College Submission
December 2023

Response to Supplementary Questions: NSW Senate Inquiry into the implementation of Portfolio Committee No.2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural, and regional health.

Initial Comments

Thank you for the opportunity to attend the Public Hearing on 24 November and present evidence to the Inquiry. ACRRM is dedicated to building a national rural and remote workforce with a Rural Generalist (RG) skill set, and the provision of a network of RGs would ensure rural and remote communities in New South Wales (NSW) can deliver high-quality, locally based, sustainable health services.

When properly funded and intelligently designed using rural-centric models, rural health services can provide excellent health care which meets community need and a substantial longer-term return on investment. A strong RG workforce is a key solution to restoring sustainable health care services to remote, rural and regional areas of NSW.

Response to Supplementary Questions

1. Can you clarify some of the issues relating to training for Rural Generalist registrars?

ACRRM's RG training in NSW has expanded significantly in recent years and the College has welcomed the opportunity from 2024 to be able to deliver all its training directly through ACRRM staff based in regional and rural NSW. Despite the major shift from contracted services delivery through Regional Training Organisations to ACRRM-led training, initial feedback from registrars since the transition appears to be positive and enrolments for 2024 point to an increase. The transition has helped ACRRM to collaborate more effectively with health service administrators, including the NSW RG Training Program (NSW RGTP)

Despite the expanding footprint of RG training in the state and strong collaboration with the NSW RGTP particularly through the leadership of Dr Louise Baker, RG training continues to face administrative impediments related to supervision, employment, and clinical credentialing decisions. These problems often reflect the lack of representation, understanding and/or valuing of the program and its perspectives in many key decision-making forums at local, regional, and whole-of-state levels. For RG training to successfully meet its potential in rebuilding the NSW rural medical workforce, the NSWRGTP administrators need to be supported to leverage their understanding of local needs and their strong relationship with the colleges, to implement the adjustments as necessary to make the programs work. This requires strong state-wide cross-system support that has a direct reporting line to the Minister.

ACRRM together with the Royal Australian College of General Practitioners (RACGP) has submitted a joint application to the Medical Board of Australia (MBA) for recognition of Rural Generalist Medicine (RGM) as a specialist field within general practice. This will provide a protected title and establish a nationally registered RG qualification to quality assure the training and skill set of RGs. It is hoped that this formal recognition within systems, will go some way to removing current roadblocks to training, skills certification, recruitment, employment, and resource planning, together with a highly aspirational career pathway that can be promoted, which ends with a recognised title and associated recognition.

To build a strong RG network across rural and remote NSW will require not only a strong training pathway but strong local rural health and hospital services and employment opportunities for RGs in hospitals as well as in community-based clinics.

Issues relating to training for RG registrars:

RG Training Support **-** RG practice reflects a scope of practice for certain specialist GPs which is essential to meeting the broad medical needs of rural and remote communities. If training programs are to incentivise and support doctors through to Fellowship in rural careers, RG training places require sufficient, targeted funding and support that reflects the nature of the challenges of the training context. National Medical Training Survey results show ACRRM registrars (who are in rural and remote locations), compared to GP trainees on average, report working significantly longer hours, that are more likely to disrupt their training requirements, and report lower satisfaction in areas such as access to teaching resources, workspace, and internet.[1]

Funding for, and allocation of hospital placements for RG trainees is problematic from a number of perspectives.

- Under national and jurisdictional hospital and health service funding arrangements rural based training appears to be underfunded relative to training in major urban teaching hospitals.[2] It appears that RG training through the AGPT is not funded to the same level as training places for non-GP medical specialties on the Specialist Training Pathway (STP). This creates an incentive for rural and regional hospitals to preferentially provide their limited pool of training places to consultant specialties that do not have a strong record in producing long-term rural doctors, rather than RGs. As such, RG registrars have been unable to access valuable rural training posts needed to complete their Advanced Specialised Training (AST) in areas such as obstetrics, surgery, anaesthetics, emergency, and paediatrics. These issues are highlighted in the Mid-Term Review of the National Health Reform Agreement which has recommended greater transparency of funding to ensure sufficiency of amounts directed to rural training.[3]

- We have also received reports of delivery of training within hospitals, preferentially directed toward registrars from other specialties. For example, where registrars from other specialties,

[1] Medical Board of Australia (2023) *Medical Training Survey – ACRRM*, Downloaded from, https://medicaltrainingsurvey.gov.au/
[2] Huxtable R for the Australian Health Ministers Meeting (2023) *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report - 24 October 2023*, downloaded from https://www.health.gov.au/resources/publications/nhra-mid-term-review-final-report-october-2023
[3] Huxtable R for the Australian Health Ministers Meeting (2023) Ibid.

have been provided with educational events in their hospital, and RG registrars have been rostered to provide services during this time to allow the other specialties to attend while preventing ACRRM registrars from participating.

- RG registrars commonly report facing a range of other difficulties in completing their ASTs in regional and rural hospitals. The reported barriers include rural and regional hospitals losing their accreditation as training facilities due to lack of staff or resources.

These problems all reflect the scarcity of funding and ongoing workforce shortages but are compounded by a lack of strong leadership and support for RG training and practice scope in wider decision forums.

Single Employer Model – RGs serve communities by being able to pivot between the hospital and the GP clinic and elsewhere to provide services. To gain this skill set they need to transition from hospital and general practice settings over their four to five years of training; however, when trainees move between the two systems, they lose their workplace entitlements including parental leave. They also face uncertainty and lack of security and professional support, as they transfer from one workplace training setting to another during their training journey. The Single Employer Model (SEM) is one initiative which aims to address these issues.

Under SEMs, registrars maintain one employer for the duration of Fellowship training usually a jurisdictional health service. The Single Employer provides the participating registrars' salary and work entitlements, and secondment arrangements are established with the additional workplaces in which the registrar may train. In the ideal under these arrangements, training toward a Fellowship qualification as a specialist General Practitioner and RG would provide a seamless movement between hospitals, general practices and other work settings such as Aboriginal and Torres Strait Islander Medical Services or Retrieval Services.

This has been piloted in NSW through the Murrumbidgee District Health Service and is in the process of being extended across broader rural and remote NSW. For the rollout to be successful the following are necessary.

- It is essential that there is high-level coordination which enables management of training placements across LHDs towards shared workforce goals. At the same time LHDs need to be enabled to develop local solutions, and participating practices, to have appropriate input into decisions regarding their workplace.

- The model confers uneven decision-making capacity on jurisdictions, and the models must recognise the importance that each rural and remote community has flourishing general practice services and be designed to ensure that local practices are fairly and appropriately represented and remunerated for their part in the training and service continuum.

- The model needs to work closely with Colleges. This ensures training meets accreditation standards. It also facilitates a positive, well-supported training journey, to optimise the potential outcomes in terms of retaining a RG workforce in NSW. Enabling trainees to practice in a preferred rural location, will optimise the chances that they will settle in that area. Further, as RG registrars progress through training, they may need to pivot in terms of their training choices, or to get extra experience in particular work settings. Flexibility, in terms of registrar placement

is thus a key factor to successful workforce outcomes, and SEM programs must recognise and seek to accommodate the personal needs of the registrar, the service needs of the GP practice, and the training requirements in various different work settings.

Early-career training and RG linkages - Our members welcome prevocational rural programs such as the John Flynn Prevocational Doctor Program. If the investment in these is to lead to a rurally-based career outcome, they need to be expanded and to be better linked up to a rural Fellowship and thus rural career training end point. To this end, ACRRM Fellowship notably provides the strongest likelihood of return on investment in terms of producing a long-term rural doctor.

- These programs offer fewer and shorter placements than those delivered with strong outcomes through the predecessor programs, Prevocational GP Placement Program (PGPPP) which at its cessation in 2014 conducted some 900 placements annually, and before this, the Remote Area Placements Program (RAPP).

- They also incorporate minimal engagement with our College such as networking opportunities or facilitated fellowship program selection that could encourage the doctors in these programs to progress to the next and necessary step of attaining Fellowship for a rurally-based career. We consider a small time/resource investment in stronger ties to our Fellowship Training program would deliver significant dividends in terms of rural workforce outcomes.

Professional development and skills maintenance - it is critical that RGs and all rural GPs, particularly in under-served communities, can access the training they need to maintain and upgrade the skills they need to be able to continue to deliver high-quality care. Rural doctors have significant needs in terms of training and upskilling and many struggle to meet these needs particularly as this often involves difficulties and costs associated with travel, time off work, and finding locum support.

- Mechanisms are required to ensure those wishing to upskill or undertake essential skills maintenance training activities can access appropriate incentives, funding, and support to do so. Training for these should be made as accessible as possible to people in rural and remote locations, available online, or, where in-person, as close to home as practicable.

- There is opportunity to better leverage existing arrangements to build training opportunities and capacity in rural areas. For example, specialist outreach visits could include opportunities for local upskilling, and hospital education events and educational facilities could be open to broader local healthcare teams.

2. Your submission notes funding issues for emergency, maternity, and obstetrics services in remote and rural areas. Where does funding need to be targeted to address these concerns?

Rural hospitals continue to face significant challenges to service provision, including higher running costs, acute workforce shortages, and the continuing impact of natural disasters, including fires, flooding, and drought.

It is essential that funding arrangements for rural and regional hospitals reflect the actual cost of providing services in rural hospitals, together with increased accreditation and compliance costs. Funding should not be based on past activity and must accommodate situational change and facilitate readiness to

meet future trends, including increased public health demands. This is particularly significant in regions which have seen a significant population influx post-COVID.

Additional to covering operational costs pricing frameworks should be cognisant of the much broader role rural and remote hospitals must play in providing essential access to healthcare for people in rural and remote areas. There is comprehensive evidence that people in these areas have poorer heath status yet receive far fewer healthcare services than people in cities. This reflects among other things, their lack of easy access to the gamut of health and social services in cities. Hospitals are the key health infrastructure in place in many of these communities and it behoves them to be contributing wherever possible to addressing this inequity.

It is vital that pricing frameworks enable and incentivise forward-looking resource planning committed to maintaining robust locally based services. These should ensure that "rural" funding makes its way to "rurally based staff and resources" and should lend confidence in their future rural and remote doctors, staff, and communities.

As outlined above, ACRRM contends that state funding for hospital-based doctor training is directed disproportionately to urban teaching hospitals and to predominately urban medical specialties. We recommend a greater quantum of funding to teaching functions in regional, rural, and remote hospitals and health services and greater transparency in terms of the way in which funding for these hospitals is determined, which includes clear, transparent allocations for training that enables the fullest use of training capacity. ACRRM would support making funding data publicly available to support this transparency and provide accountability to communities, doctors, and patients. As noted above, these issues are raised in the Mid-Term Review of the NHRA.[4]

Emergency Departments - in order to facilitate the best possible emergency care for people in rural and remote locations, the special skillset associated with the ACRRM Fellowship and particularly that of FACRRM's with Emergency Medicine AST should be leveraged. The ACRRM RG Fellowship Program is an AMC accredited specialist training program. It includes mandatory training terms and summative assessment at the Core Generalist level in Emergency Medicine as well an option to complete an additional 12 months advanced specialised training with an associated education and assessment program in RG Emergency Medicine. Both the training and assessment are specifically designed to assure competency for practice in a low resource, clinically/geographically isolated context. Small rural hospitals across NSW extensively rely on FACRRMs to manage and staff their Emergency Departments (EDs). These rural EDs are chronically underfunded and under continuous threat of closure or bypass, with the associated loss of care and safety for the people in the surrounding community. They warrant not only more funding but greater commitment to continuity of services, which gives both staff and communities the confidence they need to in turn commit to the community. No additional qualifications are necessary to provide service in NSW Rural emergency departments. A FACRRM with an AST in EM is particularly well prepared to run ED in many settings.

Virtual Models of Care - in the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, IHACPA outlined its intention to investigate innovative models of care and services related to virtual care, with an initial focus on virtual care delivered by emergency departments.[5] Our

[4] Huxtable R for the Australian Health Ministers Meeting (2023) Ibid.
[5] IHACPA Consultation Paper, page 27

members in NSW are increasingly concerned about the trend towards replacing vital face to face emergency services with virtual FACEM consultations.

Administrative requirements and credentialing policies - Administrative hurdles represent a significant deterrent to skilled RGs providing hospital and other much needed, broad scope services in rural areas such as obstetrics, anaesthetics, and emergency care. Many experienced RGs have opted to cease providing expanded scope services and many more emerging doctors have been discouraged from pursuing RG and rural careers. Addressing these issues will improve quantity and quality of care in remote and rural areas without any financial cost.

Clinical credentialling and associated employment processes for RG VMOs and locums are unduly onerous and duplicative. Documentation associated with these services often requires provision of excessive documentation of minimal relevance, takes a significant time to complete, and doctors are often required to provide the same information multiple times.

The scope of hospital services provided by RGs where these overlap with those provided by other specialties in areas such as anaesthetics, obstetrics, emergency, and paediatrics are under constant threat of loss of privileges. This may be due to changes in the standards of training requirements to provide certain services, and at other times due to changes in the standards of in situ support resources and staff required to provide these services. In all circumstances it is critical that RGs are represented in the decision-making forums and that it is recognised that they are the experts in the provision of the services they provide in the rural contexts in which they provide them. RGs are commonly not represented on key forums, and where they are, their perspective is often overruled in favour of other medical perspectives.

This situation has already caused an exodus of rural GPs from providing VMO services in NSW and leaves our emerging doctors with little confidence that the career aspiration of providing a broad scope of services to rural communities, that had broad them to settle in rural areas will be possible. A clear set of overarching principles and structures to ensure institutional support for rural generalist practice and minimise its administration, that are consistent throughout rural NSW health services, will go a long way to restoring this confidence. ACRRM believes that that the potential success over the next 12 months of the application for specialist Recognition of Rural Generalist Medicine will see maximal benefit from such improvements.

Obstetrics and Maternity Care - in addition to deliberate and targeted efforts towards providing well trained, well resourced, appropriately pain clinicians for provision of emergency medicine services, ACRRM is particularly concerned at what seems to be inexorable declines in pregnancy care services. We are especially concerned that the combination of intermittent and permanent closures of a number of rural maternity units compromises the quality of health care of women and their babies as well as putting many obstetric and midwifery care providers at avoidable professional risk.

We believe that new models of obstetric care need to be developed. These can improve safety – both patient and clinician - mitigate the lack of job satisfaction that is increasingly seen as well as put a stable floor under a vulnerable workforce. None of this can happen without deliberate and well supported programs to develop new service models and much of this requires face to face stakeholder meetings at an LHD level. These meeting must be driven by coalface rural providers and come with the backing to act as required to start harm mitigation activities.

3. Is enough work being done to address the unique workforce and funding consideration for remote regions specifically?

Rural health care improvements will come when funding structures facilitate the best possible models of care. Too often, the opposite has been the case and systems of care have been designed to fit the funding models.

- ACRRM contends that a fit for purpose approach to funding arrangements is required to address the complex challenges faced by non-urban communities. Funding models should be tailored to the needs and challenges of rural, remote, and Aboriginal and Torres Strait Islander communities.
- Given the need to tailor funding models to these unique needs and challenges, it is important that the rural and remote sector is strongly represented in policy and decision-making processes. This representation should be reflective of the wide variety of rural hospital facilities and services.
- ACRRM also recommends that a rural-proofing lens is applied to all decisions which have the potential to impact on rural hospitals.
- Alongside revision of pricing metrics to ensure sufficiency of funding, funding models should be constructed to enable and incentivise approaches to rural health resourcing which will deliver robust rural health services sustainable over the long term.

These structures should:

- **Incentivise future-focused expenditures** to build a strong future workforce and signal a strong long-term commitment to maintaining rural capacity and resources. They should encourage investment in rurally based training. They should also incentivise the building of local services sustainability. This should include preferentially funding permanent rural positions over short-term or locum appointments. Investments in appropriately trained staff that stay in rural areas and become part of the fabric of those communities, present a much greater return on investment than reliance on locums and other expensive stop gap solutions. Most critically funding structures should strongly signal to rural communities that their health services are there to stay, and that they can build their lives there, in the knowledge that they will continue to have access to care when needed.

- **Direct 'rural' funding to staff and resources that are based in rural areas -** rural funding to urban-based FIFO specialists, telehealth providers, and administrators incrementally drains resourcing away from the rural point of care where it can be most effective. It also serves to undermine the fragile critical mass in each community necessary to sustain local services. There is substantial injustice in a Locum junior doctor or registrar being paid substantially more than a resident one and continuation of the Locum culture will lead to an even greater sense of injustice. The result of this will be harder and harder recruitment and retention. NSW Health's reliance on Locum service, especially as they impact on rural areas the hardest, must be curtailed.

- **Incentivise investment in rural models of care and resourcing** that can maximise quality services within each rural context. These approaches would include training staff with an appropriate scope of practice for the rural context such as rural generalist doctors, and nurses and other professionals with a broad rural generalist scope. It would also involve resourcing

hospitals in a manner complementary to the rural model of care. Appropriately qualified rural generalists in other states are recognised as specialists, both in terms of remunerations but also as conditions. Failure to change these arrangements will see further loss of well intentioned personnel, poorer outcomes, and higher costs as these same NSW RGs return as high cost Locums

Key to delivering on equitable funding of services in rural and remote areas will be the inclusion of rural perspectives at all levels of decision-making and this should include people from rural and remote communities. Service delivery models should be flexible and responsive to the needs of communities where they operate, and models co-designed with input from key partners and stakeholders across communities and Aboriginal and Torres Strait Islander communities.

4. Please detail how many doctors are training in rural GP in NSW and the stages of training?

The ACRRM Fellowship is a rurally-based training program. Generally it is a four or five-year program (depending on AST choice) with some flexibility for part time and other arrangements.

As at December 2023, there were 214 registrars in total in training placement across NSW. This includes, 27 in their first year of training, 48 in their second year, 51 in their third year, 40 in their fourth year, and 48 in their fifth year or more of training.

5. How many doctors have commenced training in rural GP in 2022 and 2023?

The number of doctors across Australia that commenced training in the ACRRM Fellowship Program in 2022 was 265, it was 205 in 2023, and there are currently 242 new registrars enrolled for 2024, with potential for further 2024 enrolments.

6. What steps has your organisation taken to promote rural GP to your members and potential trainees in the past five years and what actions are you planning to take?

ACRRM Fellowship training is the best possible predictor that medical graduates will become long-term rural doctors. General practitioners with ACRRM Fellowship (FACRRM) have been found to be four times more likely to be based remotely and 3.4 times more likely to be rurally based, than those without FACRRM.[6] McGrail and associates in their studies of rural workforce outcomes of GP registrars concluded,

> *"A key finding is that the stand-alone faculty that has a specific rural mission and delivers wholly rural training (FACRRM) relates to doctors of better distribution into smaller rural and isolated communities, as well as doctors who sustain practice of their advanced skills (working in areas like obstetrics atop of general practice, as rural generalists).*
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> *These findings demonstrate the value of rural faculties as a professional hub for rural doctors enabling rural, tailored training and professional support, as a critical strategy for growing and sustaining a skilled and geographically distributed primary care workforce."*[7]

[6] Islam A (2017) What are FACRRM's doing now? A look at the 2014 Mabel data. Conference Proceedings. 5th Mabel Research Forum, May 2017, Melbourne

[7] McGrail M, O'Sullivan B. (2020). Faculties to Support General Practitioners Working Rurally at Broader Scope: A National Cross-Sectional Study of Their Value. *International journal of environmental research and public health*, *17*(13), 4652. https://doi.org/10.3390/ijerph17134652

The entire College and its Fellowship Training Program is dedicated to building a strong, skilled remote and rural medical workforce.

Our approach continues to include:

- Clear program intent associated with the College name, mission, and Fellowship title (Fellow of the Australian College of Rural and Remote Medicine - FACRRM)
- Strong program of supporting medical students and junior doctors throughout their journey through to Fellowship. ACRRM Future Generalists, is a dedicated medical student and junior doctor College Committee represented across College governance. It conducts networking and advocacy and has a dedicated stream of social and educational events at annual conference.
- Selection to the Fellowship Training Program is based on assessment of rural competency
- ACRRM RG Fellowship Curriculum defines practice excellence in rural and remote contexts
- ACRRM Fellowship assessment standard is based on competence in a rural/remote context
- Fellowship training is remotely and rurally based
- ACRRMs educational programs and resources, including webinars, workshops, and online courses, are entirely dedicated to supporting rural and remote practice at all career stages. These include skills workshops specifically for rural generalist practice such as Rural Emergency Obstetrics Training and Rural Anaesthetics Crisis Management with 90 such workshops to be delivered Australia in 2024.
- Our College policy team is dedicated to advocating to ensure that the systems and policy frameworks in which our members work effectively support them to continue to serve rural and remote communities.
- The College is comprised entirely of rural and remote trained/experienced doctors who provide inspiration, mentoring and professional collegiality to each other and to aspiring rural doctors. The College apparatus supports these functions through networking events, activities, and mentoring programs.

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

ACRRM's vision is **the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care**. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and 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 local specialist and allied health services.

The College has more than 5000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

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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.