Under the Stronger Rural Health Strategy, this initiative introduces a new Medicare Benefits Schedule (MBS) fee structure and identifies non-vocationally recognised (non-VR) doctors as a distinct group for Medicare Benefits Schedule (MBS) General Practitioner (GP) item claiming purposes. The changes:

- ensure that MBS fees payable reflect recognised levels of qualification
- reward and incentivise investment in postgraduate specialist qualifications
- encourage more doctors to work in regional, rural and remote areas.

 Fee structure
Non-vocationally recognised (non-VR) doctors will be able to bill a new set of MBS items, set at 80 per cent of what VR doctors can bill, unless they are on a recognised General Practice College training program. Non-trainee doctors who choose to practice in regional and rural areas will be able to bill a standard 80 per cent of the MBS item fee to which their more highly qualified specialist GP colleagues are entitled. Other billing restrictions will apply to non-VR doctors in metropolitan areas. The new MBS items for non-VR doctors are listed under Schedule A7, and replicate the existing GP items while setting the fee at 80%.

Doctors in private practice already have the power to charge fees above the MBS rebate level, and this will not change. Ultimately, fees charged by a practice for a doctor consultation reflects the practice’s business model and what can be borne by their patients. This will depend on the level of competition between doctors in a region.

Five year grandfathering of existing provisions will apply for current Other Medical Practitioners (OMPs) participants (until 30 June 2023). Relevant OMPs programs will stop taking new entrants from 1 January 2019.

The base rate for standard consultations for non-VR doctors has been increased by 20 per cent in regional, rural and remote areas. Those on a OMPs program will have five years to attain Fellowship. All non-VR doctors will be able to apply for additional assistance through new non-VR Fellowship support programs that will be run by the General Practice Colleges.

The new fee structure commenced on 1 July 2018 and applies to all services performed on and from that date.

Pathway to Fellowship
To bill 100 percent, non-VR doctors will need to be on an approved pathway for College Fellowship as a GP.

The new fee structure and access arrangements will affect all new non-VR doctors (other than those participating on approved training programs). There are no changes to the MBS fees payable to VR
Improved Access to Australian trained General Practitioners

GPs or to GP trainees on the Australian General Practice Training Program, Remote Vocational Training Scheme and ACRRM Independent Pathway.

**Rural and remote areas**

The Modified Monash Model (MMM) classification will be used to determine geographic eligibility. The MMM designation of any location can be identified using the DoctorConnect locator map at [www.doctorconnect.gov.au/locator](http://www.doctorconnect.gov.au/locator).

There are a large number of junior doctors who are not on a Fellowship program and are not able to practice under Medicare. A new workforce program commencing in 2019 will give them access to Medicare provider numbers if they practice supervised medicine in rural and regional areas. Under the changes, non–VR doctors in specified areas will be able to bill 80 per cent of the benefit available to VR doctors and GP trainees.

Non–VR doctors in MMM–1 locations will be restricted to the existing A2 and A19 items for standard GP services, with access to the new group A7 items for after hours and other general practice services beyond standard consultations.

**Further information**

Updates on progress of the reform and further information:

STRONGER RURAL HEALTH STRATEGY
Improved Workforce Planning Tool

Under the Stronger Rural Health Strategy, the Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) tool will be a single, integrated, quality source of health workforce and services data. The tool will provide sophisticated and comprehensive evidence to inform workforce planning and analysis. It will use newly defined geographic catchments to reflect where people live and where they access health services, as well as where health practitioners and services are located.

Investment

An investment of $14.4 million over four years from 2018-19 will support the creation of the new HeaDS UPP tool.

Workforce distribution

Although Australia has plenty of doctors, they are not well distributed according to local need. There is currently limited ability to measure and analyse the health service needs of a community, and apply the right resources to improve workforce distribution.

The HeaDS UPP Tool will provide a single source of quality data and evidence for workforce planners at the local, jurisdictional and national levels to inform decisions on where services and workforce are needed.

Users of the tool will be able to visually zoom in on a geographical region to view health workforce and service usage information about that area.

Quality data for workforce planners

The tool will bring together important source information such as Medicare Benefits Schedule data, Admitted Patient Care data, and Royal Flying Doctor Service data, and map them according to geographical regions, including the newly created GP Catchments areas.

By mapping this source data, the tool will allow planners to view health workforce information about particular geographic areas. The tool will be updated every six to 12 months with new information and functionality.

The newly created General Practice Catchments are a custom designed geography, constructed using the Australian Statistical Geographical Standard and based on a number of factors including patient flows, workforce, rurality, and topography. There are 829 non-overlapping GP catchment areas.

Rural Workforce Agencies will use the tool in their assessment of applications from overseas trained doctors under the Visas for General Practitioners – targeting areas of doctor shortage initiative.
Tool availability
The tool will be available to a variety of government and non-government organisations involved in health workforce planning, including:

- Rural Workforce Agencies
- Primary Health Networks
- Local Health Districts
- Medical Colleges
- State and Territory governments.

Data privacy
Data privacy will be a key focus in the design and management of the tool. Strict access controls and protocols will be in place for each approved organisation and all will align with Privacy Legislation.

Collaboration
The HeaDS UPP Tool will become a single source of information for government and stakeholders that will improve consistency of the evidence base used to inform workforce planning, policy and program development, monitoring and evaluation activities.

The tool will also allow and encourage collaboration across parts of the health system and increase confidence in government spending.

Further information
Updates on progress of the reform and further information:

The new Junior Doctor Training Program consolidates and builds upon current training programs to create two new streams to support training in rural primary care and in private hospitals:

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

The two streams will increase access to high quality training in rural areas and the private sector, ensuring a continued supply of the medical practitioners required for health service delivery across Australia.

**Investment**

An additional investment of $63.6 million over four years from 1 July 2018 will support extra training in the private sector and deliver education and supervision for junior doctors in rural primary health care settings. This will bring the total investment to over $174 million from January 2019.

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

**Rural Primary Care Stream**

The year after graduating from university, medical students need an internship to gain general registration. Internships are almost fully hospital based.

Under the new Junior Doctor initiative, the existing Rural Junior Doctor Training Innovation Fund will continue, and allow rurally based interns to experience working in primary health care settings. Up to 240 Postgraduate Years 1 to 2 junior doctors will rotate into rural general practice.

There is a large concentration of junior doctors in public metropolitan hospitals who find it difficult to access pathways to further training. The Rural Primary Care Stream will encourage some of these doctors to work in rural general practice by supporting their training and supervision.

The Rural Primary Care Stream will help fund training and supervision making new jobs in rural general practice and ensuring junior doctors moving into these settings continue to provide high quality care.

The Rural Primary Care Stream will also help around 300 junior doctors working in rural general practices to gain Fellowship by supporting their training and supervision.

**Medicare access**

There are currently thousands of junior doctors concentrated in metropolitan hospitals. The Stronger Rural Health Workforce Strategy will create new opportunities for these doctors to move out of metropolitan hospitals and work and train in rural primary care. Other changes under the Strategy will enable these doctors to generate an income in private practice by performing Medicare eligible...
services. The Rural Primary Care Stream will provide training and supervision for many of these doctors. Participants in the Rural Junior Doctor Training Innovation Fund will not be performing Medicare eligible services.

**Private Hospital Stream**

The private health sector delivers significant medical services to the Australian community. Around 40 per cent of hospitalisations in Australia are in private hospitals. There is significant training capacity in the private hospital sector, which provides an opportunity to address the forecast shortage of 1,000 advanced training places by 2030.

The Private Hospital Stream provides salary support for junior doctors working in private hospitals. This includes up to 100 internships in 2019 and up to 115 places in 2020. Full fee paying international graduates of domestic medical schools will continue to have preference.

Return of service arrangements will not be imposed on participants, but will be maintained for doctors with agreements under the former Commonwealth Medical Internships program.

The Private Hospital Stream will also support Postgraduate Years 2 and 3 training placements that will be open to a broad range of medical graduates.

An increase in the training capacity in the private hospital sector will help to ensure new doctors can access quality training in this part of the health system.

**Further information**

Updates on progress of the reform and further information:

The role of nurses in delivering primary health care and in meeting the future health care needs of the Australian community will be strengthened under the Stronger Rural Health Strategy. This includes a central role for nurses in the delivery of team-based and multidisciplinary care, particularly for patients with chronic and complex conditions, and in rural and remote settings. Nurses will be supported to move into primary health care and to test new ways to deliver care. Better education about primary health care will also be provided to the nursing workforce.

This initiative is made up of three components:

1. Nursing in Primary Health Care (NiPHC program)
2. Raising Awareness of the Role of the Nurse Practitioner project
3. An independent review of the current preparation of nurses entering the workforce in Australia.

Investment

From July 2018, funding of approximately $8.3 million over four years is allocated to the NiPHC program, to be delivered by the Australian Primary Health Care Nurses Association (APNA). The Raising Awareness of the Role of the Nurse Practitioner project provides around $300,000 over 12 months to the Australian College of Nurse Practitioners (ACNP) to conduct an awareness campaign to increase the profile of nurse practitioners. Funding is also available over two years for the review of the nursing education programs, with findings to be publicly released.

Nurses in primary health care

Primary health care is often the first point of contact people have with the health care system. The nursing workforce – including nurse practitioners – has a breadth of skills and experience in caring for the health needs of the Australian community. Making wider use of the nursing workforce in frontline delivery is a more effective use of skills, and gives GPs time to focus on complex care needs.

There is strong evidence that shows strengthening the role of nursing in the primary health care setting enhances the delivery of health care in general practice. These benefits are clinical and economic:

- Clinical – improved access, longer consultations, improved case management and care coordination and enhanced team work across the practice
- Economic – cost effective and removes unnecessary duplication of work.

The NiPHC program will include the provision of training and mentoring for nurses to transition to primary health care, and support for nurses in regional and rural areas through training in clinical areas of need. Health care organisations, including those in regional and rural locations, will implement nurse delivered models of care that target local patient population health care needs.
**Nurse practitioners**

A nurse practitioner is a registered nurse with experience and expertise to diagnose and treat people. They have completed additional university study at Master’s degree level and are considered some of the most clinically expert nurses in our health system.

Raising the Awareness of the Nurse Practitioner Role project will promote the benefits, profile and role of the nurse practitioner workforce within primary health care service settings.

Consumers and health professionals will benefit from gaining a greater understanding of the role of the nurse practitioner, particularly in primary health care, through a number of communication activities. Making better use of nurse practitioners, and the nursing workforce in general, will be a more efficient use of their skills while giving GPs the time to focus on more complex care needs.

**3,000 additional nurses in rural general practice**

Over the coming 10 years, an additional 3,000 nurses will be supported to work in rural general practice through changes to the way in which general practices in rural and remote areas are incentivised to employ practice nurses.

**Independent review of nurse education**

An independent review will look at how current educational preparation in Australia equips nurses to meet the future health needs of the Australian community. The review will consider national and international trends and consult extensively with consumers and representatives from the health, aged care, disability, education and regulatory sectors. It will also look at student selection factors and how pathways can shape future careers. The review may result in a renewal of educational preparation.

**Further information**

Updates on progress of the reform and further information:

- Australian Primary Health Care Nurses Association website [www.apha.asn.au](http://www.apha.asn.au)
- Australian College of Nurse Practitioners website [www.acnp.org.au](http://www.acnp.org.au)
Under the Stronger Rural Health Strategy, the growth of Australia’s medical workforce will be better managed by regulating the number of overseas trained doctors seeking to work in Australia and directing them to areas of workforce shortage. These doctors will be directed away from over-serviced metropolitan and outer metropolitan areas to areas of workforce need, especially rural and remote areas.

**Overseas trained doctors**

Through the Skilled Migration Program, the number of overseas trained doctors entering Australia to work in primary health care will be reduced by 10 per cent – about 200 – annually over a period of four years. This will be a gradual process to ensure the right balance of specialist GPs is available to the Australian community, while also providing opportunities for Australian trained doctors.

**Investment**

Better managing the total number of doctors entering the medical workforce and directing them to areas of need will save $415.5 million over a four year period.

Savings from this measure are achieved by slowing the growth in the number of overseas trained doctors arriving in Australia, and the associated reduction in Medicare and Pharmaceutical Benefits Scheme (PBS) billing.

This is based on not paying the cost of services that would arise if the growth in the supply of doctors was not managed. Costs include Medicare, PBS Scheme, and diagnostic, pathology and specialist referral costs.

**Target areas**

Data shows that in some areas, particularly in major cities, the growth in medical services is due to an increase in the number of doctors, rather than genuine increases in patient need for services. Increasing numbers of overseas-trained doctors entering Australia have been working in major metropolitan areas rather than in rural and regional areas where there is a greater need.

Fewer overseas trained doctors in primary health care will ease pressure on training places, and give more opportunities to Australian trained medical graduates, whose numbers have also been growing.

This initiative will be supported by a new planning tool, which will support a more effective distribution of overseas trained doctors to areas of need – especially regional, rural and remote areas.

**State and territory based employment arrangements**

The recruitment of medical practitioners by state and territory governments who control and run rural hospitals will not be affected. The number of visas being issued to work in primary health care in metropolitan areas will be targeted and reduced over the next four years.
Visa changes

The number of visas being granted through the skilled migration program over four years from January 2019 will help to slow the growth in the number of overseas trained doctors entering Australia to work in metropolitan areas. The revised arrangements will target the occupations nominated by overseas-trained doctors seeking to work in primary health care in Australia: General Medical Practitioner, Resident Medical Officer and Medical Practitioner not elsewhere classified.

Reductions in total intake will be taken from major metropolitan locations, better managing the growth in general practice numbers anticipated in these areas, with improved targeting of visas to work in regional and rural Australia.

Improved targeting of areas of workforce shortage

The Department will work with Rural Workforce Agencies to ensure that overseas trained doctors are directed to areas of genuine workforce need. This will assist in better managing supply and pave the way for a more highly trained rural health workforce.

Further information

Updates on progress of the reform and further information:

Current bonded medical programs provide students a medical place in return for a commitment to practice in areas of workforce shortage for a specified period. Under the Stronger Rural Health Strategy, a more flexible system will be established to encourage and support more doctors to work and stay in rural and remote areas.

Key reforms include:

- simplified administration by moving from individual contract arrangements to a legislated program
- a new standard three year return of service obligation (RoSO)
- an interactive web-based portal and other digital communication channels to support bonded students and doctors to better understand and manage their bonded obligations.

**Investment**

An investment of $20.2 million over four years from 2018–19 will support reforms to the existing Bonded Medical Places (BMP) Scheme and the Medical Rural Bonded Scholarship (MRBS) Scheme.

Reforms will simplify the administrative arrangements associated with the BMP and MRBS Schemes, and provide a mobile friendly web portal to make it easier for participants to self-manage, plan and undertake RoSOs.

**Return of Service Obligation**

RoSOs relate to the period of work which is required to be undertaken by the bonded doctor to fulfill the program’s requirements.

A standard three year RoSO will take effect through the new arrangements. Existing participants will have the option to opt-in to the new arrangements.

**Current participants**

Current participants of the BMP/ MRBS Schemes will be able to choose to move to the reformed arrangements. Current contract conditions will continue to apply for participants who choose not to move across and those participants will not have access to the benefits of the reforms.

BMP Scheme participants who entered the BMP Scheme in the years 2016 to 2019 (inclusively) will be able to move across to the reformed BMPS Scheme and retain their 12 month RoSO.
Eligibility
Over 9,000 students and doctors who currently participate in the BMP and MRBS schemes, together with individuals who are planning to apply for a bonded medical place at a University, will be eligible to access the new arrangements.

Transition to new arrangements
New medical school students entering a bonded program will enter under the new arrangements from 1 January 2020. All existing bonded medical students and bonded doctors will be able to move across to the reformed arrangements from this date.

Further information
Updates on progress of the reform and further information:

- Department of Health’s website www.health.gov.au
- Rural Workforce Agencies www.rhwa.org.au
- email the Department of Health’s BMP inbox: BMPScheme@health.gov.au or MRBS inbox: MRBScholarships@health.gov.au
- Modified Monash Model of geographical classification and locations: www.doctorconnect.gov.au
The Stronger Rural Health Strategy will support the Royal Flying Doctor Service to deliver essential health care to Australians living in some of the nation’s most remote areas, including dental, mental health and emergency aeromedical services.

**Investment**

An investment of $327 million over four years to the Royal Flying Doctor Service will improve access to health services for Australians living in rural and remote areas. This is an increase of $84.1 million to support ongoing aeromedical evacuations, the extension of dental services beyond March 2019 and the introduction of mental health services from 1 January 2019.

**Current Royal Flying Doctor services**

The Royal Flying Doctor Service delivers emergency aeromedical evacuations, primary health clinics, medical chests, remote (telephone) consultations and dental outreach services to patients in rural and remote areas.

**New services**

The Royal Flying Doctor Service will continue dental outreach services for rural and remote areas. This will ensure communities in areas of most need, and beyond the reach of services, have access to dental services.

A new Mental Health Outreach Clinic program will provide professional mental health services to areas where there are currently few or none. This will include putting more mental health professionals on the ground where telehealth technology is not available or is too costly.

**Further information**

Updates on progress and further information:

- Royal Flying Doctors Service’s website [www.flyingdoctor.org.au](http://www.flyingdoctor.org.au)
Under the Stronger Rural Health Strategy, bulk billing incentives will be correctly targeted to ensure that metropolitan areas no longer have access to incentives intended for rural and remote areas. The geographic eligibility criteria that provide incentives for Medicare Benefits Schedule (MBS) items are based on how the Australian population was distributed in 1991, and will now be updated.

**Investments**

The incentives will be based on an existing rural classification which draws on the latest Australian population and distribution statistics, rather than the current eligibility conditions which are based on data from the 1991 Census.

**Eligibility criteria**

The measure updates the geographic eligibility criteria for MBS items 10991, 64991 and 74991 from Rural Remote and Metropolitan Areas (RRMA) 3–7 to Modified Monash Model (MMM) remoteness classification MMM 2–7.

These items are targeted to vulnerable patient groups, such as people with concession cards and children under 16 years of age in rural and remote areas. Doctors in these areas will have correct access to rural bulk billing incentives.

**Affected areas**

Under this initiative, around 2,100 additional doctors in rural communities will have access to the rural bulk billing MBS items. Areas that gain access to these items include:

- Jam Jerrup (Vic)
- Kiama (NSW)
- Russell Island (Qld)
- Yanchep (WA).

Areas losing access to these items have some of the highest concentration of doctors per person in Australia. Other areas that have experienced major city growth since 1991 will also lose access (i.e. population greater than 20,000). These include:

- Mandurah (WA)
- Mornington Peninsula (Vic)
- Canberra (ACT)
- Newcastle (NSW)
- Central Coast (NSW)
- Queanbeyan (NSW)
- Maitland (NSW)
- Sunshine Coast (Qld)
- Gawler (SA)
• Geelong (Vic)
• Melton (Vic)
• Pakenham (Vic)
• Ellenbrook (WA)
• Baldivis (WA).

Further information
Updates on progress of the reform and further information:

• Department of Health's website [www.health.gov.au](http://www.health.gov.au)
• Department of Human Services [www.humanservices.gov.au](http://www.humanservices.gov.au)
• Modified Monash Model of geographical classification and locations [www.doctorconnect.gov.au](http://www.doctorconnect.gov.au)
This initiative under the Stronger Rural Health Strategy will implement new arrangements to simplify existing General Practitioner (GP) training and qualification pathways, and support non-vocationally recognised (non-VR) doctors attain specialist GP status. The nine current pathways to specialist GP status will be rationalised into two; delivered through the Royal Australian College of General Practitioners (RACGP), and the Australian College of Rural and Remote Medicine (ACRRM), giving the Colleges a greater role in delivering and managing training. The initiative will support existing non-VR doctors to qualify as vocationally recognised (VR) through a targeted Fellowship Support program. The initiative also provides an additional 100 training places from 2021 earmarked to support Rural Generalist trainees.

**Investment**

An additional investment of $86.4 million over four years from 2018 will fund the initiative.

**Support for non-VR doctors**

A one-off Fellowship Support program will be available between 2019 and 2023, delivered by the RACGP and the ACRRM, for non–VR doctors who are providing GP services to attain Fellowship. By enrolling on a formal pathway to Fellowship with the RACGP or ACRRM, medical practitioners seeking to become specialist GPs will have access to the highest tier Medicare Benefits Schedule (MBS) items during training. Medical practitioners are not obligated to join a Fellowship pathway, however those who do not attain Fellowship of either the RACGP or ACRRM and who are therefore not vocationally recognised before 1 July 2023, will no longer be able to access the highest tier MBS GP items.

**Training places**

The Commonwealth will continue to fund 1,500 Australian General Practice Training (AGPT) program training places per year across the two College pathways, and will fund an additional 100 Rural Generalist places from 2021. Targets for the distribution of training places across regional and remote areas will ensure a continued focus on rural and remote GP workforce distribution.

The streamlined pathways to Fellowship and the support program for non–VR doctors will come into effect on 1 January 2019. Transition of the AGPT program to the GP Colleges will be staged between 2019 and 2021, with the RACGP and ACRRM assuming full responsibility for the program by 2022.

Trainees on the AGPT program, the Remote Vocational Training Scheme, and the ACRRM Independent Pathway will be able to continue to train as planned without any material impacts.

The 3GA programs that currently provide non–VR doctors pursuing Fellowship (of either College) access to MBS GP Items outside the above-mentioned programs will cease by 30 June 2023. Practitioners may continue to use these provider numbers until that time.
From 1 January 2019, medical practitioners on the RACGP Practice Experience Program will be able to apply for a Practice Experience Program 3GA provider number through the RACGP.

**Distribution**

There are currently around 4,900 non–VR doctors in Australia. Many of these currently work in rural and regional Australia. These changes will support these doctors to gain fellowship and ensure those communities can see a specialist GP trained to the highest industry standards. Distribution of training places will be designed to ensure a continued supply of skilled doctors in rural and remote areas.

From 2019 the overall number of places on a pathway to Fellowship will be capped, and the cap will be administered by the GP Colleges. To ensure the GP profession is neither in under or oversupply the evidence-based cap will be determined by the Department of Health and endorsed by the National Medical Training Advisory Network.

**Further information**

Updates on reform progress of the reform and further information:

Under the Stronger Rural Health Strategy, Aboriginal and Torres Strait Islander health professional organisations (ATSIHPOs) will be provided with continued and additional funding. These organisations play a key role in increasing the number of people in the Indigenous health workforce and supporting them in their careers. This means Aboriginal and Torres Strait Islander people can access culturally appropriate care, no matter where in the system they access health services. This leads to increased access to health care and optimal health and wellbeing outcomes for Aboriginal and Torres Strait Islander people.

**Investment**

Over four years, from 1 July 2018, $33.4 million will be provided to continue the important role of four ATSIHPOs to support and develop an appropriately trained health workforce and improve service provision to Indigenous Australians.

Increased investment and funding certainty will ensure the ATSIHPOs can respond proactively to the steady increase in the numbers of Aboriginal and Torres Strait Islander people studying and working in health across all disciplines.

**Priority areas**

Priority areas for investment through this initiative include:

- improving cultural safety
- professional development and mentoring
- developing leadership
- student engagement and support.

**Organisations**

The funding will expand the functions of these ATSIHPOs:

- Australian Indigenous Doctors’ Association
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Indigenous Allied Health Australia
- National Aboriginal and Torres Strait Islander Health Worker Association.

These four ATSIHPOs develop and implement strategies that improve recruitment and retention of Aboriginal and Torres Strait Islander health professionals in clinical and non-clinical roles across all health disciplines. They also improve skills and the capacity of the Aboriginal and Torres Strait Islander health workforce and promote culturally safe and responsive environments for Aboriginal and Torres Strait Islander consumers and health professionals.
ATSIHPOs assist with increasing the number of Aboriginal and Torres Strait Islander students studying to attain qualifications in health. The organisations improve completion/graduation and employment rates for Aboriginal and Torres Strait Islander health students, and contribute to building an evidence base to improve the quality of health workforce planning and future policy platforms.

Further information

Updates on progress of the reform and further information:

- Department of Health's website www.health.gov.au
The Stronger Rural Health Strategy’s Murray-Darling Medical Schools Network establishes five rurally based university medical school programs in the Murray-Darling region of New South Wales and Victoria. The new schools will enable medical students to stay in their communities while they study and train to become a doctor, increasing their likelihood of staying and working in rural areas. The network will provide an end-to-end approach to rural training to improve the future distribution of the medical workforce.

**Investment**

An investment of $95.4 million over four years will be provided to set up the *train in the regions, stay in the regions* program which includes the new Murray-Darling Medical Schools Network.

**Locations**

The network will include:

- University of NSW (Wagga Wagga)
- University of Sydney (Dubbo)
- Charles Sturt University in partnership with Western Sydney University (Orange)
- Monash University (Bendigo, Mildura)
- University of Melbourne (Shepparton)
  - with a pathway for undergraduate students from La Trobe University (Bendigo and Wodonga).

The network will provide students with the option of studying and training in more than 20 regional and rural communities.

**Training in rural areas**

The network will enable medical students and graduates to undertake the majority of their study and training in the Murray-Darling region, reducing the need for them to move to metropolitan areas.

Evidence shows that enrolling students from a rural background and having students undertake long-term rural training increases the likelihood of rural practice.

The establishment of the network means that local students will be able to study and train to become a doctor, and provide supervised medical services to rural patients.

**Investment in rural areas**

The Murray-Darling region, with large rural centres, has potential for expansion in medical training given patient population, infrastructure and clinical training.
The bulk of the network funding is for investment in infrastructure for new or expanded teaching facilities and extra student accommodation across a series of universities and main sites in the Murray-Darling region.

Rural hospitals will also benefit through increased staffing and workforce sustainability.

**Commonwealth Supported Places**

There are no new medical Commonwealth Supported Places (CSPs) established – the focus is on distribution and creating an end-to-end training continuum in the Murray-Darling region. The network will reallocate a small number of existing CSPs in a managed process, with first medical student intakes from 2021.

A pool of medical CSPs, drawn from existing allocations, will be established to provide the Government with the flexibility to address health workforce priorities as they arise over time. The Department of Education and Training will undertake consultations with universities to inform how the redistribution process will work. The Department of Health and the Department of Education and Training will work together on implementing measures to support better management of medical graduate supply.

**Rural Health Multidisciplinary Training**

The network will build on the Australian Government’s existing investment in rural undergraduate training through the Rural Health Multidisciplinary Training Program.

In addition to the Network, the train in the regions, stay in the regions program includes two new participants in the Rural Health Multidisciplinary Training Program from 2019:

- Curtin University will be funded for rural clinical school activities for medical students, supporting students to undertake short and long term clinical training placements in rural Western Australia.

- La Trobe University will be funded to establish a new University Department of Rural Health to increase clinical training opportunities for nursing and allied health students in rural Victoria.

**Further information**

Updates on progress of the reform and further information:

- Department of Education and Training’s website [www.education.gov.au](http://www.education.gov.au)
STRONGER RURAL HEALTH STRATEGY
Workforce Incentive Program

FACTSHEET

Stronger Rural Health Strategy

The Australian Government’s Stronger Rural Health Strategy is an historic 10-year plan to meet current and future health workforce challenges. It represents the largest overhaul of Australia’s health workforce in decades. It is intended to meet the challenge of redistributing the workforce across regional, rural and remote Australia, beyond the cities and metropolitan areas. The Strategy includes incentives, targeted funding, bonding arrangements and more opportunities to train and practice in rural and remote Australia.

Workforce Incentive Program (WIP)

Under the Stronger Rural Health Strategy, the WIP will provide targeted financial incentives to encourage doctors to deliver eligible primary health care services in regional, rural or remote areas that have difficulty attracting and retaining doctors. The WIP will also provide financial incentives to support eligible general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and allied health professionals.

From 1 January 2020, the WIP will replace the Practice Nurse Incentive Program (PNIP) and the General Practice Rural Incentives Program (GPRIP).

Funding under the WIP will be available in two streams:

- The PNIP will transition to the WIP-Practice Stream, where payments will be made directly to practices;
- The GPRIP will transition to the WIP-Doctor Stream, where payments will be made directly to doctors.

Better targeting of incentives

While there is an oversupply of doctors in some urban areas of Australia, there are shortages, particularly in regional, rural and remote areas. The Australian Government needs to attract not just doctors to rural areas but also allied health professionals, nurses, and Aboriginal Health Workers and Health Practitioners to better manage patients with complex and chronic conditions.

The WIP better targets incentives to address workforce requirements in specific geographic areas, giving patients in regional, rural and remote areas improved access to quality medical, nursing and allied health services.

Funding for the WIP aims to strengthen team-based and multidisciplinary models of care enabling collaborative arrangements to be put in place that will better support community needs.
WIP commencement date

The WIP will commence on 1 January 2020. General practices and doctors participating in the PNIP and the GPRIP on 31 December 2019 will automatically transition to the WIP.

The Department of Health and the Department of Human Services (Human Services) are working together on the transition to the WIP and to support administrative system changes.

From 1 January 2020, updated payment structures will be in place. In future years, the Department of Health will also conduct regular program evaluations to measure outcomes of the new program.

PNIP transition to the WIP-Practice Stream

The following changes will occur in the transfer from PNIP to the WIP-Practice Stream:

- The Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) will be replaced by the Modified Monash Model (MMM).
- Practices within Modified Monash 3-7 will be eligible for a rural loading. Different levels of rural loading will apply depending on rurality of the practice.
- Practices in all locations across Australia will be able to engage allied health professionals, not just in Urban Areas of Workforce Shortage.
- The accreditation assistance payment of $5,000 per practice will no longer apply.

GPRIP transition to the WIP-Doctor Stream

Workforce incentives currently provided to doctors under the GPRIP will continue under the WIP.

Modified Monash Model (MMM)

- The MMM is a classification system that categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and population size.
- Further information on MMM geographic classification and to check the location of a general practice or doctor is available at doctorconnect.gov.au

WIP Program Eligibility

Practice Stream

Eligibility requirements for the WIP-Practice Stream will be similar to those under the PNIP with the following change:

- a practice may engage the services of an eligible practice nurse, Nurse Practitioner, allied health professional (including pharmacists (non-dispensing)), Aboriginal and Torres Strait Islander Health Worker or Aboriginal and Torres Strait Islander Health Practitioner or a combination of these health professionals.

Doctor Stream

Eligibility requirements for the WIP-Doctor Stream will remain the same as those under the GPRIP.

Incentive payments

Around 5,000 practices and more than 7,000 doctors will be eligible for incentive payments under the WIP. The incentive funding will strengthen team-based and multidisciplinary primary care and support practices to engage the services of allied health professionals, including pharmacists (non-dispensing), in all locations.
**Practice Stream**

- An eligible practice will be able to receive incentive funding to support the engagement of an eligible health professional.
- The incentive payment for the WIP-Practice Stream will be calculated in a similar way as currently exists under the PNIP. The incentive payment amount depends on the practice Standard Whole Patient Equivalent (SWPE) value (a measure of practice size and patient demographic), and the hours worked by the health professionals at the practice. Eligible practices can receive incentive payments up to $125,000 per year.
- Payments will be made directly to participating practices, similar to current arrangements for the PNIP.
- Practices located in Modified Monash (MM) 3-7 will be eligible to receive a rural loading of up to 50% in addition to the incentive payment depending on the rurality of the practice. For example a general practice in an MM4 location with a SWPE of 3000 would be eligible to receive an incentive payment up to $75,000 and an additional rural loading.
- Incentive payments under the WIP will be paid into nominated bank accounts after the participant has submitted their Quarterly Confirmation Statement (QCS). Human Services will process the QCS and calculate the incentive payment amounts. Practices that receive a rural loading may find that amounts change with the move from ASGC-RA to the MM geographical classification.

**Doctor Stream**

- The incentive payment under the Doctor Stream will be calculated as it is under the GPRIP. Calculation of payments is based on activity levels within eligible locations and the length of time a doctor has been on the program.
- Payments will be made directly to doctors, similar to current arrangements for the GPRIP.
- Eligible doctors located in MM 3-7 can receive an annual payment of between $4,500 and $60,000.
- For example, Ceduna, South Australia, is classified as a MM 7 location. The maximum WIP incentive available to doctors in Ceduna is $60,000.
- There are two payment systems used for the GPRIP. The Central Payment System (CPS) is for doctors that bill Medicare for eligible services and the Flexible Payment System (FPS) is for doctors that provide eligible services and/or training not reflected in the Medicare Benefits Schedule.
- All continuing doctors in the GPRIP under the CPS component will continue to be eligible for a payment on completion of four active quarters within an eight quarter period.
- Participants in the GPRIP under FPS component need to continue to apply directly to the Rural Workforce Agency (RWA) in their state or the Northern Territory in which they provide the majority of services for the WIP.

**WIP Program Guidelines**

WIP Program Guidelines are being developed and will be available prior to 1 January 2020. The guidelines will contain detailed information about how the WIP will operate for the Practice Stream and Doctor Stream. Each stream will identify eligibility requirements, how incentive payments are calculated and rural loadings applied. The WIP Program Guidelines will be available on the Department of Health website.

**Further information**

Further information and updates for incentive programs will be made available on the Department of Health’s website at www.health.gov.au or on the Human Services website at www.humanservices.gov.au prior to 1 January 2020.