HealthConsult

Department of Health and Aged Care

Review of Section 19AB and District of Workforce Shortage (DWS) classification system

Discussion Paper

28 February 2024

1. Consultation overview

On 21 November 2023, the Australian Government announced the '**Working Better for Medicare Review** (the 'Review')' to investigate how to distribute doctors and other health workers around Australia more equitably. The Review will look at how current policies and programs can be strengthened to make it easier to see a doctor, nurse or other health worker in the outer suburbs of major cities and in regional, rural and remote Australia. It will look at five key policies and distribution levers used to influence the distribution of the workforce:

- **Section 19AA:** is part of the Health Insurance Act of 1973 ('the Act'), which was introduced as an amendment with Section 19AB in 1996. Section 19AA restricts access to the Medicare Benefits Schedule (MBS) to doctors that have completed or are undertaking vocational training with a recognised speciality College. Section 3GA of the Act aims to assist workforce distribution by exempting doctors working in eligible locations from Section 19AA restrictions, for a defined period.
- **Section 19AB** of the Act: restricts overseas-trained doctors (OTDs) and Foreign Graduates of an Accredited Medical School (FGAMS) from accessing the MBS for a minimum of ten years ("the 10 year moratorium"), except in areas of workforce need in Australia. There are 12 categories of exemptions that can exempt OTDs from Section 19AB restrictions.
- **Modified Monash Model (MMM):** is a classification system used to define whether a location is metropolitan, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.
- **District of Workforce Shortage (DWS):** is a health workforce classification for specialist medical practitioners that identifies areas of shortage with reference to a national benchmark for Full-Service Equivalent (FSE) specialists in an area. The DWS was introduced to support the workforce distribution aims of Section 19AB and is also used to determine where Bonded Doctors can work for three years following graduation. It currently applies to eight specialties: Anaesthetics, Cardiology, Diagnostic Radiology, General Surgery, Obstetrics and Gynaecology, Ophthalmology, Medical Oncology and Psychiatry. An area is classified as a DWS if:
    - its ratio of specialists to population is less than the national average for that speciality and the specialty reports a national FSE greater than 3 per 100,000 population, or

- it has an Australian Statistical Geography Standard Remoteness Area (RA) classification of RA 3 to RA 5 (i.e., it is classified as rural to remote).

- **Distribution Priority Area (DPA):** is a classification system that identifies locations in Australia with a shortage of general practitioner (GP) services. OTDs must work in a DPA to be eligible to access Medicare. DPA is based on gender and age demographics, and the socio-economic status of patients living in an area.

The Review is being independently led by Professor Sabina Knight and Adjunct Professor Mick Reid ('the Lead Reviewers'). HealthConsult is part of the Review team and is responsible for reviewing **Section 19AB** and the **DWS classification system**. Another consultancy – Healthcare Management Advisors (HMA) has been engaged to review **Section 19AA** and the **MMM** and **DPA classification** systems. The Review Team, comprising the Lead Reviewers, HealthConsult and HMA are collaborating to deliver a final report incorporating all five policies and levers to Government in June 2024.

The **goals of the Review** include:

- confirming the original objectives of the distribution levers
- evaluating how appropriate and robust the assumptions underpinning the levers are
- considering and reporting on the value of retaining the levers
- assessing how the levers align with current health workforce policies and priorities
- identifying key factors and barriers impacting appropriateness and effectiveness
- if appropriate, identifying opportunities to improve the way the levers achieve current medical workforce policy aims
- considering, and where appropriate making recommendations on, alternative approaches to achieve these aims, and
- identifying the future role of the levers.

1.1. Consultation processes

HealthConsult is conducting a consultation process to understand key stakeholders' viewpoints on the performance of **Section 19AB** and the **DWS** classification system and to develop and test some preliminary options for a future role for Section 19AB. [Note - A similar process is being undertaken by HMA to review Section 19AA, and the MMM and DPA classification systems.]

Feedback from the consultation process will be used to prepare an Interim Report for the Department and Lead Reviewers that summarises the key issues relating to Section 19AB and the DWS, and a range of options for the future of Section 19AB.

There are three parts to the consultation process, which are being undertaken early in 2024:

1. This **discussion paper** will be distributed to key stakeholders to submit **written responses by 5 April 2024.**
2. Targeted stakeholders identified by the Department will be invited to a **virtual consultation with the HealthConsult** team before **5 April 2024**. Stakeholders identified as relevant to both HealthConsult and HMA's review components will be invited to single joint consultation co-facilitated by the two consultancies.
3. Heartward Strategic is conducting a **public survey** about Section 19AA and 19AB of the Act, and the DWS, MMM, and DPA classification systems, which is open to the general public, health and medical professionals, and representatives from groups and organisations. Survey responses will be provided to HMA and HealthConsult, and assessed for relevance to respective policies and levers and used to inform the stakeholder consultations and the Interim Report to the Department. The survey is open until **1 March 2024**, and is accessible here: https://au.focusvision.com/survey/selfserve/8f9/240101#?

1.2. Responding to this discussion paper

Stakeholders can respond to this discussion paper by emailing a written response to WBFMReview@healthconsult.com.au. You can respond to as few or as many questions as you like. In your response, please:

- ensure that you include the number of the question/s that you are responding to (e.g. 1a, 2c, etc)
- provide a brief overview of your role, background and organisation, relevant to this review.

1.3. Questions

If you have any questions about this project or taking part in this consultation, please contact the project team at WBFMReview@healthconsult.com.au.

2. Has Section 19AB and the DWS met their objectives?

To assess whether Section 19AB and DWS have met their objectives, we have focused on whether Section 19AB and DWS encourage medical practitioners to work in areas of workforce shortages and promote equitable distribution of medical professionals across Australia.

2.1. Key issues

Section 19AA and 19AB were part of a single amendment bill to the Health Insurance Act introduced in 1996. At the time of the amendment bill, there was a view and prevailing narrative that:

- there were too many doctors.
- Medicare expenditure, particularly general practice expenditure, was growing too rapidly.
- there were too many OTDs coming into Australia.

At the time, **Section 19AB's main aims and objectives** were to:

- **contain the number of OTDs** contributing to cost pressures on the MBS and control the oversupply of OTDs.
- **distribute the medical workforce more equitably** to rural and remote areas in Australia by incentivising OTDs and FGAMS to work in areas where shortages of medical professionals exist by providing them the ability to access the MBS in these areas.
- promote OTDs and FGAMS taking up salaried positions in public hospitals that do not access MBS, and therefore help to address workforce shortages and **attract skilled doctors to the public health system.**

Our initial research suggests that objectives related to containing Medicare costs and directing OTDs to work in public hospitals are not relevant in the context of contemporary medical workforce policy. However, objectives related to addressing maldistribution are still relevant and represent a persistent challenge.

The DWS was introduced to support the workforce distribution aims of Section 19AB. The main **aims and objectives of the DWS** classification based on available documentation are to:

- identify geographical areas in Australia where people have poor access to specialist medical practitioners
- inform targeted efforts to address workforce shortages in specific areas and specialties
- encourage specialist doctors to work in underserved areas where their services are most needed, and
- target incentives such as the Bonded Medical Program (and potentially other workforce programs) aimed at attracting health practitioners to underserved areas.

Although significant maldistribution of the Australian medical workforce remains (across both medical specialties and geographical areas, the initial research suggests that Section 19AB and DWS have had a positive impact on improving the maldistribution of the medical workforce, although this impact is difficult to quantify or isolate.

2.2. Consultation questions

Consultation questions – has Section 19AB and DWS met their objectives?

1. What impact has Section 19AB and DWS had on the distribution of the medical workforce to areas of workforce need?
2. What impact have changes to the DWS (i.e. area designations and specialties in scope) had on distribution of the medical workforce to areas of need?
3. **A)** How could Section 19AB be improved or supported to better meet its objectives?

   B) Which elements should be retained or reformed?
4. **A)** What would be the implications of removing Section 19AB?

   B) What are the alternatives to Section 19AB for achieving more equitable distribution of the medical workforce?
5. Has the impact of the DWS been different (positively or negatively) when compared to other distribution levers?

3. Appropriateness of Section 19AB

Three key questions are being examined to assess the appropriateness of Section 19AB:

1. Are s19AB's objectives aligned to current workforce policies?
2. Does s19AB support effective training and supervision opportunities for medical professionals in areas of workforce shortage?
3. Does s19AB support the provision of high-quality clinical care for communities in areas of workforce shortage?
4. Are the objectives of s19AB still relevant?

3.1. Key issues

The environment has changed significantly since Section 19AB was established, with key changes being:

- the percentage increase in doctors has grown at a rate well above the population increase.
- access to General Practitioners (GPs) is a consistent concern in the community and politically.
- growth in Medicare expenditure is rarely raised as an issue in the public narrative.
- the private health system has been re-invigorated.
- there is some perception that there are not enough trained doctors in Australia.

As noted in Section 1, objectives related to containing Medicare costs and directing OTDs to work in public hospitals are not relevant today, however, addressing maldistribution of the medical workforce is still relevant and represents a persistent challenge.

Medical workforce maldistribution is a complex challenge in many other countries. Financial incentives, professional support, and training opportunities are most commonly used to attract and retain healthcare professionals in these areas. These represent 'positive levers', whereas Section 19AB and the 10-year moratorium is a 'negative lever'.

The initial research has also highlighted concerns among stakeholders regarding unintended impacts of Section 19AB and the DWS on the quality of training and supervision for OTDs. Concerns have also been raised about the quality of care communities are able to access where there is a strong reliance on OTDs as a result of Section 19AB.

3.2. Consultation questions

Consultation questions – how appropriate is Section 19AB?

6. How relevant/appropriate is Section 19AB and DWS for achieving current government policy objectives?

7. What are the benefits of s19AB in supporting access to medical professionals in areas of workforce shortage?

8. What impact (positive or negative) has the Section 19AB/DWS had on quality of training and clinical care in areas of workforce shortage?

9. **A)** To what extent do areas of workforce shortage rely on OTDs and FGAMS for their medical workforce?

B) What are the implications?

C) Is this different for different geographical regions/specialties?

D) How appropriate is this?

10. How should the Section 19AB, DWS and other distribution levers best work together to achieve government policy objectives?

11. What other levers (positive or negative) are most likely to achieve objectives of:

A) equitable distribution of the medical workforce; and

B) reducing reliance on OTDs outside of major cities?

4. Appropriateness of the assumptions underpinning the DWS

Four key questions are being examined to assess the appropriateness of the assumptions underpinning the DWS:

1. Do stakeholders support the current assumptions underpinning the identification of DWS?
2. Does DWS encourage the specialist medical workforce to work in areas of workforce shortage?
3. What are the factors that have influenced past changes to DWS areas?
4. To what extent do stakeholders agree with DWS area designation/s?

4.1. Key issues

The DWS was introduced as the main lever to support the implementation of s19AB. DWS is also used to support other workforce incentives and distribution programs such as the Bonded Medical Program.

The data analysis and documentation review has highlighted that the construct of the DWS, and the assumptions that underpin it are inconsistent, not well understood and may be limiting its effectiveness as a mechanism to identify areas of need. Key issues in the construct of the DWS that were identified include:

- there is no explanation for why 3 Full-Service Equivalent (FSE) per 100,000 is used as the benchmark for identifying which medical specialties are eligible for DWS
- the criteria for identifying DWS specialties appears to be implemented inconsistently. For example, General Surgery is listed as a DWS specialty even though it has a national FSE lower than 3 per 100,000
- a large number of Statistical Area Level 3 (SA3) locations in major cities are identified as DWS for every specialty, even though the number of doctors in major cities is significantly higher than regional, rural and remote areas
- some SA3 locations that are 'automatically' classified as DWS locations have a FSE per capita that is higher than the benchmark. This suggests that these locations already

have enough medical professionals in these disciplines and should not be automatically classified as DWS.

- Disparities existed in RA-2 and RA-3 locations, and it was felt that even the ASGC-RA system was too blunt or crude a tool for appropriate workforce distribution.

4.2. Consultation questions

Consultation questions – how appropriate are the assumptions that underpin the DWS?

12. How appropriate are the current DWS area designations in identifying areas of workforce shortage?

13. Do you support the current assumptions that underpin the DWS? Why or why not?

14. A) How could the DWS classification be modified to better meet its objectives?

B) What would be the best geographic level at which Districts of Workforce Shortage should be classified (e.g. Statistical Area Level 3, Remoteness Areas, Local Government Areas, something else)?

C) What changes should be considered to the DWS?

15. A) Are there better alternative approaches for identifying Districts of Workforce Shortage?

B) If better approaches could be implemented, how would they operate?