ACRRM / RACGP PROCEDURAL MEDICINE COLLABORATION

RURAL PROCEDURAL GRANTS PROGRAM

RURAL LOCUM EDUCATION ASSISTANCE

PROGRAM

Briefing paper

The Procedural Medicine Collaboration, representing Rural Procedural Doctors around Australia, is calling on political parties and candidates to support on-going procedural grants and training and to commit to this during the election campaign and in the life of the new Parliament.

26 April 2016

KEY FACTS

This paper provides a snapshot of the development of the Government's plan to arrest the decline of procedural medical skills in rural and remote Australia and its progress to this point.

RURAL PROCEDURAL GRANTS PROGRAM

- Supports doctors who:
  - Work in rural and remote areas and
  - Provide often lifesaving birthing, surgical, anaesthetic and/or emergency services
  - Do the hard yards after hours as part of their commitment to this

- Has two components:
  - Procedural - supporting birthing, surgery and anaesthetics
  - Emergency - supporting emergency services

- Is a workforce retention program that has contributed to:
  - Reversing the decline in all types of proceduralist and emergency competent GPs (except those doing multiple disciplines)
  - A sustained 5% annual nett increase in procedural doctors
  - Increased the likelihood of procedural doctors to stay in rural practice (69 and 80% in surveys)
  - Increased the retention of established practitioners
  - Supporting female and male practitioners
  - Supporting practitioners in every jurisdiction
  - Supporting rural and remote areas

- Is a quality program that has contributed to:
  - Increased confidence of rural doctors (97%)
  - Increased their knowledge and skills to a great extent (63%)
  - Allowed 50% to develop new skills
  - Influenced 80% to stay longer in practice

- Is administratively robust with:
  - Auditable criteria for recipient eligibility that emphasises community service
  - a consistent approach to educational eligibility
  - development of a marketplace where providers have provided increasingly high quality training
  - a low administration charge – initially 6% dropping to a consistent 3% over the last 5 years
  - a record of careful and considered tailoring of the program in response to government initiatives while staying within budget

- It is NOT a program to train for rural procedural practice but rather a program to maintain rural practice and:
  - Has been able to retain procedural doctors across all age cohorts
  - Has been more effective in jurisdictions with organised procedural GP training programs such as Queensland

RURAL LOCUM EDUCATION ASSISTANCE PROGRAM

- Is designed to help urban doctors provide rural locum support
- Helped 285 communities with 5215 locum days

INTRODUCTION

In 2000 provision of medical services to rural and remote communities was under serious threat and this particularly affected the provision of services such as obstetrics, anaesthesia and surgery, which largely relied on general practitioners with skills in these procedural areas. The cost of providing the service frequently did not cover the requirements for skill maintenance let alone provide commensurate remuneration.

In an effort to reverse the trend and bolster the existing workforce the Government designed a grants program to assist general practitioners to maintain and enhance their procedural skills.

The Rural Procedural Grants Program (RPGP) aimed to increase numbers of rural and remote procedural and emergency medicine general practitioners (GPs) accessing educational activities relevant to their respective discipline/s, maintain and increase the skill level of these GPs, and enhance retention of rural and remote GPs with these skills.

It is specifically a skills maintenance program for credential GPs already providing procedural and emergency medicine. It is not a training program for the initial acquisition of procedural or emergency medicine skills.

Support is provided through a grant payment to the GPs to assist with the professional and practice costs of attending relevant training to maintain and enhance their clinical skills. Administration costs are minimal and the vast majority of funds are going where most needed.

Analysis of the ongoing statistics shows that the rates of attrition and replenishment of rural general practitioners have reversed with increased retention of procedural and emergency GPs above loss and the workforce is much better skilled as a result of these programs. They also demonstrate that there is an appropriate distribution across all states and ASGC rural locations. There is also a pleasing trend that shows the retention of women in these aspects of professional practice and a small trend to the increase of women in a younger demographic.

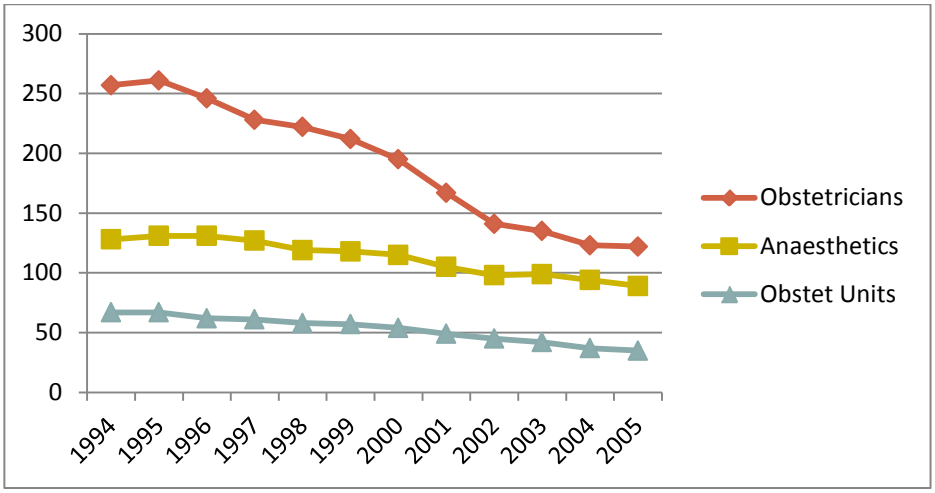
The Rural Locum Education Assistance Program (Rural LEAP) was developed from a pilot program of NSW RDN to upskill urban doctors who wished to assist rural areas by providing locums. It recognised the need to ensure that they were competent and confident in this sometimes challenging environment.

The RPGP and the Rural Locum Education Assistance Program (Rural LEAP) have proved very successful in making funds available where needed to ensure services were maintained and enhanced, in some instances, for those living in rural and remote Australia.

1. BACKGROUND

The turn of the millennium saw a serious decline in the number of doctors providing lifesaving procedural skills in rural and remote Australia. The following graph demonstrates this steady decline in the New South Wales context.

Diagram 1 *– NSW RDN Decline of Rural Proceduralists - Report 2006*



RDN Proposals for a Rural Health Plan; 2006

These trends were reflected in all other states.

The Australian Rural and Remote Workforce Agencies Group Canberra, in the ARRWAG Minimum Data Set Report as at 30 November 2003, provides us with a snapshot at the start of the program.

It reported that there were only 902 rural and remote non-specialist general practitioners out of approximately 4075 general practitioners across all states who identified as performing procedures in the three main disciplines, or a combination of these.

Diagram 2

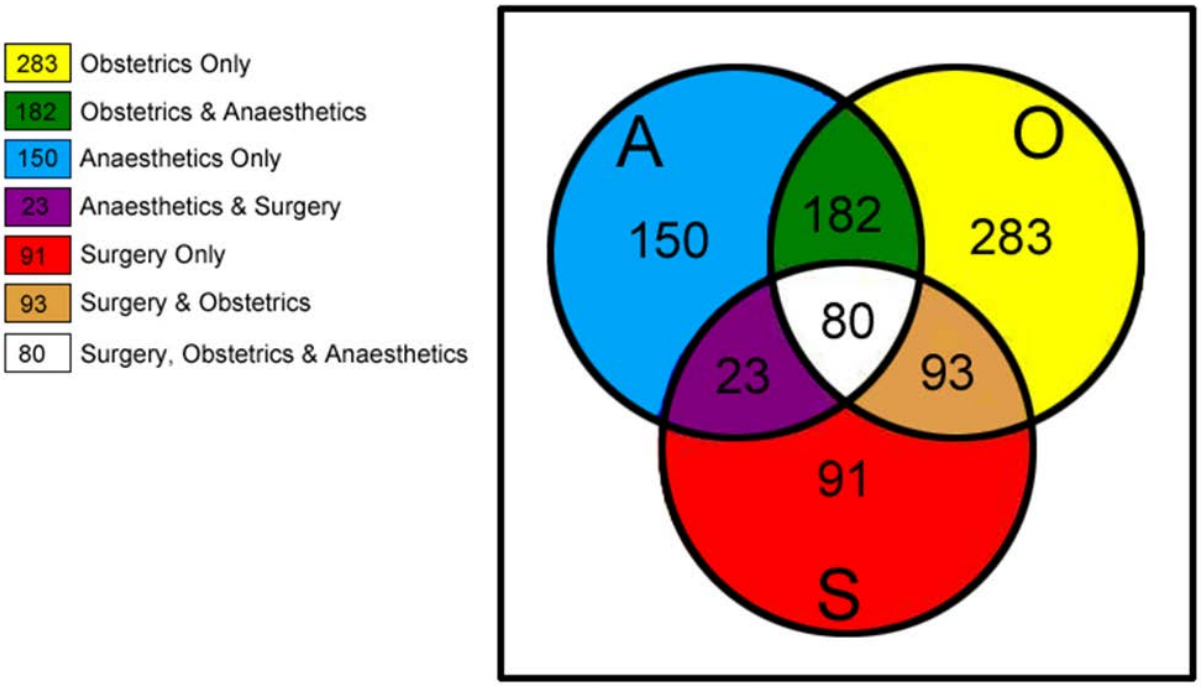


**Diagram by Chris Teakle*
Western Australian Centre for Remote & Rural Medicine

In response to this the Australian College of Rural and Remote Medicine produced a research report in 2002 on *'Barriers to the Maintenance of Procedural Skills in Rural and Remote Medicine and factors influencing the relocation of Rural Proceduralists'*.

Among the barriers to the maintenance of procedural skills, the top two barriers identified at the time were:

1. *Indemnity and other insurance costs*
2. *Changing patterns of litigation*

These were predictable given the indemnity crisis at the time and resulted in large part to the rising insurance costs and rising litigation.

The next six major barriers were:

1. *maintenance of multiple standards, benchmarks and qualifications;*
2. *costs of upskilling versus income recovery;*
3. *general undervaluing of the procedural GP;*
4. *pressures of maintaining a broad range of skills;*
5. *inability to take leave for training opportunities - time constraints, professional limitations; and*
6. *access to appropriate skills programs - type locality and cost.*

For female practitioners their views even more concentrated on these matters with their top two barriers being:

1. General undervaluing of the procedural GP
2. Cost of upskilling versus income recovery

It was recognised that many proceduralists provided services at both personal and financial cost to themselves and their families often with little recompense or recognition.

In October 2002, the Rural Doctors Association of Australia (RDAA) and ACRRM were asked to prepare a paper for the AHMAC National Rural Health Policy Sub-committee, '*Procedural Rural Medicine: Strategies Towards Solutions.'* This paper made recommendations for resolving the growing shortage of procedural skills in rural and remote Australia.

The Rural Procedural Grants Program was funded in the 2003/2004 budget by the Australian Government Department of Health (DoH), and commenced from 1 July 2004. Initially it was titled the Training for Rural and Remote Procedural GPs Program (TRRPGPP) and was funded under the auspices of the Strengthening Medicare Initiatives.

The initial budget from 2004 was over $20m and with increased participation and numbers the expenditure has approached this amount. The program has, the DoH confirms, never been over budget. The Collaboration have carefully monitored expenditure and advised government actively on implication of proposed extra inclusions that have been proposed including the Emergency component which was added in 2006 and expanded in 2008, and Rural Locum Education Assistance Program (LEAP) which was added in 2010.

After five years of successful operation, the TRRPGPP was re-funded under the Rural Health Workforce Strategy for a further three years and at that time was renamed the Rural Procedural Grants Program (RPGP). That contract has been extended to June 2016.

The Rural Health Workforce Strategy in the 2009/2010 Budget also funded a number of initiatives to enhance locum support for rural and remote GPs. One of these initiatives was the Rural Locum Education Assistance Program, which was funded under the contracts for the Rural Procedural Grants Program. The Rural LEAP has been operating for six years. Funding has transferred to a new locum assistance program at the end of March 2016.

2. PROGRAM MANAGEMENT AND VALIDATION

To provide the clinical and technical input to the Colleges' administration, the ACRRM/RACGP Procedural Medicine Collaboration was established at the commencement of the RPGP in 2004 and has provided effective oversight for both the RPGP and the Rural LEAP ever since.

This 'expert' committee is an excellent forum for exchange of information between all stakeholders, including DHS and DoH. The use of this committee has proved more cost effective than using consultants. The Collaboration monitors the Program's progress, provides significant input into the guidelines for the Rural LEAP, sets policy precedents for a number of training and eligibility issues, and guides Program staff in both Colleges to administer the Program in accordance with the aims and guidelines of both the RPGP and the Rural LEAP. This provides a consistent approach to applications by participants and education providers

The Program criteria have emphasised the requirement for service in rural communities, to rural communities as a sentinel requirement for entry to the Program. Applicants must be credentialed to provide services in rural facilities, including being regularly part of an on-call roster. Regular checks are made to ensure that participants meet these criteria of ongoing credentialing and participation in an on-call roster.

To ensure data quality/quality assurance of the database each College has mechanisms to check clinical credentialing of registrants each time a claim is lodged. No claim is approved without checking that the doctor continues to be eligible for the program. While participants may not claim for training every year the currency of their eligibility is checked when they do submit claims. In 2007, the Collaboration asked the colleges to develop a clinical privileges declaration (CPD) form, which was to be used in conjunction with the first Outcomes Evaluation Survey undertaken towards the end of the 2005-07 PDP/QI&CPD triennium.

At the end of 2007, 2010 and 2013 ACRRM and the RACGP verified the clinical privileges of participants using the clinical privileges declaration form.

The Program, including the Procedural and Emergency components, prides itself on being accountable, yet low in overheads and administrative complications.

Because the programs provide grants for training, rather than reimbursement of expenditure by the doctors, administrative costs are a very small proportion of the overall expenditure (Table 1). In this way the programs have provided funds to rural doctors serving in these areas and have encouraged a high quality market place of education providers from which rural doctors can choose their education. This has seen a flourishing of high quality education offerings. This is one of the keys to the success of the programs, as funds are directed to the areas of need and rural proceduralists are able to be supported directly.

Table 1 *- Administration costs –vs– total grant expenditure*

Financial year	Total Admin Costs (inc GST)	Total Grant Expenditure	Total Grant Expenditure (admin + claims)	% RPGP Administration Cost vs Total Grant Expenditure
2004-05	$289,779	$4,249,500	$4,539,279	6.4%
2005-06	$299,745	$6,381,500	$6,681,245	4.5%
2006-07	$393,391	$9,041,000	$9,434,391	4.2%
2007-08	$483,984	$13,062,500	$13,546,484	3.6%
2008-09	$467,927	$12,756,000	$13,223,927	3.5%
2009-10	$486,717	$13,748,000	$14,234,717	3.4%
2010-11	$512,005	$15,628,000	$16,140,005	3.2%
2011-12	$514,258	$16,842,000	$17,356,258	3.0%
2012-13	$526,909	$17,516,000	$18,042,909	2.9%
2013-14	$536,614	$17,048,000	$17,584,614	3.1%
2014-15	$545,739	$18,998,000	$19,543,739	2.8%
Total	**$5,057,067**	**$145,270,500**	**$150,327,567**	**3.4%**

3. PROGRAM ADMINISTRATION

Since its inception, the RPGP has been jointly administered by the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM) and the Department of Human Services (DHS), Medicare Program, formerly Medicare Australia.

The Colleges effectively administer the programs through their role to promote the RPGP and the Rural LEAP, assess new applications to determine GP eligibility to participate in the RPGP and the Rural LEAP, continuously check enrolled participants ongoing eligibility, and provide details of successful applicants to DHS. The Colleges also assess the grant status of training activities, assess the eligibility of grant claims and submit details of training to DHS to enable the payment of grants. DHS maintains a joint database of all enrolments and payments, processes payments for participants and provides statements of payments to participants.

All data presented in the briefing paper are taken from Collaboration statistics (unless otherwise identified). The Department of Human Services data is also reviewed by the Collaboration twice a year and data sets compared. Some proceduralists chose to registered in the RPGP by both Colleges and so combined college data overestimates participation by a predictable 110 or 6.6%)
GPs have the choice to register through either college or both but they cannot claim for the same training through both Colleges.

4. PROGRAM OBJECTIVES

4.1 RPGP Objectives

The RPGP aims to:

a) increase numbers of rural and remote procedural and emergency medicine general practitioners (GPs) accessing educational activities relevant to their respective discipline/s;
b) increase the skill level of these GPs; and
c) enhance retention of rural and remote GPs.

Support is provided through a grant payment which is designed to assist GPs with the cost of attending relevant training to maintain and enhance their clinical skills.

4.2 Rural LEAP Objectives

The Rural LEAP aims to:

a) enable urban GPs to access recommended emergency medicine courses; and (subsequently)
b) support these GPs to provide locum services in ASGC-RA 2 – 5 locations.

5. TARGET GROUP

5.1 RPGP Target Group

Initially the RPGP targeted procedural GPs providing services in Rural, Remote Metropolitan areas (RRMA) 3 to 7 locations in all states and territories in Australia.

In January 2006, the Program was expanded to include doctors providing emergency care in 24-hour triaging Accident and Emergency facilities located in RRMA 4 to 7 locations.

In April 2007, the Program was further expanded to include emergency medicine doctors working in RRMA 3 towns and the following month, the Program was expanded to include proceduralists working in RRMA 2 locations.

When the Program adopted the Australian Standard Geographic Classification Remote Area (ASGC-RA) classification in mid-2010, the target group was ASGC-RA 2-5 for both the Procedural and Emergency areas of the Program.

GP proceduralists (but not those in emergency medicine) in ASGC-RA 1 areas were dependent on additional approval and subject to them practising unsupervised in a manner akin to a rural doctor as well as participating in an on-call roster.

Since mid-2010 the RPGP has therefore targeted:

a) GP proceduralists who provide unsupervised Anaesthetics, Obstetrics and / or Surgery in ASGC-RA 1 – 5 locations
b) GPs providing unsupervised Emergency Medicine in 24 hour triaging Accident and Emergency facilities located in ASGC-RA 2 – 5 locations.

5.2 Rural LEAP Target Group

The Rural LEAP targets GPs working in ASGC-RA 1 locations. The initial guidelines were broad, however in July 2011 revised guidelines were released. These guidelines contained more specific selection criteria. Successful applicants now must be GPs with general registration, vocational registration or a fellowship with either the RACGP or ACRRM and currently practising in ASGC-RA 1 locations and be willing to do locums in RA 2 -5 localities.

6. ENROLMENTS IN THE PROGRAMS

Enrolments for the Programs must be in one of three categories:

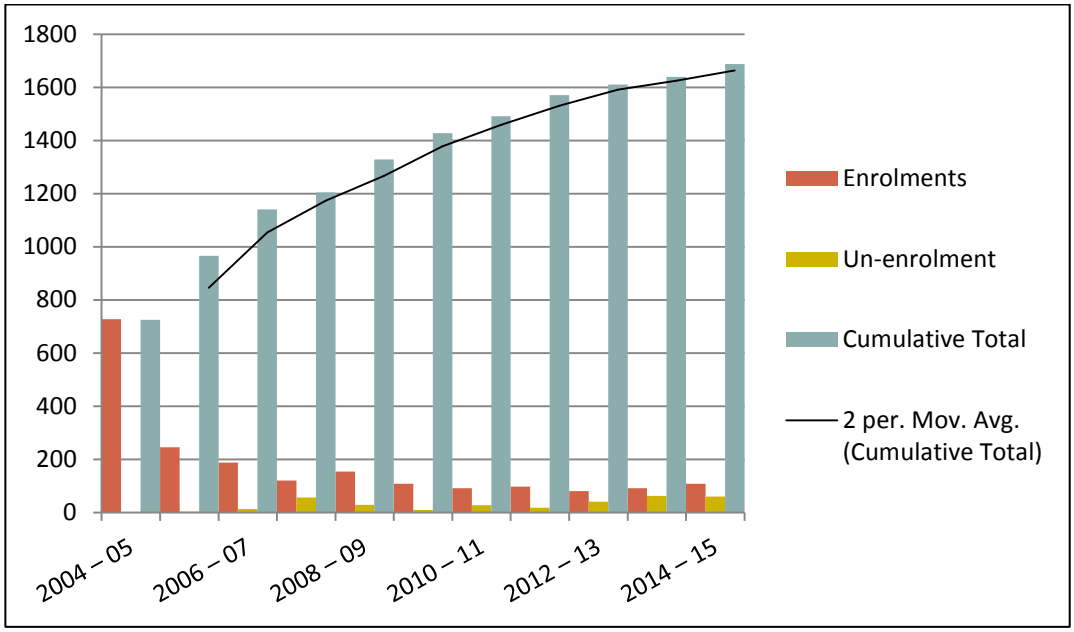
1) In procedural practice – **Anaesthetics, Obstetrics and Surgery**;
2) In **Emergency** practice; or
3) Undertaking **Locums** via LEAP from RA 1

6.1 RPGP Procedural Enrolments

Total Enrolments

A large number of procedural participants (36%) were registered in the RPGP by both ACRRM and the RACGP during its first year of operation, as shown in Diagram 3. Within two years it approximated the ARRWAG estimate of rural procedural GPs.

Diagram 3 - Procedural enrolments, un-enrolments and the cumulative total per financial year

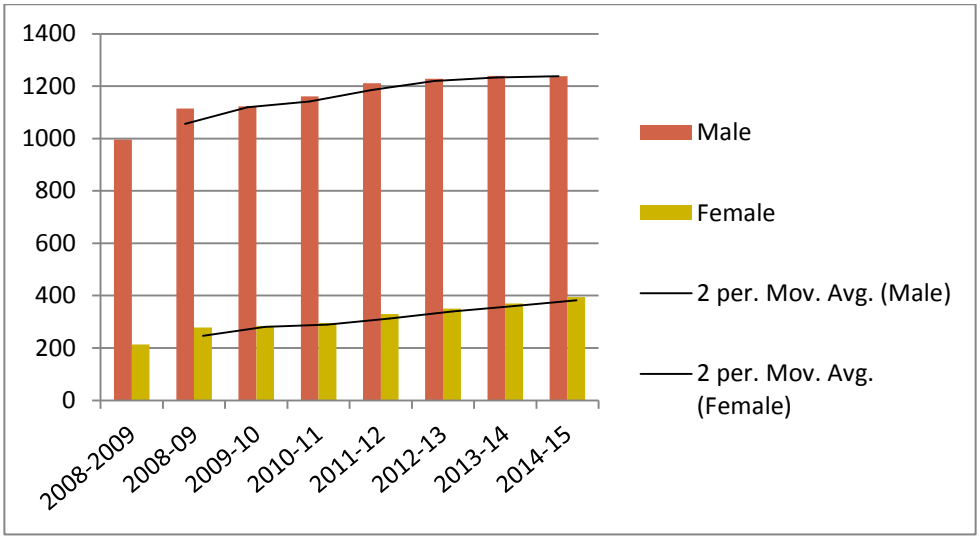


The yearly enrolment rate steadied from 12% in 2005-2006 to 8% in 2008-2009 and since then has remained relatively steady at 5% per financial year. This is consistent with the initial up-take by existing procedural GPs, the on-going replenishment rate of new doctors taking up these posts and a modest increase in numbers. The attrition rate has been relatively low with 354 proceduralists un-enrolled over the life of the Program because they no longer met eligibility criteria. As discussed above these data overestimate the total numbers in an ongoing manner by about 7% year on year.

Gender

At the end of June 2015, 1,656 proceduralists were enrolled in the Program through the RACGP and ACRRM. Seventy-six percent are male and 24% female with a higher trend towards growth in the female workforce

Diagram 4 *- Gender breakdown per financial year*

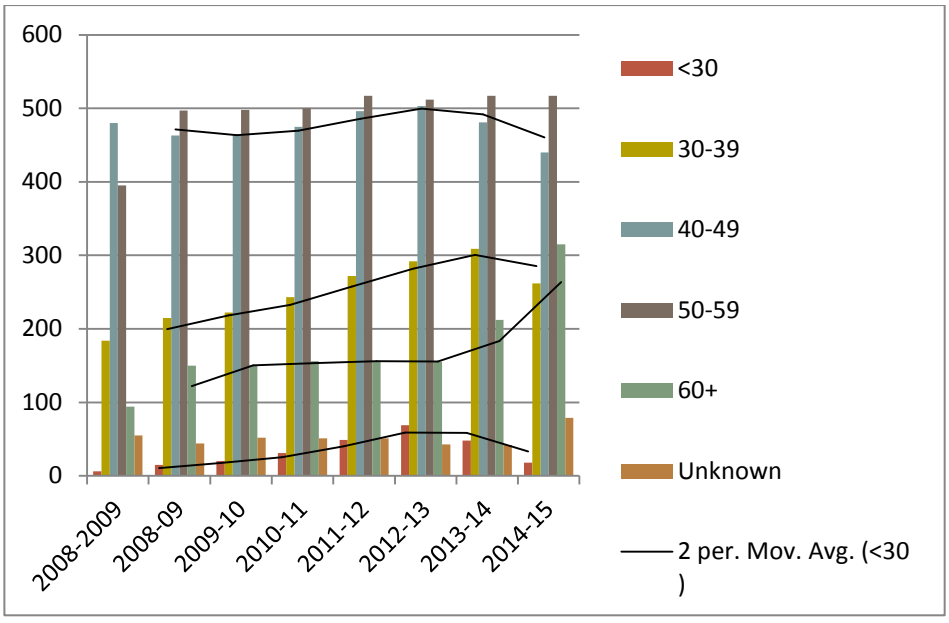


Age

Diagram 5 shows the age groups of procedural registrants per financial year from 2008 to June 2015.

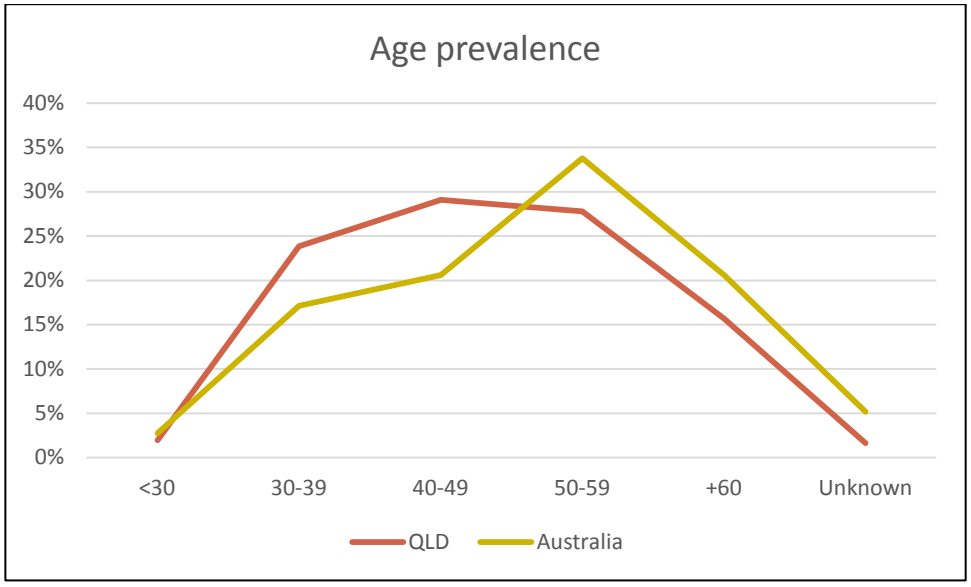
The majority are aged between 40 and 59 years. However there are 13% that are 60 years and older. Many registrars do not complete their training and enter practice till after 30 and so the low figures for this age group can be expected. Still approximately 20% are 39 years or younger. Over the period enrolments by the over 60 age group steadily increased. The under 49 age group have also shown steady growth but have recently plateaued out possibly reflecting a lack of training programs to encourage entry into procedural skills. RPGP figures maintained by DHS show a similar trend.

Diagram 5 *- Age group breakdown per financial year*



The latter hypothesis is supported by the fact that the age profile in Queensland which does have a structured procedural preparation pathway is skewed to younger age groups than the national sample.

Diagram 6 – Age Comparison with Queensland Proceduralists



Other challenging factors may include indemnity and infrastructure issues in other states.

All other age groups increased which shows GPs are staying on the program and new GPs are training with procedural skills.

Jurisdictions

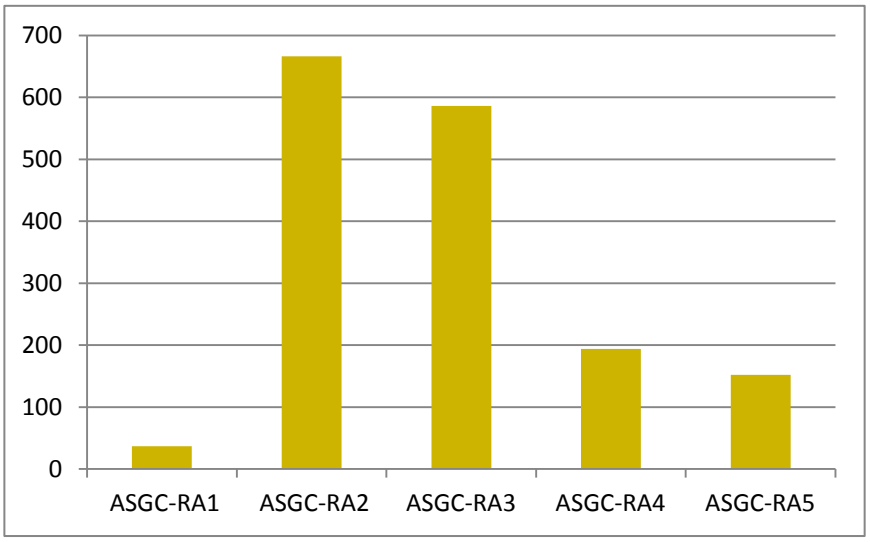
The state distribution of these proceduralists (Diagram 7) shows the majority are working in Queensland with 25%, 22% practising in Western Australia, 19% in Victoria, and 18% in New South Wales. Considerably fewer proceduralists work in South Australia (13%), 3% are in the Northern Territory and only 1% in Tasmania.

Diagram 7 - *Procedural enrolments by State*

Rurality

The largest group of current registrants (41%) are practising in ASGC-RA 2 closely followed by 36% practising in ASGC-RA 3 locations. Twenty-one percent are located in remote and very remote locations (Diagram 8).

Diagram 8 *- Procedural enrolments by ASGC-RA*



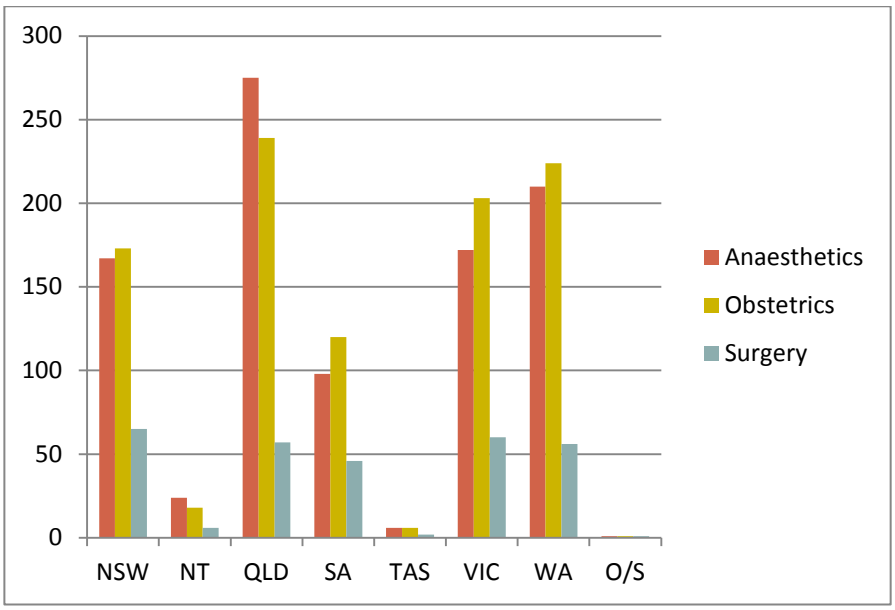
Category	ASGC-RA
Major City	1*
Inner Regional	2
Outer Regional	3
Remote	4
Very Remote	5

** In July 2010 the program was extended to include proceduralists working in ASGC-RA1 areas. However, Doctors in ASGC-RA 1 require additional approval from the Rural Procedural Grants Program Collaboration Committee and relatively few proceduralists working in city locations meet the eligibility criteria`*

Procedural discipline per jurisdiction

Diagram 9 below shows the geographic spread of these proceduralists.

Diagram 9 *- State distribution of proceduralists by discipline*



The largest group are GP Anaesthetists with 29% practising in Queensland, 22% in Western Australia, followed by New South Wales and Victoria, both on 18%, South Australia 10%, Northern Territory 3%, and Tasmania 1%.

The distribution for GP Obstetricians has the largest group working in Queensland 32%, then a drop to 21% in New South Wales, and 19% in Victoria. Western Australia has 15% and South Australia 10%, with Northern Territory and Tasmania both sharing 1%.

More GP surgeons practise in New South Wales at 22%, followed closely by Victoria 20% and Queensland and Western Australia both share 19%. South Australia has 16% and Northern Territory has 2%.

Procedural discipline mix

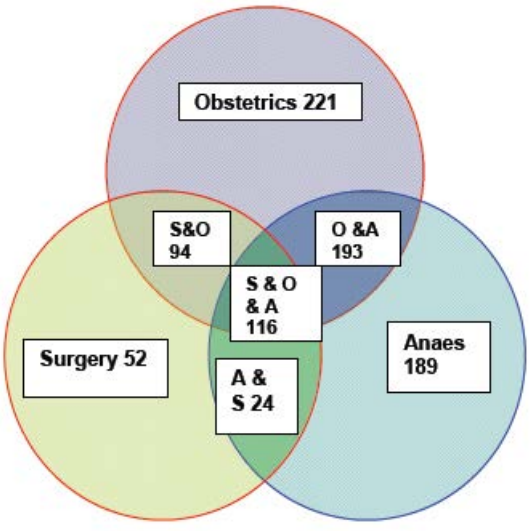
Sixty-two percent of proceduralists registered in the Program by the RACGP and ACRRM, have clinical privileges in Obstetrics compared with 59% in Anaesthetics. Only 19% are GP Surgeons

A total of 100 proceduralists were enrolled in all three procedural disciplines. Thirty-two percent of registrants were enrolled in Anaesthetics (817) or Obstetrics (821), while 14% (358) were enrolled in Anaesthetics and Obstetrics.

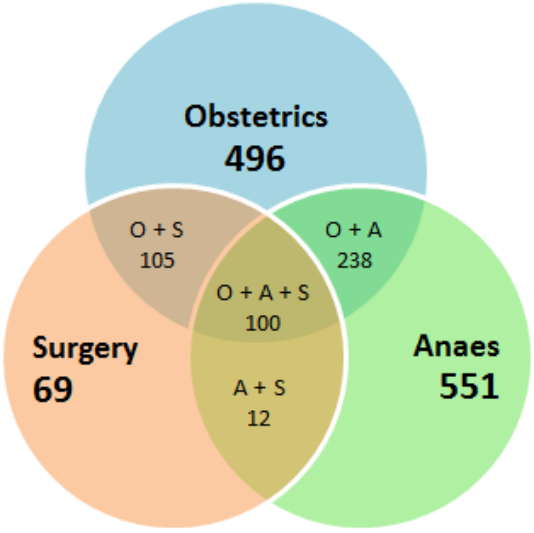
Diagram 10 shows the comparison between enrolments in the program in March 2006 compared to 30 June 2015.

Diagram 10 *– Comparison between enrolments over time*

As at March 2006



As at 30 June 2015



It is noticeable that there are large increases in those doing Obstetrics only and Anaesthetics only but a smaller increase in those doing Surgery only and a drop in those doing surgery in combination with other disciplines.

A comparison with Department of Humans Services – Medicare shows a good correlation with Collaboration data.

GPs with one or more procedural disciplines								
		RACGP	ACRRM					
Discipline		No. of GPs 30/06 2015		Colleges		DHS 31/03/2016	Variation	
Anaesthetics		294	257	551	34%	534	17	3%
Obstetrics		266	230	496	31%	461	35	8%
Surgery		23	46	69	4%	66	3	5%
Anaesthetics / Obstetrics		105	178	283	17%	268	15	6%
Anaesthetics / Surgery		7	12	19	1%	20	-1	-5%
Obstetrics / Surgery		36	69	105	6%	104	1	1%
Anaesthetics / Obstetrics / surgery		25	75	100	6%	104	-4	-4%
Total registrations		**756**	867	1623	100%	1557	66	4%

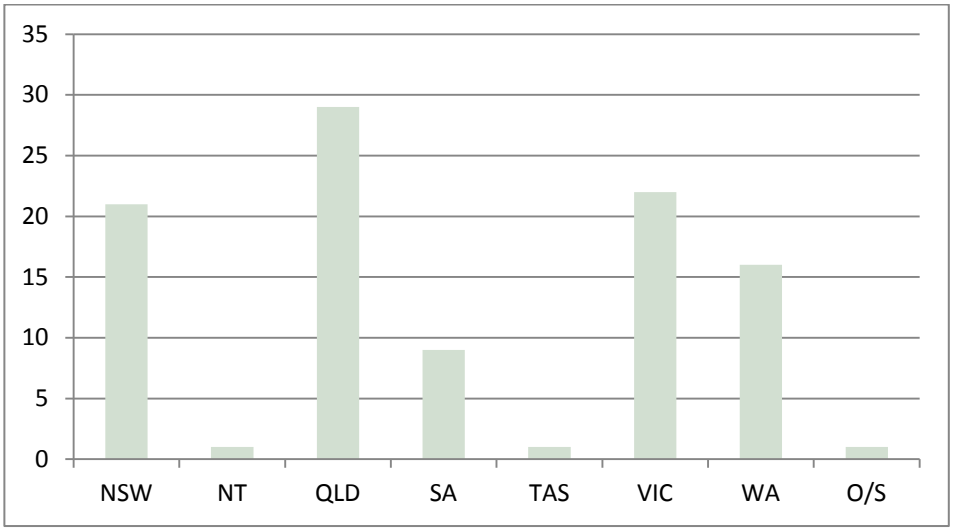
The largest increase has been in anaesthetics, closely followed by obstetrics with much more moderate increase in surgery.

The number of dually credentialed proceduralists has risen only marginally and the number credentialed in three disciplines has declined. One hundred GPs are enrolled in all three procedural disciplines under the Program.

Twenty-nine percent are in Queensland, followed closely by 22% in Victoria and 21 % in New South Wales.

Diagram 11 below shows the number of GPs practising all three procedural disciplines across the states.

Diagram 11 *- GPs enrolled in all three procedural disciplines across the states*



Un-enrolment and data assurance

The Colleges monitor the ongoing eligibility of participants and GPs who no longer meet the eligibility requirements are withdrawn and DHS is advised of these withdrawals.

Three hundred and seventy four have been withdrawn from the Program because they no longer met eligibility criteria. Table 2 provides a breakdown of the specific reasons why these proceduralists were withdrawn from the Program.

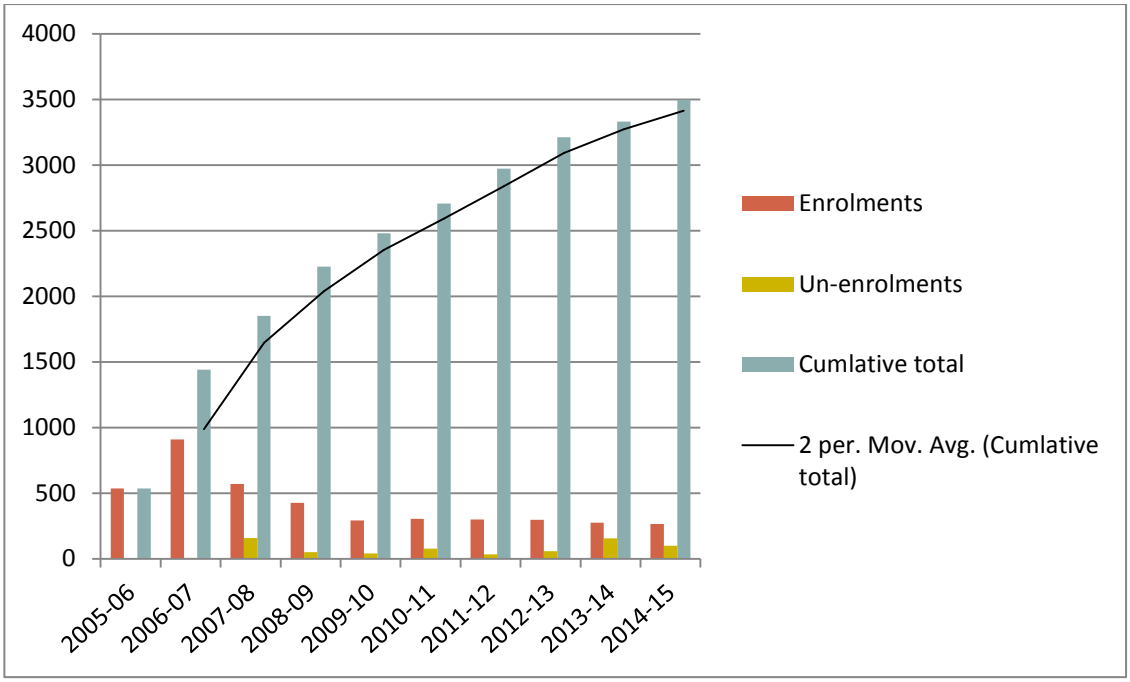
Table 2 *– Reason for un-enrolment from the RPGP*

Reason	n	%
No longer practising the registered discipline	213	56%
Moved to RRMA 1 / RA 1	68	17%
Unable to contact to confirm ongoing clinical privileges	31	8%
Didn't want dual registration in grants program	20	6%
Enrolled in Rural LEAP	2	1%
Overseas	10	3%
Didn't meet revised surgical privileges	5	1%
Started specialist training	5	1%
Retired	5	1%
Ceased procedural locums	3	1%
Deceased	11	3%
Cessation of grand-parenting	1	1%
Total un-enrolments	**374**	

6.2 RPGP Emergency Medicine Enrolments

Thirty-five percent of Emergency Medicine participants were registered in the RPGP by both ACRRM and the RACGP by June 2007.

Diagram 12 *- Emergency Medicine enrolments, un-enrolments and cumulative total per financial year*



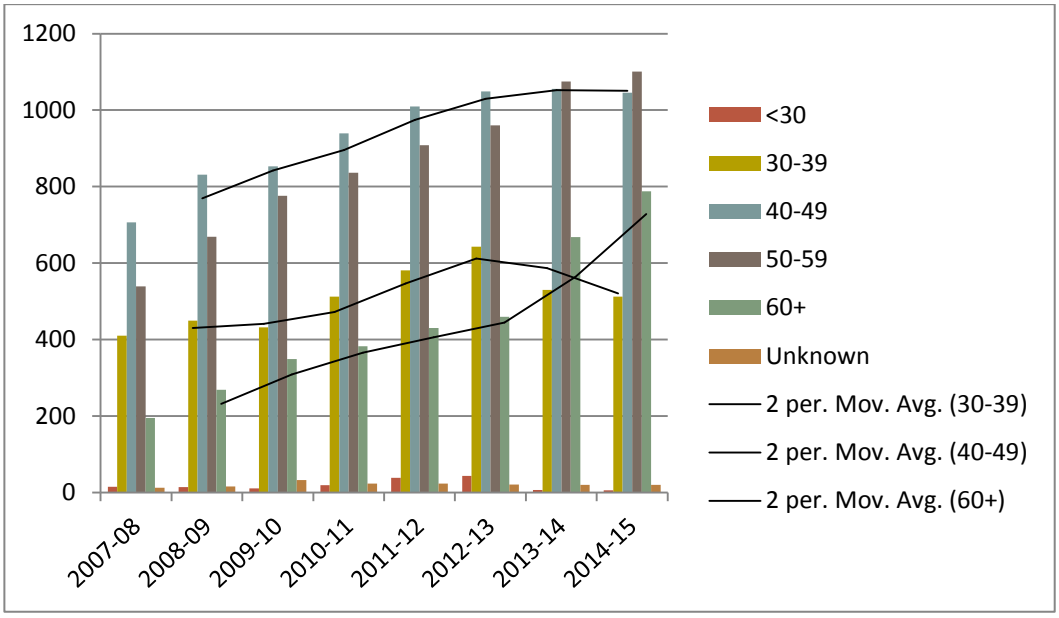
In a similar fashion to the procedural component, there was an initial high enrolment rate and then enrolments moderated after 2007-2008, representing the take up of the program by existing practitioners. The rate since 2008-2009 clearly represents the replenishment rate of new doctors entering this area. The rate has remained steady at 6-7% from 2009 to 2015 representing the steady rate of retirement of existing doctors and the replenishment rate of new doctors.

Since the commencement of the emergency component of the program, 10% of registrants (688) have been un-enrolled because they no longer met the program's eligibility criteria.

Age

At the end of June 2015, 3496 GPs were currently registered in the emergency component of the program through the RACGP and ACRRM. The majority are aged between 40 and 59 years and this is the strongest growing group. However 19% are 39 years or younger and 18% are older than 59 years. As with the procedural group the 30-39 group appears to flattening out somewhat in numbers.

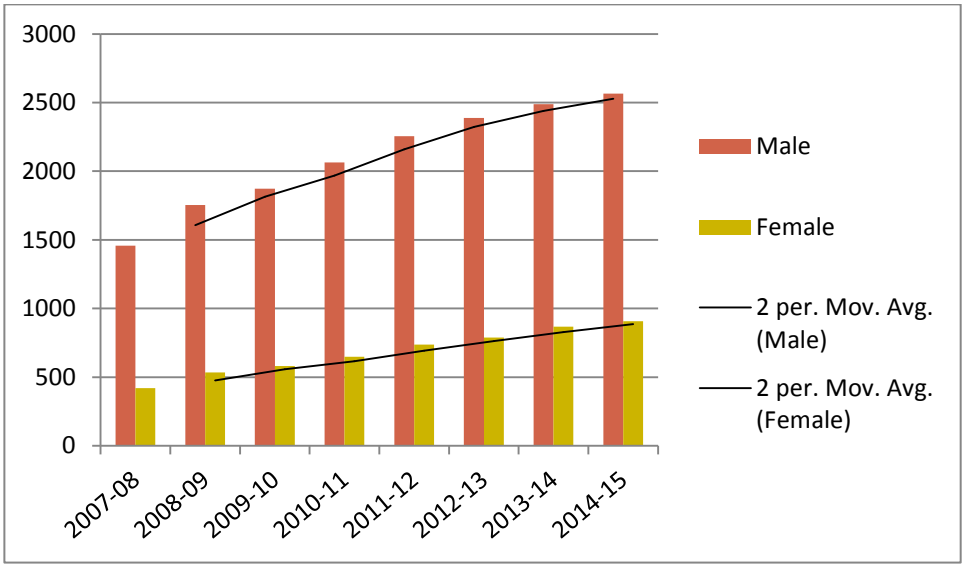
Diagram 13 *- Age breakdown per financial year*



Gender

Seventy-four percent of registrants are male and 26% female, as shown below.

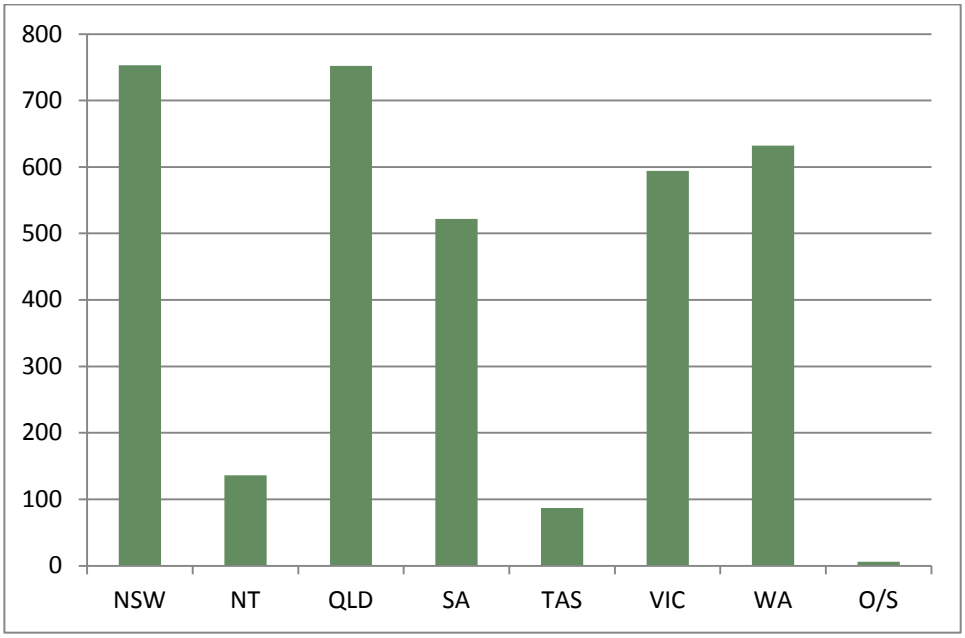
Diagram 14*- Gender breakdown per financial year*



Jurisdictions

The state distribution of these emergency medicine GPs shows the majority are working in New South Wales and Queensland (22%), with 15% to 18% practising in South Australia, Victoria and Western Australia respectively while considerably less work in the Northern Territory (4%) and Tasmania (2%).

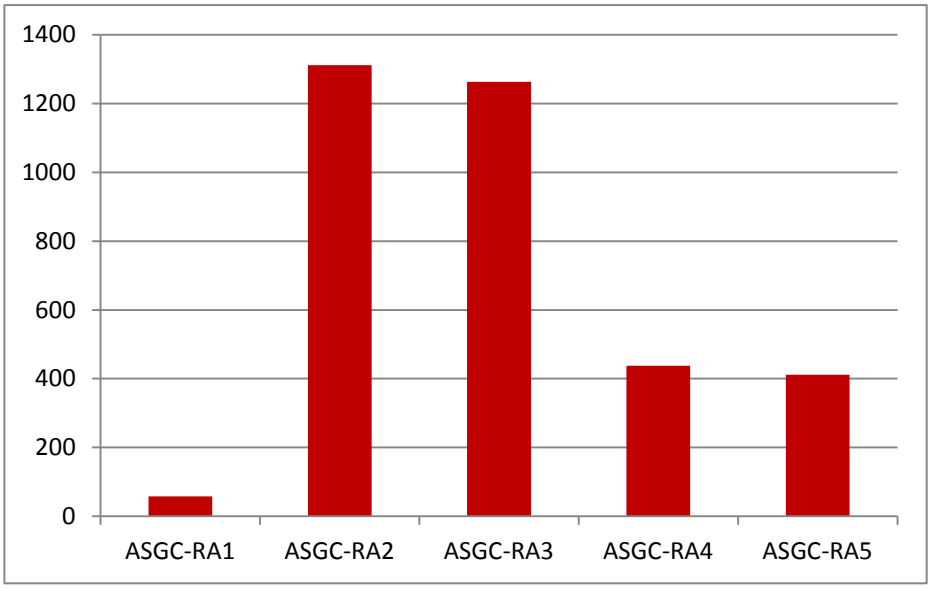
Diagram 15 - *Emergency medicine enrolments by State*



Rurality

The majority of current GPs (38%) are practising in ASGC-RA 2 and 36% are practising in ASGC-RA 3 locations. Twenty-five percent are located in remote and very remote locations.

Diagram 16 - *Emergency medicine enrolments by ASGC-RA*



GPs working in ASGC-RA 1 locations were enrolled in the Program prior to July 2010 on the basis of their RRMA (previous rural descriptor) eligibility. The grand-parenting provision enabled their enrolment in the Program until July 2013.

Some GPs based in ASGC-RA 1 locations are working as rural Locums in ASGC-RA 2-5 locations.

Un-enrolments

Six hundred and eighty-eight emergency medicine registrants have been withdrawn from the program because they no longer met eligibility criteria. Table 3 provides a breakdown of the specific reasons for un-enrolments from the Emergency Medicine component of the Program.

Table 3 *- Reasons for un-enrolments*

Reason	**n**	%
Relocated to RRMA 1 / RA 1	209	30%
No longer work in A/E	169	25%
No longer met revised GP Registrar Criteria	70	10%
No longer meet locum criteria	65	9%
Unable to contact to confirm clinical privileges	59	9%
Retired	36	5%
Overseas	24	3%
Cessation of Grand-parenting	21	3%
Didn't want dual registration in grants program	15	2%
Deceased	12	2%
Started GP Registrar Training & didn't meet GP Registrar criteria	5	1%
Started ACEM training	2	0%
Enrolled in Rural LEAP	1	0%
Total un-enrolments	**688**	

6.3 Rural Locum Education Assistance Program

The Rural LEAP was piloted under the auspices of the RPGP, with a set number of places allocated per financial year, with 30 in the first six months of the program, 105 in 2010/2011, 42 in 2011/2012, 49 places in 2012/2013, and 49 in 2013/2014. No cap was set on the number of places available in 2014/2015.

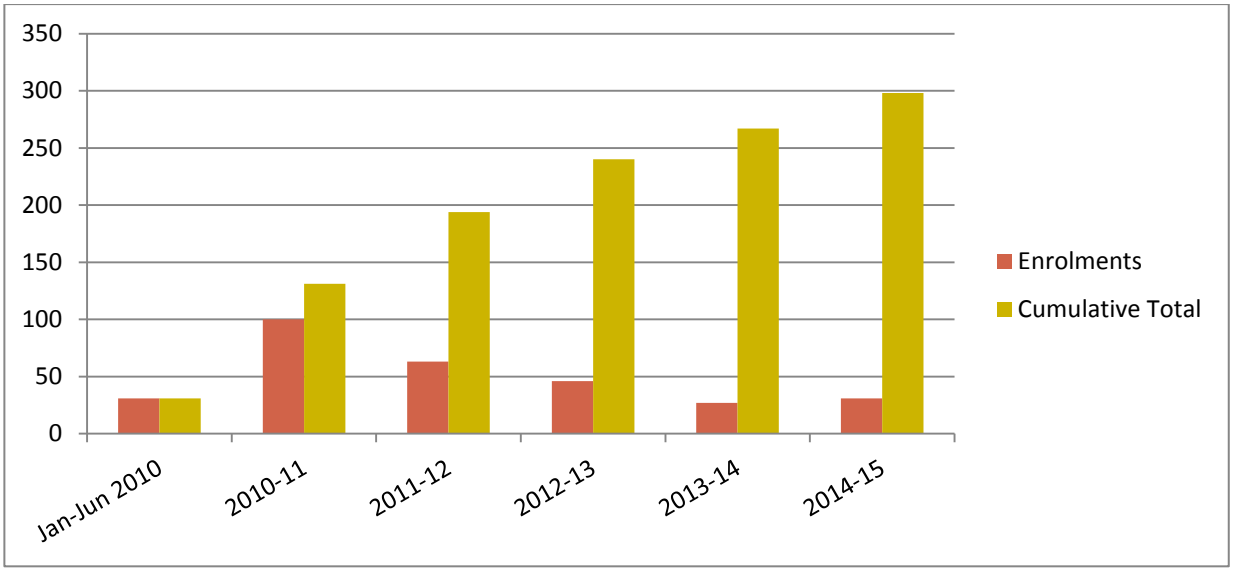
The Program ceased at the end of March 2016 with the program being included in a new locum initiative that will be known as the Rural Locum Assistance Program (Rural LAP). This incorporates various locum programs for GPs, GP obstetricians, GP anaesthetists, nursing and allied health. This means that the RACGP and ACRRM will no longer administer the Rural LEAP in its current format. The successful tenderer for the administration of the Rural LAP has been announced as Aspen Medical.

6.4 Rural LEAP Enrolments

Since January 2010 to 30 June 2015, a total of 298 GPs enrolled for the Rural LEAP. Seventy-nine GPs have withdrawn from the program for various reasons.

Diagram 17 below shows the total number of GPs enrolled in the Rural LEAP for each financial year and the accumulative totals.

Diagram 17 *- Rural LEAP enrolments and cumulative total per financial year*



Between January 2010 and June 2015, 44% of enrolments were female. Graph 18 shows the gender breakdown of new enrolments per financial year. The 50-59 age group had the highest number of new enrolments over the period at 40% (119), followed by 26% (77) in the 40-49 age group, and 21% (63) in the 60-69 age group. Eleven (4%) were 70 years of age and over.

Diagram 18 *- Gender breakdown of new enrolments per financial year*

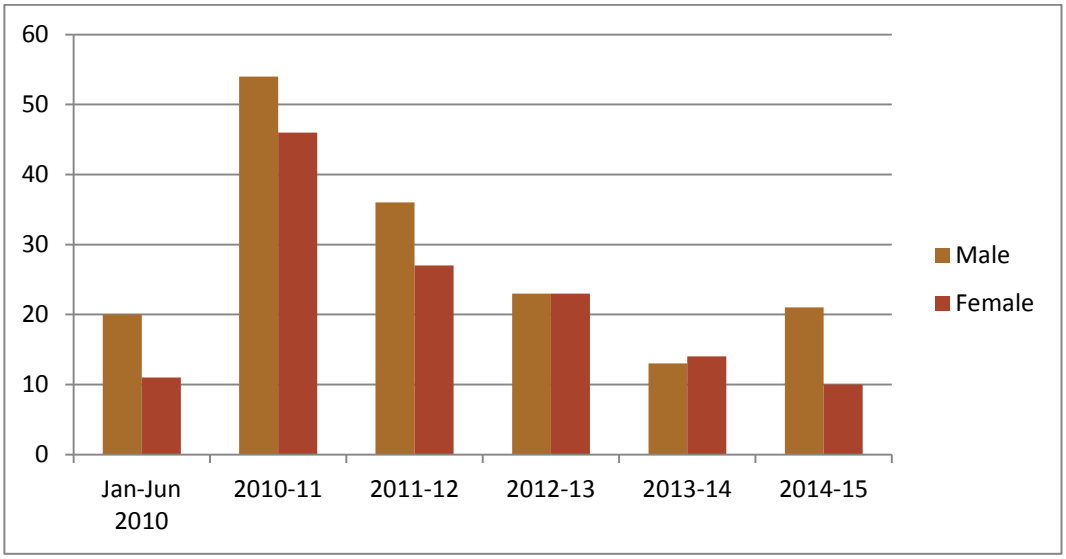
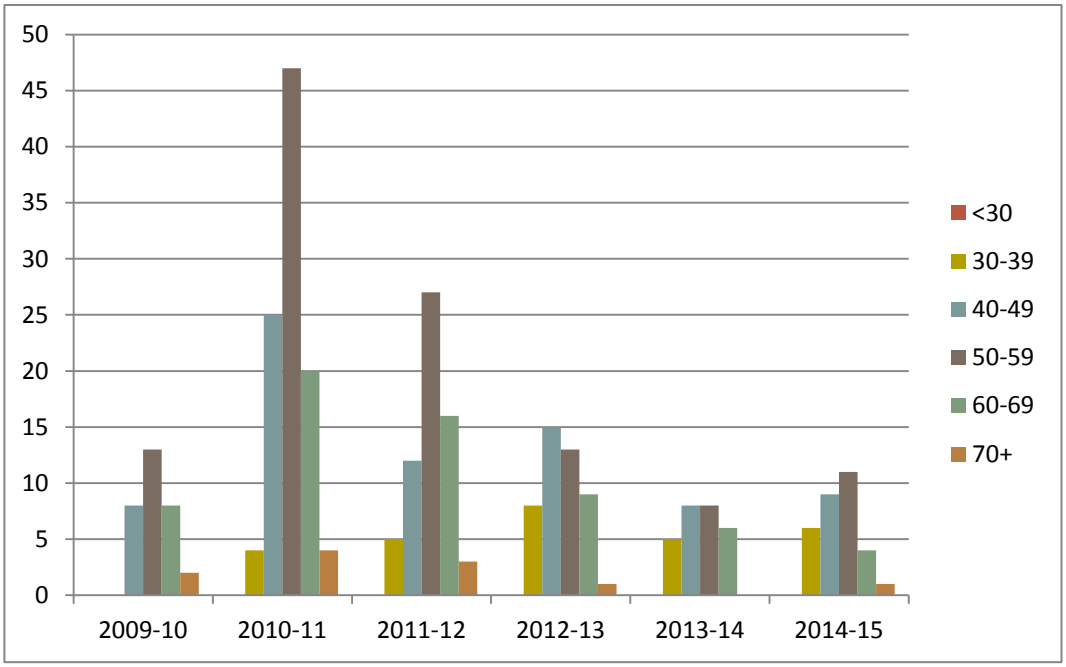


Diagram 19 *- Age groups of new enrolments per financial year*



As at 30 June 2015, Rural LEAP participants totalled 223 including, 169 who have completed the Program and 55 who are still participating. Fifty-six percent are male and 44% are female. The majority (38%, 85) are aged between 50 and 59 years. Twenty-two percent (49) are in the 40 to 49 age bracket and 12% (26) are 39 years and younger. Sixty-three participants (29%) are 60 years and older.

The state distribution of Rural LEAP participants shows the majority are working in urban areas in Victoria (37%). Twenty-two percent are practising in New South Wales, 20% in Queensland, and 12 % in South Australia. Only 8% of city GPs working in Western Australia and 2 % in the ACT have been recruited into the Program.

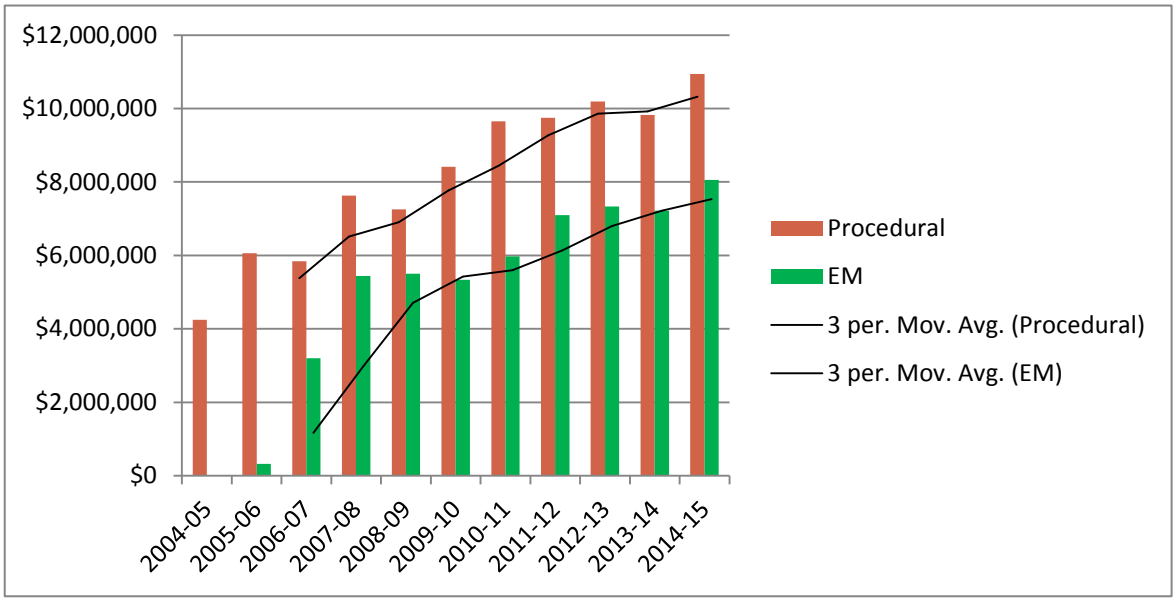
Diagram 20 *- Rural LEAP enrolments by State*

7. RPGP PROGRAM OUTCOMES

7.1 Increased Participation in Training

The following graph shows the increase of grant payments and educational activities attended under the Procedural Medicine and Emergency Medicine components since the beginning of the Program. At 30 June 2015, a cumulative total of $144,550,000 had been paid to grant recipients.

Diagram 21 *- Grant payments for both components per financial year from 2004 to 30 June 2015*



A noticeable increase in grant payments and activities attended was in 2009-2010 and 2012-2013 financial years which may be attributed to an increased number of doctors undertaking training to gain their professional development points for the triennium.

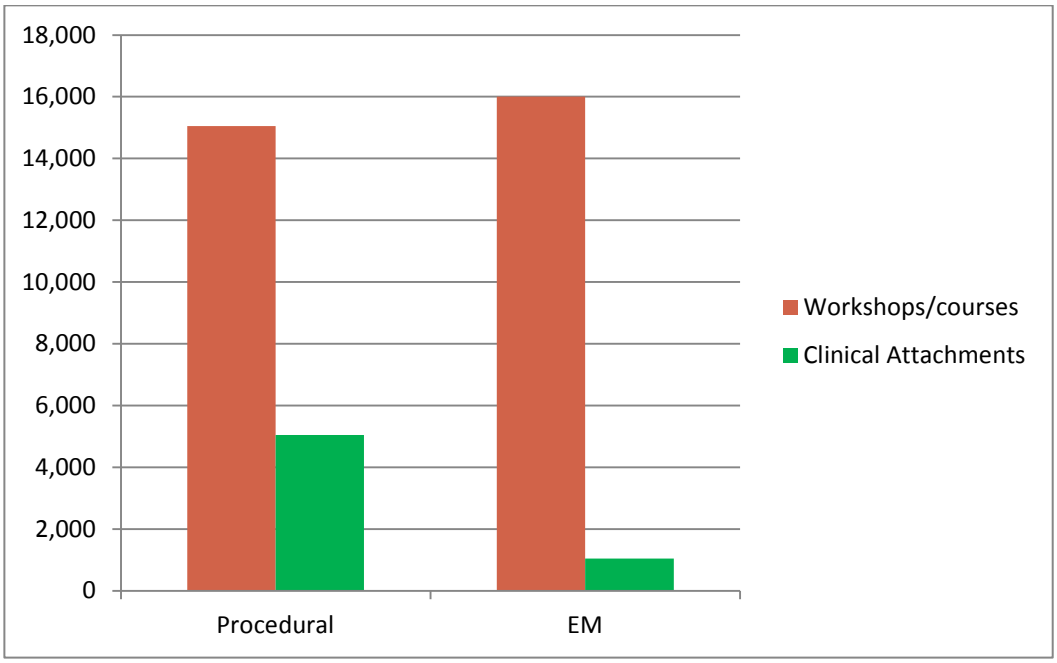
The requirement of completing Advanced Life Support training for ACRRM Fellows and Basic Life Support for non-Fellows and RACGP members also added to the increase in the amount of emergency medicine activities attended.

Educational activities

Diagram 22 below shows the type of educational activities attended over the period for Procedural and Emergency Medicine. 37,152 were attended – 6,091 clinical attachments were undertaken and 31,061 workshop/courses/conferences were attended. The majority of the clinical placements were in the procedural area.

GPs working in remote and very remote area are more likely to undertake clinical attachments than their colleagues working in less remote locations.

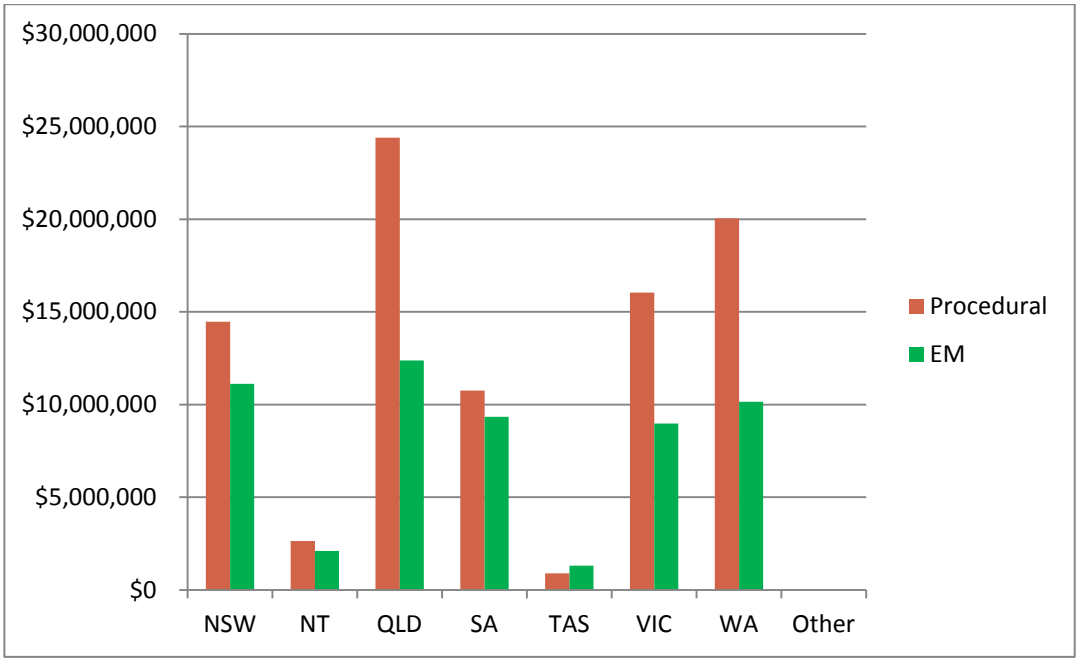
Diagram 22 *- Number of educational activities attended to 30 June 2015*



Jurisdictions

Diagram 23 below shows the distribution of grant payments by state and ASGC-RA to 30 June 2015. Queensland had a total of $36,787,000 followed by Western Australia with a total of $30,196,000. Predictably, Tasmania and Northern Territory have the least amount paid with $2,212,500 and $4,739,000 respectively.

Diagram 23 *- Distribution of grant by state 2004 to June 2015*



Rurality

Diagram 24 below shows the distribution of grant payments across ASGC-RA between 30 July 2010 and 30 June 2015. RA 2 and 3 have the highest amounts with RA2 a total of $30,807,000 and RA3 $29,838,000. RAs 4 and 5 are relatively even on $11,050,000 and $10,591,000 respectively.

Diagram 24 *- Distribution of grant by ASGC-RA to 30 June 2015*

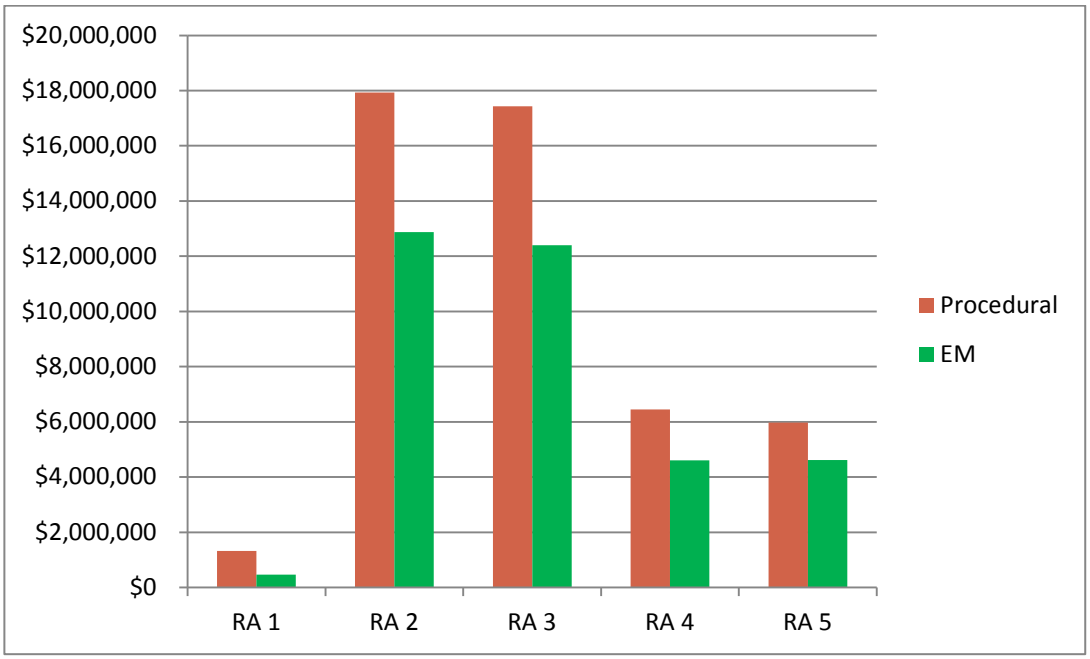
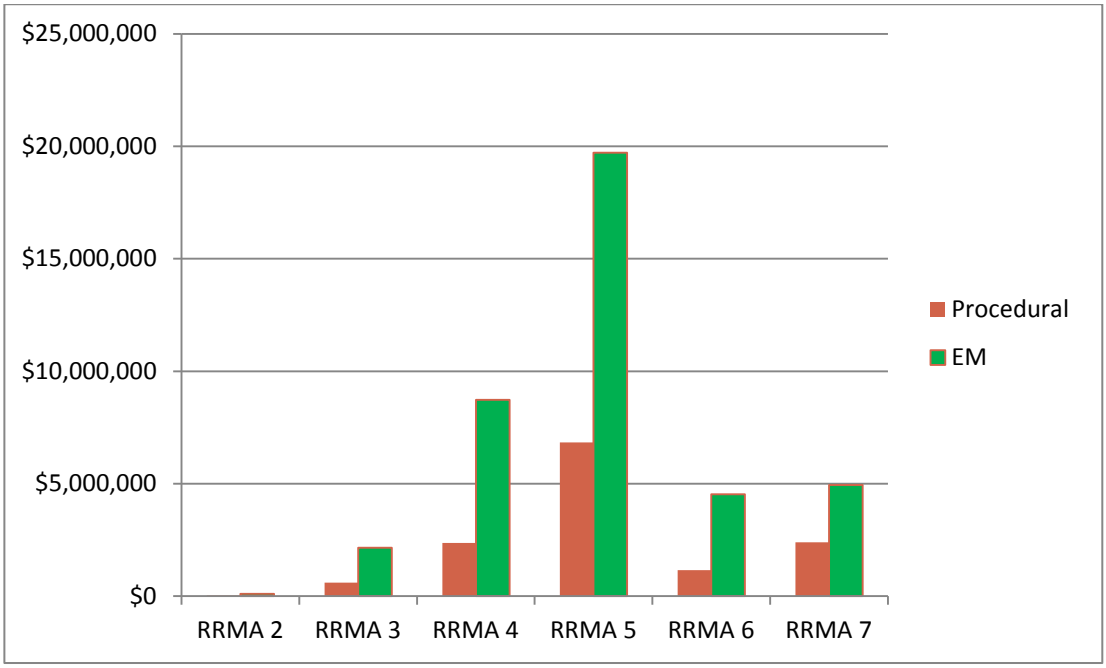


Diagram 25 below shows the payments disbursed during July 2004 and June 2010, prior to the introduction of the ASGC-RA classification system.

Diagram 25 *- Distribution of payments under the RRMA classification system*



7.2 Increased Skill Level/Confidence

To ascertain the potential of the programs to increase the skill level and confidence of proceduralists in rural and remote locations, ACRRM and the RACGP have surveyed their participants every 3 years to assess the extent to which the intended outcomes of the RPGP were being met. To ascertain whether the programs increase skill levels and confidence the surveys look at perceived levels of skills and knowledge and perceived confidence levels and how the assisted training has impacted on the proceduralists' practice.

7.2.1 Perceived level of skills/knowledge data

Results for 2013/2014 RACGP/ACRRM survey were very similar to those for 2010 and 2007. Respondents were asked to indicate the extent to which grant approved training had maintained and increased their procedural and emergency medicine knowledge and skills.

The overwhelming majority of 2014 ACRRM respondents (98%) indicated that their confidence to perform procedures had been maintained to a great extent (79%) or moderate (19%) extent. Similar ratings were observed from the Emergency Medicine component.

The majority of procedural medicine respondents (66%) and a similar number (69%) of emergency medicine respondents indicated that the funding has served to greatly increase their knowledge and skills in these areas. A further 30% to 32% of respondents reported moderate impact of the grant-funded training on the elevation of their emergency and/or procedural medicine skills.

All but two 2013 RACGP respondents perceived the training they had received had maintained their knowledge and skills in Anaesthetics, Obstetrics and/or Surgery. All respondents reported their Emergency Medicine skills had been maintained to a great or some extent through the training they had received.

Furthermore, results indicate, that as a direct result of this training, perceived levels of emergency medicine knowledge and skills have increased to a 'great' or 'some extent' for all but two of the respondents. 71% of respondents noted their emergency medicine skills have increased to a 'great' extent compared with 63% of respondents who reported this level of impact on their procedural skills.

7.2.2 Perceived confidence levels data

Registrants were asked to indicate the extent to which RPGP training had maintained / increased their confidence in their procedural and emergency medicine practice.

In the 2014 ACRRM survey, 79% of respondents reported that training accessed through the program has maintained their confidence to perform these disciplines to a great extent. Moderate impact on confidence was reported by almost 20% of procedural medicine respondents and over one-third of those engaged in emergency medicine.

Almost half of respondents reported a moderate increase in confidence to perform new procedural and / or emergency medicine procedures.

The most recent RACGP survey demonstrated that the program's impact on confidence levels to continue to perform procedural or emergency medicine is marked with all respondents with the exception of 4, reporting that their confidence level had been maintained. However, the impact of grant-approved training on confidence to perform new procedures was less marked with 3% of respondents reporting their confidence to perform new procedures remained the same.

7.3 Enhanced Retention in Rural Practice

The Colleges' surveys explored the impact of the program on retention in rural practice. Results clearly demonstrate that the Program has had a positive impact on the retention of rural and remote GPs participating in the RPGP. A substantial majority of RACGP respondents (80%) reported the Program has influenced them to stay longer in rural practice. Furthermore, the Program's perceived impact of facilitating retention of rural doctors' emergency skills is seen as a strength of the Program.

These results were corroborated by those of the ACRRM survey in 2014 which showed 69% of respondents reported that their participation in the Program had positively influenced their intent to continue working in rural and remote Australia.

7.4 High Level of Satisfaction with RPGP

The results of both Colleges' latest surveys are similar to previous ones. Participants in the surveys were asked to identify the strengths of the RPGP. The most common response related to financial support provided to maintain and update skills. The second most commonly reported strength was the perception that the Program encouraged and supported access to skills maintenance and upskilling.

The flexibility of the Program in selecting learning appropriate to the individual's needs was also viewed as a strength, as was the variety of high quality educational Programs and good publicity of grant approved training.

Increased confidence in skills, improved work satisfaction, improved patient care and enhanced networking with colleagues were seen as strengths.

Respondents also commented on the Program's lack of bureaucratic "red tape". They praised the relatively low level of administration required in registering in the Program and accessing grants.

Results also indicated that the Program is valued because it is seen as an acknowledgement of the importance of rural doctors maintaining their procedural and emergency medicine skills and is a validation of the vital role of the general practitioner in rural and remote communities.

8. RURAL LEAP PROGRAM OUTCOMES

Both Colleges also surveyed their respective Rural LEAP participants in 2014 to assess the extent to which intended outcomes of the Rural LEAP were being met. These surveys indicated the Program has been effective in enabling city GPs to attend emergency medicine courses and undertake rural GP locum placements.

8.1 Numbers attending recommended Rural LEAP courses

The substantial majority of RACGP respondents (97%) reported they had attended a course. Of the three respondents who had not undertaken training, two had joined the program six months prior to the survey and were registered in a course. The third respondent has experienced difficulties in finding time to attend a course.

ACRRM results were similar with 98% of participants confirming that they have undertaken emergency medicine training and only 2% still completing training.

8.2 Numbers undertaking rural Locum placements

RACGP results indicated 92% of respondents had completed a rural locum placement. Of the six respondents who had not done so, one has been withdrawn from the Program because she was unable to do any locum work within the required timeframe. Two respondents had not completed a course at the time of the survey but intended to start locum work following their attendance at a course. Time constraints precluded the remaining three GPs from doing a locum placement by the time the survey was conducted.

The majority of respondents (82%) had fulfilled their Rural LEAP locum obligation of 20 working days. Eighty percent of these respondents reported they had continued to do rural locums. The remainder had not done further rural locum work for a variety of reasons, including work and family commitments and bureaucratic red tape. Two had moved to rural practice.

ACRRM results indicated that 88% of participants indicated that they have performed one or more rural locum placements. For participants who have not yet performed a rural locum placement, time constraints and difficulties arranging leave from urban practice were cited as the main reason for not undertaking locum work.

8.3 Level of satisfaction with the Rural LEAP

Survey results indicate strongly that the Program is meeting its intended aims and objectives; that is, to enable urban GPs to access emergency medicine training and to support them in providing locum services to regional, rural and remote communities. Respondents valued the financial support and incentive to attend courses and the support the Program provided city GPs to do rural locum work. Confidence to undertake rural locums was also highlighted.

Perhaps the greatest indicator of the impact of the Rural LEAP is the proportion of participants who have continued to perform rural locum work after the Rural LEAP obligations have ceased. ACRRM survey findings indicate that 77% of participants continue to provide locum services in

regional, rural, or remote communities.

When asked for suggestions on how to improve the Program, almost one third of respondents indicated no change was necessary. A number of changes were recommended including the availability of more courses, the opportunity to repeat the LEAP, increased publicity of the program, more flexible timelines and increased financial support.

9. CONCLUSION

The Rural Procedural Grants Program and the Rural Locum Education Assistance Program are both aimed at maintaining the skills of rural proceduralists who are providing the highest quality of health care to the rural and remote communities that they serve. The Programs have encouraged training providers to develop procedural training initiatives that particularly meet the needs of this group and encourage skills maintenance and enhancement.

In this way procedural general practitioners now have far greater opportunity to access relevant professional development to ensure they are not being deskilled by their rural or remote locations. This is an essential part of the provision of medical services to those in isolated locations and supports the equitable delivery of such services to all Australians.