Mr Mark Cormack  
Chief Executive Officer  
Health Workforce Australia  
GPO Box 2098  
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Dear Mr Cormack,

Re: Submission to Health Workforce Australia (HWA) Rural Medical Generalist Draft National Framework

Thank you for your letter of 5 June 2013 inviting the AMA to participate in the public consultation process for the Rural Medical Generalist (RMG) Draft National Framework. We welcome the opportunity to comment on the paper.

Improving the distribution of the medical workforce, providing greater support for generalist career pathways and placing a greater emphasis on team based care is central to delivering high quality cost-effective health care to patients regardless of locality, and is especially important for people living in outer metropolitan, regional, rural and remote communities.

The AMA supports the RMG Draft National Framework in principle but believes there are a number of political, industrial, financial and workforce barriers to its implementation. The framework will only be progressed if Governments take a strong lead, particularly in respect of funding, and that other broader policy initiatives are supportive of its implementation. The Federal Government’s intention to cap self-education expenses is an example of a policy initiative that is counterproductive to achieving the aims of this framework.

Generalist medical practitioners play a vital role in the health system as clinicians, teachers and researchers in all settings, from tertiary public hospitals to remote practices. It is crucial that generalism is seen as a career path in itself, and is accompanied by a supporting framework and shift in status to establish it as an attractive vocation for all medical practitioners. The AMA supports in principle the direction and intent of the RMG Draft National Framework. Once implemented, this framework will improve access to health care for people living in rural and regional communities. The AMA looks forward to the key principles being transferred to improve access to other areas of generalist medical practice, such as general medicine and surgery.

The AMA is pleased to note that the draft framework adheres to the agreed key principles developed by the Rural Doctors Association of Australia in collaboration with member
organisations of United General Practice Australia, including the AMA, which could be used as the basis for a national rollout of an advanced rural training program.

The AMA believes it is essential that this training pathway is developed in such a way that encourages participation by providing not only opportunities to develop additional skills, both procedural and non-procedural, but that also provides adequate recognition for those skills through appropriate and competitive remuneration post training.

In order for the successful implementation of a national rural generalist training pathway to occur, it is essential that careful and detailed planning is undertaken to design an effective funding model, establish a timeframe for implementation, identify the most appropriate, credible and properly resourced lead agency to undertake implementation, and, most importantly, achieve a funding agreement among Federal and State governments and other relevant health services and training providers.

We trust that the comments we have provided in the attached questionnaire will make a useful contribution to the development of the national framework and we look forward to following its progress through to implementation.

I have also attached the AMA Position Statement on Fostering Generalism in the Medical Workforce, AMA/RDAA Rural Rescue Package and AMA Regional/Rural Workforce Initiatives 2012 Position Statement, in support of this submission.

Yours sincerely

Dr Steve Hambleton
President

8 July 2013
Consultation questions

Please read section 2.2 of the RMG draft national framework and then answer this question.

1. What are the key reforms required to streamline selection into the Rural Medical Generalist (RMG) training pathway?

The AMA believes that a range of options should be available throughout medical school, prevocational and vocational training to encourage a career in generalism. The early and continuing exposure of medical school students to regional/rural medicine and measures to encourage students from regional/rural areas to enrol in medical schools is the most likely of all initiatives to encourage and support a career in generalism. The rural clinical schools (RCS) program, with a greater emphasis on primary care, generalism and community medicine, is another example of alignment between community need and training and should also be supported and encouraged.

Collaboration and promotion of the scheme within existing rural scholarship pathways – the Medical Rural Bonded Scholarship (MRBS) and Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme – should also be considered as well as promotion to those who have already signed up for return of service obligations in programs such as the Bonded Medical Places (BMP) Scheme.

The AMA agrees, in principle, with Recommendations 1, 2 and 3 listed in the draft framework, and broadly supports the initiatives to attract and select medical students/junior doctors into the Rural Medical Generalist pathway with a few exceptions: return of service obligations and quarantining of training places.

Return of service obligations

The AMA is supportive of incentivised, voluntary return-of-service schemes. Incentives may include expanded HECS relief, training fee relief, professional development allowances, access to courses and scholarship payments linked to remote locality. These incentives should be available to RMG trainees, as well as other medical students and junior doctors who are interested in working in rural and remote areas.

It is also important to clarify if entry into the program will count as return of service for junior doctors already enrolled in existing rural scholarship pathways mentioned above.

Quarantined places

With regard to access to training posts, the AMA does not support the quarantining of training places as a strategy in the first instance as this may make it more difficult for GP Registrars to obtain training experience. There are currently insufficient posts available for GP registrars who are committed to rural practice and who may be disadvantaged by quarantining of training places. This could prove divisive and discourage some GP registrars from a long-term career in rural general practice.

Instead, the AMA recommends an overall increase in training places commensurate with need. As medical graduate numbers grow, the Commonwealth Government will need to build on the significant investments it has already made in relation to prevocational and vocational training positions.

Programs such as the Prevocational GP Training Program, the Specialist Training Program and the GP Training Program are essential to satisfying unmet need in the community and will play an important role in expanding medical training capacity. It is becoming increasingly clear that these programs will need to be expanded beyond current targets and planning for this needs to start immediately.
Once sufficient numbers of training places become available, then there is the potential for the quarantining of training places to be revisited.

Evaluation of the effectiveness of initiatives to attract students and junior doctors into RMG training will be essential in determining the success or otherwise of any framework. The development of data linkages with the Medical Schools Outcomes database (MSOD), the Australian Institute of Health and Welfare and the Medicine in Australia: Balancing Employment and Life (MABEL) project would be of great value in evaluating this work.

**Please read section 2.3 of the RMG draft national framework and then answer this question.**

2. What do you consider are the key reforms required in the RMG training pathway (from prevocational training through to Fellowship) to improve the quality of the training experience and increase the demand for and supply of RMG training positions in rural, remote and regional locations?

The AMA agrees, in principle, with Recommendations 4, 5, 6 and 7, with the exception of quarantining of advanced skills training posts for RMGs, which forms part of Recommendation 6. As mentioned under Question 1, the AMA does not support the quarantining of training places as a strategy in the first instance. Current posts should continue to be available to trainees who are not on the RMG pathway and should not be removed or re-allocated by any quarantining of training positions for RMGs. The AMA continues to promote the need for fully funded, high quality training positions to meet both the increasing number of medical graduates and future medical workforce requirements.

Further, the AMA Position Statement on *Fostering Generalism in the Medical Workforce – 2012* emphasises that quality of care and patient safety must be the highest priority in any effort to reform the health workforce. Improved training models and pathways, better recognition and support for generalist medical practitioners, and appropriate remuneration will lead to improvements in safety and quality of care, and improved patient outcomes.

In this position statement, the AMA identifies four key reforms to encourage a career in generalism:

- a. the development of clearly defined training programs and pathways for generalist medical practitioners;
- b. greater recognition and support for generalist medical practitioners;
- c. more comparable remuneration for generalist medical practitioners; and
- d. further work to quantify and predict generalist workforce requirements and distribution as a matter of urgency.

**Training pathways**

As outlined in the AMA’s position statement, the development and provision of articulated generalist training pathways, curricula and infrastructure within hospital and community sectors will assist junior doctors to develop the skills to become generalist medical practitioners. Training pathways should provide training in a diversity of skills and a variety of experience allowing the development of a generalist skill set. Currently, exposure to general practice and community care may be seen as a detour from hospital based training and it is vital that early training experiences balance exposure to community and hospital medicine.

The expansion of the provision of formal qualifications, through completing specific special interest training pathways (such as the Diploma of Obstetrics of Gynaecology or DRANZCOG) should also be considered.

Central to this is the provision of adequate funding to support innovative and emerging generalist training models and improve access to generalist training pathways. In particular, the development of appropriate teaching infrastructure and satisfactory supervisor standards and support needs to be addressed. To enable sufficient numbers of practices to be recruited to training and supervision roles, measures such as infrastructure support grants are needed to improve infrastructure in general
practices, particularly to remodel existing physical space or for the additional space necessary to deliver training effectively. It is important to note that medical colleges face additional challenges and costs in establishing suitable training posts in regional/rural areas. Where appropriate, medical colleges should be able to access specific funding to assist in meeting such costs.

There should also be a variety of flexible entry and exit points for trainees both into and out of the pathway and trainees should not be unnecessarily penalised if their training is interrupted due to personal or family circumstances.

Recognition and support
Strategies that recognise and promote the value of a generalist medical practitioner career are central to improving the attractiveness of this as a career option. These include:

- Proper medical infrastructure, a strong training experience, access to community and professional resources, and support for continuing medical education are essential to the provision of a rewarding professional and personal experience.
- Consideration must be given to not only the needs of the medical practitioner, but also their family – particularly with respect to access to employment opportunities, health and education, and social amenities.
- A critical mass of doctors within a region is important in improving the viability of practice, as well as enhancing professional development.
- Improving support for generalist medical practitioners to lessen high workloads and burn out, such as adequate locum cover to manage workloads and facilitate professional development leave, and the provision of an appropriate clinical environment (for example, adequately skilled support staff and operating theatres) to enable a range of procedural work to be performed locally.
- Providing generalist medical practitioners and trainees with support to access continuing professional development (CPD) activities. The appropriate use of technology has the capacity to enhance learning opportunities particularly in regional and rural areas; such initiatives might include access to clinical updates via podcasts and use of videoconferencing facilities.
- Increasing state and federal government funding to increase generalist and procedural training capacity in both public hospitals and private practice in line with medical workforce planning recommendations and commensurate with community need.
- Providing professional indemnity insurance cover and support for generalists that is sufficiently broad in scope to ensure there are no legal or financial impediments to practice.

Remuneration
Adequate financial remuneration is arguably the most important incentive to create demand for RMG training positions in rural, remote and regional locations. The results from MABEL show that overcoming some of the lack of interest in particular specialty areas and geographic regions can be achieved by improving the financial incentives for the practitioner.

The AMA/RDAA Rural Rescue Package provides a model for providing additional financial incentives for doctors working in rural areas, including those with advanced skills training completed via a rural medical generalist program. A two-tier incentive package is proposed, including further enhancements to rural isolation payments and rural procedural and emergency/on-call loading. It includes:

- a rural isolation payment to be paid to all rural doctors (including GPs, specialists and registrars) to reflect the isolation associated with rural practice; and
- a rural procedural and emergency/on call loading to better support rural procedural doctors (including procedural specialists) who provide obstetric, surgical, anaesthetic or primary emergency on-call services in rural communities.
The adoption of this package would encourage more doctors to work in rural areas and put in place incentives to improve access to doctors with the advanced skills set that rural areas often require.

Models for remuneration need to be explicit across the country to assist in informing career choices. Consideration of models for remuneration include salaried, salaried with MBS support through exemption, GP private practice or a combination of these. This must not be dismissed as simply 'industrial detail'; it is again fundamental to the career choice.

Consideration should also be given to providing access to MBS items based on the advanced skill of the recognised RMG. For example, if the RMG has an advanced DRANZCOG qualification then patients seeing this RMG should be able to access specialist O & G rebates for relevant work performed. These principles would also apply to other advanced skills e.g. Emergency Medicine, Psychiatry, and it is important that both RMGs and their patients can access the full range of GP MBS items for all other work.

Gathering data to inform the training experience

The AMA recommends that further work to quantify and predict generalist workforce requirements and distribution in line with community needs undertaken as a matter of urgency.

While workforce planning is mentioned in the HWA document, this analysis must begin as soon as possible to inform the number of RMG training posts required. This should be done to avoid a gross imbalance between available posts at the end of training and the number of trainees coming through. This information is also needed to guide those considering RMG in their career choices. That is, how many of these generalists are needed to meet the current workforce shortages and how many are needed in the future to meet any increase in demand and replace those retiring or moving out of this workforce. Consideration of advanced skills training requirements to meet community need and inform further planning must also be included.

As outlined more broadly in the AMA’s submission to the National Medical Training Advisory Network Consultation, in the first instance, annual workforce surveys administered by the Australian Health Practitioner Regulation Agency should be optimised. Looking forward however, capturing both quantitative and qualitative data through an annual National Training Survey (NTS) would allow for the modification of the RMG training pathway and assessment of the national framework to improve the quality of the training experience. As alluded to in Question 1, data linkages with the MSOD and the MABEL project could also be explored.

The demand for RMGs will also need to be informed by the modeling of activity based funding in rural areas to determine how much funding is needed to support the training places required. The Independent Hospital Pricing Authority (IHPA) is currently working on this issue and could provide advice to HWA on funding models. While this issue could easily be ignored, it is a crucial part of matching the required RMG workforce with the realities of service provision and fiscal constraints.

Please read section 2.4 of the RMG draft national framework and then answer this question.

3. What are the key coordination functions required of an effective RMG program at:
   a. A national level?
   b. A state / territory level?
   c. A regional / local level?

The AMA agrees, in principle, with Recommendations 8 and 9 and with the roles listed on pages 34-36 of the discussion paper.

The AMA acknowledges that the pathway to become an RMG involves negotiating a complex system with multiple agencies having responsibility for organising, setting standards, monitoring and implementing different elements of the pathway. These elements are also controlled or managed variously by states and territories, national bodies, specialist colleges, and health/hospital service managers.
An integrated and effective training pathway relies on national bodies, jurisdictions, regions, training providers and medical colleges working together. The Commonwealth and State/Territory Governments should co-operate in order to set aside specific funding to establish additional training positions in regional/rural areas with appropriate infrastructure, supervision and support. At a national level, the development of a clear implementation plan and funding mechanism for the framework will be integral to achieving this, the detail of which is yet to be determined. An accountability framework must sit alongside such a plan to ensure that funding is being used effectively and efficiently to provide high quality training places, infrastructure and support and achieve real results for rural and remote communities. The AMA looks forward to the development of such a plan in due course.

At a local level, there needs to be cooperation from health services, colleges and training providers to create and accredit additional training positions outside of metropolitan centres without the addition of bureaucratic administrative hurdles.

The AMA Position Statement on Fostering Generalism in the Medical Workforce – 2012 supports the development of improved linkages between tertiary, regional and rural hospitals, universities and medical colleges. The development of functional and reciprocal links between these institutions and the integration of prevocational and vocational training pathways within these networks must be a priority to ensure trainees undertaking generalist training have adequate access to relevant terms in larger urban hospitals. Creating new positions within such networks is also important so that trainees do not feel isolated from other GP trainees.

This link must also continue after training is completed to allow for skill refreshment and updating. These linkages will promote generalism, facilitate the articulation of training pathways by potential trainees, and enhance the capacity of regional and rural centres to provide junior doctors with the sufficient breadth and depth of training.

Further, in addition to the dot points listed on page 27, support for an RMG training pathway from jurisdictions and regions must also include access to appropriate training infrastructure. The historical closure and downgrading of rural hospitals has affected the adequate delivery of health care in rural areas. While such decisions are normally driven by economic considerations they have significant consequences for the local community and the sustainability of the medical workforce. The loss or downgrading of public hospitals often results in the loss of the procedural services provided by GPs or specialists with a resultant loss of skills in rural areas and the de-skilling of staff. This also results in the loss of vital skills to train registrars, medical students, and less experienced doctors.

Governments must ensure that regional/rural hospitals are properly resourced with adequate infrastructure, information technology support and staffing to ensure that doctors work in an environment that is conducive to delivering:

- quality patient care
- a strong and relevant training experience to junior doctors, with adequate supervision
- an environment to develop their procedural skills
- opportunities for professional development
- safe working hours

Please read section 2.5 of the RMG draft national framework and then answer this question.

4. Are there any innovative supervision models that you are aware of that could inform this Draft National Framework?

Educational infrastructure and oversight

Appropriate supervision is essential to maintaining patient and junior doctors safety and to ensure the educational validity of placements. Innovative models of rural and remote supervision and mentoring must be explored and expanded where possible to facilitate generalist training in these settings. Development of appropriate educational infrastructure is a core part of this process. Programs that provide clinicians with additional skills in rural and remote clinical supervision and
support, leadership and teamwork are essential and will improve the quality of education supervision provided to trainees.

Historically there has been a gap in the educational infrastructure and oversight of prevocational doctors in rural areas and this has implications for patient safety and for the educational validity of placements. The AMA agrees that strategies should be developed and implemented to improve supervision capacity across the continuum of rural medical training. States and territories should be encouraged to invest in educational infrastructure to support such models and models that have worked well in other settings should be explored. Examples of excellent practice that have been successful in expanding opportunities for junior doctor teaching, supervision and learning in rural and remote areas, and in locations that have had difficulty in providing sufficient educational oversight, should be identified and promoted.

As an underlying principle, trainees should not be placed in a position where they are not adequately supported by senior medical staff. This is more likely to occur in more remote settings and has the potential to harm the professional development of trainees and increase the risk of adverse events. It is vital that trainees are adequately supported where they undertake placements with minimal on-site supervision. This can include specific preparation and training prior to the placement, briefing on the likely clinical problems and situations trainees will encounter, use of telehealth to communicate with senior doctors and other members of the supervising team, regular debriefing and mentoring.

**Sufficient funding and support for training**

Despite a range of initiatives, such as teaching incentives and infrastructure funding grants, to support GPs to teach, the number of practices teaching medical students, pre-vocational practitioners and GP Registrars remains relatively low. Currently only 10% to 20% of vocationally registered GPs teach or are accredited to teach. In addition, the percentage of Practice Incentive Program (PIP) practices hosting medical students has barely grown. This continuing low uptake of teaching highlights that improved or additional initiatives, including the provision of teaching infrastructure and resources, are required to further enable GPs and GP practices to overcome the barriers preventing them from teaching.

The AMA’s *Federal Budget Submission 2013-14: Let’s Make Every Health Dollar Count* notes that the Federal Government generally has responsibility for the funding of medical training places in general practice and in non-traditional settings such as the private sector. This is relevant in respect of the RMG training pathway. The AMA is calling on the Government to:

- increase the Practice Incentive Payment for teaching medical students to $200 per teaching session so that it better reflects the costs to general practice of teaching medical students;
- commit to the ongoing funding of at least 100 intern places a year in expanded settings, including private hospitals;
- increase the number of places in the Prevocational GP Placements Program to 1500 places a year by 2016 and to 1700 by 2019, supporting more junior doctors to have a quality general practice experience;
- increase the GP training program intake to 1500 places a year by 2016 and to 1700 by 2019; and
- expand the Specialist Training Program, which is currently oversubscribed, so that it provides 1500 places a year by 2016 and 1700 by 2019.

**Remote supervision in postgraduate training**

The AMA supports, in principle, the flexible supervision models for the prevocational and advanced skills training and vocational training identified on page 28.
Remote supervision models are being increasingly used in postgraduate general practice training in remote Australia and northern Canada. Under these models, general practice supervisors and registrars working in different locations are able to communicate via information and communication technology, improving the quality of interactions, teaching and supervision between registrars, their patients and supervisors.

The Government is currently advancing telehealth/videoconferencing arrangements as a means of improving access to medical services for Australians who live in rural and remote areas and cannot easily access medical care. There is an opportunity to use this improved technology to create extra training posts by extending remote supervision in the RMG pathway. As described by Wearne, clinical supervision gaps at a local level could be supplemented by supervision from medical practitioners at tertiary centres, using facilities now in place for telehealth, to create a supervision team.

In support of this, extending Medicare rebates to include GP video consultations for patients living in rural and remote areas would not only considerably improve access to medical care for these patients but also further enhance opportunities for remote supervision and training. Currently Medicare rebates for video consultations are not available for GP consultations and only apply for referred specialist consultations.

The Royal Australian College of General Practitioners standards scheduled for introduction in 2014 allow remote supervision. This training model could also be introduced in the context of a RMG Training Pathway.

Please read section 2.6 of the RMG draft national framework and then answer this question.

5. To better prepare RMG graduates for independent practice, what reforms need to occur during advanced and vocational training?

The AMA supports exploration of alternate funding models (Recommendation 12) in support of efficient and flexible training options. In respect of the STP program, the AMA believes that it is time for the program to be evaluated to ensure high quality vocational training is provided in line with community need. This could include consideration of expanding its remit to include funding for advanced and vocational training options within the RMG training pathway. As a general principle, any changes to models of funding must be evidence based and have undergone adequate consultation with key stakeholders to ensure no intended consequences are evident.

Developing and expanding the provision of remote supervision, as discussed under Question 4, will provide the additional benefit of helping RMG graduates to prepare for independent practice.

Please read section 2.7 of the RMG draft national framework and then answer this question.

6. What are the barriers to ensuring national acceptance and portability for procedural and non-procedural RMGs?

The AMA agrees that national recognition and portability of an advanced skill requires an agreed national curriculum and assessment process. Historically trainees in other rural GP training programs, e.g. Australian College of Rural and Remote Medicine’s Independent Pathway, have reported significant barriers in securing training posts and must deal with multiple agencies to get approvals (practice, college, workforce agency, Medicare and sometimes DoHA). This causes delays in completing training and obtaining Fellowship. It is essential that the RMG training program does not suffer the same fate.

How can these barriers be addressed?

It is important that the RMG training pathway is supported by both general practice colleges and relevant medical specialist college, and to this end the AMA supports Recommendation 13 to

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1. Wearne, S. M. (2103) Remote supervision in postgraduate training: a personal view, MJA 198(11), 17 June 2013
2. Royal Australian College of General Practitioners. RACGP Vocational Training Standards, Version 1 August 2012.
develop dialogue and consultations between these colleges to review curricula to ensure national acceptance of the RMG role in the disciplines of surgery and emergency medicine, and for non-procedural disciplines including paediatrics, mental health, internal medicine and indigenous health.

As mentioned in response to Question 3, the AMA Position Statement on *Fostering Generalism in the Medical Workforce* – 2012 supports the development of improved linkages between tertiary, regional and rural hospitals, universities and medical colleges. The development of functional and reciprocal links between these institutions and the integration of prevocational and vocational training pathways within these networks must be a priority to ensure trainees undertaking generalist training have adequate access to relevant terms in larger urban hospitals. This link must also continue after training is completed to allow for skill refreshment and updating. These linkages will promote generalism, facilitate the articulation of training pathways by potential trainees, and enhance the capacity of regional and rural centres to provide junior doctors with the sufficient breadth and depth of training.

The AMA also supports the effort to build on earlier research to develop a quality and safety framework relevant to rural, remote and regional practice (Recommendation 14).

Please read section 2.8 of the RMG draft national framework and then answer this question.

7. What do you think needs to occur to ensure the RMG graduates work to their full capacity and make an appropriate contribution to rural health care?

In addition to the AMA’s four key reforms listed in Question 2, the AMA has the following comments to make.

**Recognised qualifications**

It is important that the RMG training pathway leads to a nationally recognised and portable qualification so that RMG graduates can serve Australian communities in an efficient and timely manner in areas of medical workforce need. Hand in hand with this is access to employment opportunities following graduation. The Queensland’s Rural Generalist Pathway (QRGP) for example, has experienced some early success in delivering procedurally trained doctors to rural locations across the state. The QRGP offers a career pathway for junior doctors wishing to pursue a vocationally recognised career in rural generalist medicine, though there is concern that this program is too hospital focussed.

**Use locally trained RMGs to fill positions in rural and remote areas**

Australia currently utilises large numbers of IMGs to fill workforce gaps, particularly in rural and remote areas. IMGs make an enormous contribution to the health system and should be supported in their role with access to structured and comprehensive training and support systems that maximise their contribution.

As increasing numbers of RMG graduates progress through training and attain qualification, Australia will be in a position to reduce its reliance on IMGs and harness the benefits of a growing locally trained medical workforce. Shifting the equilibrium to slowly favour domestic training and reciprocal international exchange will be the most efficient course of action to ensure ongoing service requirements are met. Policies should concentrate on reducing the ‘pull’ factors that attract IMGs in the first place and increasingly use local graduates to fill these positions.

Health services should ensure that the recruitment of suitably trained domestic medical practitioners is prioritised over the recruitment of IMGs. The use of integrated training networks that connect hospitals within a region will be an effective strategy at reducing the need to recruit from overseas to fill vacancies based on maldistribution and temporary deficiencies in staffing.

**Self-education expenses**

Trainees in rural and remote areas experience greater costs associated with accessing required clinical education and training to allow them to achieve specialist qualification and maintain
continuing professional development. The changes to tax deductions for self-education expenses proposed by the Federal Government have the potential for an enormous impact on trainees in rural and remote areas and could cause some to rethink their decision to undertake a generalist medical career. This measure must be abolished as a matter of urgency. It is vital that the unintended consequences of other policy decisions do not impact on the success of attracting junior doctors to a career in rural and regional areas.

Supportive working environments

Government needs to provide better support for GPs/RMGs to maintain their procedural skills with visiting rights to local hospitals, surgical assistance opportunities with visiting specialists, access to clinical workshops, short-term skills enhancement placements with regard to regional or metropolitan hospital, and locum support during such absences.

Trainees should have access to mentoring programs to assist them in making a smooth transition to the regional/rural medical workforce. These programs should be co-ordinated by the trainee’s employer, and where appropriate developed in consultation with the relevant medical college.

Please read section 3 of the RMG draft national framework and then answer this question.

8. Does the integrated model represent an efficient and effective training and engagement model for RMGs across Australia?

The AMA supports in principle the RMG draft national framework. It is crucial that generalism is seen as a career path in itself, and is accompanied by a supporting framework. Moving forward, the AMA would like to see the framework supported by a clear implementation plan and sustainable funding mechanisms. In order for the successful implementation of a national rural generalist training pathway to occur, it is essential that careful and detailed planning is undertaken to design an effective funding model, establish a timeframe for implementation, identify the most appropriate, credible and properly resourced lead agency to undertake implementation, and, most importantly, achieve a funding agreement among Federal and State governments and other relevant health services and training providers.

The development of an efficient and effective training model for RMGs is an important step in improving the distribution of the medical workforce and providing greater support for generalist career pathways. Placing a greater emphasis on team-based care is central to delivering high quality cost-effective health care to patients; this is especially important for people living in outer metropolitan, regional, rural and remote communities.

It is pleasing to note that the draft framework adheres to the agreed key principles developed by the Rural Doctors Association of Australia in collaboration with member organisations of United General Practice Australia, including the AMA, that could be used as the basis for a national rollout of an advanced rural training program. These principles relate to:

- meeting the workforce and clinical needs of rural and remote Australia;
- early entry and on-going support;
- curricula training and assessment;
- qualifications;
- management and organisational oversights;
- impact on established programs; and
- availability of training positions and recognition.

Areas for further consideration as strategies in the national RMG training pathway include:

- incentivised, voluntary return-of-service schemes available to RMG trainees, as well as other medical students and junior doctors who are interested in working in rural and remote areas;
- an overall increase in GP registrar training places commensurate with need; once sufficient numbers of training places become available, then there is the potential for the quarantining of training places to be revisited;
- further investment in infrastructure to support RMG trainees and
abolition of the proposed self-education expense cap, which has the potential for an enormous impact on trainees in rural and remote areas and could cause some to rethink their decision to undertake a generalist medical career.

Thank you for providing your feedback. Feedback from this consultation will inform the development of the final framework. A final framework with recommendations for a nationally-coordinated approach to rural medical generalism will be produced in the second half of 2013.