Australian College of
Rural and Remote Medicine

ACRRM submission to the Senate Standing Committee on Community Affairs'

"Inquiry into the Factors Affecting the Supply of Health Services and Health Professionals in Rural Areas"

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Organisation name :	**Australian College of Rural and Remote Medicine**

Introduction

The Australian College of Rural and Remote Medicine (ACRRM)

ACRRM is an Australian Medical Council (AMC) accredited medical college for the specialty of general practice. ACRRM was founded by rural doctors in 1997 for the purpose of establishing the standards for rural and remote medical practice and to provide education and training pathways that skill doctors to work independently and safely in rural, remote or urban environments.

The founders of ACRRM established the college to provide a vertically integrated approach to education and training for rural generalist practice. ACRRM administers a number of student programs such as the John Flynn Scholarship Program and Rural Bonded Student Program, works with junior doctors in shared hospital and general practice placements, provides vocational training through three AMC accredited training pathways which leads to fellowship and VR and ongoing professional development through the Professional Development Program.

ACRRM would like to thank the Senate Standing Committee on Community Affairs for the opportunity to contribute and provide comment to this inquiry. In the development of this submission ACRRM has consulted its members who have identified a number of issues but at the forefront ACRRM members believe the key factors affecting the supply of health services and health professionals in rural areas is the availability of an appropriately trained medical workforce who are well supported to provide services to the rural communities which they serve.

Defining rural and remote medicine

Rural and remote medicine is a broad, horizontal field of practice that intersects many medical specialties. General practitioners in rural and remote communities are commonly called upon to provide a continuum of care from primary presentation to resolution, and deal with issues associated with public health in small communities. Because rural and remote practitioners are required to undertake many of the tasks that their urban counterparts would refer to specialists, their practice is both advanced and extended. They may provide services in areas such as obstetrics, surgery, anaesthetics, and emergency care, and may do so across primary, secondary and tertiary settings. Their office-based consultations will often require more complex decision-making and the use of more diverse clinical and procedural skills. There is considerable evidence that general practitioners working in rural and remote areas both in Australia and overseas are providing an increased range of procedural, emergency and other advanced care services.

Training for rural practice

As rural practice is an often demanding and specialized medical discipline that requires advanced training, ACRRM's AMC accredited training program is designed to develop the skills, knowledge and attitudes required to provide safe quality services to rural and remote communities. The ACRRM curriculum was established fifteen years ago and was developed as one of the first to describe the expectations of competence and requirements for general practitioners who practiced in rural and remote areas. This drove ACRRM's development of a structure of eleven principles to support educational initiatives, seven domains related to areas of practice and a strong experiential

perspective to the curriculum. Training to fellowship of ACRRM is a minimum of four years of full time (or part time equivalent) post internship. This may be retrospectively accredited via recognition of prior learning (RPL). The training comprises: one year of Core Clinical Training (CCT); two years of Primary Rural and Remote Training (PRRT); and one year of advanced specialty training (AST).

There are three vocational training pathways that lead to Fellowship of ACRRM. They are: *The Vocational Preparation Pathway (VPP).* This training pathway is through Australian General Practice Training which is managed by General Practice Education and Training and delivered through regional training providers. *Remote Vocational Training Scheme (RVTS).* This scheme is also funded by the Australian Government and delivered by an independent company established in 2006. *Independent Pathway (IP).* This is a RPL based pathway which is administered by ACRRM and the trainee funds their own participation in the program.

The IP is designed for experienced medical practitioners working in rural and remote communities with a sincere interest in rural practice and a desire to have the skills, knowledge and attitudes required to provide safe quality services in rural and remote communities. The IP is a flexible program for self-directed learners. Training is based on a learning plan, developed following assessment of the candidate's skills and experience against the ACRRM educational standards as defined in the ACRRM curriculum. Candidates are directed to ACRRM accredited practices within their region and develop their training portfolio in consultation with the ACRRM medical educator and an ACRRM mentor/supervisor. The benefit is the doctor continues to work providing medical services in their rural and remote setting while undertaking training. Doctors training in this pathway are both Australian graduates and overseas training graduates.

This pathway was specifically designed to provide training in rural and remote environments to doctors who are committed to practice in rural and remote Australia and provide to rural communities the procedural and other advanced medical services they require.

A major barrier for many doctors wishing to participate in the IP is that it is self-funding. Unlike the VPP or RVTS, neither ACRRM nor the candidate receives any financial assistance with training. Funding support from Government for this training pathway would increase training opportunities for many, attract doctors to rural and remote practice, retain those already working in rural and remote practice and maintain quality medical services in rural and remote Australia.

More detail on ACRRM's training pathways and curriculum can be found on the ACRRM website www.acrrm.org.au

Rural Generalist Program

The Rural Generalist Program (RGP) is a structured, fully supported, incentive based training pathway for junior doctors wishing to become vocationally recognized specialist general practitioner's working across both primary and secondary care settings. It is a four year program that includes one year of Advanced Specialized Training and assessment in either one of the following 10 procedural or cognitive disciplines: Surgery, Anaesthetics, Obstetrics, Emergency Medicine, Aboriginal Health, Paediatrics, Adult Internal Medicine, Mental Health, Population Health or Remote Medicine. RGP was designed to "*develop and sustain an integrated service and training program to form a career pathway supplying the rural generalist workforce that the bush needs*"

A Rural Generalist is defined as a rural medical practitioner who is vocationally recognized as a specialist general practitioner and credentialed to serve in:

- hospital and community-based primary medical practice; and
- hospital-based secondary medical practice without supervision by a medical specialist in at least one specialist medical discipline; and
- hospital and community-based public health practice.

Key components of the RGP are: early merit based selection and support of candidates; structured prevocational component linked to AST and PRRT; career advice and support service in prevocational stage; assessment of "rural readiness" to progress to rural practice; support and advice regarding appropriate AST posts; intensive preparatory and procedural skills workshops in both PGY 1&2; quarantined training opportunities – prevocational and AST; Enculturation; AND of great significance: senior professional and financial recognition that reflects the extended and complex range of skills provided to rural communities by FACRRMs working in RGP designated posts.

The RGP in Queensland has experienced success in delivering procedurally-trained doctors to rural locations across the State. The Queensland RGP is offering a fully supported career pathway for junior doctors wishing to pursue a vocationally recognized career as a rural generalist hence supporting an early entry pipeline to rural and remote practice. The RGP is drawing the next generation of doctors into rural practice. While other States have announced the introduction of RGP there is the need for the Federal Government to support a national approach to the delivery of advanced rural training specific to meet the needs of rural and remote communities. A nationally consistent approach to rural generalist training is a most promising way to ensure high quality patient care in rural based primary and hospital settings.

The national expansion of a much needed rural training pathway provides Government with the opportunity to invest in a range of initiatives to ensure that students and junior doctors with a commitment to rural and remote practice can access clear pathways through medical school, prevocational and vocational training. Such investment must include building capacity to enable teaching within rural and remote practice environments. Currently there is an under investment in areas such as practice and community infrastructure to increase teaching capacity and opportunity and funding for teaching and supervision.

Rural Medical Workforce and Overseas Trained Doctors (OTDs)

The rural medical workforce shortage is well documented. To fill this shortage, Australia has actively pursued a policy of recruitment of doctors from overseas. Currently approximately 41% of doctors working in rural and remote Australia are overseas graduates. OTDs have significant variability in the level of their training, experience, clinical skills and communication skills. Due to currently policies, OTDs are often sent to areas where there is little personal, professional and cultural support. Many have very little access to the support, supervision and training they need.

Underlining Principles

There are seven key principles which ACRRM believes are fundamental in the development and implementation of policies and programs to address medical workforce issues including the recruitment of OTDs as an important part of the medical workforce in rural and remote Australia.

1. Long term self- sufficiency for Australia's rural health workforce

The National Health Workforce Strategic Framework (2004) calls for the focus to be on national self-sufficiency and acknowledges that underinvestment has influenced approaches to self -sufficiency and use of OTDs to meet workforce needs particularly in Areas of Need (AON).

The Productivity Commission report (2005) recognized Australia's current reliance on an internationally trained health workforce and the need for compliance with ethical protocols in recruitment. The report acknowledges medical workforce shortages and misdistribution issues particularly in regard to AON and the number of OTDs filling these positions. ACRRM agrees with the reports identification of the need to continue to progress self- sufficiency and adoption of a range of measures including:

- Progressively increase locally trained doctors;
- Improving the capacity and productivity of education and training; and
- Continuing to develop effective recruitment and retention approaches.

2. Melbourne Manifesto

The principle of self- sufficiency is one of the subjects incorporated into the Melbourne Manifesto to which ACRRM is a signatory. The Melbourne Manifesto was developed at the World Organization of Family Doctors (Wonca) World Rural Health Conference held in Melbourne in 2002 and reaffirmed at the Cebu conference February 2011. The Melbourne Manifesto is a Code of Practice for the International Recruitment of Health Care Professionals (HCP) built on six key principles.

These principles have significantly influenced the development of a Global Code of Practice, by the World Health Organization (WHO) which was adopted by the World Health Assembly in 2010. This code was initiated following the Kampala Declaration in 2008 and the subsequent G8 communiqués (2008).

3. Fairness, transparency and supportiveness

ACRRM believes that assessment processes must be fair, transparent and supportive but rigorous to ensure safe and quality services to communities. The WHO code stresses that "international recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and mutuality of benefits".

4. *Maintenance of Australian medical standards*

ACRRM believes that all assessment systems must support the maintenance of Australian medical standards to ensure safe, quality health care for all Australians. This should be true for both the assessment systems for Australian graduates as well as for doctors trained overseas.

5. *AMC accreditation*

ACRRM supports AMC as the accreditation body and believes that the development of Specialist Pathway, Competent Authority Pathway and Standard Pathway assessment processes are valid as each end point supports the maintenance of and are in line with those required for Australian trained doctors to obtain registration e.g. Specialist Pathway requires education, training and assessment equivalent to those of an Australian Fellow to obtain specialist registration, Competent Authority is calibration to PGY1 = general registration and Standard Pathway provides special registration time to enable the non-specialist doctor to undertake AMC accredited education, training and assessment required to obtain either specialist or general registration.

6. *Area of Need*

ACRRM believes that OTDs who fill an AON position must be given additional support. There are a high number of OTDs working in isolated remote practices with limited support systems. This must be addressed if they are to have equity to education and support system that will assist them in obtaining Australian qualifications.

7. *Future education and support*

ACRRM strongly believes that not only should improvements be made to assist OTDs in the registration process but future investment focus of governments, medical colleges and other professional organizations must include the post- employment/registration components of the system to ensure once an OTD is working in Australia they are adequately supported through improved supervision, mentoring, education, training and ongoing professional development to obtain full registration.

Training OTDs for rural practice

ACRRM acknowledges that the House of Representatives OTD inquiry is looking at the issues affecting OTDs but feel it is very important that this inquiry consider the issues of a national approach to providing appropriate initial and ongoing assessment, education, training, support and supervision for OTDs as they are major factors affecting supply of quality health services and appropriately trained medical practitioners in rural and remote Australia.

As previously stated the RGP offers a much needed integrated approach to training for rural practice. A similar approach needs to be developed to enable OTDs to move in a seamless way between assessment for limited and general registration and vocational training to gain recognition as a specialist with the skills, knowledge and attitudes to work in rural and remote Australia.

Changes are required to secure a rural assessment and training pipeline for OTD's and Government has an opportunity to further invest in a range of initiatives to ensure OTDs can also access clear appropriate training pathways that offer rewarding career opportunities in rural and remote medicine.

An example where Government has through the Department of Health and Ageing (DOHA) supported an innovative program to support OTDs move between limited and general registration is the ACRRM Workplace Based Assessment Program (WPBA). This opens opportunity for OTD's to

move from limited to general registration and on to vocational training within a shorter timeframe without needing to move from the rural or remote environment.

Workplace Based Assessment

OTDs with limited registration have four years under the new national registration policy to gain either general or specialist registration. The process for limited registered OTDs within the Standard Pathway to move to general registration is the AMC Clinical Examination. Unfortunately OTDs can wait for up to two years before gaining a place on the examination.

The development of a WPBA process and tools has been funded by the DOHA to pilot an alternative process to the AMC clinical examination. Twenty OTDs on the standard pathway will be support through this alternative process and hence improve the timeframe for them to meet their general registration requirements and enter vocational training.

ACRRM has developed WPBA processes and tools that have been accredited by AMC to provide practical evidence based assessment methods conducted in the workplace to determine if the clinical performance and competencies of the OTD are equivalent to those required to be met within the AMC clinical exam.

While an outcome of this pilot will be an alternative route with improved timeframes a major benefit of a WBPA process for rural and remote communities is that the doctor will undertake their learning and assessment in their own communities and will not have to leave to access education or sit examinations. A further benefit is that it uses existing education and training infrastructure to provide assessment and medical educator support. ACRRM will work in collaboration the General Practice Education and Training (GPET) and Regional Training Providers (RTPs) in the implementation of the pilot.

A key feature of the WPBA model is the integration of formative processes that assist learning with summative examinations for the assessment and allocation of performance scores. The modalities overlap to help ensure that the candidate's performance rating is attained through measuring knowledge, skills and attitudes that are being taught within the educational components of the formative modalities and that these are directly in line with the curriculum.

RTPs will provide education and training to candidates and conduct formative direct observation based assessment to assist their learning. ACRRM will provide the summative assessment and allocate performance scores.

This pilot is being evaluated and it is hoped that at the completion of the pilot this much needed alterative pathway will be expanded and receive ongoing funding support to enable it to be offered to more OTDs on a permanent bases.

While WPBA as an example of an innovative way of moving OTDs through the assessment process to vocational training, it also demonstrates the importance of an integrated funding approach to provide educational support during the vocational training process to build competent rural doctors.

Incentives

During ACRRM's consultation process, members, while acknowledging that a number of Commonwealth initiatives and incentives contribute to supporting rural and remote practice raised several issues in regard to policies and programs that impact on practice viability. Of particular concern was the introduction of the Australian Standard Geographical Classification – Remoteness Area (ASGORA) and the potential impact on rural doctors that Medicare Locals in rural areas will have.

The Australian Standard Geographical Classification – Remoteness Area (ASGCRA)

There are four financial incentive programs that support rural doctors and rural practices. They are: the General Practice Rural Incentive Program; the Rural Locum Education Assistance Program; the Rural Procedural Grants Program and the HECS Reimbursement Scheme. While these programs are considered beneficial, the extent of the financial benefit they provide to rural doctors and practices is in part is subject to where the doctor or the practice is located and the remoteness of the location. The ASGCRA is the classification system used to determine the remoteness of the location is considered by many of our members as being flawed as it classifies small rural communities as being equally remote as larger regional centres. This is impacting on the ability of some more rural and remote communities being able to attract and retain doctors.

The Rural Doctors Association of Australia (RDAA) have provided to this inquiry examples of the negative affect this classification system is having on the recruitment and retention of doctors in rural Australia. ACRRM supports their call for an independent review of the ASGCRA.

Medicare Locals in Rural Areas

A coordinated primary health care system in the rural setting with the rural generalist practice at the centre is essential in providing quality health outcomes for rural and remote communities. Rural doctors are the principal providers of primary health care as well as afterhours and hospital based service in rural and remote communities. There is concern about how Medicare Locals will benefit rural and remote communities as their operation is still unclear and there is apprehension about the efficiency, effectiveness and transparency of this system of primary health care planning and delivery. It is essential that rural doctors play a significant role in the governance of Medicare Locals and that Medicare Locals have a very clear accountability process.