suggests that the majority of these doctors are either practising in public hospitals, are overseas, or not practising medicine.

Table L.4: Rural Locum Relief Program — number of doctors by State/Territory at 30 June 2005	
State/Territory	**Number of Doctors**
New South Wales	152
Victoria	98
Queensland	93
South Australia	30
Western Australia	22
Tasmania	15
Northern Territory	18
Australian Capital Territory	N/A
Total	**428**

Source: Department of Health and Ageing (GP Divisions and Information Branch)

The tables below are the head counts (not Medicare-billing related) for the Australian General Practice Training Program (AGPTP), the Rural and Remote Area Placement Program (RRAPP) and the Prevocational General Practice Placements Program (PGPPP), as provided by the program areas within the Department of Health and Ageing. Data is for the first six months of the 2005 calendar year (AGPTP and PGPPP) and the 2004 calendar year (RRAPP). The 2004–05 headcount for AGPTP in Table L.1 does not equate to the total count in Table L.5 due to the different reporting periods used.

Table L.5: Australian General Practice Training Program — number of doctors by State/Territory* and Pathway — 1 January to 30 June 2005*			
State/Territory	**General Pathway**	**Rural Pathway**	**Total**
New South Wales	377	128	505
Victoria	242	179	421
Queensland	203	119	322
South Australia	59	54	113
Western Australia	55	41	96
Northern Territory	21	30	51
Tasmania	26	23	49
Total	**983**	**574**	**1557**

* AGPTP placements that occur in the ACT are covered by the NSW Regional Training Providers (RTP) as there is no separate RTP for the ACT.

** figures correct as at 31 March 2005.

Source: Department of Health and Ageing (GPET Management Unit, GP Programs Branch)

Table L.6: Rural and Remote Area Placement Program — number of placements by State/Territory — 1 January to 31 December 2004	
State/Territory	**Placements undertaken**
New South Wales	2
Victoria	6
Queensland	5
South Australia	11
Western Australia	12
Northern Territory	14
Tasmania	0
Australian Capital Territory	0
Total	**50**

Source: Department of Health and Ageing (GP Training and Incentives, GP Programs Branch)

Table L.7: Prevocational General Practice Placements Program — number of general practice placements from 1 January to 30 June 2005	
State/Territory	**Placements undertaken**
New South Wales	6
Victoria	8
Queensland	0
South Australia	31
Western Australia	8
Northern Territory	4
Tasmania	2
Australian Capital Territory	0
Total	**59**

Note: General practice placements undertaken during the first six months of operation of the Program

Source: Department of Health and Ageing (GP Training and Incentives, GP Programs Branch)

Appendix M — Description of workforce programs

Workforce Programs under section 3GA of the *Health Insurance Act 1973*

Health Insurance Regulations 1975, Schedule 5 (Regulation 6E) Part 2

Medicare provider number restrictions introduced in 1996 apply to prevocational and junior doctors. Section 19AA of the *Health Insurance Act 1973* (the Act) restricts access to Medicare benefits to Australian citizen or permanent resident doctors who were first recognised as medical practitioners after 1 November 1996 and who are neither vocationally recognised nor hold Fellowship of a recognised medical college.

Section 19AA aims to ensure doctors have appropriate qualifications. It also addresses workforce shortage and distribution issues. It requires Australian trained doctors as well as permanent resident and Australian citizen overseas trained doctors to acquire Fellowship of the Royal Australian College of General Practitioners (RACGP) or one of the medical specialist colleges before they are able to access Medicare.

There are exemptions from this general restriction for certain training and workforce programs. Section 3GA of the Act allows medical practitioners undertaking postgraduate education or placements on approved workforce programs to provide professional services that attract Medicare benefits. Exemptions for training programs, therefore, allow doctors to receive access to Medicare benefits while undertaking vocational training to receive Fellowship of the RACGP or one of the medical specialist colleges. This applies to most medical college training programs, including the Australian General Practice Training Program.

The exemptions for workforce programs reflect Australian Government concern about shortages in the medical workforce and the resulting difficulties experienced by some communities in accessing the services of GPs. Consequently, the Government has introduced a number of initiatives to ensure that medical services are provided where they are most needed. These 3GA workforce programs are described below.

Approved Medical Deputising Services Program

The purpose of the Approved Medical Deputising Services (AMDS) Program is to expand the pool of available medical practitioners who provide after hours only services on behalf of the Principal. These medical practitioners are eligible to provide a restricted range of professional services for which Medicare benefits will be payable if they work in an Approved Medical Deputising Service.

The AMDS Program was established under section 3GA of the Act in 1999 in response to concern about the shortage of medical practitioners providing after hours home visit services in metropolitan areas. Initially, the AMDS Program only covered home visits.

Following an independent review of the AMDS Program in 2001, the Program was extended to include work in accredited "after hours only" clinics operated by medical deputising services, provided they also offer after hours home visits.

The Program is administered by the Department of Health and Ageing.

Approved Placements for Sports Physicians Program

Sports medicine is not currently recognised as a medical specialty under the *Health Insurance Act 1973*. The Australasian College of Sports Physicians (ACSP) has submitted an application to the Australian Medical Council's Recognition of Medical Specialties Advisory Committee seeking recognition of sports medicine as a specialty. A review team is currently being established and an assessment of the sports medicine application will commence shortly.

The Approved Placements for Sports Physicians Program was established in April 2004 as an interim measure until such time as a decision is made on the College's application. The Program allows sports physicians to bill Medicare at the higher rate for selected items on the Medicare Benefits Schedule, pending the decision on the ACSP's application.

The Program is administered by the Department of Health and Ageing. Four practitioners have applied to the approved placement program to date.

Approved Private Emergency Department Program

Ideally all staffing of private emergency departments should be by emergency physicians, however, as demonstrated in an Australian Medical Workforce Advisory Committee report this will not be achieved until at least 2007. In the intervening period, private emergency departments may have difficulty recruiting adequate numbers of specialist emergency medical staff. One of the ways to meet this short term staffing need is to allow accredited private emergency departments access to a sessional pool of medical staff through the Approved Private Emergency Department (APED) Program.

The APED Program was established to enhance public access to private emergency departments by expanding the pool of doctors who are able to work in private hospital emergency departments. The Program allows advanced specialist trainees undertaking emergency medicine training to work under supervision in accredited private hospital emergency departments.

The Program is administered by the Department of Health and Ageing.

Australian General Practice Training Program

The Australian Government established General Practice Education and Training Limited (GPET) in March 2001 as an independent company to manage a new regionalised approach to general practice vocational training.

Since the beginning of 2002, GPET has managed the Australian General Practice Training Program (AGPTP) which aims to provide doctors with the knowledge, skills and attitudes necessary to undertake competent, unsupervised general practice; meet

their community's health care needs; and support the current and future goals of the Australian health care system. GPET separately contracts with 22 regional training providers to deliver the training.

The end point of the training program is vocational recognition through Fellowship of the Royal Australian College of General Practitioners (FRACGP). FRACGP enables general practitioners to access A1 Medicare rebates. As AGPTP placements are approved for the purposes of section 3GA of the Act, GP registrars can access Medicare when undertaking their supervised general practice terms.

General practice registrars applying to the training program can elect to train on either the Rural Training Pathway or the General Training Pathway. The Rural Pathway is designed for doctors willing to commit to undertake the majority of their training in RRMA 4–7 locations. Registrars undertaking their training on the Rural Pathway are eligible for generous financial and other incentives.

Registrars on the General Pathway are required to complete a six month rural placement and those based in State capital cities must also undertake a six month placement in an area of defined workforce shortage or area of consideration under the Outer Metropolitan Registrars Program.

As part of the Government's A Fairer Medicare package (retained under Strengthening Medicare), funding of $189.5 million over four years was provided for an additional 150 general practice vocational training places each year to assist in the provision of an adequate general practice workforce. The additional training places became available from the commencement of the 2004 training year, bringing the total number of available places each year to 600.

During the first half of the 2005 training year, a total of 1,557 GP registrars were enrolled in the training program, of which 983 were on the General Pathway and 574 were on the Rural Pathway.

The Government has also provided substantial additional funding to general practice training and support through the measures announced in Strengthening Medicare in 2003 which took effect in 2004. These measures include provision for increasing teaching allowances for supervisors, 100 additional supervisors for the training program, funding for accreditation of training practices, the establishment of new academic training posts for registrars, and support for general practitioners wishing to return to the workforce.

The Metropolitan Workforce Support Program

In November 2003, the Australian Government announced a range of overseas trained doctor initiatives as part of the Strengthening Medicare package, developed in response to overall medical workforce shortages in Australia. These initiatives sought to increase the supply of appropriately qualified overseas trained doctors working in Australia.

The Metropolitan Workforce Support Program (the 'Program') is a pilot project established under section 3GA of the Act. The aim of the Program is to alleviate the undersupply of general practitioners in the outer metropolitan areas of Perth by recruiting and placing 21 permanent resident overseas trained doctors by 31 December 2004. The Program is

also required to provide participating doctors with the necessary support to assist their achievement of vocational recognition by 31 December 2006.

This Program is being piloted in 'outer metropolitan districts of workforce shortage' and 'areas of consideration' in Perth.

Approximately 300 applications were received and 30 applicants were referred to the Royal Australian College of General Practitioners Western Australia for assessment. Fourteen placements were made. Approximately seven of these placed doctors are not likely to have achieved Fellowship by 31 December 2005, being the end date of the contract with Metro Medic, a co-operative of five general practice divisions. It is anticipated that up to six doctors will remain on the Program on 1 January 2006.

There is little evidence to suggest the pilot program would be more successful in other States as Metro Medic has implemented two marketing campaigns to increase participation rates including national advertising through websites.

Prevocational General Practice Placements Program

The Prevocational General Practice Placements Program is an initiative introduced by the Australian Government in November 2003, as part of the Strengthening Medicare package.

The Program aims to encourage junior doctors to take up general practice as a career. It provides up to 280 general practice placements each year in outer metropolitan, regional, rural and remote areas (Rural, Remote and Metropolitan Areas (RRMA) 3–7 locations). The eligible areas for the Program have recently been extended to include areas of workforce shortage and RRMA 2 locations on a case-by-case basis.

For the purposes of this Program, general practice placements can also be undertaken in Indigenous health services, refugee health services, migrant health services, and other areas of medical service need regardless of their location. General practice placements average 12 weeks.

Funding for the initiative is $70.3 million over four years. This includes funding for salaries, supervision and other infrastructure requirements to support the educational experience of junior doctors. Funding is also provided to hospitals for salary and recruitment costs for backfilling the vacancy created in the hospital when doctors are released for general practice placements.

The Program is managed by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) on behalf of the Department. ACRRM manages general practice placements in rural, remote and small regional areas. The RACGP manages general practice placements in larger regional and outer metropolitan areas.

A National Advisory Committee (NAC), which includes representatives from key general practice and medical organisations, provides policy advice to the Department and program guidance for the two organisations managing the Program.

General practice placements commenced in January 2005. Approximately 60 general practice placements were underway or had been completed by 30 June 2005. It is expected that approximately 200 placements will take place in 2005–06. A significant increase in uptake of the 280 available placements is expected in 2006–07.

Queensland Country Relieving Doctors Program

The Queensland Country Relieving Doctors (QCRD) Program provides a locum service to Queensland Health's rural medical practitioners by drawing on a pool of junior medical staff employed with the State's public hospitals. The QCRD Program is thought to have been in operation for at least 35 years.

The 3GA exemptions only apply to practitioners who are providing relief for Medical Superintendents or Medical Officers with Right of Private Practice, so not all practitioners in the Program require 3GA exemptions. Positions with Right of Private Practice are unique to Queensland. Such positions are generally in small rural localities where the hospital doctor also fulfils a general practice role. The 3GA component of the QCRD Program enables practitioners to provide services that attract Medicare benefits.

The QCRD Program is a valuable tool for Queensland Health in retaining medical practitioners servicing rural and remote communities in Queensland. The QCRD Program provides relief to approximately 160 rural medical practitioners throughout the State. Many of these are solo medical practitioners that would have limited opportunities for relief if they relied on the recruitment of private locums. Approximately 70 are Medical Officers with Right of Private Practice.

Rural and Remote Area Placement Program

The Rural and Remote Area Placement Program was established as a pilot program to increase the exposure of junior doctors (Postgraduate Years 1 to 3) to rural general practice. The Program commenced in April 2000 and was completed in December 2004. Rural general practice placements continue to be provided under the new Prevocational General Practice Placements Program.

Rural Locum Relief Program

The Rural Locum Relief Program was introduced in 1998 to help address the shortage of general practitioners providing services in rural and remote Australia. It enables doctors who are not otherwise eligible to access Medicare to have temporary access to Medicare benefits when providing services through approved placements in rural areas.

Rural Workforce Agencies (RWAs) in each State and the Northern Territory administer the Program on behalf of the Australian Government. Doctors without postgraduate qualifications who fall within the scope of the restrictions in section 19AA of the *Health Insurance Act 1973* are able to make an application to their respective State or Territory RWA for a placement on the Program. RWAs report that the Program is vital as a tool for recruiting doctors to rural and remote areas.

The objectives of the Program are to provide:

- an avenue through which doctors who are otherwise unable to provide services which attract a Medicare benefit to have temporary access to Medicare benefits to render general practice services in rural areas; and
- ensure doctors on this scheme are appropriately enrolled, supervised and supported in their placement.

Eligible locations for the Program are:

- small rural and remote areas and large remote centres (RRMA 4, 5,6 and 7);
- large rural centres (RRMA 3) that are districts of workforce shortage;
- "Areas of Consideration" (as determined by the Minister for Health and Ageing); and
- all Aboriginal Medical Services (including RRMA 1 or 2 locations).

These placements may be filled by doctors who are registered to practice in a particular State or Territory and have been assessed as having suitable experience and skills to practice in the particular location.

Medical practitioners on this scheme must be able to offer primary, continuing, comprehensive whole-person care for individuals, families and communities.

Special Approved Placements Program

The Special Approved Placements Program was established under section 3GA of the Act in December 2003. The Program allows medical practitioners to access Medicare benefits in metropolitan areas, if they can demonstrate exceptional circumstances that render them unable to participate in any other training or workforce programs established under section 3GA.

Exceptional circumstances include:

- substantial hardship due to particular family circumstances of the medical practitioner which is directly related to not being able to access Medicare benefits in a metropolitan area; and
- demonstrated serious illness of the medical practitioner or his or her immediate family and where treatment for the illness is limited to particular locations.

The Program is administered by the Department of Health and Ageing.

Temporary Resident Other Medical Practitioners Program

The Temporary Resident Other Medical Practitioners Program was established in 2001 to overcome an unintended consequence of legislative amendments that would have seen a number of temporary resident doctors who entered medical practice in Australia before 1 January 1997 lose access to Medicare. Affected long term temporary resident doctors were automatically placed on the Program in 2001 in order to preserve their access to Medicare.

The Program allows affected doctors to access Medicare for a transitional period, while they work towards attaining Fellowship.

The Program is administered by the Department of Health and Ageing.

Appendix N — Rural, Remote and Metropolitan Area Classification

The Rural, Remote and Metropolitan Area (RRMA) classification was developed in 1994 by the Departments of Human Services and Health and Primary Industries and Energy, based on earlier work by various researchers and agencies. It was developed as a broad measure of remoteness in response to the growing need for knowledge and information about issues of concern to rural and remote Australia and the lack of a suitable geographic classification.

The Australian Standard Geographical Classification produced by the Australian Bureau of Statistics (ABS) did not, at this time, address this need. The ABS participated in the development of a standard national classification of remoteness. RRMA was developed using 1991 Statistical Local Area (SLA) boundaries and population data from the 1991 Census.

The RMMA classification is currently under review by the Department of Health and Ageing. The Review aims to devise a more accurate classification method which includes measures relating to workforce shortage and the health and wellbeing of regions. The new classification method should be suited for use across the Department of Health and Ageing and capable of being regularly updated. Preferably the new method will also be applicable at a locality level.

RRMA classifies each SLA into three broad groups — metropolitan areas, rural areas and remote areas. These three broad groups are further broken down to a total of seven categories as described below:

1. **Metropolitan areas** consist of State and Territory capital city Statistical Divisions (SDs) plus other Statistical Subdivisions (SSDs) or groups of SSDs, which include urban centres of population 100,000 or more in size. There are two metropolitan categories:

   Category 1 — State and Territory capital city SDs; and

   Category 2 — Other metropolitan areas consisting of one or more SSDs which have an urban centre of population 100,000 or more in size. The SD, not the SLA, is the primary geographic unit for other metropolitan centres.

2. **Non-metropolitan areas** consist of rural and remote zones:

   Rural zones consist of non-metropolitan SLAs whose index of remoteness is less than or equal to 10.5. There are three rural categories:

   Category 3 — Large rural centres, comprising SLAs where most of the population reside in urban centres of population 25,000 or more;

Category 4 — Small rural centres, comprising SLAs in rural zones containing urban centres of population between 10,000 and 24,999 people; and

Category 5 — Other rural areas, comprising the remaining SLAs within the rural zone.

Remote Zones consist of those SLAs whose index of remoteness is greater than 10.5. There are two remote categories:

Category 6 — Remote centres, comprised of SLAs in the remote zone containing urban centres of population 5,000 or more people; and

Category 7 — the remaining SLAs within the remote zone.

Rural and remote centres are defined according to the population size of their associated urban centres, not according to the population size of their SLAs.

Source: Australian Government Departments of Primary Industries and Energy, and Human Services and Health Rural Remote and Metropolitan Area Classification 1991 Census Edition, November 1994.

Appendix O — Approved Medical Deputising Service Program service providers

NSW

After Hours (Newcastle) Medical Service
After Hours (Northside) Medical Service
Eastern Suburbs Medical Service
Sydney Medical Service Co-operative Ltd
Wollongong Radio Doctor

VIC

Australian Locum Medical Service
Casey Medical Deputising Service
Eltham Ridge Medical Deputising Service
Footscray Medical Deputising Service
Greenvale Medical Deputising Service
Melbourne Medical Locum Service
Millennium Medical Deputising Service
St Kilda Medical Deputising Service

QLD

Chevron After Hours Medical Service
Family Care Medical Services
Medcall
Medeco After Hours

SA

GP Solutions

WA

GP After Hours Armadale
West Australian Deputising Emergency Medical Service (Inc)

TAS

After Hours Doctor

21 service providers

Appendix P — Medical Training Review Panel member organisations

ACT Department of Health and Community Care
Australasian College for Emergency Medicine
Australasian College of Dermatologists
Australian and New Zealand College of Anaesthetists
Australian College of Rural and Remote Medicine
Australian Divisions of General Practice
Australian Government Department of Health and Ageing
Australian Medical Association
Australian Medical Association Council of Doctors-in-training
Australian Medical Council
Australian Medical Students' Association
Australian Medical Workforce Advisory Committee
Australian Salaried Medical Officers Federation
Confederation of Deans of Australian Medical Schools
Confederation of Postgraduate Medical Education Councils
Department of Health and Human Services Tasmania
Department of Health SA
Department of Health WA
Department of Human Services Victoria
General Practice Education and Training
Northern Territory Postgraduate Medical Council
NSW Department of Health
Queensland Health
Royal Australasian College of Medical Administrators
Royal Australasian College of Physicians
Royal Australasian College of Surgeons
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australian and New Zealand College of Radiologists
Royal Australian College of General Practitioners
Royal College of Pathologists of Australasia
Rural Doctors' Association of Australia

33 member organisations

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J.1 Number of advanced vocational training positions/trainees in programs in 2004

J.2 Number of advanced vocational training positions/trainees in programs in 2005

K.1 Specialist training programs approved under section 3GA

K.2 Workforce programs approved under section 3GA

L.1 Number of doctors on 3GA placements for financial years 2003–04 and 2004–05

L.2 Approved Medical Deputising Service Program — number of doctors by State/Territory for financial years 2003–04 and 2004–05

L.3 Rural Locum Relief Program — number of doctors by State/Territory for financial years 2003–04 and 2004–05

L.4 Rural Locum Relief Program — number of doctors by State/Territory at 30 June 2005

L.5 Australian General Practice Training Program — number of doctors by State/Territory and Pathway —1 January to 30 June 2005

L.6 Rural and Remote Area Placement Program — number of placements by State/Territory — 1 January to 31 December 2004

L.7 Prevocational General Practice Placements Program — number of general practice placements from 1 January to 30 June 2005

List of Acronyms

ABS	Australian Bureau of Statistics
ACRRM	Australian College of Rural and Remote Medicine
ACSP	Australasian College of Sports Physicians
AGPTP	Australian General Practice Training Program
AMA	Australian Medical Association
AMC	Australian Medical Council
AMDS	Approved Medical Deputising Service
AMWAC	Australian Medical Workforce Advisory Committee
APED	Approved Private Emergency Department
ARRWAG	Australian Rural and Remote Workforce Agencies Group
CPMEC	Confederation of Postgraduate Medical Education Councils
DoHA	Department of Health and Ageing
FRACGP	Fellowship of the Royal Australian College of General Practitioners
FTE	Full-time Equivalent
FWE	Full-time Workload Equivalent
GP	General Practitioner
GPRG	General Practice Representative Group
GPET	General Practice Education and Training
HIC	Health Insurance Commission
JFICM	Joint Faculty of Intensive Care Medicine
JMO	Junior Medical Officer
MDS	Medical Deputising Service
MS/MORPP	Medical Superintendent/Medical Officer with Right of Private Practice
MTRP	Medical Training Review Panel
NAC	National Advisory Committee
NAMDS	National Association for Medical Deputising Australia Ltd
OMP	Other Medical Practitioner
OTD	Overseas Trained Doctor
PDS	Provider Directory System
PGPPP	Prevocational General Practice Placements Program
PGY	Postgraduate Year
PGY 1	Postgraduate Year 1 (intern year)
PMEC	Postgraduate Medical Education Council
QCRD	Queensland Country Relieving Doctors

RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RCPA	Royal College of Pathologists of Australasia
RLRP	Rural Locum Relief Program
RMO	Resident Medical Officer
RRAPP	Rural and Remote Area Placement Program
RRMA	Rural, Remote and Metropolitan Area classification
Rural OMPs	Rural Other Medical Practitioners
RWA	Rural Workforce Agency
SD	Statistical Division
SSD	Statistical Subdivision
SLA	Statistical Local Area
TRD	Temporary Resident Doctor
TROMP	Temporary Resident Other Medical Practitioner
VR	Vocational Register/Vocationally Registered/Vocationally Recognised

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