

Parliament of Australia

Senate Inquiry

“The factors affecting the supply of health services and medical professionals in rural areas”

Introduction:

My submission to this inquiry is unfortunately brief. I note that submission of the RDAA and I would endorse the sentiments of that submission in its entirety. My comments relate to my personal experiences as a Rural General Practitioner, and GP Obstetrician of 22 years. I have been a long Term Resident of Emerald in Central Queensland. My submission is a personal reflection and not representative of the opinions of any organization I represent or have been associated with in the past.

Discussion:

In many ways my long term commitment to the Bush relates to the classical research finds that relate to the sort of people that choose a rural medical occupation. I was a country boy, who grew up in Longreach Queensland, and attended the local high school. My parents were not professional people rather a Nurse and a Police Officer. Research confirms that country students, with a willing spouse are still much more likely to settle in a Rural or a regional Area.

Medical Schools purport to offer access to Rural Students and some such as James Cook University have proven that retention rates can be improved by preferential access for Rural Students. I believe that greater investment in Rural Clinical Schools is necessary to further promote and encourage a career in rural medicine.

My next comment relates to access to quality Medical Education at a low cost, I grew up in the ear prior to HECS and Student fees. My parents were able to afford the room, textbooks and board but nothing else. Today the costs associated with Education and training naturally restrict both access and the willingness to enter relatively poorly remunerated jobs in the Bush.

The lack of a guaranteed access to further specialist training further restricts any opportunity for young clinicians thinking of trying sometime in the Bush. Access to appropriate training further restricts the numbers likely to consider a rural career. I grew up in an era when there was still a “return of services” where you could phone your regional or metropolitan training hospital and get back in to a Training program. Having Rural Experience counted for something back then.

I am a Rural Generalist in all but name. My training was self directed with time spent in Obstetric Hospitals as well as General Practice. There is tremendous promise in this new pathway to the acquisition of important skills vital to a rural medical Career.

The advent of Rural Generalism as a workforce measure to reinvigorate Queensland Rural and Regional Hospitals has captured the imagination of other States. Rural Generalism is a sought after pathway for students and young clinicians as it offers access to some desirable Specialist terms and exposure to more relevant hospital terms applicable to rural and independent practice. The Pathway also provides a significant financial incentive to complete and serve out time in rural locations.

As medical school and medical training becomes much more competitive it has become desirable to enter this priority pathway of guaranteed training. There are risks to promoting Rural Generalism as it has for at least some Medical Students become the perceived de facto ticket of entry into Rural Medicine and if they don't get on the stream they are not suitable to go. There is a need to strike a balance between strong support for Rural Generalism, and alternative pathways that do guarantee appropriate skills training to allow other junior doctors unsuccessful in getting on the RG Pathway and opportunity to fulfil their desire for a rural career.

I have been a GP Trainer since 1997. I live and work in Emerald Queensland. I enjoy the attention of two GPET Training Consortia. Queensland Rural Medical Education (QRME) and Central & Southern Queensland Training Consortia (CSQTC) offer high quality training and support for GP Registrars on the GPET training Pathways. Each Consortium has their own theme and branding with subtly different Strengths and weaknesses.

As a GP trainer though dealing with two consortia is sometimes a challenge and I have come to believe that it is time to rationalise the recruitment and education of GP registrars in my Regional Area. To be specific I believe that GPET needs to develop a strong focus and theme around Rural Education and Training that is consistent across Consortia and across boundaries. I am not convinced that competition between consortia produces the best outcomes for medical workforce.

I believe that it is time that mobility and flexibility for Registrars to control their training is maximised. I strongly believe that Consortia should work closely with Workforce agencies to develop strategic placement and support for Educational Nodes that can allow vertical integration from Student, through intern/ junior medical Officer to GP/Specialist training. Rural Clinical Schools should be wedded to Training Consortia. Health Departments should recognize and work with training consortia in growing local workforce solutions, and use their expertise in the training of junior clinicians.

There is much that could be done to bring medical recruitment, training, retention and support together with ongoing vertical integration to Medical Workforce development. What is needed is support for Vision in Government and innovation in the development of a comprehensive Australia wide plan for growing our Rural Workforce. We have a Rural Workforce agency for every state, numerous consortia, many universities, two primary care colleges and several rural clinical schools. I appreciate that Australia is a very diverse environment but I equally believe that we need to start making a Career Map for Rural Medical Practice as accessible as possible.

My final comment relates to the continued use of International medical graduates, for whom we have contributed nothing to their initial training and have thrust out into areas of workforce shortage, often ill prepared and certainly poorly supported. Queensland in particular has relied heavily on an IMG workforce with over 50% of clinicians in the Bush trained in another country.

It is high time that we ensured that our International Colleagues receive the same level of support and training that we expect our own trainees to have. It is past time that pastoral care, cultural and social factors are addressed for International Graduates. At the very least I think it is distressing that some of my IMG colleagues cannot access Medicare for themselves or their families but are

expected to provide medical services to others in circumstances that are often suboptimal and isolated. In this matter synergies between Medical Workforce Agencies and Training Consortia could be almost immediately directed to address the support of IMG doctors in Rural and Regional Areas.

In Conclusion:

I appreciate that this is a brief submission. I have outlined some of my thoughts around the factors affecting the recruitment and retention of medical workforce. I recognize that this is a complex problem, and that my opinions may be somewhat naive. I would be happy to speak to my suggestions if required.

I believe that there are many very eminent people with more insight than mine, who with proper support and commitment to see some synergies between disparate organizations and Government Initiatives could do some real good in promoting a rural career.

With due respect

Dr Ewen McPhee