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AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Kristine Battye Consulting

By Email: manager@kbconsult.com.au

AMA submission to the evaluation of the Rural Health Multidisciplinary Training Program

The AMA appreciates the opportunity to provide input into the evaluation of the Rural Health Multidisciplinary Training Program (RHMTP). The AMA believes it is important that all government programs and initiatives are evaluated to ensure that they are delivering on outcomes and are cost effective.

The RHMTP is an important program and must be retained, however it can be refined to better achieve its goals of addressing the maldistribution of the health workforce. This submission outlines the AMA's recommendations for how that can be achieved.

While many medical students have positive training experiences in rural areas, progression through prevocational and vocational training often requires a return to metropolitan centres. At this point many trainees develop the personal and professional networks integral to their future life and career path. Such trainees are less inclined to return to practice in rural areas. The AMA believes that reforms to the RHMTP should focus on delivering in this area.

The key recommendations of the AMA to achieve this are:

1. Increase the intake of medical students from a rural background from 25 per cent of all new enrolments to one-third of all new enrolments and increase the proportion of medical students required to undertake at least one year of clinical training in a rural area from 25 per cent to one-third. It is crucial that these students receive adequate support on placement to ensure their rural experience is positive.
2. Redirect the funding for regional training hubs to the AMA recommended Regional Training Networks.[1] While the hubs have had varying degrees of success in different jurisdictions, overall they have not contributed to developing a structured pathway for retaining students interested in pursuing a rural career. The hubs should be replaced with regional training networks as outlined in the AMA position statement.

Much of the infrastructure for regional training networks already exists, but this must be fully leveraged and adequately funded where it needs development. The RHMTP should be the tool used to build the infrastructure for training and practice. This includes infrastructure for senior staff roles and private specialist practice to support sustainable models of supervision, education and training. This will require a dedicated strategy from policy makers and flexibility within the networks.

[1] AMA Position Statement: Regional Training Networks 2014. https://ama.com.au/position-statement/regional-training-networks-2014

In addition to this, it is important that no new medical schools are established and that a cap is placed on full fee-paying students to Australian medical schools.[2]

Australia is now training more medical practitioners per head of population than most countries in the Organisation for Economic Co-operation and Development, yet we are still reliant on international medical graduates to provide services in rural and regional areas. This is due to misplaced belief in the "trickle out" strategy – the idea that market forces will direct an oversupply of doctors to rural locations, and expecting that rural exposure during medical school alone will result in more rural medical practitioners.

The evaluation of the RHMTP is an opportunity to develop clear strategies for the current generation of medical students to support them to pursue a rural medical career, rather than expect them to pursue of their own accord or due to lack of opportunities in metropolitan settings. Recommendations and strategies must be considered in the context of the development of a National Medical Workforce Strategy, the review of the Specialist Training Program, and the upcoming commencement of the National Rural Generalist Pathway.

Response to specific questions:

1. What has been your organisation's engagement and/or experience with the RHMT program to date?

The AMA supports the RHMTP in its stated aims of improving the recruitment and retention of medical, dental, nursing and allied health professionals in rural and remote Australia. Rural Clinical Schools and University Departments of Rural Health have been mostly reported as very positive. The AMA strongly believes that rural clinical exposure for medical students increases the likelihood of graduates returning to practise rurally, which is supported by research.[3] End to end training for the entire four years of training at Rural Clinical Schools is soon to be introduced in places such as Rockhampton and Bundaberg. This is anticipated to be a positive strategy for retaining graduates in these areas, however it must still be subject to evaluation.

The AMA has received mixed reports on the ability of regional training hubs to support doctors in training. Despite the marketing and propagating of rural training, there has been limited return for this expenditure on regional training hubs as students are not choosing regional hospitals. While some have provided support for graduates and have been able to facilitate rural and regional training, others have not. Often where accredited vocational training places have been established, lack of continuous funding or inability to retain senior specialists has undermined the longevity of the position. 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. Another compounding factor is that all Universities did not win funding to develop regional training hubs and this consequently excludes potential pockets of the medical workforce. For example, in Queensland, the six Hubs were funded at James Cook University and University of Queensland (three each) to the exclusion of Griffith University. However, Griffith University has a large rural footprint and therefore exclusion seems counterproductive.

The difficulty with Hubs is that they are navigating a State employed workforce to deliver training yet have little engagement with the States. A model is needed that provides closer support to the employer (States) to not only provide services but also supports training. The AMA has not seen signs that this is being achieved in any meaningful way. There needs to be more meaningful

[2] Letter: Drs Bartone and Kennedy to Minister Hunt, 30 July 2019.
[3] Wendy Brodribb, Maria Zadoroznyj and Bill Martin (2015) "How do rural placements affect urban-based Australian junior doctors' perceptions of working in a rural area?" *Australian Health Review* 40(6) 655-660.

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.

2. What is the value/benefit of the RHMT program to your profession or stakeholder group?

The AMA believes that the current benefit of the RHMT is limited to supporting medical students to have positive rural experiences during their education and in supporting rural health and medical research.

3. In relation to your engagement with the program, what aspects could be improved?

As noted in the response to Question 1, rural clinical exposure for medical students increases the likelihood of graduates returning to practise rurally. As such, the AMA recommends that the number of students on rural placement be increased from 25 per cent to 33 per cent. It is essential that these places are adequately funded and supported to ensure students have positive experiences which focus on learning and developing clinical skills within their capabilities and do not place students in unsafe situations.

The AMA also recommends increasing the targeted rural origin student intake from 25 per cent to 33 per cent. There is evidence that shows rural origin students are more likely to return to rural locations.[4] However, it is important that when selecting students for rural placements that students from metropolitan backgrounds are encouraged to pursue rural medicine if they demonstrate genuine interest or intent.

The AMA recommends that funding for regional training hubs is redirected at the end of the current cycle of funding and regional training networks be established in their place.

As detailed in the AMA's position statement,[5] regional training networks support specialist training in rural and regional areas, utilising existing accredited training posts and building on existing infrastructure such as rural clinical schools and universities, with the involvement of specialty Colleges. This would shift the focus to training in rural and regional location, rotating trainees through metropolitan centres for advanced training where possible and provide opportunities for trainees to develop mentoring and networking contacts.

Achieving this will require Governments, their agencies, employers and training providers to collaborate. Building and retaining a critical mass of doctors within a region is important in improving the viability of practise as well as enhancing professional development. Networking, peer support and mentoring will be an important consideration, particularly for locations that may only have one or two trainees of a similar speciality.

4. What opportunities are there to strengthen the transition from training in rural locations to working rurally for your profession/ stakeholder group?

There are significant opportunities. As already noted, the current structure of regional training hubs has not leveraged these opportunities to provide realistic pathways in regional and rural areas for the vast majority of doctors in training.

[4] Denese Playford, Hanh Ngo, Surabhi Gupta and Ian B Puddey (2017) "Opting for rural practice: the influence of medical student origin, intention and immersion experience". *Med J Aust* 207(4): 154-158.
[5] AMA Position Statement: Regional Training Networks 2014. https://ama.com.au/position-statement/regional-training-networks-2014

The manner in which the infrastructure of RCS and UDRHs can support prevocational and vocational training in rural and remote areas can be as simple as granting access to university libraries and online journal subscriptions to trainees. Strong, flexible networks that provide supervision, collegial interaction for case conferencing, and most importantly continuity of funding for accredited positions must also be incorporated. To achieve this, specialist Colleges must be empowered to respond reflexively to trainee intent and community need.

Current industrial arrangements are not well structured to support regionally based training programmes. Doctors in training who are rotating from metropolitan areas to regional areas often receive housing support, relocation and transport payments; however, doctors from regional areas rotating into metropolitan areas receive no access to such payments, despite the fact that housing and travel can be considerably more difficult to obtain on a short term basis.

Employment conditions for trainees must be designed to provide clearer paths to specialist qualification and employment post-Fellowship through continuity of employment for trainees, support from their home hospital to undertake additional training, and negotiating with hospital administration for employment post training. This would help to address the problem of doctors being trained for jobs that do not exist or hospitals not prepared to invest in the infrastructure to support specialist positions. This will require the involvement of medical workforce planners. Longer-term employment contracts for trainees recruited to rural areas should also be explored.

Remuneration for specialist trainees on a rural training pathway must be enough so that they do not need to consider pursuing additional work, for example as a private assistant, to cover the cost of living. This detracts from case load experience and undermines the overall rural training experience, which increases the likelihood of doctors returning to the city.[6]

Coordinated and accurate workforce data will be crucial to the success of any pathway, as training positions, infrastructure, and supports must be targeted to ensure that communities receive the workforce they require. Addressing specialty as well as geographic distribution will require providing trainees with better workforce data to assist career decision making, as well as providing opportunities for positive training exposure and immersion early enough to allow for trainees to establish a connection with a rural area.

Colleges should be supported to create or transfer accredited posts in regional or rural areas to support specialty training.[7] Many Colleges have formulated their own strategies for developing and implementing rural training pathways.

5. In considering the appropriateness of the RHMT program as a continuing response to addressing rural health workforce shortages and improving workforce distribution:

a) To what extent is the development and maintenance of academic capacity and training infrastructure in rural and remote areas the right approach to improving workforce outcomes for your profession/ stakeholder group? What else is required?

The AMA believes that supporting the development and maintenance of academic capacity and training infrastructure will have positive flow on effects. This will improve student experience and strengthen engagement with the community.

[6] Brodribb et al (2015) "How do rural placements affect urban-based Australian junior doctors' perceptions of working in a rural area?" *Australian Health Review* 40(6) 655-660.
[7] Australian Medical Association (2018) *Medical Workforce and Training Summit Report*.

An additional benefit is that it could address the lack of work for partners, which is a common issue for recruiting and retaining medical professionals to rural areas. Academic posts attached to an RCS or URDH create viable professional opportunities for partners when relocating.

Academic posts can be offered as incentives to senior specialists as part of recruiting to regional hospitals. The attachment to a University is prestigious and provides rewarding professional opportunities.

The AMA would like to see more medical research funding directed to regional universities. This would provide funding for training infrastructure as well as local hospitals and health services. The AMA is advocating for a dedicated rural health stream from NHMRC funding.

In terms of other suggestions that should be considered to address rural health workforce shortages, the 2018 AMA Medical Workforce and Training Summit Report included a list of strategies to build. These included:

- A clear enunciation of the expectations of rotated rural/regional training.
- Longer-term employment contracts for trainees recruited to rural areas.
- Mentored supervision.
- Accreditation of training posts.
- Rotation into metropolitan centres for advanced training.
- Incentivised selection for trainees with rural background and/or experience.

b) To what extent is selection of health students on rural origin or interest, and training in rural locations, the right approach to contribute to rural service provision after graduation for your profession/ stakeholder group? What else is required?

This is a major factor as outlined in the answer provided to Question 3. It is important to reiterate that rural origin is not enough on its own – positive experiences during clinical placements and structured pathways that support prevocational and vocational trainees to live and train in rural and regional areas are also essential.

There is ample evidence that medical students trained in Rural Clinical Schools do not remain there at the completion of their studies because emphasis has not been placed by universities on the selection of the right students to train regionally. The selection process therefore needs to be overhauled, so that the right students (those schooled rurally, have a rural heritage, have strong family ties to regional and rural areas and those that are perceived most likely to remain and work rurally) are offered training in regional areas.

Further information

The AMA would be happy to discuss these ideas in more detail with Kristine Battye Consulting. Should you require any further information or clarification on the AMA's response, please contact Nicholas Elmitt at nelmitt@ama.com.au.

Yours sincerely

Dr Sandra Hirowatari,
Chair, AMA Council of Rural Doctors