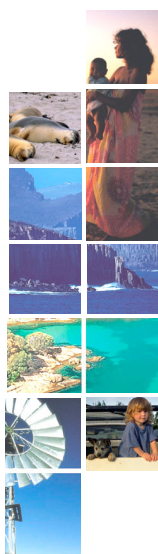


# Rural retention payments: lessons from the front

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## BACKGROUND

In 1999, Dr Wooldridge, the Minister for Health and Aged Care introduced the Rural Retention Program as part of a “package to retain and attract long-serving country doctors”<sup>1</sup>. The Commonwealth Department of Health and Ageing said it was an “initiative that aims to recognise and retain long-serving general practitioners in rural and remote communities that may experience significant difficulties in retaining general practitioners”<sup>2</sup>. The guidelines to the program say “it is hoped that encouraging such GPs to continue practising in these communities will contribute to better access, continuity in medical care and better health outcomes in rural and remote Australia”<sup>3</sup>.



## PROGRAM GROUNDRULES

The Rural Retention Program pays eligible primary health care medical practitioners (eligible doctors) annually for practicing in designated rural and remote locations. The program has two parts, the Central Payments Scheme (CPS) and the Flexible Payments Scheme (FPS). The Health Insurance Commission (HIC) administers the CPS and Rural Workforce Agencies (RWAs) administer the FPS.

CPS payments are paid directly to eligible doctors using HIC Medicare information, while FPS payments require the completion of an application form and are for eligible doctors whose work isn’t covered adequately by Medicare information.

To become eligible for a retention payment, doctors need to complete a qualifying period of service by accumulating 24 qualifying units (see Table 1). For the purposes of the program service is broken down into quarters that are examined individually and classified as active or inactive. Qualifying units are only awarded to active quarters and if the doctor has too many inactive quarters then he/she must start qualifying again.

**Table 1 Accumulation of retention payment qualifying units by payment category<sup>3</sup>**

Retention payment category	Qualifying period	Accumulation rate
A	24 active quarters (6 years active service)	1.0
B	20 active quarters (5 years active service)	1.2
C	12 active quarters (3 years active service)	2.0
D	8 active quarters (2 years active service)	3.0
E	4 active quarters (1 year active service)	6.0



On completion of the qualifying period, doctors receive annually, one of six payments depending on their Retention Payment Category (see Table 2). These categories start from the least remote eligible locations (Retention Payment Category A) and end at the most remote eligible locations (Retention Payment Category E).

**Table 2 Annual retention payments by payment category<sup>3</sup>**

Retention payment category	Qualifying period	Maximum annual payment rate
A	6 years	\$5,000
B	5 years	\$10,000
C	3 years	\$15,000
D	2 years	\$20,000
E	1 year	\$25,000

Having qualified for a payment the amount payable is calculated on the Payment Category of the primary location where they worked for each of the last four active quarters and the doctor's work load. These quarter results are then amalgamated and the annual payment calculated.

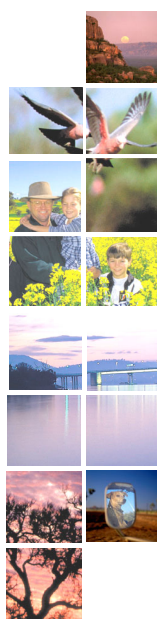
For the majority of GPs, because their primary health care work goes through the HIC Medicare system, the CPS picks up their workload and automatically calculates their retention payment correctly. However, there are three situations where the CPS's Medicare information is inadequate and the FPS is needed to be brought into play. These are **alternative employment, leave or top-up**.

**Alternative employment** covers doctors providing primary health care like state salaried doctors and Royal Flying Doctor Service (RFDS) living in remote locations such as the Pilbara and Kimberley Regions of Western Australia. These doctors normally do not have any HIC Medicare activity.

**Leave** provisions are for circumstances where GPs are away from eligible locations for allowable reasons such as upskilling. However, they have exceeded the limits under the CPS for allowable inactive quarters and under the CPS have to start qualifying again. The FPS leave provisions are the means by which such doctors are not required to begin qualification for the program from scratch.

**Top-up** payments cover primary health care doctors such as Aboriginal Medical Service (AMS) doctors who have enough HIC Medicare activity to get a CPS retention payment, but it does not cover their total workload. A calculation of their full entitlement is undertaken and the difference between this amount and the CPS payment is their top-up.

Doctors who feel that they fall into one of these three categories ask their RWA for an FPS application form. They complete it, return it to the RWA, who assess it and determine what if any payment should be made. The RWA give the information to the HIC who make the payments.



## PROBLEMS ENCOUNTERED AT THE FRONT AND THEIR RESOLUTION

As with any large program, there will always be problems encountered at roll out. The HIC runs the CPS and our paper covers FPS problems and more specifically FPS problems in Western Australia. To put this in context, Western Australia accounts for around 50% of the nation's FPS applications or 181 between the start of the program in 2000 and the end of June 2002.

### Problem

Because the system for locations' *Rural Retention Category* classification was done by way of a program encompassing all of Australia, some locations were inappropriately classified (eg Port Hedland and its suburb, South Hedland had different classifications).

### Resolution

After representations from GPs in locations who felt that their towns were incorrectly classified, a process for reclassification was organised. This involved arranging a meeting with the team setting up the original program, the Department of Health and Ageing, the HIC and the RWAs. Discussions were held setting out the ground rules for the reclassification process, and the RWA representatives used their local knowledge to translate these ground rules into proposed reclassifications. An improved classifications list was agreed, which was put to the Rural Retention Program Taskforce and this translated into a better list of category classifications. This new list has nearly done away with any complaints that we at WACRRM have encountered.

### Problem

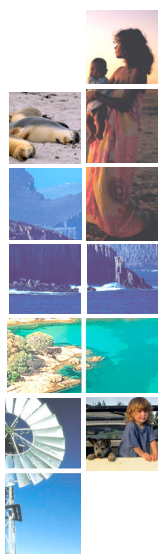
In situations where a doctor has moved from being paid under the CPS to the FPS and back, payments may be made after an incorrect quarter. This can happen when a private practicing GP moves from Medicare invoicing to being a state salaried primary health care providing doctor for a short spell and then returns to being a private practicing Medicare invoicing GP. In these circumstances, the CPS payment will be made later than it should have been. Should we make a part FPS payment, or should the next CPS payment be made sooner to account for the previously unrecognised work.

### Resolution

It was decided that part FPS payments would only complicate matters and that it made more sense to "rephase" the next CPS payment to a sooner payment date. That way, all the payments remained within the CPS system.

### Problem

It is all very well having the FPS in place to take into account CPS problems but how do the stakeholders and especially the RWAs inform potential FPS recipients of their entitlements?



### *Resolution*

An initial publicity blitz was undertaken by the Department of Health and Ageing informing rural doctors of the scheme and asking those who knew they would not be covered by the CPS to send in a FPS application form. Since the initial payments, RWAs have taken over the primary role of informing eligible doctors. RWAs regularly inform all potentially eligible doctors of the FPS (eg via newsletters and at educational events) and previous year's FPS recipients are sent new application forms at the time the RWAs estimate that their next payment is due.

### **Problem**

The application process was necessarily thorough and, especially for state salaried and RFDS doctors in remote Western Australia who accrue their own retention payment, was also daunting. For those doctors accruing an employer retention payment, this had to be deducted from the Commonwealth FPS payment. These doctors had to get letters from their employer that were very specific. This caused delays in these doctors getting their payments. It also led to claims that they were being treated inequitably in that they were not getting the full Commonwealth payment.

### *Resolution*

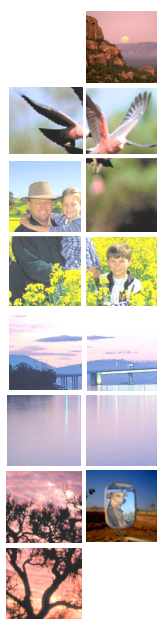
Eligible state salaried doctors and the Western Australian Department of Health's administrative staff soon got to realise what was needed and delays have been cut down to a minimum. Eligible RFDS doctors have been able to access their retention payments by sending us statutory declarations in place of letters from their employer. The Rural Retention Program Taskforce reiterated three times its ruling that adding the two retention payments together would be interfering with employer's intentions and would add to the disparity with the salary package of the less well paid AMS doctors. This would make it even harder to get doctors to work for AMSs.

### **Problem**

The way the FPS was initially set up it had a complex payment process and had heavy reporting requirements. It involved getting funding through a third party and a multitude of different reports that often showed the same data but in different ways. As a result, payments were delayed and the information overload caused confusion.

### *Resolution*

The payment and reporting processes have been simplified. All payments are now made by the HIC cutting the time it takes for the GPs to get paid by over a month. The information required has been changed so that it is only provided once. This has all but eliminated the confusion about what the information means.



## OUTSTANDING QUESTIONS

### Has the rural retention program worked?

The *Rural Retention Program* has been paying doctors for staying in rural/remote Australia since December 2000, over two years. Has it been able “to retain and attract long-serving country doctors”<sup>1</sup> as it was intended. In other words, has it led to an increase in the lengths of time that that eligible doctors have stayed in rural and remote locations?

Anecdotal evidence given to us and, initial statistical evidence, indicates that it has. The funding for the program runs to 30 June 2003, and the government has to decide whether to continue with the program, end it or revamp it. An evaluation is currently being undertaken on behalf of the Department of Health and Ageing. This will help determine whether to continue the program or not, but we believe that it has made a significant contribution to attracting and retaining doctors in the bush.

### Could rural retention payments be given to other remote health professionals?

Assuming that the *Rural Retention Program* for primary health care medical practitioners will be continued, a natural question is should the program be expanded to include other health professionals. Already there are some forms of monetary incentives for health care professionals other than doctors to locate to the bush. These vary from location to location, profession to profession and state to state. However, there is no co-ordinated effort in this regard.

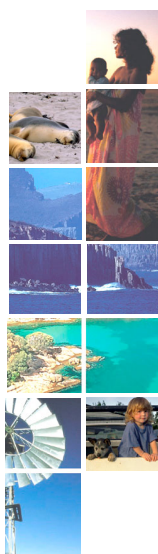
The ability of one type of health professionals to work in isolation from other health professionals is unrealistic. Therefore a shortage or high turnover in any health professionals in rural or remote locations impacts on the capacity of other health professionals to do their jobs. Indeed, this is the basis for a research project currently being undertaken in the Goldfields region of Western Australia.

If then we accept that other health professionals should get rural retention payments, could it be done? Setting aside the question of whether this should be the states or the commonwealth’s responsibility, is it possible to set up a program?

Because there are no HIC Medicare type records for nursing and other health professionals that would allow for a CPS the whole process would have to be a FPS type one. This would require a large administrative office with slow processes and therefore slow payouts. This would essentially rule this type of program out. What alternatives are there?

One of the options is to use the taxation system. This could be a tax allowance such as the allowance for taxpayers living in remote locations. This has some merit in that it would be relatively simple to run. However, it will not be given out on the basis of remoteness, but rather on the basis of the marginal rate of tax of the health care professional.

Payments could be made through the registration boards/authorities. This could be done by way of a declaration as to where the health care professional worked in the



previous year. Unfortunately not all health care professionals have to register annually and that may cause problems.

Employers may be used as a vehicle for the payment. One way would be for employers to pay their employees in remote locations the retention payments and claim it back against their tax liability. This may however be used by employers to decrease the salary package available for health care professionals in remote locations defeating the purpose of it.

Whatever the method used, governments, both state and commonwealth should seriously look at a co-ordinated effort to look at the possibility of expanding the rural retention program to other health professionals.

To conclude, the *Rural Retention Program* has worked and it should be used as a basis for rolling out retention payments in a co-ordinated national effort to other health professionals working in rural and remote locations.

## REFERENCES

1. Wooldridge Hon Dr M, 13 December 1999 *A bumper Christmas for rural health* Media Release MW129/99
2. Commonwealth Department of Health and Ageing, March 2002 *Rural Retention Program* Commonwealth Department of Health and Ageing website
3. Commonwealth Department of Health and Ageing, July 2001 *Rural Retention Program: Central Payments System* Commonwealth Department of Health and Ageing website

## PRESENTER

**Mike Seward** is Business Manager for the Western Australian Centre for Remote and Rural Medicine (WACRRM) of the University of Western Australia. The Flexible Payments System of the Rural Retention Program in Western Australia is amongst the business operations Mike manages.

Prior to joining WACRRM, Mike worked at Royal Perth Hospital as a Business Manager. Before that he had experience in the banking, stock broking and industrial sectors.

In April 2002 Mike presented a paper at the 3rd National Conference of the Australian Rural and Remote Workforce Agencies Group on how collaboration with stakeholders leads to improved medical services for rural communities, citing our experiences in WA's Northern Wheatbelt.

