



Senate Inquiry Submission

Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

October 2021

1. Qualifying our submission

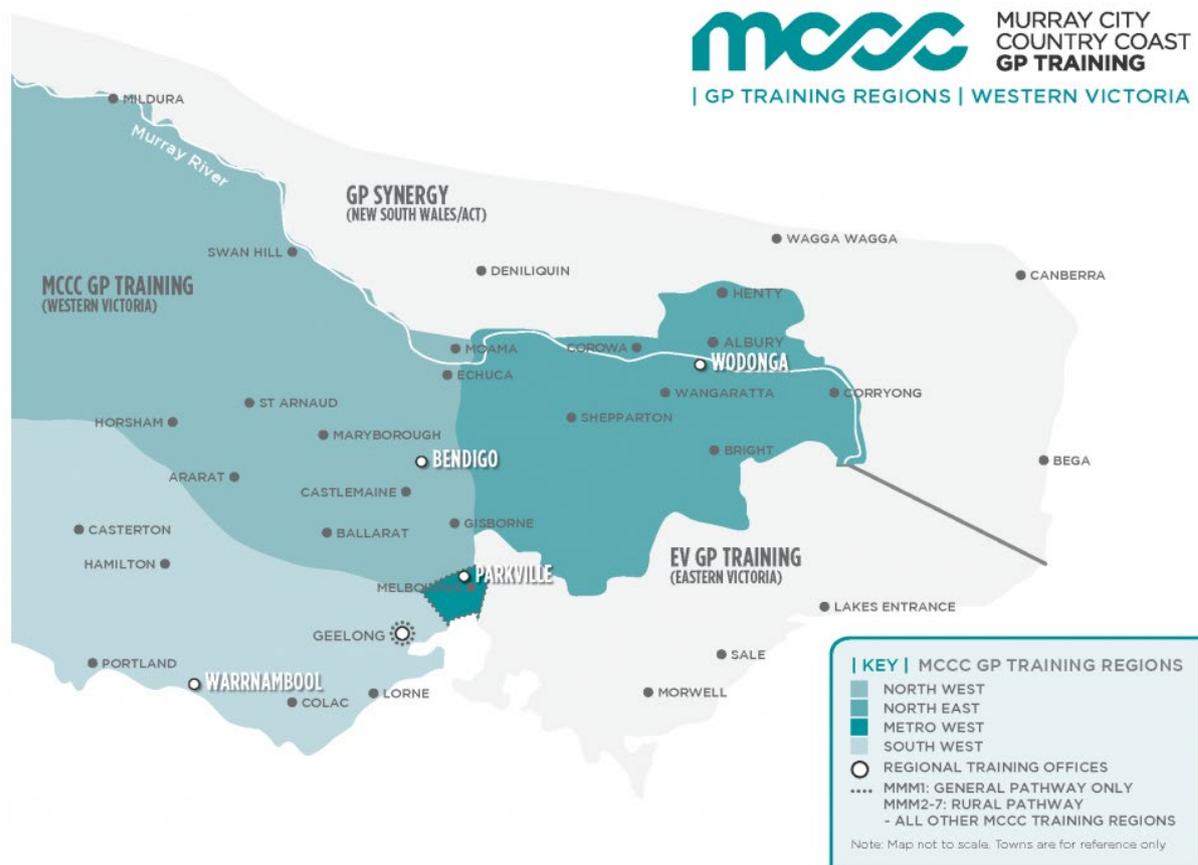


Figure 1: MCCC GP Training Footprint 2021

Murray City Country Coast GP Training (MCCC) is well qualified to submit to the **Federal Government’s Senate Inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians.**

We are one of nine Regional Training Organisations in Australia funded by the Commonwealth to deliver the Australian General Practice Training (AGPT) Program.

Our footprint covers three-quarters of Victoria and is home to 50% of Victoria’s population - over 3 million people.

Each year, up to 646 MCCC registrars work and train in over 250 General Practices, Hospitals and Health Services across the State.

In recognition of our significant rural and regional reach, MCCC’s GP ‘trainee workforce’ comprises approximately 65 % rural and 35 % general pathway registrars¹.

Currently, 36% of our registrars train in 169 facilities located in large, medium and small rural towns classified MM 3-5², across our regional footprint.

¹ 6-year average - MCCC trainee enrolment 2016 - 2021

² Modified Monash Category (MMM 2019) – MM 3 – 5

<https://www.health.gov.au/sites/default/files/documents/2020/07/modified-monash-model---fact-sheet.pdf>

2. Framing the challenge

A continuing lack of cohesion at and between all levels of government is contributing to the critical shortage of regional doctors.

The struggle to train, attract and retain doctors in rural and regional Australia is increasing in urgency and scale. Although the number of doctors per head of population has increased, the gap in medical workforce distribution and scope of practice between metropolitan areas and the rest of Australia is still widening.

With the **transition to a college-led model of general practice training**, the complex and often siloed rural and regional medical doctor workforce development and training pipeline seems set to become even more fragmented, with projected lower levels of focused investment diluted across disconnected Federal, State and regional training systems.

The Commonwealth Department of Health is seeking to address these medical workforce issues of national significance through its **5-year National Medical Workforce Strategy**³ and the **National Rural Generalist Pathway initiative**.

However, the lack of systems-level cooperation and shared planning required to effectively link stakeholders at Federal, State and regional levels in a shared 'end-to-end' approach to rural medical workforce development, training and retention stands in the way of real progress towards adequately meeting the growing healthcare needs of rural and regional Australians.

3. Policy

It can take at least 10 years to produce an independently practicing General Practitioner (GP) or Rural Generalist (RG)⁴. However, GPs and RGs are then more than likely to go on to contribute to our rural and regional health systems for up to 40 years.

This means that any adjustment to policy and major programs made at the beginning of the training pipeline will take more than a decade to have a full effect on service delivery. Therefore, the introduction of reforms and new policy levers create long-term impacts at all levels of our rural and regional health systems. This illustrates that there are likely very few 'quick fixes' capable of supporting the scale of change required to address chronic and long-standing rural and regional workforce issues.

In this context, the Commonwealth continues to affirm its commitment to improving the scope of practice and distribution of doctors throughout rural and regional Australia through its **5-year National Medical Workforce Strategy**⁵, the **National Rural Generalist Pathway initiative** and the recommendations that inform its **Primary Healthcare 10 Year Plan**⁶.

⁴ Based on 4 years Medical School, intern year, postgraduate year 2 (PGY2) and up to 4 years to complete sub-specialty training

⁵ National Medical Workforce Strategy

[https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A398D58837F631ACA2583F8007D1CC7/\\$File/FAC TSHEET%20-%20NMWS%20-%20March%202020.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A398D58837F631ACA2583F8007D1CC7/$File/FAC%20TSHEET%20-%20NMWS%20-%20March%202020.pdf)

⁶ Specifically, Primary care workforce development and innovation recommendations 10, 11,12,13,14

<https://www.health.gov.au/resources/publications/draft-recommendations-from-the-primary-health-reform-steering-group>

What’s needed: a framework for change

However, MCCC sees that real and sustained progress will only be made if the following priorities outlined in the National Medical Workforce Strategy⁷ are aligned at Commonwealth, State, regional and local levels as part of a cohesive, cross-sectoral and collaborative planning, investment, resourcing and implementation framework:

- Improve coordinated medical workforce planning activities at all levels of government to build a sustainable, highly trained medical workforce,
- Reduce geographic maldistribution,
- Achieve the right balance between generalist and sub-specialist skills to deliver a broader scope of practice,
- Address the growing over and under supply of doctors in a range of specialities,
- Simplify the training and workforce development pipeline and remove the barriers to make it easier for doctors to navigate their career pathway.

Such a capacity building framework could be based on the widely recognised collective impact model⁸ - a collaborative approach to addressing complex issues, consisting of five conditions: a common agenda; continuous communication; mutually reinforcing activities; backbone support; and shared measurement.

4. Australia’s Rural General Practice and Rural Generalist Training Pipeline

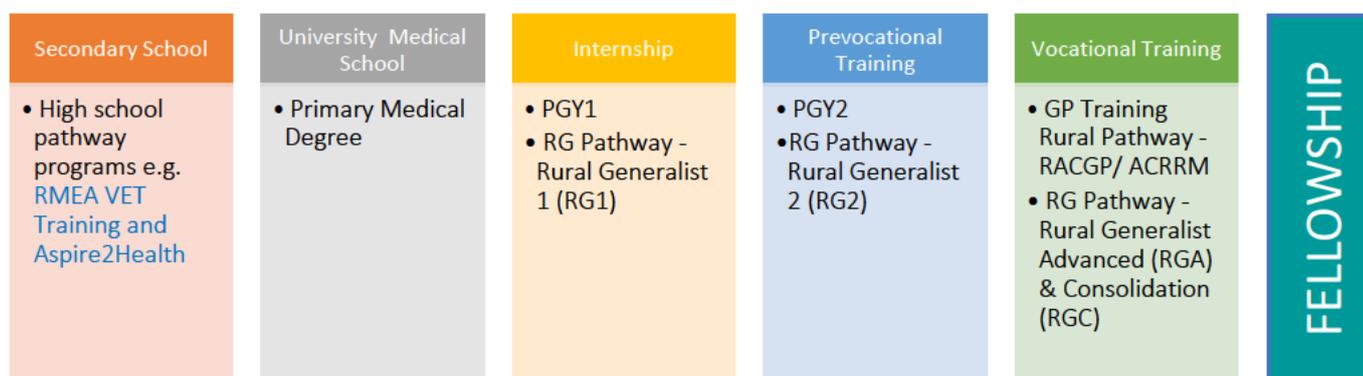


Figure 2: Australia’s General Practice Training Pipeline
Source: ABS 2016 & Health Workforce Australia 2014⁹

Commonwealth and state investment in Australia’s rural medical training pathways

Secondary School	University	Internship	Prevocational training	Vocational Training	Workforce Agencies	GP Supervision & Training Practices
<ul style="list-style-type: none"> – State – Non-Govt 	<ul style="list-style-type: none"> – 21 Universities – 18 Rural Clinical Schools – 13 University Departments of Health – 26 Regional Training Hubs 	<ul style="list-style-type: none"> – 136 Health Services comprising – 750+ Public Hospitals 	<ul style="list-style-type: none"> - 7 Rural Generalist Programs - 136 Health Services comprising - 750+ Public Hospitals 	<ul style="list-style-type: none"> 9 Regional Training Organisations Delivering 2 GP training curricula – RACGP/ ACRRM 	<ul style="list-style-type: none"> 7 Rural Health Workforce Agencies 	<ul style="list-style-type: none"> Rural & regional GP & RG Supervisors and training practices drawn from a cohort of 10,634 regional GPs (headcount)

⁷ National Medical Workforce Strategy [https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A398D58837F631ACA2583F8007D1CC7/\\$File/FACTSHEET%20-%20NMWS%20-%20March%202020.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A398D58837F631ACA2583F8007D1CC7/$File/FACTSHEET%20-%20NMWS%20-%20March%202020.pdf)

⁸ Collective Impact Model <https://probonoaustralia.com.au/news/2019/09/what-can-collective-impact-offer-part-one-the-challenge/>

⁹ <https://www.health.gov.au/sites/default/files/documents/2021/03/doctors-australia-s-future-health-workforce-report.pdf>

.4. Australia's Rural General Practice and Rural Generalist Training Pipeline (cont.)

In 2014, the Commonwealth Department of Health in its *Australia's Future Health Workforce – Doctors Report*¹⁰ made this insightful observation:

Australia's general practitioner training system is delivered through a complex interconnection of funding and organisational channels that span Commonwealth and state and territory governments, Universities, regional health services, private and non-government organisations and a broad network of general practices.

The cross-sectoral nature of delivering and funding medical training in Australia makes good workforce planning difficult for any one agency or sector to deliver in isolation.

Unless there is a coordinating mechanism that can operate across these bodies, there will be an ongoing mismatch in the medical workforce that is trained and the medical workforce that the community requires to provide services.

Despite the development and implementation of endless policy levers and targeted funding streams, there remains a lack of alignment and coordination along and across Australia's medical workforce training pipeline.

Hundreds of individuals are making decisions on how many and what type of doctors are trained in Australia. Ensuring these decisions align to ensure the right doctors are in the right places at the right time to meet community need requires a coordinated systems-level approach that translates clearly from policy to collaborative 'grass roots' implementation at local and regional levels.

What's needed: Joined up GP and RG pathways and pipelines into regions

Australia **requires a coordinated, 'joined-up' approach to rural and regional general practice and rural generalist training** to better address many of the long-standing shortages and barriers impacting the delivery of quality healthcare to rural and regional Australians.

This **'joined-up' pipeline needs to start early**, offering coordinated medical career programs and incentives to rural and regional secondary school students.

Through **integrated Commonwealth and State policy, joint planning, shared goals and measurement, resource sharing and mutually reinforcing activities**, trainees are funnelled along multiple, well-supported pathways.

These **pipelines transition students seamlessly** from high school to University, intern and prevocational training within State-funded Health Services to college-led and Commonwealth-funded training undertaken in regional and rural communities.

We also suggest that **primary health medical workforce development and training need to be incorporated** into each State and Territory's **annual Department of Health and each regional health service Statement of Priorities** thus **formally recognising primary care's role as a fundamental contributor** to the effective function of a well-coordinated state or territory healthcare system.

We see this **contemporary multi-jurisdiction and sector 'system's' approach** would likely **yield increased return on investment for Commonwealth and state funding, better 'end-to-end' planning and coordination, opportunities for improved integrated healthcare** and more general practitioners and rural generalist making their homes and livelihoods in regional, rural and remote Australia.

¹⁰ Commonwealth Department of Health, 2014, *Australia's Future Health Workforce - Doctors*

5. Monash Medical Model supports maldistribution in Victoria

In 2015, the **Modified Monash Model (MMM)** became the Commonwealth's key tool to better target equitable distribution of medical workforce throughout regional, rural and remote Australia. The Model classifies a location according to its population size and geographical remoteness.

Victoria is the most densely populated state in Australia yet only 15% of the population live beyond Melbourne, Geelong and the ring of regional cities¹¹ that surround the State's capital.

According to the **Modified Monash Model (MMM)**, 80% of Victorians live in locations classified MM1 or a major metropolitan area, with approximately 10% living in MM2 - regional centres, and the remainder (10%) living in small, medium and large rural towns. Less than 60 Victorian locations are classified remote - MM6 and none classified very remote - MM7.

In this context, 65% of MCCC trainees undertake their training in **Rural** (training in MM2+) or **Rural Generalist** (training in MM3+) pathways with the remainder training in a **General pathway** (training in MM1).

Over the years, MCCC GP Training has seen a disproportionate percentage of our Rural and Rural Generalist trainees use the **Modified Monash Model (MMM)** to preference **Rural** training locations classified **MM3-5 within 100 km radius or an hour's drive of Melbourne**.

These choices reflect a trainee's desire to retain professional metro connections and easy access to a very attractive mix of cosmopolitan and country lifestyles. However, the **Modified Monash Model (MMM)** classification that enables access to these attractive options is also actively handicapping recruitment of doctors and trainees to outer regional small-medium sized communities experiencing chronic medical workforce shortages. This disparity in classification works against proactive measures undertaken by MCCC, its East Victorian RTO counterpart, EVGPT, regional health services, general practices and local governments to recruit trainees and fellowed doctors to these communities.

According to the **Modified Monash Model (MMM)**¹, a post in Kyneton or Woodend (less than 1 hour's drive from Melbourne) or Fairhaven (45 minutes' drive from Geelong) is classified no differently in terms of remoteness and level of incentive than chronically hard-to-fill training positions in outer regional Victorian communities such as Edenhope or Corryong (both about 5 hours' drive from Melbourne). **All these posts are classified MM5 – small rural community** yet the disparity in the **level of trainee interest** in training at an inner regional MM5 practice and outer regional practice often **couldn't be wider**.

What's needed: Modified Monash Model (MMM)¹ needs to reflect level of disadvantage

For the **Modified Monash Model (MMM)**¹ to become a truly effective tool to better target equitable distribution of medical workforce that addresses the chronic healthcare needs of regional, rural and remote Australia, changes are needed to redefine each location by an index that reflects the level of healthcare need and social disadvantage, proximity/remoteness and access to healthcare.

These key changes to the **Modified Monash Model (MMM)**¹ classification would improve the tool's capacity to act as an effective systems-level lever to reflect and address chronic maldistribution of medical workforce, thus providing greater incentive for doctors and trainees to go where they are really needed.

¹¹ Ballarat, Bendigo and Latrobe

6. Conclusion

The current reforms to GP training including the transition to the college-led training model are concerning to MCCC GP Training as we see this reform, at least in the short to medium term, is unlikely to contribute to overcoming the many layers of complexity, fragmentation, competition for resources and siloed operations that persistently dog the effective function of Australia's health system.

Our submission has sought to **identify** and **suggest possible systems-level solutions** to the issues that **underpin coordinated approaches** to medical workforce development and training that are **'fit for purpose'** for regional, rural and remote Australia communities.

In short, we suggest these six (6) measures are required to better support the provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians:

1. The goals and objectives of the **5-year National Medical Workforce Strategy** are adopted by each State and Territory to **enable high-impact systems-level outcomes and increased value for money and return on investment**
2. **Integrated Commonwealth and state policy levers**, planning, strategies, resources and joint programs
3. **Coordinated 'joined-up' approach** to the development and **delivery of 'end-to-end' training pathways** to ensure the right doctors are in the right places at the right times to meet the needs of Australia's rural, remote and regional communities
4. General Practitioner and Rural Generalist **workforce development and training is articulated in each State's and each regional health service's Statement of Priorities** to better support a systems approach to regional and rural medical workforce development
5. **Stakeholder organisations at national, State and regional level work together** to plan, resource, simplify and deliver mutually reinforcing activities that **strengthen 'end-to-end' rural general practice and rural generalist pipelines and training pathways**
6. **Increase the effective of the Monash Medical Model** by incorporating an index that holistically reflects a location's level of healthcare need and social disadvantage, proximity/remoteness and access.