Chapter 6

The role of universities and medical schools

Current pathways into rural medicine

6.1 The numbers of medical students in Australia has risen significantly in recent years with domestic student numbers at Australian universities rising to 12 946 in 2010 from 8768 in 2006.[1] The Department of Health and Ageing project that by 2014 graduate numbers will have doubled in the space of a decade.[2]

6.2 According to evidence from James Cook University (JCU) this will place Australia significantly ahead of countries like the US, UK, Canada or New Zealand. However, they maintain that this increase is not reflected across rural areas:

> With the increase in medical students in the last decade, we acknowledge that the number of doctors is increasing; however, it is becoming apparent that maldistribution is still a problem. Australia now has more doctors per head of population than at any other time. At about three per 1000, we approach the OECD average, and we have significantly more than the US, UK, Canada or New Zealand. We are still continuing to lift the number of medical students; I think we are up to about 15.9 per 100 000 of population per year, which is the second highest after Austria. However, on the ground it appears that the structural problem is still a geographic maldistribution and distribution of specialist medical workforce. Rural communities still have fewer doctors per 100 000 than metropolitan areas.[3]

6.3 While these are global figures, and it is not possible to say how many students will go on to become doctors in rural areas, there has been a gradual increase in the number of rural clinical schools across the country and the majority of these are in receipt of government funding through the Rural Clinical School (RCS) program.[4] There are now 17 RCSs across Australia and they are managed by 16 universities across multiple training locations.[5] Of the 17 schools, 10 were established in 2000–01 while another four were launched in 2006–07 as a result of a second round of RCS

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1 Department of Health and Ageing, *Submission 74*, p. 13.

2 Department of Health and Ageing, *Submission 74*, p. 13.

3 Ms Pam Stronach, JCU, *Committee Hansard*, 23 April 2012, p. 1.

4 Department of Health and Ageing, *Rural Clinical Schools Program evaluation*, 2008, p. 1, http://www.health.gov.au/internet/main/publishing.nsf/Content/F113F29BD0A03FB8CA2575DE00227803/$File/udrh5.pdf, (accessed on 2 August 2012).

5 Department of Health and Ageing, *Rural Clinical Training and Support*, http://www.health.gov.au/internet/main/publishing.nsf/Content/work-st-rcts, (accessed 1 August 2012).

support.[6] The objective of the RCS is to increase the exposure of medical students to training in a rural area, and hopefully attract them to rural areas.

6.4 This RCS program is part of the broader Rural Clinical Training and Support Program (RCTS). The RCTS combines the RCS with Rural Undergraduate Support and Coordination Program (RUSC). This program mandates that 25 per cent of medical students must be from a rural background. This approach accords with the submissions form various organisations and individuals that there is a strong body of evidence that students from rural areas are significantly more likely to work in a rural areas than those from metropolitan areas. Rural Health Work Force Australia (RHWA) cited a South Australian review that concluded 'that the likelihood of working in rural practice is approximately twice greater among doctors with a rural background.'[7]

6.5 Ms Stronach from JCU concurred:

> There is much national and international evidence now to show that, to increase the rural and medical workforce, you need to select students who have a rural or regional background; train them in a rural or regional area; and give them enough meaningful and appropriate clinical exposure in rural, remote and regional health environments. That is important at both the undergraduate and postgraduate levels.[8]

6.6 The University of Western Australia also cited evidence in their submission that supported the claim that students with rural backgrounds are more likely to work in rural areas:

> In a 2003 article for the Medical Journal of Australia (MJA), Laven et.al., revealed the results of their national study on the factors influencing where GPs worked, particularly those in rural locations. The study found that 'GPs who have spent any time living and studying in a rural location are more likely to be practicing in a rural location. Those whose partners have also lived and studied for any period of time in a rural location are six times as likely to become rural GPs than those with no rural background' (Laven et.al., 2003, p.77)…The University of Western Australia recognises that medical students with a rural background are more likely to be interested in working in rural and remote areas their urban counterparts.[9]

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6 Department of Health and Ageing, *Rural Clinical Training and Support*, http://www.health.gov.au/internet/main/publishing.nsf/Content/work-st-rcts, (accessed 1 August 2012).

7 Rural Health Workforce Australia, *Submission 107*, p. 23.

8 Ms Pam Stronach, JCU, *Committee Hansard*, 23 April 2012, p. 1.

9 University of Western Australia, *Submission 5*, p. 7.

Quota of students from a rural background

6.7 The RUSC program specifies a target of 25% of Commonwealth-supported medical students must be from a rural background.[10] The current program was implemented on 1 July 2011 and all universities offering Commonwealth Supported medical school places are included in the scheme apart from Griffith University who decided to opt out due to its focus on servicing outer-metropolitan regions in Southern Queensland.[11]

6.8 Despite this program, and the increase in rural clinical schools, there is still a low conversion rate for students graduating and returning to a rural area. Health Workforce Queensland (HWQ) provided the committee with results of a longitudinal study they have been carrying out to measure the proportion of medical graduates from four medicals schools that are now working in rural areas. The study measured the proportions from four medical schools—the University of Queensland (UQ), JCU, Griffith and Bond Universities—and the numbers are generally disappointing, with an average across the schools of 5.2 per cent of students now working in rural areas. Although the figures show JCU has an 11.2 per cent conversion rate. The HWQ submission reported the findings:

> Health Workforce Queensland has been actively tracking the number of Queensland trained doctors who are currently working in rural and remote locations. Data indicates that of the 5,618 graduates from the University of Queensland, James Cook, Griffith and Bond Universities between 1990 and 2010 only 294 (5.2%) are currently working in ASGC 2 to 5 locations.[12]

6.9 Charles Sturt University (CSU) is a strong proponent of increasing the proportion of students from the current 25 per cent to a figure proportionally more representative of the general population. The most recent figures available have 31.4 per cent of people living outside metropolitan areas in Australia.[13]

6.10 In evidence provided to the committee in Albury, CSU argued not only that 25 per cent was not reflective of the population who live in rural and regional areas but also that the definition of a rural background is also flawed:

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10 Department of Health and Ageing, *Rural Clinical Training and Support (RCTS) 2011-2014 – Program Guidelines*, p. 1, available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/1E915ABB10570BF7CA257989000AE7F5/$File/Guidelines%20RCTS%202011-14.pdf (accessed on 13 August 2012).

11 Department of Health and Ageing, *Rural Clinical Training and Support (RCTS) 2011-2014 – Program Guidelines*, p. 3, available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/1E915ABB10570BF7CA257989000AE7F5/$File/Guidelines%20RCTS%202011-14.pdf (accessed on 13 August 2012).

12 HWQ, *Submission 66*, p. 3.

13 ABS, *Population Distribution*, 2006, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008 (accessed 11 April 2012).

> No matter how you define where the regions are, it is closer to 30 per cent of the population of Australia, so for starters 25 per cent does not make a lot of sense.[14]
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> …
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> As you are aware, there is a 25 per cent target for medical schools to enrol students from rural backgrounds. We would suggest that the definition may not be good and that it only requires five years of residence in a rural area over the course of their life up to that point. That is not a very good definition[15]… The definition allows for you to have been born in Broken Hill, for your family to have lived there for five years and for you to move to Melbourne for the rest of your life and you could still be designated as a rural student. It is ludicrous.[16]

6.11 However they emphasised that they did not see a definition of a rural background as the most crucial aspect, but indicated that they would like to see 'rural students' defined by a desire to work in a rural area:

> A definition would involve a program where you looked at applicants for medical school and discussed with them why they might be designated a rural student. The fundamental issue they would have to convince you of is that they had a rural background, they love rural life, they are rural focused, their families have a rural focus. In other words, you would be looking for evidence that they had a genuine intention, no certainty, to practise their craft in a rural community on graduation[17]…We believe that an orientation towards rural practice is actually more important than that definition of rurality.[18]

6.12 Dr Lennox from Queensland Health described their approach to the quota for students with a rural background which also does not entail an overly rigid approach:

> We have been working very closely with the medical schools, particularly James Cook University, the University of Queensland Rural Clinical School, and through Griffith and Bond medical schools to ensure that we provide maximum opportunities for medical students with a rural background to stream into the pathway. In fact, rural heritage is one of the selection criteria for entry into the pathway. However, we do not disadvantage those who do not have a rural background but have fallen in love with the idea of becoming a rural doctor. In the merit selection process we also recognise what they have done to prepare themselves for rural practice through the medical school years.[19]

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14 Prof. Klomp, CSU, *Committee Hansard,* 5 June 2012, p. 4.

15 Prof. Vann, CSU, *Committee Hansard,* 5 June 2012, p. 2.

16 Prof. Dwyer, CSU, *Committee Hansard,* 5 June 2012, p. 3.

17 Prof. Dwyer, CSU, *Committee Hansard,* 5 June 2012, p. 3.

18 Prof. Vann, CSU, *Committee Hansard,* 5 June 2012, pp 1-2.

19 Dr Lennox, Queensland Health, *Committee Hansard,* 10 July 2012, p. 4.

6.13 Professor Humphreys from the CRERRPHC expressed his support for the principle of having a target of students from rural backgrounds. However he suggested that this was only one part of the equation:

> I have to say I think that program has done very well at the front end of the training spectrum. It has encouraged universities to train their entrance programs, their selection processes; it has created dean's lists and opportunities for disadvantaged rural people. It has done a lot there in terms of early immersion. It is in need of a little bit of scrutiny at the moment, because I think there is a bit of fudging of some of the figures around 25 per cent and what that really means, but effectively it has been a very significant and worthwhile impetus to get the front end of the training spectrum right. Within the graduate and undergraduate medical programs, I think things are going well.[20]

6.14 There has been some recent controversy around whether all universities subject to the quota have been meeting their target. The publication of the figures from 2010 that detail the numbers of commencing students studying medicine from a rural background stated that only 7.5 per cent of commencing medical students at UQ had a rural background.[21] The RDAA also reported from the same figures that only nine per cent of students at the University of Adelaide, and 13 per cent of students from the University of Sydney, were from a rural background.[22]

6.15 This UQ figure in particular was brought up by CSU in their discussions over an appropriate target:

> For medical student entrants in 2012, 141 places that should be occupied by rural students are being occupied by metropolitan or overseas full-fee-paying students. The University of Queensland only has 7.5 per cent. The biggest medical school in Australia only has 7.5 per cent rural. [23]

6.16 On the back of that evidence the committee invited the UQ medical school to give evidence. They strongly refuted the claim that they had not achieved the target of 25 per cent, stating that the data was incorrect. Professor Nicholson, the Head and Director of Research from the UQ School of Medicine, took the opportunity to correct the record suggesting that administrative processes were responsible:

> The review panel report of 2010 into medical training stated that six medical schools had not achieved the 25 per cent rural background target and that for the University of Queensland it was 7.5 per cent. This hit the press and has caused a great deal of difficulty. This data is incorrect but has been used by some to advocate for changes in the funding model, so I think it is quite important that I set the record straight. I do not know where the 7.5 per cent came from and neither does anybody at the school of medicine, but presumably it came from information provided to MDANZ, which is

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20 Prof. Humphreys, CRERRPHC, *Committee Hansard*, 5 June 2012, p. 23.

21 Department of Health and Ageing, *Submission 74*, Attachment A, p. 17.

22 Rural Health Workforce Australia, *Submission 107*, p. 24.

23 Prof.Dwyer, CSU, *Committee Hansard*, 5 June 2012, p. 3.

> Medical Deans Australia and New Zealand, by central UQ administration. But the actual situation in 2010 was that we had 25.7 per cent of 138 graduate entry students who had a rural background and there had been a quota in place for a number of years. But the rural background amongst the majority of 178 undergraduate entry students was unknown. So we had a denominator of X and a numerator of Y and ended up with 11.4 per cent, which was technically correct, not 7.5 per cent. But I will be able to produce some data that corrects that. [24]

6.17 Professor Nicholson also suggested that the changing pattern of the university's entry pathways may also have played a role in the incorrect data collection systems:

> It is important to understand there are two entry pathways. One is an undergraduate…[t]he other entry pathway is graduate entry. Initially, the University of Queensland was entirely graduate, but about five years ago they started to introduce the undergraduate program. It started with quite small numbers but then ballooned to become the majority of the entrants. That explains some of the other data I am going to present to you[25]…After this information came out I initiated a survey of the entire year 1 and year 2 cohorts. That is 609 students. We had a very high response rate of 93.2 per cent. If we look at the rural background by MBBS year, 22 per cent of year 1 and 21 per cent of year 2 students reported having a rural background. This is based on the standard criteria of RA2 to 5 for at least five years since beginning primary school. I am very happy to table that report if the committee would like that.
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> In addition we have surveyed all students in the undergraduate pre-med course and consistently find around 13 per cent of those have a rural background. There is a clear difference between the proportion with rural background in the undergraduate versus the postgraduate program, but I would like to say very clearly that we are absolutely committed to achieving the 25 per cent target. Quotas will be in place next year for both streams, and we will ensure that the 25 per cent is met or exceeded. Very senior management has taken responsibility for this.[26]

6.18 The committee also discussed the issue with the Department of Health and Ageing when they appeared for the second time in Canberra. On hearing of the disputed data claims the department said they were 'aware there have been issues with the UQ's reporting under the Rural Clinical Training and Support program. We are working with them again on this year's data, so if that is a continuing problem we can get that sorted out with them.'[27]

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24 Prof. Nicholson, University of Queensland, *Committee Hansard,* 10 July 2012, pp 7–8.

25 Prof. Nicholson, University of Queensland, *Committee Hansard,* 10 July 2012, p. 7.

26 Prof. Nicholson, University of Queensland UQ, *Committee Hansard,* 10 July 2012, p. 8.

27 Department of Health and Ageing, *Committee Hansard,* 10 July 2012, p. 15.

6.19 While the issue of a quota was discussed as a contributing factor in increasing rural doctors, none of the evidence received by the committee suggested that there was one single solution to the problem.

Committee View

6.20 The committee understands the call for an increase to the target for students from a rural background from 25 per cent to a figure more representative of the general population. The contributors who proposed an increase highlighted the performance of some universities in meeting that target. In the case of the University of Queensland, the committee is satisfied that the reported figure was incorrect, though it remains unclear what the accurate figure may be. The committee is not persuaded that increasing the target will mean that universities will then meet that new target. In fact the opposite may occur, given the problems that some medical schools have been facing in meeting the current target.

6.21 The evidence from across the board suggests that while the target should be met and enforced, it is only one element of a complex problem, and by itself holds no promise of an increase in the rate of graduates practicing in rural areas. However the committee heard evidence that suggests that regional universities are more likely to meet the target and consequently provide more graduates that will practise in rural areas. The committee supports meaningful sanctions for those institutions that do not meet the current target, and although it understands that this is now a mandatory target with funding conditions attached, it would like those sanctions to be in the public arena, and would also like evidence of those sanctions being applied where appropriate.

6.22 The committee also considers that the definition of a rural student for the purposes of a quota needs to be reviewed.

Recommendation 10

6.23 The committee recommends the publication of those cases where universities do not meet the target of 25 per cent of medical students from a rural background, and subsequent publication of information about the sanctions that are applied in those cases.

Recommendation 11

6.24 The committee recommends that the commonwealth government explore options to provide incentives to encourage medical students to study at regional universities offering an undergraduate medical course.

Recommendation 12

6.25 The committee recommends that the definition of a rural student for the purposes of a quota be reviewed, and that the review should consider strengthening the definition to only include students who have spent four out of six years at secondary school in a rural area; four out of the last six years with their home address in a rural area; or city students showing 'ruralmindedness',

defined as an orientation to work in rural and regional areas, and demonstrated by a willingness to be bonded.

A multifactorial problem

6.26 CSU referred to reports from RHWA and the Deloitte Access Economics that show the current policies designed to provide enough rural health and medical practitioners are not working:

> Some of the figures that have been mentioned, for instance, by Rural Health Workforce Australia and the Deloitte's report, are that possibly only 2.7 per cent of 3,000 medical graduates actually intend to pursue a career in rural practice. We think that is an indictment of the current policy settings. A number of reports have been released over the last several months, but the Rural Health Workforce Australia report on the workforce in 2025 very clearly said that the policy settings are not delivering what is required for rural and regional areas, and are unlikely to unless there are changes to the policy settings into the future.[28]

6.27 Many submissions and evidence received throughout the inquiry has outlined that the problems of recruiting and retaining rural health professionals are complex and involve a number of factors. The University of Western Australia cited evidence that a student's background is only one of the factors that will impact on the decision of where someone will work after graduation:

> The decision of whether or not to work in a rural area is a multifactorial one and the influence of a multifaceted rural backgrounds is only one part of this complex decision making process.[29]

6.28 This position is supported by the CRERRPHC, which cited a number of studies in its submission that found that there are many variables that influence a practitioner's decision:

> Health workforce recruitment studies have highlighted the importance of student background, aspirations and interest in rural practice, needs of spouses and partners, the extent to which the training program has a rural mission, rural mentoring and support systems for students and rural educational experiences as the best predictors for taking up rural practice. While some of these background variables (such as rural background and interest in rural practice) continue to influence practitioner satisfaction in rural practice, other research has found that practice issues such as income and workload were far more significant predictors of practitioner retention in rural areas.[30]

6.29 Professor Murray, President of the Australian College of Rural and Regional Medicine (ACRRM) and Dean of the JCU's medical school, also acknowledged the

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28 Professor Vann, CSU, *Committee Hansard*, 5 June 2012, p. 1.

29 University of Western Australia, *Submission 5*, p. 7.

30 CRERRPHC, *Submission 32*, p. 4.

issues are complex and outlined what the medical schools can do to address some of the issues:

> Recruit rurally so that there is a better mix and make sure that you have also got underrepresented groups. Indigenous students, low SES et cetera is part of that. This helps to form a peer culture and a sense of values and belonging. Provide curriculum that is rurally rich with lots of inspiring experience. Our member medical students here, for instance, do not darken the doorstep of a city teaching hospital unless they do an elective. It is a completely different experience, and all of them do 20 weeks of small rural and remote placement. They are making choices, which we are very pleased to see, that are actually extraordinary and unprecedented.[31]

6.30 Professor Murray also described what he sees as a current opportunity being missed with the increase in medical students flowing through the system:

> We have engineered a solution to these three problems, which is to more than double the number of medical schools in the country and increase by about 2½-fold in a decade the production of medical graduates so that we will now almost top the OECD…However, we have not built the pipeline so that these new graduates—my new colleagues—will be going into the sorts of careers that we need them to do, that is, careers which are regional and general with a population health and a team orientation…There is an imperative of now.' We call it a national policy emergency. Jobs will be found for these young doctors in training. They will be shoehorned into the big city teaching hospitals supplemented by the big private hospitals. They will be doing transplant matters in their second year. It is a workforce that we do not need and that we will rue for a long time.[32]

6.31 As part of the discussion on future health care needs CSU informed the committee of their current proposal to the Commonwealth government to establish a new rural medical school in Orange that would provide placements for both health and medical practitioners, expanding its current campus. The proposal emphasises that future health care needs will be serviced by multidisciplinary primary care teams with a focus on preventative health.

6.32 Unlike the Rural Clinical Schools that primarily service students for rural medicine rotations, the CSU proposal is for a full rural medical school that would introduce a 'six year undergraduate medical program…with the following features':

> …an annual intake of 80 students; a Positive Rural Recruitment Program with 60% of students from a rural, regional or Indigenous background or disposed to rural practice; and, streaming of students from their fourth year

31 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, JCU, *Committee Hansard*, 23 April 2012, p. 3.

32 Prof. Richard Murray, Faculty of Medicine, Health and Molecular Sciences, JCU, *Committee Hansard*, 23 April 2012, p. 3.

> to focus on providing those students committed to rural practice with procedural skills suitable for rural practice.[33]

6.33 In addition CSU proposes that health related courses other than medicine would be doubled to 'build the skills and capabilities of graduates for integrated health care' and 'significantly increase the number of rural doctors, nurses and other health and human service professionals in rural areas.' [34] The proposal recognises that there are similar professional, social and economic factors that limit the supply of those health professionals in rural areas.[35] Of particular importance is the intention to integrate an e-health curriculum into the courses to prepare students for current and future utilisation of e-health and telemedicine. [36]

6.34 The Commonwealth government does fund the Nursing and Allied Health Scholarship and Support Scheme which is a program that supports allied health and oral health students to undertake a clinical placement in a rural or remote Australian community during their degree. However the committee received evidence that the program was vastly oversubscribed. The allied health component of the scheme is administered by Services for Australian Rural and Remote Health (SARRAH) who pointed out that this is a potential opportunity missed:

> …applications for the 2012 intake under the Allied Health Clinical Placement Scholarships Scheme, which we administer on behalf of the government, recently closed. For the 150 places under the scheme we had 1,046 applicants, of which 864 were eligible. This scheme encompasses all allied health professions and targets settings across rural and remote Australia. So, basically we are saying that there are over 700 eligible applicants who were unable to take up a placement in rural and remote Australia. Given that there is a workforce shortage, it is not rocket science to work out one strategy that could be adopted.[37]

6.35 The Department of Health and Ageing agreed that there are issues around finding clinical placements for postgraduates and pointed out that this is one the reasons why student placements are tightly regulated because of the flow-through of students for periods of 10 years or more that have to be accommodated. In response to questions about the proposal from CSU for a rural medical school, the department discussed the issues that need to be considered:

> …Commonwealth-supported medical places are capped under legislation administered by the minister for tertiary education. The views of the Minister for Health are sought on proposals to either establish new medical

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33 CSU, *Supplementary Submission 68,* Growing the Next Generation of Rural Health Practitioners, pp 4–5.

34 CSU, *Supplementary Submission 68,* Growing the Next Generation of Rural Health Practitioners, p. 4.

35 Professor Karen Francis, Royal College of Nursing, *Committee Hansard,* 11 May 2012, p. 38.

36 CSU, *Supplementary Submission 68,* Growing the Next Generation of Rural Health Practitioners, p. 4.

37 Mr Rod Wellington, SARRAH, *Committee Hansard,* 11 May 2012, p. 2.

> schools with new Commonwealth supported places or to extend the number of places within existing medical schools. The advice that the Minister for Health has been providing for some time now is that the clinical training environment is very stretched and there is not really the capacity to support additional numbers of medical students because of the large expansion over the last few years in the numbers of students training in Australian universities. Also, we now have evidence—modelling, I suppose—provided by Health Workforce Australia that shows that the number of doctors that we are producing and are expected to produce out to 2025 is relatively in balance. There may be a short-term oversupply followed by a fairly small comparative undersupply unless we change policy settings, but governments have agreed that they need to change policy settings rather than continue increasing the number of graduates…
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> When people are doing their undergraduate training at university, they need access to fairly extensive clinical training placements in order to complete their undergraduate training. That is usually provided through hospitals. Once they graduate, there can be issues with finding places for junior doctors. Again, that is capacity within the large teaching hospitals, generally public hospitals. There is also, once people are going through vocational training, a need to find people access to clinical training, so it is right through the scope of people's training.[38]

Committee View

6.36 The committee was impressed by the model proposed by Charles Sturt University. The provision of a full scale medical school based in regional Australia would have a significant impact on the numbers of doctors, nurses, allied health and other essential health professionals that would come from rural areas and would therefore be likely to remain in those areas after they complete their training. The inclusion of telemedicine and integrated team based care was also welcomed.

6.37 However the committee is also mindful that the current pressing issue is not the student numbers but the capacity in the system to adequately train those students all the way along a pathway from student to health professional who will work in rural areas.

Student Entry requirements

6.38 Queensland Health gave evidence to the committee that they are going further back in the educational pathway to try and attract rural students into the health sector as a whole:

> We have a program which deliberately targets rural based secondary school students to interest them in health careers—not just in medicine but in other disciplines as well. That has been operating over quite a number of years now, so we have a good track record of the number of rural secondary

38 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, pp 20–21.

> school students who have now tracked into health careers, and a significant number of those in fact are now moving into rural generalist medicine. [39]

6.39 There was also some discussion about the standard required for entry into medical schools and whether this should be revised for students from rural areas to take into account educational inequalities outside metropolitan areas. Dr Lennox from Queensland Health described one of their 'affirmative action' programs:

> What I can share with greater authority is the selection of secondary school students with a rural background through a program like our Health Careers in the Bush, for example, giving them affirmative action or assistance to enter into vocational training or enter into basic training in health disciplines including medicine, and then, through programs like those of James Cook University—and I think the University of Queensland now are establishing a very strong affirmative action program as well—assisting those students who have not had the best opportunity academically in secondary school or, for that matter, even in primary school to be able to bridge those gaps and move very well into tertiary education and vocational training in medicine. From what I can see, the evidence is very strong that they are very worthwhile programs. I have no doubt that we will see in the end strong evidence coming out of that evaluation that students or trainees with a rural heritage, including an Indigenous heritage, who have tracked through this program will provide exemplary service in the long haul in rural practice in future.[40]

6.40 CSU also supported differential entry requirements for students from rural and regional areas:

> …a major driver of university behaviour is about the prestige of student selection on entry, which is not necessarily anything to do with their ability to study the course. Medicine is a very competitive field. Sometimes the argument is put that we cannot let students in from rural and regional areas because they are not sufficiently qualified. My answer would be that they do not meet the market price but the market price is not necessarily an indication of ability. As John pointed out, this was the experience at JCU. There are entrenched factors which reduce the ability of bright students in regional areas to compete. You do need to have some process of affirmative action or at least recognise the educational disadvantage that feeds into this.[41]

6.41 Dr Mourik, a consultant obstetrician and gynaecologist in Wodonga suggested a rural loading for rural students would be effective:

> Any government program which supports rural students being accepted into Medicine needs to be enhanced. Rural students in secondary schools are disadvantaged compared to city students, so a rural loading of the TER

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39 Dr Lennox, Queensland Health, *Committee Hansard*, 10 July 2012, p. 4.

40 Dr Lennox, Queensland Health, *Committee Hansard*, 10 July 2012, p. 6.

41 Professor Vann, Charles Sturt University, *Committee Hansard*, 5 June 2012, p. 5.

> scores would improve the number of rural students entering medical studies and subsequently returning to the country after they graduate.[42]

6.42 Dr Mourik further expanded on his submission when giving evidence to the committee:

> I do not think you have to be that smart to be a doctor, but you do have to work hard. We know that rural students who go to rural secondary schools do not have the same teaching as the […] schools in the city. So there must a loading for rural students.[43]

Committee View

6.43 The committee strongly supports the efforts of Queensland Health, James Cook and Queensland University in their affirmative action programs. The introduction of options for underprivileged young people to enter a career in health and the provision of appropriate support throughout their training is highly commendable. The committee urges other regional and rural institutions and appropriate education providers to examine ways that can increase the opportunities of young people in the health field, with the added benefit of increasing the likelihood of retaining a health workforce if they are sourced locally.

Teaching and mentoring places for medical students

6.44 There are a number of barriers in current pathways for medical students to practise in rural areas. One of the most significant issues is whether the number of internship places for medical students can keep up with the recent expansion in medical graduates.

6.45 The internship is the first year out of medical school and is followed by one or more years as a Resident Medical Officer, or 'resident'. Both of these stages usually involve work rotations in clinical departments in the public hospital system.[44]

6.46 There has been recent media coverage of an article in the Medical Journal of Australia that claims that there will not be enough intern places available for the number of graduates leaving medical school.[45] The AMA concurred with the assertion. Catherine Joyce form Monash University suggested that 'what we need to

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42 Dr Pieter Mourik, *Submission 12*, p. [2].

43 Dr Pieter Mourik, *Committee Hansard*, 5 June 2012, p. 61.

44 AMA, *Becoming a doctor and bonded medical school places - a guide for prospective medical students*, http://ama.com.au/node/4130#Undergraduate_medical_Education, 31 October 2007, (accessed on 4 August 2012).

45 ABC News AM, *Not enough internships for medical graduates*, http://www.abc.net.au/am/content/2012/s3550909.htm, 23 July 2012, (accessed on 4 August 2012).

explore is a wider range of settings in which these internships take place', and this call was supported by Catholic Health.[46]

6.47 Professor Nicholson from UQ discussed the reliance on major teaching hospitals for post graduate training which excludes rural and regional hospitals:

> …postgraduate training is not done by the universities; it is done by the colleges and they basically rely on the state teaching hospitals. There need to be positions in the hospitals that are fully funded for training. Going back to my experience in Geelong, there was no position. I established the position where essentially the senior doctors paid the salary of the registrar in order to get somebody through, you needed to use innovative schemes. It was not considered reasonable or proper to train somebody in a regional hospital. I am sure that you will find that the vast majority of training positions in all states, including Queensland, are situated in metropolitan teaching hospitals.[47]

6.48 Professor Nicholson argued that this has direct consequences on efforts to entice doctors and specialists into rural areas:

> One of the drivers is that some students want to work rurally but want to train in surgery, so they hang about metropolitan teaching hospitals. Then they get married, get a mortgage and that is the end of it. [48]

6.49 The RDAA discussed the broadening of the settings of training postgraduate rural doctors:

> The Rural Doctors Association has published a set of national principles on the pathway for advanced training. That set of principles clearly identifies that there is an issue in some states for the availability of training positions that are required to do rural medicine and that other states may have to be brought in to provide some of that access. It is the same with the Northern Territory, for example, where we do not have the number of public hospitals required. So we believe that doctors should be able to move within that pathway into those other areas as the training simply may not be available in some of the smaller states. It may have to be provided by other areas with more regional hospitals.[49]

6.50 The issue of training for potential rural GPs becomes more acute at the registrar level, when training in rural medicine is normally delivered by GPs in community practices. Dr Mara from the RDAA commented on the difficulties and pressures that are placed on GPs in these scenarios:

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46 ABC News AM, *Not enough internships for medical graduates*, http://www.abc.net.au/am/content/2012/s3550909.htm, 23 July 2012, (accessed on 4 August 2012).

47 Prof. Geoff Nicholson, UQ, *Committee Hansard*, 10 July 2012, p. 14.

48 Prof. Geoff Nicholson, UQ, *Committee Hansard*, 10 July 2012, p. 14.

49 RDAA, *Committee Hansard*, 11 May 2012, p. 17.

> I personally, in my practice, would not be able to take on an intern in their vocational training year. The registration requirements, the risk requirements and the other arrangements for their training are very difficult to supervise. But I know that some practices are geared up to do it and they do it very effectively and very well.[50]

6.51 The AMA in their submission commented on the impact of the age profile of doctors in rural areas who are often relied upon to provide training and mentoring services as part of rural clinical rotations:

> The average age of rural doctors in Australia is nearing 55 years, while the average age of remaining rural GP proceduralists – rural GP anaesthetists, rural GP obstetricians and rural GP surgeons – is approaching 60 years. This means that the ageing of the health workforce has serious implications for sustainable health service delivery and for the supervision and mentoring of trainees and new graduates into the future. These issues impact on the health workforce nationally and in all settings, but are even more pressing in regional, rural and remote areas.[51]

6.52 The Royal College of Physicians commented on how valuable the increase in University Rural Clinical Schools has been in providing the opportunity for training to be delivered in a rural or regional setting by senior professionals:

> These have provided education and training opportunities in regional communities for some years and have enabled senior professionals to engage in supporting the teaching and training of local or temporary residents and trainees and is a win for both the professional community, the general community and the students who wish to study, work or live in a community which they have grown up in.[52]

6.53 The City of Mount Gambier, in discussing the success of the Flinders University Rural Clinical School, added that:

> These facilities enable students to experience the benefits of rural living and medical practice informing them about placements in the country on completion of their studies thereby improving the capacity of the region to deliver medical services in our region. Without this, rural areas tend to lose potential medical professionals from their own populations when they are required to relocate to major capital cities for their education needs.[53]

6.54 However this can also cause difficulties in supplying the colleges with adequate teaching resources. Dr Mourik described the situation in Albury Wodonga:

> I am teaching women's health at the university, and that is one of the best initiatives the federal government has done. It really does work well, except it lacks teachers. Out of the eight O&G specialists in this town I am the

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50 RDAA, *Committee Hansard*, 11 May 2012, p. 17.

51 AMA, *Submission 42*, p. 2

52 Dr Leslie Bolitho, Royal Australian College of Physicians, *Committee Hansard*,11 May 2012, p. 53

53 City of Mount Gambier Council, *Submission 89*, p. 1.

> only one who does teaching—and it is onerous—because they are too busy doing the work…[w]e lack the teachers, and there is no incentive for teachers.[54]

6.55 A report from the Rural Doctors Workforce Agency in South Australia emphasised how important it is that young doctors studying at postgraduate years one and two (PGY1 and 2) are provided with training from existing GPs in a rural setting because 'there are no GP role models or champions in metropolitan hospitals'.[55] This view that hospitals are not appropriate for training GPs is supported by a study by NSW Health that found that:

> …the current NSW hospital service model does not meet the accreditation requirements of ACRRM or the RACGP to enable GP trainees to complete all of their GP training in a hospital setting. Continuity of care is considered a necessary part of GP training and primary care under both College programs and NSW hospitals do not meet this training requirement.[56]

6.56 The Australian College for Rural and Remote Medicine (ACRRM) emphasised the need to invest in teaching, and in situ mentoring capacity in rural areas:

> …we do need to invest more in developing the infrastructure for teaching out there, really developing the mentoring and the supervision type levels. We would like to be providing a higher level of mentoring and supervision, particularly mentoring for overseas trained doctors, but, again, we have not got funding to do that. You do need to. Infrastructure for training in rural is essential.[57]

6.57 Dr Kirkpatrick from the Royal Australian College of General Practitioners described the current situation for GP practices across the country that have the capacity to teach:

> We would like to see the number of rural places and the length of rural placements increase, but it cannot be without support for supervisors. We are already stretching our teachers, but there are only some 1,500 general practices in Australia that teach. One of the things that we need to do is to make teaching valuable to the teacher, but not to the detriment of providing health care within the community.[58]

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54 Dr Pieter Mourik, *Committee Hansard,* 5 June 2012, p. 59.

55 Rural Doctors Workforce Agency, *R2RGP, Road the General Practice,* June 2011, p. 3.

56 NSW Health, *Securing a Stable Medical Workforce for NSW Rural Communities,* August 2011, p. 5.

57 Ms Dianne Wyatt, Australian College for Rural and Remote Medicine, *Committee Hansard,* 5 June 2012, pp 14-15.

58 Dr Kathryn Kirkpatrick, Royal Australian College of general Practitioners, *Committee Hansard,* 5 June 2012, p. 36.

6.58 Dr Kirkpatrick also pointed out that there are developments overseas to provide the teaching skills at an early stage that will increase the capacity for students now to become skilled teachers later in their career:

> Can I say that in Britain they are mandating education and teaching models for all of their medical students and registrars so that everybody has some degree of understanding of educational method and how to teach. In Australia there is an understanding that everybody will teach but often times there is no 'teach the teacher'. It is becoming recognised as a need but it has not been a mandated activity. [59]

6.59 Ms Bell from the Central Australian Aboriginal Congress informed the committee of the particular difficulties with regard to providing teaching and mentoring opportunities in their delivery of Aboriginal health services:

> A challenge for us, when we are dealing with that number of trainee positions, is that we do not have adequate training facilities for when they are onsite. For instance, having four registrars and four trained supervisors who look after each of them becomes an issue for us in ensuring adequate space and opportunity for them beyond the clinic. That has been an ongoing issue for us over the last three or four years of being recognised as a training facility. Even though we only receive these trainees, there is an impact on our environment when we have them there on site, and we do not have adequate facilities to look after them in a way that students need to be looked after when they are there.[60]

Committee View

6.60 Effective translation of medical students into rural and regional practice requires appropriate support at all stages in the training and placement process. There does not appear to be adequate systems that will support the internships, rotations, or mentoring of the expanding number of medical students. The committee did not receive detailed evidence on the funding and policy mechanisms that support internships and workplace training, but the situation will need to be improved in regional areas if the current drive to expand the number of students is going to translate into actual health professionals working on the ground.

6.61 The committee is looking forward to the Department's forthcoming review of rural health and would like to see a full exploration of ways in which blockages in the system such as the shortage of rural clinical placements can be addressed. Support for training providers, be they public or private hospitals or GPs in rural communities is essential. Infrastructure funding is important to support these providers, but simple steps like introducing the UK's recent policy of incorporating teaching training into

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59 Dr Kathryn Kirkpatrick, Royal Australian College of general Practitioners, *Committee Hansard,* 5 June 2012, p. 36.

60 Ms Stephanie Bell, Central Australian Aboriginal Congress, *Committee Hansard*¸ 20 February 2012, p. 3.

the medical curriculum could also provide local GPs with the tools and confidence to provide high quality training in a local setting.

Recommendation 13

6.62 The committee recommends that the Commonwealth, state and territory governments review their incentives for rural GPs with the aim of ensuring that rural GPs who provide training to pre-vocational and vocational students are not financially disadvantaged.

Recommendation 14

6.63 The committee recommends the Commonwealth government consider the establishment of a sub-program within the National Rural Locum Program that would provide support for rural GPs to employ locums specifically to enable the GP to deliver training to pre-vocational and vocational medical students in rural areas.

Accommodation issues during clinical placements

6.64 A number of contributors to the inquiry discussed the difficulties that doctors and other health practitioners encounter in securing accommodation during clinical rotations and placements in rural areas. The situation seems to be *ad hoc*; there are no significant Commonwealth government policy drivers in place,[61] and there is a lack of coherent strategy across the medical school sector.

6.65 Dr Mourik described what his students regularly encounter when trying to access affordable accommodation:

> They find their own accommodation. A couple of students just got digs with the midwives. Some of them share houses.[62]

6.66 He also suggested that significantly lower incomes for rural practitioners are a real barrier to attracting doctors to rural areas:

> How many years have we been talking about rural loading? We pay the same insurance as a city obstetrician and our income is about one-third. We can cope with a half, because the cost of houses and land and other expenses is less, but not three or four times…We cannot attract a young person here when they have HECS, a partner, two kids and a dog. By the time they are a senior registrar or graduate as a specialist, they do not want to come here and earn one-third of the income they can earn in the city. We cannot attract them.[63]

6.67 Dr Lennox from Queensland Health informed the committee that there is some provision for accommodation as students move through the training pathway as part of their rural generalist model:

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61 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p.21.

62 Dr Pieter Mourik, *Committee Hansard*, 5 June 2012, p. 59.

63 Dr Pieter Mourik, *Committee Hansard*, 5 June 2012, p. 59.

> The key elements of this pathway is that trainees are able to progress to the completion of training in-service with Queensland Health. So as they progress through the pathway, they have an entitlement to accommodation, particularly when they are appointed in the rural locations. Their appointment as a senior medical officer provisional fellow entitles them to accommodation by the health and hospital service in which they are located.[64]

6.68 The University of Queensland also has some provision for accommodating its students, particularly if they are in rural areas:

> Part of our funding requirements is that the students are not disadvantaged, so there are a number of models. There is a rental subsidy. We do home stay. They could be put up in Queensland Health facilities. In a few places like Roma we have our own facilities… At all the other sites the 120-odd students are essentially given free accommodation for the year or two years.[65]

6.69 SARRAH described the accommodation provided through the the Nursing and Allied Health Scholarship and Support Scheme. The scheme supports allied health and oral health students to undertake a clinical placement in a rural or remote Australian community as part of their degree.[66] The rural placement:

> …entails students in their third or fourth year going out to a rural and/or remote location for up to a maximum of six weeks—an accommodation, travel and sustenance allowance is paid. Generally, that costs around about $11,000 per placement. It has been running for two or three years only.[67]

6.70 JCU also highlighted that difficulties in training medical practitioners in rural areas are equally applicable to training the broader health workforce including nurse and allied health practitioners:

> Just focusing on the training of the broader health workforce—medical, nursing, allied health—for rural service, there are significant costs associated with training health professional students in rural, regional and remote locations. These include all the common ones: the provision of the teaching infrastructure, the difficulty in attracting and obtaining appropriately trained supervisory staff, the travel costs for your staff and your students, accommodation costs—which are a huge gate that is holding back being able to place more students in small rural towns—and costs for students in having to maintain two residences. At JCU we expect our students to do a long placement in at least one rural area. We expect that of all our health professional students.[68]

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64 Dr Dennis Lennox, Queensland Health, *Committee Hansard*, 10 July 2012, p. 3.

65 Prof. Geoff Nicholson, UQ, *Committee Hansard*, 10 July 2012, p. 10.

66 SARRAH, *Nursing and Allied Health Scholarship and Support Scheme (NAHSSS)*, http://www.sarrah.org.au/site/index.cfm?display=74996, (accessed on 4 August 2012).

67 Mr Rod Wellington, SARRAH, *Committee Hansard*, 11 May 2012, p. 3.

68 Ms Pam Stronach, JCU, *Committee Hansard*, 23 April 2012, p. 2.

6.71 Tropical Medical Training, which manages the placement of a significant cohort of JCU postgraduate students, also highlighted the importance of accommodation and in the placement of all health practitioners and the work that it has carried out:

> There is also mapping about all the accommodation that is being provided over the year and who owns it—which university, which medical school and or which physiotherapist school, and where we can place the doctors.[69]
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> …
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> Obviously, especially with the mining boom at the moment, it is very hard to get trainees into some of our western towns. It is $1,200 a week for rent, which is fairly hard to sustain… so accommodation is a big issue, whether it is renting or actually buying a building, which might be cheaper in the long run, so that people have somewhere to stay.[70]

6.72 Health Workforce Queensland described the situation as being not only difficult to house health practitioners on clinical placements, but also having to provide appropriate professionals infrastructure for visiting practitioners:

> Infrastructure accommodation is on a couple of levels. There is the need for overnight accommodation for all health professionals. You have heard the horror stories about the cost in mining towns. It is not only a matter of availability; it is also about quality and safety. You need to be mindful of those things. The other one which goes with it is the clinical space for the health professional and the teaching space as well.
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> Then, on top of that, you have got fly-in fly-out services. There are a number of very successful programs run across the country called the SOAP programs, Specialist Outreach Assistance Programs—specialist outreach programs—and others. They bring people into town, which is wonderful, but if you have not got a second, third or fourth consulting room or a bed or this or that or high speed internet then it is actually problematic. I mentioned Cherbourg before and I would like to mention it again. There are something like 72 services going into that community, but put 72 single professionals in a row and then try to put them anywhere.[71]

6.73 The housing difficulties for Aboriginal Health Workers was also highlighted by the Aboriginal Medical Services Alliance of the Northern Territory:

> One of the biggest hindrances is housing. It is the policy of this government in the Northern Territory to supply housing for police, for Aboriginal community police officers, for nurses and for doctors, but it is an explicit policy of this government not to supply Aboriginal health worker housing. Apart from the fact that this is really discriminatory given that these other professions—including health professions—get housing, we have lots of places where housing is so overcrowded that Aboriginal health workers

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69 Mr Ian Hook, Tropical Medical Training, *Committee Hansard*, 23 April 2012, p. 13.

70 Dr Rod Nan Tie, Tropical Medical Training, *Committee Hansard*, 23 April 2012, p. 17.

71 Mr Ian Mitchell, Health Workforce Queensland, *Committee Hansard*, 23 April 2012, p. 27.

> basically have to go to the clinic in the morning to shower and get changed into clean clothes, because their own living conditions are too poor and too crowded.[72]

Committee View

6.74 The committee acknowledges that a placement program can only work effectively if students have somewhere to live while undertaking it. The committee notes that existing programs and stakeholders are seeking to address this issue. Given the number of students coming through the system who will require appropriate, and importantly, secure accommodation and support as part of their rural placements and clinical rotations, it is imperative that adequate policies and programs are established to manage the increasing demand. While it may be argued that accommodation issues are not unique to health workers it is an obvious impediment to increasing the health workforce in rural areas and one that requires a whole of government approach involving federal, state and other key stakeholders.

6.75 The specific issue of housing for Aboriginal Health Workers needs to be addressed. The committee is aware of the difficulties this causes in Aboriginal communities, both for staff working in remote communities and for attracting staff to those communities. The committee urges to Commonwealth government and the state and territory governments to work together to address this need.

Recommendation 15

6.76 The committee recommends that a coordinated accommodation strategy for be developed for rural health workers, including Aboriginal Health Workers, in the government's forthcoming review of rural health programs.

72 Mr Chips Mackinolty, Aboriginal Medical Services Alliance of the Northern Territory, *Committee Hansard*, 24 February 2012, p. 3.