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AMSA Submission to the Inquiry into Provision of General Practitioner and Related Primary Health Services to Outer Metropolitan, Rural, and Regional Australians

By email to community.affairs.sen@aph.gov.au

Medical students are acutely aware of primary care workforce shortages across the country, particularly in outer metropolitan, regional and rural Australia (henceforth referred to collectively as 'non-metropolitan'). Despite this, significant barriers exist to pursuing a career both in primary care and in non-metropolitan areas.

Key Recommendations

1. Reject efforts to address workforce maldistribution by increasing medical student numbers without evidence-based modelling that suggests a positive workforce impact.
2. Support medical students, universities and GPs to improve the quality of primary care clinical placements in medical school by dissuading silent observing and encouraging active participation.
3. Reform the prevocational training space to support increased GP placements for doctors-in-training.
4. Assess the feasibility of an employment model that delivers equitable working conditions for general practice registrars, such as a single employer model.
5. Mandate increased recruitment of students from non-metropolitan backgrounds, low socioeconomic backgrounds and sociocultural underserved populations in the funding agreements with universities for medical student Commonwealth Supported Places.
6. Provide all students, regardless of the status of their enrolment, with the opportunity to undertake non-metropolitan training during medical school through Rural Clinical Schools.
7. Provide sufficient financial investment to increase medical student access to Rural Clinical Schools, and to improve placement quality, ongoing evaluation, supervision, research and student support.
8. Implement a standardised survey framework to ensure consistency and cohesive clinical experiences between all Rural Clinical Schools.

9. Support reform of medical school curriculum to place greater emphasis on primary care, health equity and inequity, rural health, global health, social determinants of health and underserved populations, so as to build social-accountability and rural and generalist intent.
10. Recommend a review of the Bonded Medical Program and its capacity to retain a non-metropolitan medical workforce.

Student Interest in Primary Care

In 2019, General Practice was the second most preferred specialty of future practice of final year medical students, with 15.2% of the graduating cohort hoping to pursue a career in primary care. This is compared to “Adult medicine/internal medicine/physician” which was preferred by 20% of medical graduates.¹ Intention to pursue primary care has increased over the years from 12.3% of graduates in 2010.²

These numbers are however insufficient to meet workforce demand. The Deloitte Access Economics General Practitioner Workforce Report 2019 reports a projected shortfall of nearly 9,300 full-time General Practitioners (GPs) by 2030, representing about a quarter of the GP workforce.³ Should this be true, student preference for primary care would need to increase dramatically, by 5.72% annually, over the next ten years to prevent workforce shortages. See table below.

Year	Number of medical school graduates	Graduating cohort who intend to pursue GP	Number of future GPs from graduating cohort (should intent= outcome)	Predicted GP shortage
2021	3637	15.20%	552.824	
2022	3637	20.92%	760.824	
2023	3637	26.64%	968.824	
2024	3637	32.36%	1176.824	
2025	3637	38.08%	1384.824	
2026	3637	43.79%	1592.824	
2027	3637	49.51%	1800.824	
2028	3637	55.23%	2008.824	
2029	3637	60.95%	2216.824	
2030	3637	66.67%	2424.824	-60

Shifting student interest towards a career in GP is multifactorial, and requires stakeholders to address the current standards of clinical GP exposure in medical school and prevocational training, GP remuneration and workplace protections, and stigma.

Increasing medical student numbers is notably not the solution to workforce maldistribution. In 2020, 3,845 students commenced a medical degree in Australia, compared to 2,222 in 2006.^{4,5} This has contributed to a rise in medical student numbers by 61% during this period.

Consequently, national modelling by the Department of Health predicts a potential oversupply of around 7,000 doctors by 2030.⁶ This oversupply, particularly in the absence of increased prevocational and vocational training positions, is placing strain on an already overburdened training pipeline.

At a medical school level, clinical sites are becoming saturated with students, preventing access to quality clinical training, adequate supervision, and academic and wellbeing support. In the prevocational and vocational space, this oversupply is preventing access to sufficient training opportunities and timely career progression, without addressing issues of geographical and specialty workforce shortages.⁵

Clinical exposure to primary care in medical school

The quality of clinical exposure to primary care in medical school varies widely, not only between universities but between each practice that a student may be placed in. When undertaking a primary care placement, the majority of medical students are silent observers in a GP room. Silent observers often feel that they are intruding on the doctor-patient relationship, impeding therapeutic management, or are unwelcome in the clinical setting. Integration of students into clinical teams with clinical teachers in a mentoring role increases active engagement of students, improves the student-teacher relationship and facilitates the breaking down of student-patient barriers.⁷

The quality of a clinical placement also has a significant impact on a student's interest in pursuing a career in that particular field. Anecdotally, most medical students consider or exclude potential career pathways based on their experience of each field during their clinical years. This includes, but is not limited to; the degree to which they were actively incorporated into the clinical team, the support and supervision provided to broaden their skillsets, their capacity to interact with and support patients, and their capacity to safely influence diagnostic and management decisions. The passive learning and silent observing typical of primary care placements often does not fulfil a medical student's desire to contribute to their clinical team and the patients they encounter. This leaves many medical students with a negative impression of their primary care placement and a career in primary care.

Conversely, medical students who are supported by their supervising GP to take medical histories from patients, perform assessments and clinical examinations, and contribute to discussions surrounding diagnosis and management usually have a more positive clinical placement experience, become more clinically competent, and are more likely to consider a career in general practice.

Supporting medical students, universities and GPs to improve the quality of primary care placements in medical school is needed to increase medical student interest in primary care and to grow the GP workforce.

Clinical exposure to primary care in prevocational training

Prevocational training in Australia is almost entirely confined to inpatient care in the hospital setting. The prevocational years are often the time in which doctors finalise their intended career path. A lack of exposure to primary care during these influential years is detrimental to efforts to grow the GP workforce, and prevents doctors-in-training who may consider a

career in primary care from accessing networking, career planning and career advice. Reform of the prevocational training space to support increased GP placements for doctors-in-training is needed.

Remuneration and workplace protections

Doctors practicing rurally require a diverse range of skills; however the number of GP proceduralists, or generalists, working in non-metropolitan Australia has declined from a quarter of the rural and remote general practice workforce in 2002, to just under 10% in 2014.⁸ This, combined with an increased growth in the specialist medical workforce relative to GPs, is adding to the strain the non-metropolitan health workforce is facing.

The drive towards sub-specialisation is, in part, due to the higher remuneration available to sub-specialised doctors. More equitable remuneration for GPs is needed to increase medical student and junior doctor interest in primary care.

AMSA echoes calls from the AMA to assess the feasibility of an employment model that delivers equitable working conditions for general practice registrars, such as a single employer model. A single employer model would ensure that trainees have access to adequate equitable remuneration and parental and other leave entitlements compared to non-GP registrars as they complete their training across multiple workplaces.

Stigma

Significant stigma persists surrounding the decision to pursue a career in primary care, and is perpetuated by both the medical profession and the general public. Medical students and doctors are required to be competitive at every point in their training, starting with the medical school admissions process. The non-competitive nature of entry into GP vocational training contributes to its reputation as a less desirable career pathway. Anecdotally, hospital doctors are often disinterested or unimpressed when a student reports an interest in pursuing a career in primary care, reinforcing the messaging that medical students and doctors-in-training should strive for sub-specialisation.

Further, the majority of the general public are unaware that GPs are specialists who undergo vocational training. Students are frequently asked if they intend to specialise or “just a GP”, contributing to stigma.

Recruiting a non-metropolitan workforce

Understanding the impact of selection and medical education on practice intentions and eventual practice is an essential component of training a fit-for-purpose health workforce distributed according to population need.

The Training for Health Equity Network (THEnet) is an international research collaboration between twelve medical schools, including James Cook University (JCU), with a primary interest in building social accountability in medical school. Research conducted by THEnet has found that students from rural and disadvantaged backgrounds are more likely than others to express an intention to work in underserved locations after graduation at both entry and exit from medical school. Rural and low income background and regional location of medical school are the most important predictors of intent to practice in a rural location.⁹

JCU, in particular, is known for its capacity to graduate a rurally inclined workforce. In QLD, JCU graduates account for 9% of the total health workforce, but comprise more than 40% of clinicians working in outer regional, remote and very remote settings. Nationally, 1 in 5 non-metropolitan healthcare workers are JCU graduates. Further, 98% of JCU-graduate GP registrars at training in non-metropolitan areas.¹⁰

Research supports that the JCU medical school produces significantly more graduates with a generalist rather than specialist career focus compared to a similarly experienced group of Australian medical practitioners. Contributing factors may include the JCU selection process, and the curricular focus on providing students with a wide range of generalist experiences and exposure to rural, remote, Indigenous and tropical health. Developing approaches that facilitate local vocational training and subsequent specialist practice is also an important part of the regional, rural and remote training pathway. These findings are in line with international evidence and have implications for other jurisdictions planning, and educational and workforce strategy to meet the needs of their own regional, rural and remote locations.¹¹

Medical school admissions criteria

Research from theNET demonstrates that students from a rural background are overall 3.3 times more likely to intend to practice rurally. Students from a small rural town are the most likely to intend to practice rurally - 6.3 times more likely than their peers. Students of a low socioeconomic background and those who identified as belonging to a sociocultural underserved group are 1.7 times more likely and 1.3 times more likely respectively to intend to practice rurally. These demographic characteristics are also associated with intention to pursue a generalist career pathway, including primary care.¹²

Research from the University of Western Australia (UWA) is also supportive of the impact of selection criteria on intention to practice rurally. In a study of UWA medical students, students from a rural background were almost 8 times more likely to intend to practice rurally compared to their urban-background counterparts. During the medical school admissions process, those with rural intent had significantly lower academic entry scores, marginally lower interview scores and similar Undergraduate Medicine and Health Sciences Admission Test (UMAT) scores. Those intending to work in non-metropolitan settings were also 1.9 times more likely to be female, 2.5 times more likely to come from a lower socioeconomic background, and 2 times more likely to have studied at a Government vs independent school.¹³

Very high academic scores generally required for medical school entry may have the unintended consequence of selecting fewer graduates interested in a rural practice destination. Increased efforts should be made to recruit students from lower socioeconomic backgrounds and those who identify as belonging to an underserved sociocultural group. The Federal Government should consider greater regulation of the medical schools admissions processes as a means to growing the non-metropolitan health workforce. This could be enforced through requirements set out in the university funding agreements for medical student Commonwealth Supported Places (CSPs).

Rural Clinical Schools

Rural Clinical Schools (RCS) play a significant role in the clinical education of medical students, and provide a pathway to future rural workforce retention. RCS are funded through the Department of Health, and are a substantial investment in the effort to rectify the shortage of medical doctors in non-metropolitan areas.^{14,15} Studies show that the RCS program for clinical students has a positive future impact on the regional medical workforce.¹⁶

At least 25% of CSP-funded medical students must undertake a placement of a minimum of one year at a clinical site in an area with a Remoteness Area status of 2-5.¹⁷ Half of all CSP-funded medical students must also undertake a rural training experience of at least four weeks throughout the duration of their medical degree. There are two predominant clinical placements facilitated by RCS: within regional hospitals and within general practice in smaller communities.¹⁸

There is currently no requirement for Australian-trained international students to have exposure to RCS, nor does the funding from the Australian government take international students into consideration. This is a significant oversight in the current execution of medical school rural training considering the proportion of international medical students who will eventually work in non-metropolitan areas. All students, regardless of the status of their enrolment, should be provided the opportunity to undertake non-metropolitan training during medical school through access to RCS. Expressions of future rural intent should be considered when selecting students to attend RCS.

An independent evaluation of RCS by KBC Australia has shown that longer-term non-metropolitan medical school training has a strong positive impact on future rural workforce outcomes. However, there were significant areas for improvement across the domains of placement quality, ongoing evaluation, supervision, research and student support.¹⁸ RCS must receive sufficient financial investment to increase access to non-metropolitan medical school training, and to address the areas for improvement outlined in the KBC report.

Thorough and regular evaluation of RCS through a standardised survey framework should be implemented to ensure consistency and cohesive clinical experiences between all Rural Clinical Schools.

Social accountability in the medical school curriculum

Medical curriculum plays a significant role in influencing the commitment of graduating students towards more socially accountable practice. A commitment to socially-accountable practice over financial reward and/or prestige is significantly associated with graduate preference to practise in non-metropolitan areas and intent to choose a 'generalist' medical discipline.¹⁹ Reform of medical school curriculum is needed to place greater emphasis on primary care, health equity and inequity, rural health, global health, social determinants of health and underserved populations, so as to build social-accountability and rural and generalist intent.

Retaining a rural workforce

Bonded Medical Program

The Bonded Medical Program (BMP) is the largest government strategy to address rural workforce maldistribution. The Government's Bonded Programs have been in operation since 2001. The statutory BMP commenced on 1 January 2020. Up to that point, there were two legacy schemes - the Medical Rural Bonded Scholarship (MRBS) Scheme and the Bonded Medical Places Scheme - which are both now closed to new participants.²⁰ Participants of the BMP and the two legacy programs are referred to collectively as BMP participants.

The BMP provides 25% of medical students a Commonwealth Supported Place (CSP) in a medical course at an Australian university in return for a commitment to work in eligible regional, rural and remote areas for one to six years after completion of their medical course. This commitment is referred to as a Return of Service Obligation (RoSO). The BMP costs the government millions of dollars annually, as every medical student in the program costs approximately \$450,000 to train.²¹

Despite the administrative efforts, and considerable financial investment from the Commonwealth Government, the BMP remains ineffective in addressing rural workforce distribution. There is no evidence that doctors will stay rurally after they complete their RoSO, or complete their RoSO at all.

According to the Department of Health, in 2017 only 32 participants in total had completed their rural service obligations, compared to 518 who had withdrawn from the program. This represents an attrition rate of 55% of eligible participants.²²

Most BMP participants have no confidence in the program's capacity to provide doctors with a positive training experience in rural Australia. Further, over recent years the chronic mismanagement of the Bonded Medical Program has compromised the health and wellbeing of program participants, and has perpetuated a sense of mistrust and resentment towards the program and governance. This is particularly true over the past 18 months during which long-standing participants have been incorrectly transitioned ("opted-in") to the agreements under the Health Insurance Amendment (Bonded Medical Programs) Bill 2019, incorrectly told they have completed their Return of Service Obligation (RoSO), informed they were in breach of their Agreement due to the failed opt-in process, or have had their Medicare Provider Number revoked for breach of their Agreement due to the failed opt-in process. This has caused significant undue anxiety and confusion amongst BMP participants.

Further, by requiring prospective medical students to accept the conditions of the program at as young as 16 years of age, the BMP is coercive in nature.

Continued investment in the BMP should be guided by evidence. A review of the BMP is required to assess the capacity of the program to retain doctors in non-metropolitan areas, and to support doctors to complete their RoSO. A review of the program may also help to identify key demographics of doctors choosing not to complete their RoSO, assisting the government in future policy development. A review of the BMP will also support

governments and stakeholders to develop a stronger, evidence-based model for rural training, that recruits participants who are motivated to serve regional Australia and are incentivised to live, work and train rurally.

AMSA

The Australian Medical Students' Association (AMSA) is the peak representative body of the 17,000 medical students in Australia. AMSA advocates on issues regarding health workforce reform and workforce distribution, rural medical training schemes and rural health inequities.

Contact

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