The Royal Australasian College of Physicians

Senate Standing Committees on Community Affairs

Inquiry into the factors affecting the supply of health services and medical professionals in rural areas

Executive summary

The current focus on medical training in metropolitan area keeps trainee physicians in urban centres. However, trainees who have had a positive rural experience and quality training time, preferably within a rural-based training program, are more likely to stay in a regional area. Longer rotations are preferable to provide a more favourable experience. The Royal Australasian College of Physicians (RACP) recognises this and is in the early stages of developing a model of rural-based, dual-trained physicians. Additionally, trainees and physicians and their families need support to settle into a new regional area.

The RACP also considers Medicare Locals to be an efficient and effective provider of health services to rural areas. Specialist physicians can play a crucial role in the planning, resourcing and coordination of healthcare and management of multidisciplinary teams through Medicare Locals in the primary and ambulatory care settings. This would begin to address the gap and unmet need for continuing services in major rural and regional centres.

Finally, the RACP considers the Commonwealth's Specialist Training Program vital for allowing for trainees to obtain the necessary skills and experience to work in new environments, particularly in rural areas and in Aboriginal health. The Program has the potential to improve the distribution and flexibility of physician specialist services in rural areas.

Comments against Inquiry Terms of Reference

1. The factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres;

There is a gap in specialist services in major regional centres as well as smaller regional centres. One aspect of securing the specialist physician workforce in rural areas is the training experience. A good training experience will mean trainees are

more likely to return and stay in the areas as a physician, providing the community with a sustainable and secure workforce. A bad experience almost guarantees he or she will not return.

"*Rural training is a double edged sword. Whilst giving you the experience to be independent and learn how to be a consultant, it is at the expense of a very busy and somewhat stressful time. I have spoken with a number of my colleagues who are completing or have completed the rural term. For many of them it has been difficult in terms of feeling isolated and remote from their families and also the wider medical community. There have also been a number of cases of exhaustion related to the demands of the job associated with travelling. Other trainees have been routinely working 100-120hrs per fortnight with minimal consultant support and little or no teaching."* RACP Trainee

1.1. City connections and moving to the regions and rural areas

Students graduate from university then do up to two years as interns and residents before commencing specialist physician training programmes. Specialist physician training then requires the completion of three years basic training, with a mid –career qualification examination, followed by at least three years advanced training in one or more specialty areas.

Trainees mainly receive basic and advanced training within a metropolitan hospital with rotations out to region hospitals to gain rural experience. At this stage many trainees are in their late twenties or early thirties when their personal lives and social networks are embedded in the city and a move to the country is difficult. Many may have partners and young families that they must leave for the duration of the rural rotation. Many trainee physicians will have partners who are also professionals and career-orientated which means two lives, and more if there are children, need to be considered in a longer term move to the regions and rural areas.

Rural trainees and physicians have indicated that financial incentives such as HECS relief or scholarships, realistic and competitive salaries, as well as support for the trainee's partner and family to find employment and a place to live and settle would increase the motivation to move to the regions. Additionally, motivation would be improved with sensible, safe and family-friendly on-call commitments is necessary, taking into account that a family that has newly arrived in an area will not have immediate social support.

Taking family into account also applies when attracting specialist physicians and paediatricians to rural and remote areas. For example, a group of paediatricians in a remote area of Western Australia have raised concerns about the workload, work-life balance, family commitments and ongoing professional education. While they have had some initial success in recruiting additional staff to the area…"it has been because of the lack of support for their spouse and children (employment issues, childcare) that has led to these contracts falling through." There is a strong belief from this group that if health professionals are to be retained in a rural area, major efforts put into accommodating the whole family are imperative. Additionally, opportunities for specialist physicians to access incentive programs offered by the Federal Government would also enhance recruitment and retention.

1.2. Rural-based training

Physician trainees have strongly indicated a preference for positive incentives to consider rural training and practice, i.e. 'pull' factors, rather than 'push' factors, such

as bonded placements. However, for trainees who are interested in becoming rural physicians, the current metropolitan-based training creates disincentives to coming back to the regions. Evidence supports providing longer-term training placements in rural areas to establish trainees within the community. A further enhancement would be training programs that are based in rural areas, with specific rotations into metropolitan hospitals. This would enable greater retention and a sustainable and secure physician workforce.

The RACP is in the early stages of developing a model of rural-based, dual- trained physicians. Trainees interested in a rural physicianship will be given the option to train in general medicine as a core and in a specialty based on local needs. To facilitate this, the RACP is looking to develop tailored training pathways based in the regions. It is possible that the other specialty component will be in a metropolitan area, although there are options in some of the larger rural centres. In essence, this proposed model will be a reverse of the current system of training, removing the disincentives for trainees with a genuine interest in rural practice. The provision of a clear, dual-training career pathway is an additional incentive.

There is anecdotal evidence to suggest that trainees are interested and keen to participate in dual- training with generalism as the core specialty, within a rural area. This is provided there is the capacity to train physicians within the rural facility, there is a facilitated career pathway, and quality and supportive supervision and mentorship.

1.3. Training and Capacity-to-Train

"The consultants I got to know during my terms were although not always there with the support I needed were in fact very grateful to have an "advanced trainee" to be part of the team. Often rural and regional centres are staffed by non RACP paediatric trainees. The consultants in these regions are very busy with a mix of private and public work and having an advanced trainee to facilitate things on the ward and clinics and take some of the load from them" - RACP Trainee.

Anecdotally, trainees of the RACP who have undergone rural training have raised concerns about receiving adequate supervision. Some of the key issues related to capacity-to-train identified by the National Health Workforce Taskforce include:

- increasing demands on medical practitioners - clinical workloads, administration, private practice, unpaid supervision
- work/life balance which challenges the expectations of work hours
- gender balance - higher proportion of women in the medical workforce
- a highly specialised workforce which potentially limits training capacity.

The RACP recognises the need to understand the capacity-to-train. The RACP is looking at how it can address the training needs of an increasing number of junior doctors who are trained by senior physicians who have less and less time. This includes developing and applying a general methodology to establish the capacity-to-train. Once the current and future capacity-to-train is established, then potential models for future training can be tested, to understand which one provides a viable alternative.

The training of future generations of health workers can also be accommodated in regional and rural centres. The development of Centres of Excellence in Rural

Medical Education (CERMEs) will enhance learning opportunities and coordinate high quality education services throughout regions and local hospital networks.

These centres, co-located with undergraduate Rural Clinical Schools, will provide coordinated learning experiences in the post graduate medical education environment. The CERMEs will ensure consistency and quality education of future generations of regional and rural health care workers, including physicians in general and acute care medicine. This will facilitate easy access to ongoing medical education and up-skilling. The development of telecommunications, such as telehealth and podcasts will facilitate work, supervision and training, as well as attracting physicians, trainees and students.

The on-going development and implementation of the Specialist Training Program (outlined in section 3) will bolster the capacity of supervisors to train rural physicians and improve the experience of trainees in rural areas.

2. The effect of the introduction of Medicare Locals on the provision of medical services in rural areas

The RACP supports the introduction of Medicare Locals. Medicare Locals will drive more efficient use of our health resources by encouraging the delivery of primary care, ambulatory and acute care in the centres that are most able to safely and effectively provide them. Patients will benefit by experiencing shorter and safer patient journeys, within streamlined, and better focused clinical systems. Greater efficiency will mean that more 'health' can be provided for the same healthcare dollar.

Medicare Locals can play a crucial role in population health, with a focus on health promotion and health protection and a particular emphasis on reducing socio-economic differentials in health, with appropriate attention to housing, education and future employment opportunities. People who live in rural areas experience poorer health outcomes than those in urban areas and the introduction of Medicare Locals is expected to improve rural health service delivery and access to health care.

The RACP supports a multidisciplinary approach and early intervention across disease areas such as:

- early detection of cancer through screening and prevention activities to improve treatment outcomes and reduce the number of cancer-related deaths
- better palliative care
- chronic disease prevention and management.

Specialist physicians can play a crucial role in the planning, resourcing and coordination of healthcare and management of multidisciplinary teams through Medicare Locals in the primary and ambulatory care settings. Medicare Locals, in conjunction with Local Health Networks, could facilitate physicians in the primary/ambulatory care setting, and improve access to specialist care for the most vulnerable. Coordination of care within and between ambulatory and primary healthcare settings and other health-related services could be improved through the following strategies:

- improved communication between service providers
- facilitation of the development and implementation of shared information

- systems to support the coordination of care; for example, e-health, telehealth and the National Broadband Network
- coordination of clinical diagnosis, management, treatment and care
- joint planning, funding and/or management
- coordination of care within hospitals, particularly for patients who have co-morbidities and who are under the management of more than one medical unit.

The reintroduction of general physician (Generalists) could facilitate the coordination of care within hospitals and the primary/ambulatory care setting. The benefits will include:

- reduction in unnecessary and avoidable admissions
- reduced pressures on our hospitals, which reduces the financial impact on the hospital and the taxpayer
- better delivery of care within the community that is patient centred
- reduced incidence of misdiagnosis and incorrect treatment in hospitals
- improved long-term capacity
- increased quality and safety of the healthcare system
- reduced duplication of diagnostic procedures and treatments within hospitals
- improved quality of life for a large number of people and promotes a healthier community
- coordination of agreements between organisations
- sustained follow-up especially for high risk and disadvantaged groups
- implementation of care plans for use by a range of providers.

3. Current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:

i. their role, structure and effectiveness

ii. the appropriateness of the delivery model

iii. whether the application of the current Australian Standard Geographical Classification Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes; and …

3.1. The Commonwealth Specialist Training Program

The changing patterns of disease and ill health, increasing complexity of treatment and advances in medical technology is altering the way medical services are delivered. More services are now provided outside major public teaching hospitals in private hospitals, day hospitals and other community based locations. The Specialist Training Program (STP) is a Commonwealth Government initiative that funds training places in settings other than public teaching hospitals. This is so trainees obtain the necessary skills and experience to work in these new environments as independent practitioners.

Through STP funding, the RACP facilitates medical specialist training in a range of settings where trainees can benefit from the skills and experience required to meet the professional standards of their discipline. This year the RACP has been managing 188 positions in expanded settings. In 2012, the RACP will be managing 232 positions in expanded settings beyond traditional teaching hospitals.

The delivery of well-supervised, high quality specialist training opportunities is a partnership between the States and Territories, training organisations, including the Medical Specialist Colleges of Australia, the private sector and the Commonwealth.

Expanded settings include:

- rotations to accredited training posts in health care settings such as private hospitals
- specialists' rooms
- clinics and day surgeries
- Aboriginal Community Controlled Health Service (ACCHS)
- publicly funded health care facilities which can provide training opportunities not available in major public teaching hospitals (such as regional, rural and community health settings
- non-clinical settings (such as simulated learning environments
- the introduction of videoconferencing and future potential of NBN need to be explored and incorporated into rural training and supervision programs.

The objectives of STP facilitated by the RACP include:

- to increase the capacity of the health workforce to train specialists
- to better train specialists with education that matches the nature of demand and reflects the way health services are delivered
- to develop networked specialist training arrangements:
  - integrated series of accredited training sites
  - focusing on providing health care, through which trainees may rotate in the pursuit of specialist qualification;
  - based on health service delivery requirements of a region.

The Commonwealth Government's announcement in March 2010 to "Expand and Enhance the Specialist Training Program" will result in additional resources to:

- increase the number of specialist training places to be made available under the Program to 900 by 2014
- support private sector clinical supervision and infrastructure
- contribute to salaries and 'Rural Support Loading' to supplement the additional costs incurred by trainees in RA2-RA5
- provide system - wide education and infrastructure support projects (including the Private Infrastructure and Clinical Supervision program) to enhance training opportunities for eligible trainees.

Benefits of training in expanded settings are:

- trainees have improved training opportunities and experiences

- both trainees and medical specialists have greater opportunity to expand their training to match service delivery due to provision of high standard, multi-discipline patient care that meets community expectations/needs
- patients benefit due to greater access to high standards of care in the expanded range of training settings
- expansion of the range of training settings beyond major teaching hospitals increases the health care sectors capacity to take in more trainees.

3.2. Evaluation

An evaluation was commissioned by the RACP between July-October 2010 to gain a better understanding of the perspectives of STP trainees and supervisors. The results will form part of a comprehensive evaluation of specialist training posts being undertaken by the RACP.

Positive aspects of the Program identified included the diverse case-mix and good supervision, and a good contribution to skill development. Areas for improvements lay predominately in the need for more protected learning time. Supervisors identified working with Aboriginal health communities as a unique aspect of the STP experience, providing a unique insight into the social issues and living conditions in remote Aboriginal communities, and the challenges for patients trying to manage health problems. Supervisors also highlighted some gaps in the training program including the uncertainty of whether posts will continue to be funded from one year to the next.

Expanding specialist training into non-traditional settings means additional supervisors are needed. By expanding and networking training environments means more supervisors (both current and new) also need to be trained. Training is needed in order to ensure that supervisors in each of the specialties are properly skilled and are able to incorporate the changes into their training and assessment approaches. The number of current and potential supervisors who may need to be trained is unknown although this is an area of work that the RACP is undertaking.

To improve training experiences and the capacity of supervisors to train under the STP (and other situations), workshops have been conducted through 2011 and will continue to be run into the future. This is includes the distribution of interactive resources packages for supervisors. There has also been development of more online PREP learning tools, resources and lecture series.

The RACP sees the future of expanded STP training as:

- increased number of specialist trainees rotating through an integrated range of settings beyond traditional teaching hospitals
- better distribution of physician specialist services
- increased capacity within the sector to train specialists
- improved quality of specialist training with trainees gaining appropriate skills not otherwise available through traditional settings
- improved access to appropriate training for overseas trained specialists seeking Fellowship with a College
- increased flexibility within the physician specialist workforce.