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AMA submission on the activities of Jurisdictional Coordination Units supporting the National Rural Generalist Pathway.

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The AMA welcomes the opportunity to provide feedback about the proposed activities of Jurisdictional Coordination Units that will support the rural generalist workforce throughout their training and post-fellowship.

The introduction of the National Rural Generalist Pathway is a positive move from the Government that, as part of a broad suite of measures, will help to both increase community access to health care and address the significant medical workforce issues in rural and remote Australia. The effective delivery and coordination of the rural generalist training program is of great importance.

The AMA is broadly supportive of the proposed functions of the Rural Generalist Coordination Units. Notably, the proposed functions and activities of the Coordination Units closely mirror those of the AMA's Regional Training Networks model for generalist and specialist rural training pathways[1].

The AMA has long advocated for this type of collaborative training model for rural Australia. It can enable the critical links between regional and metropolitan centres, rural clinical schools, universities and medical schools to leverage infrastructure and resources. This model can also support prevocational and vocational trainees, as well as doctors who have obtained fellowship. Such a model would provide rural specialist and generalist trainees with access to a sufficient breadth and depth of generalist training in both larger metropolitan and smaller regional and rural centres. Regional training networks, consequently, would build a medical workforce responsive to community needs including the health needs of Australians in regional and rural locations.

The AMA acknowledges that the Government has attempted to support rural medical trainees through the introduction of regional training hubs. However, the AMA has received mixed reports on the ability of regional training hubs to support doctors in training. In the AMA Submission to the evaluation of the Rural Health Multidisciplinary Training Program[2], the AMA outlined that employees of hubs often act as little more than advocates – identifying spaces where a training post should exist, but lacking the ability to acquire funding, accreditation, or staff to train and supervise. This is because hubs are navigating a State

[1] AMA Position Statement Regional Training Networks 2014
[2] AMA Submission to the evaluation of the Rural Health Multidisciplinary Training Program 2019

employed workforce to deliver training yet have little engagement with the States. Regional training hubs also have no real influence over GP and other non-GP specialist vocational training, which of course remains within the scope of the Colleges and the Regional Training Organisations. The AMA called for more meaningful engagement between the Commonwealth and the States at policy level that addresses shared funding, drivers and outcomes. This can be achieved through Regional Training Networks that have a shared governance structure, or perhaps now through the proposed Rural Generalist Coordination Units.

The AMA notes that the Coordination Units may act as the single employer for Rural Generalists in Training under the National Rural Generalist Program. This effectively creates the State-based 'single employer model'. In this regard, the AMA has been strongly advocating for the concept of the single employer model as the basis for the employment of GP registrars[3]. The AMA believes that the single employer model should be extended to all GP trainees in order to address longstanding issues in GP training such as poorer remuneration and access to leave entitlements compared to their hospital counterparts, and difficulties in training between hospitals, community health centres, non-GP specialist services and general practice. This would also rectify the significant conflict of having an employer who also determines progression through training via assessment.

It is worth noting that the adoption of the single employer model for rural generalists by Coordination Units is likely to create a significant divide between the rural generalist workforce and all other rural trainees. While it is outside the scope of this submission, the impact of this policy will have substantial flow on effects for the rural medical workforce. This is because there is a risk that a large proportion of rural generalist graduates will continue to work in salaried practice in preference to private rural general practice. If the States only employ rural generalists and leave small towns without a hospital to the private system, it may become increasingly difficult to recruit to those locations as private practice will be competing against significantly better salaries and conditions in the state system. The implementation of the single employer model for all rural trainees and GP registrars would alleviate these issues.

The AMA has some comments specific to the *functions of the Coordination Units* as follows:

Governance

The AMA commends the inclusion of strong rural general practice leadership, and the range stakeholders required for the governance of Coordination units. A cooperative relationship between the Colleges, training organisations and the States is essential for long-term success. The AMA recommends that local communities and local doctors be involved in governance at all levels, and that interjurisdictional Coordination Units be chaired or otherwise led by a rural generalist.

Data collection and analysis

The collection and analysis of workforce data is critical for long-term workforce planning across Australia. Ensuring that this workforce data is considered alongside available data on the activity of all rural GP and non-GP specialist trainees would provide a richer and more comprehensive dataset for longitudinal service delivery of all medical graduates with extensive rural training.

Case management

[3] AMA Pre-Budget Submission 2020-21. Page 20

The support provided to rural generalist trainees through case management will help to address barriers to rural training such as professional isolation, and a lack of support for families/partners.

Policy Development

Community general practice in rural and remote areas is facing significant workforce shortages. Rural areas without hospitals rely on general practitioners as their sole healthcare providers. The minimum amount of time that rural generalists train in community general practice should reflect the critical role of general practice in these communities, given the ongoing workforce shortages.

The AMA is pleased to see that credentialing has been identified as an area for policy development. This is a longstanding issue for rural GPs that often prevents them from working to their full scope of practice in some rural facilities despite being fully qualified[4]. The AMA recommends that jurisdictional Coordination Units direct rural representation into clinical governance and credentialing throughout all levels of the National Rural Generalist Pathway, including engagement with external stakeholders. The AMA believes this will assure quality clinical governance that is contextualised and appropriated to the jurisdiction and rural setting. This includes in centralised credentialing committees in metropolitan areas that are involved in decision making directly affecting rural practitioners.

Workforce Planning

The ongoing closure of maternity units in rural areas is causing a rapid deterioration of rural maternity services. In 2019, expectant mothers in Queensland were sent DIY birthing kits because their nearest birthing units were not within reasonable distance. This has the effect of decreasing the capability of rural facilities due to workforce deskilling, and the deterioration of facilities due to disuse. As a result, this is now an urgent issue in many communities that must be addressed explicitly within the terms of reference of Jurisdictional Coordination Units. The provision of medically led maternity care should be an essential aim of the National Rural Generalist Pathway.

Collaboration and communication

Communication and partnerships will be crucial to ensuring that rural generalist training meets community needs. These should be between the Colleges, regional training organisations and the local community. This will support the formation of training and professional networks and allow movement between hospital and community training. Coordination Units should seek to provide a national strategy for approach to strengthening collaboration in rural medical training and post-fellowship support.

Post-fellowship support

This component is essential to ensure that the significant investment in rural generalist training is not wasted by lack of support for fellowed doctors. Personal and professional support are both required for long term retention. This includes access to peer and professional networks, support for partners/family, access to locums for relief, professional development, training opportunities and appropriate remuneration. The freedom of movement provided by the Coordination Unit oversight ensures that rural generalists can relocate to areas of need or as personal circumstances dictate, allaying significant concerns for those considering the training pathway. All rural trainees would greatly benefit from this kind of

[4] 2019 AMA Rural Health Issues Survey

support after fellowship. The State-wide consistency would also help in retain rural and remote medical workforce.

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