COLLEGE SUBMISSION

Response to Discussion Paper
Redistribution Pool of Medical Places

October 2019

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is *the right doctors, in the rights places, with the right skills, providing rural and remote people with excellent health care.* It progresses this through the provision of quality vocational training; professional development education programs; setting and upholding practice standards; and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

Background

ACRRM welcomes the opportunity to comment on the Discussion Paper, noting that the Government is establishing a small pool of medical Commonwealth Supported Places (CSPs) drawn from existing university allocations to provide it with flexibility to support key Government health workforce priorities as they emerge. The College also notes that this pool will withhold up to 60 commencing medical CSPs every three years, to be allocated through a competitive process to support workforce priorities.

ACRRM strongly supports the policy priority for the 2021 pool distribution round, which is to help build the rural and regional medical workforce.

The Rural and Remote Medical Workforce

Many rural and remote communities find it difficult to attract and retain doctors, and there is still a high reliance on Overseas Trained Doctors (OTDs) to fill gaps in the rural and remote medical workforce in many areas.

The Discussion paper notes that in spite of a potential future oversupply of doctors, there remains a significant imbalance in both the geographic distribution of the medical workforce (with a significant deficit in rural and remote areas); and in the skills of that workforce (with an oversupply of sub-specialists as opposed to generalists). It also notes that these issues have persisted in spite of the increased numbers of Australian universities with medical schools, and the total intake of medical students.

It is obvious that market forces alone will not address the ongoing maldistribution issues. High reliance on market forces may in fact have perverse outcomes and potentially create an oversupply of doctors who are looking for jobs in urban and metropolitan areas, resulting in a trend to over-servicing and subspecialisation which places further strain on the health budget.

The Paper also acknowledges the evidence that students who undertake longer-term training placements in rural areas are more likely to return to rural and remote practice.

Important current Commonwealth workforce policy responses include the Stronger Rural Health Strategy which was announced as part of the 2018-19 Federal Budget; and support for the development of a National Rural Generalist Pathway which is designed to train, recognise and reward doctors who gain the skills required to deliver a wider range of services in the rural and remote setting, and then apply those skills.

ACRRM supports a multi-faceted but coordinated approach to workforce training, policy and planning which is flexible and responsive to community need.

The Role of Medical Schools in Supporting Workforce Policy

Medical schools play three crucial roles in medical workforce distribution:

1. Their selection processes determine which individuals have the opportunity to become doctors
2. They provide medical students' initial exposure to doctors as teachers and as such shape their formative perceptions of what is valued by the medical profession, and
3. They determine medical graduates' readiness to train in the more challenging circumstances of rural hospitals and clinics (including having the competence, confidence and clinical resilience required).

There is considerable diversity across Australia's medical schools in the degree to which these opportunities to cultivate positive workforce outcomes have been addressed.

There is substantive scholarship to suggest the success of medical schools where they have taken a strategic, institutionally supported approach to cultivating medical students to become rural doctors. There is also expansive evidence defining the common characteristics associated with successful programs. [1,2,3 ,4, 5]

One particularly important finding of evidence is that positive policy interventions designed to increase the likelihood of medical students becoming rural doctors have a multiplier effect in their effectiveness, that is, the more policy levers are applied the more effective they will be.[6,7]

[1] Strasser R. (2016). Learning in context: Education for remote rural health care. *Rural and Remote Health 16*(2): 4033.
[2] Sen Gupta T, Woolley T, Murray R, Hays R, McCloskey T. (2014). Positive impacts on rural and regional workforce from the first seven cohorts of James Cook University medical graduates.
[3] Viscomi M, Larkins S, Sen Gupta T. (2013) Recruitment and retention of general practitioners in rural Canada and Australia: a review of the literature. *Can J Rural Med*. 18(1)
[4] Rabnowitz H, Petterson S, Boulger J, Lunsaker M, Diamond J, Markham F, Bazemore A, Phillips R. (2012) Medical School Rural Programs: A Comparison with IMGs in Addressing State-Level Rural Family Physician and Primary Care Supply.
[5] Barrett F. Lipsky M, Lutfiyya M. The impact of rural teaching experiences on medical students: a critical review.
[6] Walker J, DeWitt D, Pallan J, Cunningham C. (2012). Rural origin plus a rural clinical school placement is a significant predictor of medical students' intentions to practice rurally: a multi-university study. *Rural and Remote Health* 12:1908.

The College recommends that these factors, together with the initiatives announced as part of the Stronger Rural Health Strategy and the National Rural Generalist Pathway, be given a strong focus in determining how and where the redistribution of places occurs.

Factors for Consideration

The redistribution should consider the following:

1. **Successful workforce outcomes -** positive recognition in terms of places should be given to schools based on their measured and ongoing success at producing doctors for rural and remote areas and for Aboriginal and Torres Strait Islander communities.

2. **Commitment to Rural and Regionally-based training –** As consistent with the evidence around predictors for rural practice, positive recognition should be given to those medical schools which have displayed an ongoing commitment and a strong record in implementing longitudinal placements and rural and regionally-based training.

3. **Engagement with the National Rural Generalist Training Pipeline –** The effectiveness of the rural training pipeline is critical to translating rurally-interested medical students into rural doctors and this has been emphasized through the recognition of Rural Generalism and the implementation of the National Rural Generalist Training Pathway.

   Rurally-oriented medical programs will maximise their effectiveness if there are vertical linkages with training and service provision at subsequent steps in the rural career continuum, especially with rurally-focused vocational training providers. Positive recognition should be given to schools which show a commitment to rural generalism establish connections with rural hospitals and training sites and rurally-oriented training programs.

4. **Support education programs that motivate for rural, remote and practice and providing services to Aboriginal and Torres Strait Islander peoples –** the extent to which selection, curriculum and assessment processes identify and foster students who display a commitment to rural and remote practice and who value meeting the needs of their patients and their patient communities.

   Assessments based on interest and motivation to rural, remote and Aboriginal and Torres Strait Islander practice not only directly address the government's key workforce needs but have been found to also select and cultivate community-oriented doctors. [8]

The Assessment Framework

The College supports a robust and transparent assessment framework and notes that a '*panel of senior staff with the relevant expertise'* will be convened to conduct this process. ACRRM strongly recommends that this panel include majority representation from rural and remote doctors who have practical and 'on-ground' experience in rural practice and

[7] Frame Exit Survey 2013 original data. http://www.ausframe.org/index.php/2012-06-15-05-28-07/national-rcs-project-secure-data-linkage
[8] Quinn K, Hosakawa M. (2010). Factors contributing to the specialty selection, practice location and retention of physicians in rural practice. Annals of behavioral science and medical education. 16 (1);21-27.

education; and that representatives from broader rural community stakeholder organisations should also be included.

Applications should be 'ground-truthed' to ensure that the written rhetoric is consistent with the reality of its application within communities, and that consideration is given to the commitment to achieve longer-term workforce retention in rural and remote medical practice.

ACRRM recommends that the evaluation of the success of the redistribution initiative should also be based on these criteria. It should also seek to identify and address any unintended and adverse consequences of the initiative – there should be systems in place to allow these to be identified and addressed as a matter of priority in the shorter term.

Summary

In order to achieve its maximum potential, the redistribution initiative must be viewed as a component of a longer-term, coordinated, well-funded and cohesive plan. This needs to take into consideration a range of factors including the creation of a seamless rural training pathway from graduation through intern, junior doctor and vocational training; the health care needs of rural and remote communities; and promoting rural medical practice as an interesting and rewarding career.

The redistribution initiative should recognise and reward those universities which are already providing high quality rural training which is shown to be making a positive and longer-term contribution to increasing the number and skills of rural medical practitioners. Priority should be given to those schools which display an ongoing commitment to longitudinal and rural and regionally-based training, and the National Rural Generalist Pathway.

A committed, consistent and longer-term approach must be adopted in order to achieve any meaningful outcomes.

Assessment of both redistribution place applications and the impacts of the initiative should include feedback from rural and remote community stakeholders and medical practitioners in order to achieve a valid rural perspective. Evaluation should be strongly focussed on qualitative criteria rather than quantitative data.

The success of the initiative should be viewed in terms of longer-term retention rather than short-term training placements.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live and pay respect to their elders past present and future.