Submission from Queensland Rural Medical Education (QRME; www.qrme.org.au) to the Senate Committee considering the factors affecting the supply and distribution of health services and medical professionals in rural areas.

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Thank you for the opportunity to submit to the Committee.

Queensland Rural Medical Education (QRME) is a non-for-profit company delivering Rural Medical Education based in rural areas. The group is lead by a Board of and representing rural medical practitioners, rural health consumers, other rural health professionals and indigenous health workers.

Queensland Rural Medical Education supports rural medical services through rurally focused and based medical education services. For QRME this includes having medical students living in rural communities and working in rural hospitals and practices in the Queensland Rural Medical Longlook Program (QRMLP), the QRME PGPPP a prevocational Rural GP placement for junior doctors to experience Rural GP in a supported manner, and the QRME AGPT program as a Regional Training Provider, funded by GPET.

The Australian General Practice Training program delivered at QRME succeeds in supporting the placement of in excess of 60 FTE in rural practice each year with another 20 Registrars in any year undertaking advanced skill training in preparation for Rural GP. Above all, two thirds of all these doctors trained at QRME are still in Rural General Practice and districts of workforce shortage. The QRME PGPPP places 20 junior doctors in accredited supervised rural practice every term to work and learn of the benefits of rural practice. The QRMLP in partnership with Griffith University and Queensland Health mobilized grant funds from the Commonwealth to build student accommodation and teaching facilities at a dozen rural towns in our district – these are the limiting elements in priming the rural health workforce pipeline to engage medical students to consider a career in Rural Medicine or at least appreciate it.

The key messages to the Committee from our success and work in rural medical education are these:

1. **Rural Medical Education can be a workforce multiplier** generating the workforce of the future and augmenting the workforce of today with learners who become part of the rural health team, this is effectively done by;
2. **Vertical integration of rural medical education** to efficiently use the limited resources of supervisors and teaching in rural hospitals and practices while utilising learners to also be teachers as well as deliver services to rural communities as part of the rural health team, which becomes more efficient with;
3. **Longitudinal rural placements** of Registrars (vocational trainees in Rural GP) and medical students living and working in a rural community for sufficient time to understand the longitudinal nature of Rural GP and positively contribute to the rural community and become a contributing part of the rural health team.
4. **Rural focus and rural base** are essential parts of a Rural Medical Education program, whereas being a side program on a larger metropolitan based program does not focus on the needs of rural communities or those who aspire to care for them.
5. **Rural Clinical Supervisors and Medical Educators are the foundation** for Rural Medical Education so that at QRME Supervisors and access to their placements are recognized as the essential resource of the program, they are paid and resourced for the specialised services they provide; and Medical Educators are nurtured from Registrarship, developed as specialists, paid accordingly and required to maintain rural clinical practice.

There are many other details of Rural Medical Education to support the Rural Medical Workforce. The staff and Board of QRME would be delighted to provide further input to the Committee. Thank you again for the opportunity to submit this statement.