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Working Better for Medicare Review
Department of Health and Aged Care
GPO Box 9848 Canberra ACT 2601 Australia

Via email: WBFMReview@healthconsult.com.au

To the Working Better for Medicare Review team,

Re: Working Better for Medicare Review: Review of Section 19AB and District of Workforce Shortage (DWS) classification system

The Royal Australasian College of Medical Administrators (RACMA) appreciates the opportunity to provide our expertise and advice to the Review of Section 19AB and District Workforce Shortage (DWS) classification system.

We are also grateful for the extension provided to us, noting constrained resourcing at this time.

RACMA

RACMA is the only specialist medical college that trains doctors to become specialist Medical Administrators. As demonstrated by the pandemic and the increasing complexity of health systems, leadership of organisations and systems change has never been more pivotal to health outcomes.

Our education programs, including our accredited flagship Fellowship Training Program, equip doctors with the leadership and management skills needed to influence and lead the Australasian health care systems with the clear aim of improving health outcomes of Australians and New Zealanders. RACMA Members fill diverse roles, including Chief Executives, Chief Medical Officers, Director of Medical Services, Heads of Departments, as well as working in the university and defence sectors. As such RACMA is a recognised and respected voice of medical leadership, management and clinical governance and a pre-eminent provider of medical leadership and management education and training.

Around 7 million people, about 28% of the Australian population, live in remote, rural and regional areas (ABS 2017e).1 These Australians face unique challenges due to their geographic location and often have poorer health outcomes than people living in metropolitan areas. According to the Australia's Health 2020 report https://www.aihw.gov.au/reports/australias-health/australias-health-2020-data-insights/summary, data shows that people living in rural and remote areas have higher rates of hospitalisation, death, injury and also have poorer access to, and use of primary health care services, than people living in major cities.

One of the major causes for the imbalance in health outcomes is the maldistribution of the medical workforce. This workforce maldistribution also extends to Medical Administrators and those who apply Medical Leadership and Management skills as part of their clinical work.

To address the inequities in health outcomes in remote, rural and regional areas, locally based health care services:

- should have a close and unique relationship to the communities they serve.
- require Medical Leadership and governance, underpinned by population health, which integrates a holistic approach so that primary health care aligns with all levels of hospital care.
- require a medical workforce that is wherever practicable locally resident and provides genuine continuity of clinical care and cultural safety to patients and population health services to Australian communities.
- require a holistic clinical governance model informed by population health involving genuine engagement between managers and clinicians.
- should embody, in addition to excellent quality clinical care, high levels of education, training and research built on the foundation of population health.
- should foster a better professional environment for medical practitioners across Australia.

Response to consultation questions

Section 19AB and DWS has overall had a positive impact over the last decade, in providing an improved distribution of workforce but rural, regional and remote (RRR) Australia has substantially smaller number of both GP specialists and non-GP specialists compared to metro areas, so there are still many challenges and opportunities to ensure ongoing sustainability. The provision of primary care in rural communities is particularly challenged, with issues around the sustainability of general practices as small business entities in the current market, with small practices with less than five GPs struggling to survive leading to market failure.

It is important to note that there is currently a limited workforce willing and/or able to work outside of metropolitan centres in both general and specialist practice. Changes to 19AB exemptions alone will not address this issue. The recruitment of doctors into rural areas is more complex and measures adopted must ensure that we do not see any shift between rural and outer metropolitan areas and that there is strong encouragement for more locally trained doctors to work in underserviced communities. It is also important to note that the focus on bulk billing rates is a limiting factor to increasing the GP workforce. The costs of running a practice continue to outstrip the indexation of MBS rebates and GP earnings continue to significantly lag their non-GP specialist colleagues. This is detrimental to GP recruitment and, in the absence of further initiatives to improve GP remuneration, will continue to impact negatively on recruitment across the sector.

We strongly advocate for targeted support for health services based in Modified Monash Model (MMM) 4-7 communities, which is classed as ‘Real Rural’. Large regional towns 1-2 hrs from the city that have access to all amenities are classed MMM2 and these regional towns being classified as rural within Government programs or initiatives targeted at rural and remote health services significantly disadvantages those services based in ‘Real Rural’ communities.

It is appropriate and necessary to design mechanisms to increase rural workforce. For those programs and levers intended to increase distribution to rural areas, there needs to be recognition of the differences between rural and outer regional areas, with preferential support for rural.

RACMA has also identified a potential issue with GP practices recruiting overseas practitioners when they have little experience of assessing work suitability, which results in the undesirable outcome of low-quality practitioners in remote settings. Our recommendation is to set up initial placements in hospitals for all overseas practitioners so that they can be assessed in better resourced settings to ensure they have the skills to work independently. Rural, regional and remote areas are not always the best place for supervision and assessment prior to working independently.

In rural and remote (MM4-7) areas there needs to be career pathways to ensure sustainability for both non-Fellowed GPs and non-vocationally registered GPs. The 3GA program provides access to a Medicare Provider number and billing whilst non-Fellowed GPs work towards fellowship.

Whilst the successful completion of a Fellowship can provide for A1 billings, an A7 (80%) rate should be allowed for non-vocationally registered GPs to assist with current workforce shortages.

Other incentives that may be considered include Commonwealth/State reduction of University debt for any health professional who works in MM 4 – 7 areas for 5 years or more, for example, and consideration of higher Medicare rebates for doctors working in MM 4-7 areas.

Section 19AB was initially successful in attracting GP specialists and International Medical Graduates (IMGs) undergoing GP training to RRR areas and to a lesser extent non-GP specialists. There are many associations and alliances advocating for strategies to address the shortages of GPs in RRR areas but not many address the issue of shortages of non-GP specialists. The 2023 census shows that 29% of Australians live in RRR areas but only 12% of Royal Australasian College of Surgeons (RACS) Fellows work in RRR Australia. In addition, a large cohort of non-GP Specialist IMGs who entered Australia between 2002-2008 completed their mandatory 10-year moratorium and have now either relocated to metro areas, started entering the private hospital system and reduced their public appointments, or have exited the public system. In addition, a number of exemptions have also contributed to this drift from RRR to metro particularly of the non-GP specialists.

The solutions devised to counter the problems faced in the 1990s might need some modification to be relevant in years to come. This may include a review of the 10-year moratorium and a modified approach for newly trained specialists in specialities where there is oversupply or moderate supply with a reduced mortarium.

In summary, we require innovative thinking to find a balanced solution to distribution levers to address the supply and demand of the medical workforce in RRR areas, taking into consideration socioeconomic factors, evolving demographics, and current workforce in establishing what is and isn't an area of genuine need.

References and Attachments

For the review's reference, and to ensure we continue to build on the decades of work in workforce, culture and funding issues in rural, regional and remote healthcare we have attached:

- Appendix 1: RACMA Submission - Service Registrar and Career Medical Officer Framework Working Document.: National Medical Workforce Strategy
- Appendix 2: RACMA Submission – Kruk Report: An Independent Review of Overseas Health Practitioner Settings
- Appendix 3: Submission to the Legislative Assembly Select Committee on Remote, Rural and Regional Health
- Qualitative Research for Culture Change – A Better Culture (By the Nous Group)

If RACMA and/or its Members can be of assistance in progressing this important work, please do not hesitate to contact me. Thank you once again for the opportunity to comment.

Yours sincerely

Dr Helen Parsons CSC FRACMA

RACMA President

Appendix 1

RACMA Submission - Service Registrar and Career Medical Officer Framework Working Document: National Medical Workforce Strategy

18 August 2023

Ms Valerie Ramsperger
Director Medical Workforce Policy and Strategy
Health Workforce Division, Health Resourcing Group
Australian Government Department of Health and Aged Care

valerie.ramsperger@health.gov.au

To Ms Ramsperger,

Re: Service Registrar & Career Medical Officer Framework Working Document

The Royal Australasian College of Medical Administrators (RACMA) thanks the Australian Government Department of Health for the opportunity to comment on the *Service Registrar & Career Medical Officer Framework Working Document*.

As detailed in the RACMA Medical Administration Scope of Practice workforce is one of the eight core dimensions of practice for a Medical Leader. It is RACMA Members who lead the engagement, deployment, and accountability of the medical workforce, lead and advise on the most effective configuration and delivery of clinical services to meet the needs of the population served and bridge the interface between management and clinicians in complex health systems.

As such, the College believes a strong framework for Service Registrars and Career Medical Officers (CMOs) is crucial for establishing a clear and well-defined career path in the medical profession. It supports professional development, quality patient care, and effective workforce succession planning, while also contributing to the overall success and stability of the healthcare system.

When reflecting on the *Service Registrar & Career Medical Officer Framework Working Document,* at the very outset a reevaluation of the perception of Service Registrars and CMOs and their integration into hospitals and health services is needed, as well as consideration of their identity within the workforce.

RACMA has identified the following areas which need further consideration and development within the *Service Registrar & Career Medical Officer Framework Working Document*:

- Training, Education and Credentialing
- CPD & CPD Homes
- Valuable Pathways
- Diversity of Conditions, including pay scales and professional development
- Accreditation Pathways
- Cultural Change

Training, Education and Credentialing
Service Registrars need dedicated training and education programs, which may best be provided by incorporating and/or linking to existing specialist training opportunities in the jurisdictions along with the appointment of Director or Supervisors of Training. This framework will also be needed to assist Service Registrars to comply with the new Ahpra Continuing Professional Development (CPD) Framework requirements.

In the same way training registrars are assessed, Service Registrars should also have a framework of credentialing and competencies, i.e., logbooks, Direct Observation of Procedural Skills (DoPS) and Workplace Based Assessments (WBAs) that allow them to have a "credentialed" Scope of Clinical Practice (SoCP) that they can carry forward onto substantive training programs or CMO roles.

Similarly, many large hospitals run credentialing processes for accredited and unaccredited procedural trainees on the basis of logbooks and direct supervision, leading to lists of procedures that they are allowed to undertake with remote supervision. A similar pathway could be developed for Service Registrars, but this would mean that the credentialing process would need to be in place a priori in the institution. The College suggests exploring such credentialing and SoCP pathways which may also support pathways for Service Registrars to transition to CMO roles.

It is important to note this is a structure for employed service registrars and not short-term locum registrars, though they too would also be expected to work within a defined scope of practice for their role.

CMOs, particularly those who have chosen this as a career path and are expected to have career progression to more senior positions, need a defined SoCP and therefore should be credentialed. There also needs to be assurance they are working within a safe and defined SoCP – both for their own protection and to ensure good governance from a credentialing and licensing perspective.

CPD & CPD Homes
All Service Registrars and CMOs will need a dedicated CPD home and fulfil their CPD requirements. They should therefore be allowed to participate in the health service peer review processes and have access to study leave and CPD activities, in addition to the training, education and credentialing processes described above.

Valuable Pathways
Creating a valuable pathway to training posts by investing in Service Registrar training and education will make these posts more attractive and aid recruitment and retention. It could also help some progress to substantive CMO posts as a career pathway, which may be critical in shoring up sustainable workforce particularly in regional and remote settings.

There needs to be paid non-clinical time for Directors/Supervisors of Training and Medical Educators to coordinate and oversee this, in conjunction with Medical Administrators in the hospital settings, but consideration should also be given to

- Specialty based Service Registrar networks if numbers are high across a jurisdiction
- A network of mixed specialty service registrars that can be linked into Supervisors of Training and training programs at the local or jurisdictional level.

Diversity of Conditions
Most Service Registrars are working under the relevant State Award or the Medical Practitioners Award (under the Federal Fair Work Commission Modern Award). It is noted that pay scales and industrial instruments determining how and when they can work are quite different and Service Registrars are a very heterogeneous group, both in terms of pay and conditions but also professional development goals and pathways depending on the role and jurisdiction in which they are working.

Similarly, for CMOs, pay and conditions can vary widely. The NSW CMO Award which describes progression of seniority and expected roles and responsibilities; this is also reflected to a lesser degree in the Modern Practitioners Award (under the Federal Fair Work Commission Modern Award) but neither articulate the diversity of CMO roles that are found across different health services and jurisdictions

It is also important to understand the CMOs are a very diverse group as well, occupying a range of roles across both public and private systems in different jurisdictions:

- CMOs may be represented by doctors from PGY 3 up to PGY 10 and beyond;
- Some CMOs will effectively be working as middle grade service registrars whilst other Senior CMOs will be working as independent practitioners with extended SoCP and responsibilities with their own procedural lists, clinics, or almost autonomous practice.

Accreditation Pathways
The role of accreditation bodies in the pre-vocational space needs to be explored. It would be much preferable that an external body such as a post graduate medical council, or equivalent, has oversight of Service Registrar (and CMO) trained education and accreditation framework, with standards for term descriptions and monitoring the efficacy of the Directors of Training, supervision and educational programs/etc. However, this will come at a cost both at the level of the employing institutional and accreditation body, so consideration as to who and how this will be funded needs to be given.

Cultural Change
Cultural change will be essential across the (salaried) profession if we are to change the perception of Service Registrars and CMOs and value their integration into hospitals and health services.

The term "Service Registrar" implies they are not entitled to training and education, professional development, or career progression. The term "unaccredited trainees/registrars" is being adopted by some and also has similar potentially negative connotations. It implies the person in the position is not qualified when it is the position which is unaccredited, whilst the registrar in the position is a fully qualified medical graduate with experience to registrar level. We suggest some further consideration of an appropriate title is needed to support attitude change and consolidate the importance and the need for these roles across the health system.

With respect to doctors in training there needs to be an understanding of the overall success rates of getting onto an accredited training program as reported in the *Service Registrar & Career Medical Officer Framework Working Document* and that, with the right supporting frameworks, alternative career pathways are available through the Service Registrar and CMO pathways. With respect to senior medical officers, the contribution to their craft group with delegated senior decision makers and sharing the service burden, including after-hours service provisions may also provide additional benefits for workload burdens, work-life

balance, and some protections against burnout, particular in regional and remote areas where recruitment and retention of senior medical staffing can be difficult.

Closing Comments

The Service Registrar & Career Medical Officer Framework Working Document attempts to address many of the issues raised above, but given most of the Service Registrar and CMO roles are appointed by individual health services, what is the incentive to drive forward this change?

Service Registrars are primarily employed to address staffing deficits at middle grade level – though there are also a number of junior medical officers who take these roles whilst waiting for a position on a training scheme. Given the necessity to fill middle grade rosters to ensure continuity of service provisions by health services, there are some levers in play to incentivize jurisdictions to put some of these recommendations in place, such as reducing reliance on locums and premium labour costs, improving longer term recruitment and retention to build capacity for service sustainability and growth. Even then, they will need to commit strongly to the proposals for them to work.

It is hard to see how we can ensure implementation of the recommendations without the additional support of the the Colleges and aligned professional bodies. This will need ongoing input from the Federal and States and Territories governments and consideration should be given to recommendations being integrated into health service contracts such as the National Health Reform Agreements (NHRA).

If RACMA and/or its Members can be of assistance in progressing this important work, please do not hesitate to contact me. Thank you once again for the opportunity to comment.

Yours sincerely

Mr. Cris Massis
Chief Executive

Appendix 2

RACMA Submission – Kruk Report: An Independent Review of Overseas Health Practitioner Settings

13 June 2023

Regulatory Reform Division
Australian Government Department of Finance
HealthRegReview@finance.gov.au

To whom it may concern,

Re: Independent Review of Overseas Health Practitioner Settings – Interim Report

The Royal Australasian College of Medical Administrators (RACMA) welcomes the opportunity to comment on the Interim Report developed by Ms Robyn Kruk AO. Our feedback is outlined below according to the questions in the invitation to comment.

Which reform options do you think should be prioritised?

"Better Workforce Planning" should be prioritised to ensure leaders and decision makers are equipped to make well-informed decisions. The demand for healthcare practitioners in Australia can vary across different regions and specialties. While there may be shortages in some areas, other regions or specialties may already have a surplus. Balancing the supply and demand of healthcare practitioners, both locally and overseas, is pivotal to ensure equitable distribution and specific needs/gaps are addressed first so the right people are recruited where needed. However, the removal of the requirements to demonstrate need through labour market testing is concerning if we simply limit requirements to certain classes of health practitioners. This could be easily manipulated to fill metro jobs where there is an arguable need.
Other reform options which should be prioritised are "Improve the applicant experience" on the 'tell us once' theory to avoid duplication, and "Expand 'fast track' registration pathways" to ensure a more streamlined system with better coordination between employer, college, Ahpra and DFAT.

What, if any, reform options are missing?

While RACMA believes this is a very much needed review which addresses many key issues, we have identified some critical gaps. It is crucial the delivery of quality and safe healthcare is not compromised in this process. The review and proposed reforms appear to only address the process of attraction, application and assessment phase and nothing beyond that. To ensure the employment of overseas health practitioners is successful and sustainable in helping solve some of our healthcare workforce shortages, while maintaining the delivery of quality and safe healthcare for all, the reforms need to recognise and include processes for:

- Improved cultural screening;
- Improved supervision framework;
- Impact on low and middle income countries;
- Retention and adjustment;
- Employment and professional development support; and
- Arrangement for MBS billings.

Improved clinical and cultural screening

Communication is vital in the healthcare field. While English language proficiency is generally required, there may be variations in, medical terminology, and cultural differences that can impact effective communication with patients and colleagues. The cultural values and awareness of some overseas practitioners may not be in accord with Australian values, for example Middle Eastern attitudes towards women. To address this properly, clinical and cultural interviews should be in place to ensure overseas practitioners can reach an adequate knowledge attitude standard.

Improved supervision framework

The College has identified an issue with GP practices recruiting overseas practitioners when they have little experience of assessing work suitability, which results in the undesirable outcome of low-quality practitioners in remote settings. Our recommendation is to set up initial placements in hospitals for all overseas practitioners first so they can be assessed in better resourced settings to ensure they have the skills to work independently.

There then needs to be some recognition of strengthening processes and/or resources available for overseas practitioners who are not meeting required standards after their supervisory period ends. This can be an issue in centres with workforce shortages, where the practitioner is not readily replaceable, but it emerges over time that the performance is at or below the low end of requirements.

On top of this, structured additional support for supervisors also requires acknowledgment in the reforms. There is an amplification in areas with medical workforce shortages in that the demand on supervisors, or their ability to provide additional support, is limited as a consequence of operating in an already resource constrained environment. As a result, there is great concern about the level and quality of supervision overseas practitioners receive after they arrive.

Impact on low- and middle-income countries

There is no acknowledgement in the review relating to the ethical arguments for encouraging migration of practitioners away from low- and middle-income countries, and the potential impact that this has on these already vulnerable populations. Did the review explore other ways to continue encouraging migration while supporting the country of origin? Establishing collaborations and partnerships with overseas organisations, universities and healthcare institutions could facilitate this, including establishment of exchange programs.

Retention and adjustment

The reforms lack acknowledgement of the importance of retention and adjustment support services. Overseas practitioners may face difficulties adjusting to a new healthcare system, culture, and work environment. Relocation challenges, social integration, and professional adaptation can impact their job satisfaction and long-term retention. The College suggests implementation of standardised orientation processes by employers with distinction between core elements (such as language and cultural supports) and elements that are specific/relate to the location / setting where the practitioner is practising. We know that those from the UK will often only stay for 1-2 years whereas those from south-east Asia are more likely to migrate permanently, which means these two groups would have very different needs. Providing comprehensive language and cultural support programs, as well as mentorship opportunities, can assist overseas health practitioners in improving their English language skills, understanding medical terminology, and adapting to the Australian healthcare system.

In terms of career development and progression, is there equitable access for overseas doctors who want to enter specialist training? This contributes to helping retain overseas practitioners, in turn making them a more sustainable and viable option to address workforce shortages.

Auditing and Employment and Professional Development Support

There needs to be consideration of implementing regulation to monitor and audit overseas practitioner complaints regarding, for example, pay and conditions. There have been cases where overseas practitioners are being asked to complete observation placements or work-based assessments for 3-6 months without pay and with no guarantee of a job at the end. This puts them at risk of exploitation, calling for recommended standard practices for employers in relation to this.

Arrangement for MBS billings

A review of the arrangements for MBS billings is needed with consideration of the impact of this on workforce distribution; currently overseas practitioners have limitations on billing depending on where they are practising and whether they are employees / contractors.

If RACMA and/or its Members can be of assistance in progressing this important work, please do not hesitate to contact me. Thank you once again for the opportunity to comment.

Yours sincerely

Mr. Cris Massis
Chief Executive

Appendix 3

Submission to the Legislative Assembly Select Committee on Remote, Rural and Regional Health

Mr Joe McGirr MP
Chair
Portfolio Committee Number 2
Parliament House
Mcquarie Street
SYDNEY NSW 200

21 October 2023

Dear Mr McGirr

Legislative Assembly Select Committee on Remote, Rural and Regional Health

The Royal Australian College of Medical Administrators (RACMA) appreciates the opportunity to provide our expertise and advice to the inquiry into the implementation of Portfolio Committee No. 2 recommendations specifically relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

We are also grateful for the extension provided to us, noting constrained resourcing at this time.

RACMA

RACMA is the only specialist medical college that trains doctors to become specialist Medical Administrators. As demonstrated by the pandemic and the increasing complexity of health systems, leadership of organisations and systems change has never been more pivotal to health outcomes.

Our education programs, including our accredited flagship Fellowship Training Program, equip doctors with the leadership and management skills needed to influence and lead the Australasian health care systems with the clear aim of improving health outcomes of Australians and New Zealanders. RACMA Members fill diverse roles, including Chief Executives, Chief Medical Officers, Director of Medical Services, Heads of Departments, as well as working in the university and defence sectors. As such RACMA is a recognised and respected voice of medical leadership, management and clinical governance and a pre-eminent provider of medical leadership and management education and training.

Context and Aspirations

Around 7 million people, about 28% of the Australian population, live in remote, rural and regional areas (ABS 2017e).1 These Australians face unique challenges due to their geographic location and often have poorer health outcomes than people living in metropolitan areas. According to the Australia's health report 2020, data shows that people living in rural and remote areas have higher rates of hospitalisation, death, injury and also have poorer access to, and use of primary health care services, than people living in Major cities.

RACMA through community engagement supports the findings in the Household, Income and Labour Dynamics in Australia (HILDA) survey (Wilkins,2015) that, despite poorer health outcomes for some, Australians living in towns with fewer than 1,000 people generally experienced higher levels of life satisfaction than those in urban areas and major cities (Wilkins 2015).

One of the major causes for the imbalance in health outcomes is the maldistribution of the medical workforce. This extends to Medical Administrators and those who apply Medical Leadership and Management skills as part of their clinical work.

To address these inequities, remote, rural and regional health care services:

- should have a close and unique relationship to the communities they serve.
- require Medical Leadership and governance, underpinned by population health, which integrates a holistic approach so that primary health care aligns with all levels of hospital care.
- require a medical workforce that is wherever practicable locally resident and provides genuine continuity of clinical care and cultural safety to patients and population health services to Australian communities.
- require a holistic clinical governance model informed by population health involving genuine engagement between managers and clinicians.
- should embody, in addition to excellent quality clinical care, high levels of education, training and research built on the foundation of population health.
- foster a better professional environment for medical practitioners across Australia.

Connection to Community:
Remote, rural and regional health services have a high level of involvement by community members and are highly scrutinised by the communities they serve, which includes Indigenous communities. There is a real sense of local "ownership" of remote, rural and regional health services that often contributes not just to the health care but also the economic well-being of their communities. This is especially important in regard to the priority of improving the health of Indigenous communities. It also requires a strong focus on population health.

Effective Medical Leadership and Management skills provided by those specialty-trained in Medical Leadership and Management is necessary to ensure that health services work genuinely with the people they serve to achieve the best individual and population health outcomes possible for their communities. RACMA Members have a focus on reducing inequities that exist not only between rural and metropolitan areas, but also within remote, rural and regional communities themselves.

RACMA Members as Medical Leadership Specialists in a remote, rural or regional setting often come to be seen as leaders in their community. Members engage with and work in coalition with other community leaders, consumers, patients and carers to serve the community and to implement whole of community initiatives for health improvement and population health.

Medical Leadership & Governance:
Remote, rural and regional health care services require Medical Leadership and governance, underpinned by population health, that integrates a holistic approach so that primary health care aligns with all levels of hospital care.

Remote, rural and regional services are unique in the way that primary care interacts with secondary and tertiary levels of care. Primary care practitioners provide hospital care and population health services as well as individual patient care across a range of specialty areas including procedural services in anaesthetics, obstetrics and general surgery.

RACMA members who are specialty-trained in Medical Leadership and Management are key to ensuring effective and efficient integration of the numerous component parts of a health system to ensure optimal functioning and service delivery across the continuum of care where health resource stewardship is fundamental to innovation in models of care to serve a diverse community. Remote, rural and regional health care services are leaders in integrated care and innovations in this sector may be able to inform system change in other areas of the health system.

Medical Workforce:
Remote, rural and regional health care services require a medical workforce that is wherever practicable locally resident and provides genuine continuity of clinical care and cultural safety to patients and population health services to Australian communities.

Strategic medical workforce development and deployment for remote, rural and regional health services is a complex problem and should be led by RACMA members who are specialty-trained in medical leadership and management who will:

RACMA recommends consideration of some key areas of focus in addressing the workforce issues in remote rural and regional and rural health services including:

a) The role of the general practitioners in hospital and community care
b) Generalist medical and surgical workforce in the hospital setting
c) The impact of a locum workforce and the FIFO model
d) The role of International Medical Graduates (IMGs)
e) Consideration of Scopes of Clinical Practice
f) Models of care including telehealth and hub and spoke models
g) Award arrangements and Industrial Relations
h) Federated Model of Care

a) General Practice in Hospitals

The role of the general practitioner is central to the adequate provision of both primary care in the community and population health services in addition to hospital care and individual patient care across a range of specialty areas including procedural services in anaesthetics, obstetrics, and general surgery.

We are facing a significant issue with few numbers of medical graduates training in primary care and for those who do, fewer are training as GP proceduralists who are able to contribute to hospital-based care.

Other barriers to hospital-based GPs in the rural and regional setting include the volume of work in their community general practice which means that there are no financial incentives or time to also work in their local hospital. Their skills and experience often mean they may not have equitable relationships with hospital managers. Issues of professional isolation and lack of onsite specialists means GP are often concerned about risk with complex patients and feel underprepared for the breadth of practice in what is often the only hospital for many hundreds of kilometres.

b) Generalist medical and surgical workforce:

The importance of a generalist medical and surgical specialist workforce cannot be understated. In regional and rural settings, the relatively low number of resident specialists combined with the breadth and depth of clinical presentations requiring emergent care requires an expansion of the generalist specialty workforce. Although some of this is currently provided by community GPs who work in the hospital setting as above, current College training programs are increasingly focused on subspecialisation resulting in pipeline issues for the generalist speciality workforce, further impacting the ability to deliver adequate hospital services outside the metro or large regional hospital settings.

The development of a local specialty generalist workforce supplemented by upskilling GP proceduralists with advanced scopes of practice in obstetrics, anaesthetics, general surgery and other medical subspecialties is critical to ensuing ongoing equitable access to care in regional and rural communities.

c) Locums and FIFO

Specialist Workforce:
Whilst essential for short-term crisis workforce solutions and for providing much needed leave cover, we are now seeing a rural, regional, and remote workforce increasingly dependent on locum medical professionals. This may be regarded as positive or helpful in the very short term, whilst government works to find more sustainable solutions. However, as those more sustainable solutions have not been forthcoming over the last decade, we are now left with a two-tiered rural workforce. Due to the inconsistent nature of the work, locums earn significantly more than locally resident doctors, without the responsibility for providing continuity of care.
As this has become entrenched as the ongoing model, instead of the short term or leave relief option, it becomes less and less attractive for a medical practitioner to make any ongoing commitment to either an ongoing role or building a practice in a rural or regional area.

Although FIFO specialist models have been a key part of rural and regional health care, especially for healthcare that requires advanced specialty training (such as intensive care and some surgical and medical specialties), and will continue to be needed, there are increasing issues in the disparity between pay, working conditions and professional isolation that makes the FIFO model increasingly attractive, discouraging specialists to establish a more permanent practice in regional rural settings.

Junior Medical workforce:
As detailed in the RACMA Medical Administration Scope of Practice, workforce is one of the eight core dimensions of practice for a Medical Leader. It is RACMA Members who lead the engagement, deployment, and accountability of the medical workforce, lead and advise on the most effective configuration and delivery of clinical services to meet the needs of the population served and to bridge the interface between management and clinicians in complex health systems.

As such, the College believes a strong framework for Service Registrars and Career Medical Officers (CMOs) is crucial for establishing a clear and well-defined career path in the medical profession. It supports professional development, quality patient care, and effective workforce succession planning, while also contributing to the overall success and stability of the healthcare system.

When reflecting on the *Service Registrar & Career Medical Officer Framework Working Document,* at the very outset a re-evaluation of the perception of Service Registrars and CMOs and their integration into hospitals and health services is needed, as well as consideration of their identity within the workforce.

RACMA has identified the following areas which need consideration and development to ensure a sustainable workforce addressing maldistribution and retention of a skilled workforce.

- Training, Education and Credentialing
- Continuing Professional Development (CPD) and CPD Homes
- Career Pathways
- Diversity of Conditions, including pay scales and professional development
- Accreditation Pathways
- Cultural Change

RACMA also recommends that whilst the regional and rural workforce dependency on locums continues, consideration should be given as to how NSW Health can influence the internal market to ensure a reliable and appropriately credentialed locum/casual workforce to provide safe and quality care to the communities they serve including:

- Creation of a statewide casual pool with rate guided escalation points endorsed by MOH policy
- Development of a Credentialing framework to ensure locums are working within their Scope of Clinical Practice (SoCP) and to avoid the risks of locums employed in roles beyond their skills and ability because of the perceived need for continuity of service provision
- Mandatory supervision and training competencies/expectations for the locum workforce
- Pathways of integration of casual/locum workforce into training programs and/or substantive positions.

d) International medical graduates

International medical graduates are an integral part of the rural, regional and remote workforce and for this reason, more investment is needed to ensure they are well supported and transitioned to the permanent workforce.

To ensure the employment of overseas health practitioners is successful and sustainable in helping solve some of our healthcare workforce shortages, while maintaining the delivery of quality and safe healthcare for all, there needs to be focus on:

- Improved cultural screening and training;
- Improved supervision frameworks;
- Impact on low and middle income countries;
- Retention and adjustment;
- Employment and professional development support; and
- Arrangement for Medicare Benefit Schedule (MBS) billings.

RACMA has identified an issue with GP practices recruiting overseas practitioners when they have little experience of assessing work suitability, which results in the undesirable outcome of low-quality practitioners in remote settings. Our recommendation is to set up initial placements in hospitals for all overseas practitioners first so they can be assessed in better resourced settings to ensure they have the skills to work independently. Rural, regional and remote areas are not always the best place for supervision and assessment prior to working independently.

e) Telehealth and virtual health

Telehealth and virtual health have become an integral part of the delivery of medicine – in all location settings, accelerated by the pandemic. This mode of delivery and care is a useful augment to existing in-person health care.

Government should resist the temptation to see tele and virtual health as a possible solution to the workforce and funding crisis, particularly in regional and rural areas, but see it more as an enabler to help upskill and augment already existing services.

There are some excellent examples of this such as the Westen NSWLHD remote critical care service delivered in conjunction with ED and Intensive Care specialists from the regional base hospitals in real-time with GPs and hospital clinicians across smaller sites to facilitate early decision making and interventions for patients needing higher level care whilst waiting for retrieval. It also provides early decision making for patients who are not likely to survive and palliation or other measures to be put in place locally, avoiding resource intensive unnecessary transfers to regional or tertiary centres, away for family, carer and community. Not only does this provide rural and remote in-reach services, but it also provides clinicians in the rural hospital direct access to live specialist input and a platform for upskilling in complex decision making and emergent care.

f) Scope of Practice

Rural, regional and remote areas require practitioners to be able to practice at the top of their clinical scope of practice, supported by clinical experts in their fields. They are also ideal areas to pilot expanded scopes of practice to support the community access the care it requires, for example the HEP C prescribing and fibroscan services provided by GPs and Nurse practitioners (NPs) in regional areas (WNSWLHD) supported by hepatologists from tertiary centres.

Extended scopes of practice and diversification of workforce roles in health care settings for health practitioners provide pathways for professional development and career progression including:

- Advanced Nurse Practitioner pathways especially in ED supporting our regional and rural services;
- Assistants in Medicine and Medicine Management Technicians;
- Clinical pharmacist prescribers working with medical practitioners to facilitate medication reconciliation on admission, discharge medication prescribing and medication management within given specialty frameworks.

Any extended scopes of practice need to be considered under strict credentialing frameworks underpinned by the four key pillars of clinical practice, leadership, research and education for any advance practice domain.

g) Award arrangements and Industrial Relations

The industrial instruments governing all elements of the medical workforce are limiting innovation and recruitment and retention in an ever-changing market and in roles where the breadth of delivery varies from service to service.

In professions experiencing chronic shortages, we now see state governments actively advertising and poaching staff from other states and overseas. This is particularly problematic when recruiting and retaining regional, rural and remote medical workforces in and near cross-border towns. There is also increasing diversity in the funding and models of care, including fee for service, sessional VMO contracts, permanent staff, agency staff and FIFO options – all of which are remunerated differently.

As with the teaching workforce, greater consideration should be given to locality-based retention allowances. These must not be time limited to ensure people don't come to communities for the length of the allowance and then return to a metropolitan service.

Most Service Registrars are working under the relevant State Award or the Medical Practitioners Award (under the Federal Fair Work Commission Modern Award). It is noted that pay scales and industrial instruments determining how and when they can work are quite different and Service Registrars are a very heterogeneous group, both in terms of pay and conditions but also professional development goals and pathways depending on the role and jurisdiction in which they are working.

Similarly, for CMOs, pay and conditions can vary widely. The NSW CMO Award describes progression of seniority and expected roles and responsibilities; this is also reflected to a lesser degree in the Modern Practitioners Award (under the Federal Fair Work Commission Modern Award), but neither articulate the diversity of CMO roles that are found across different health services and jurisdictions.

In summary, RACMA recommends several key areas of focus under to address these issues including:

- Mechanisms to manage pay discrepancies due to Awards and cross border industrial instruments including recommendations for Award reform;
- Addressing out of Award arrangements whilst taking into consideration equitable incentivisation programs to address workforce shortages;
- Review contractual models of care – including Fee for Service (FFS) versus Sessional VMO contracts in metro/regional centres including dual appointments and reverse hub and spoke modeling for employment contracts.

h) Federated Model of Care

The federated model is increasingly limiting innovation and delivery.

For instance, the Murrumbidgee model of GP training was stalled to the detriment of the workforce and patient care for many years. Whilst this is now widely regarded as the future of GP training, where the Local Health District employs trainees, it is important to note that it was met with suspicion by the Commonwealth government initially and for many years. All levels of government, but especially the Commonwealth government remain focused on the risk of cost-shifting meaning many missed opportunities for reform and innovation.

Whilst many Inquiries in NSW and other jurisdictions have called for long term plans for the rural, regional and remote workforce, the Commonwealth is yet to deliver. The challenge is that the impact of this non-delivery is felt by state governments with increased hospital presentations and increased patient complexity.

If collaborative co-design between jurisdictions is not possible, then one level of government needs to ‘own’ the problem in its entirety. Attracting and retaining new graduates to rural GP practice is going to require new and different models and at present, no government is responsible for delivering that.

RACMA membership provides effective Medical Leadership and Management skills which are necessary to ensure remote, rural and regional health services have a highly skilled medical workforce. Their role is key, and they will:

- Lead the strategic development of a rural medical workforce that is fit for purpose and contextualised to the local Clinical Services Framework and future projections of their region’s health care needs.
- Ensure that the workforce composition matches that of the local population including the Indigenous community.

- Build robust relationships with key stakeholders to drive a shared vision of a rural medical training “pipeline”, with particular reference to rural generalist training matched to the local community need.
- Advocate for recruitment and retention strategies that support the resident workforce, inclusive of the capacity to participate in quality activities, research and education.
- Analyse the barriers for remote, rural or regional sites to recruit to medical positions and develop innovative strategies for addressing these barriers.
- Ensure that the locum medical workforce operates within a framework that ensures continuity of care for patients, support for resident clinicians, and an expectation that locums will engage in training, and patient safety and quality initiatives.
- Set the standard for medical governance that actively fosters a workforce culture that is focused on patient safety and consumer engagement.
- Develop culturally safe and appropriate models of care that are enabled by innovative workforce solutions in challenging remote, rural and remote environments to enable equity of access to health care.
- Analyse the cost and revenue drivers impacting on medical workforce establishments to ensure a sustainable workforce is developed with a balance of skill mix and seniority.
- Actively support workforce strategies that foster Indigenous employment aligned with principles endorsed by appropriate indigenous organisations.
- Facilitate succession planning for key medical roles in their region, including their own.

RACMA Members in remote, rural, and regional Australia combine specialist Medical Leadership and Management knowledge with personal investment in, and commitment to, their local community. This promotes engagement with and support for peer medical specialists, both of which are factors contributing to attracting and retaining a high-quality medical specialist workforce.

Clinical Governance:

Remote, rural and regional health services require a holistic clinical governance model informed by population health involving genuine engagement between managers and clinicians.

Clinical governance needs to be viewed and modelled differently in rural and regional health care, where there may not be large tertiary public hospitals, a mix of private and public options and easy access to multidisciplinary care. A close partnership of all clinicians is central to achieving good governance in the areas of pro-active assessment of care; research linked to population health which includes Indigenous people, community and patient centred care; training and supervision; performance reporting and transparency; and workforce capability, planning and performance.

RACMA is uniquely placed to assist and advise government on developing different models of clinical governance that are more appropriate for these settings instead of replicating metropolitan models. In the absence of large hospitals and health institutions, networked approaches should be funded and trialed more often. RACMA Members have specialist medical knowledge in clinical governance and are skilled in shaping rigorous clinical governance systems in remote, rural or regional settings while preserving the privacy of patients and staff (risks which sometimes deter clinical governance actions). These skills are particularly useful in implementing a robust yet nuanced clinical governance approach in a remote, rural or regional setting where clinical governance stakeholders are often high-profile members of a local community and Indigenous people.

Education training & Research:

Remote, rural and regional health care services in Australia should embody, in addition to excellent quality clinical care, high levels of education, training and research built on the foundation of population health.

Remote, rural and regional health services should provide excellent quality clinical care with high levels of education, training, research and quality improvement.

Research and quality improvement encompass the continuum from audit and quality improvement projects through to involvement in multi-site clinical trials. Remote, rural and regional health services should not just be "receivers" of research and outreach services. They should be leaders of innovative research given the different nature of the context of care provided, and the unique nature of the workforce and challenges found. This will improve the translatability of research to remote, rural and regional areas and foster a mindset that actively seeks collaboration with larger studies. This involvement will also improve the patient experience and quality of care as connectivity and peer support between urban and non-urban clinicians is fostered during the activities.

Medical education and training should, wherever possible, be locally planned and delivered, and linked to the current and emerging service needs of the community. Trainees and/or Candidates should be aware of the ability to access certain experiences and infrastructure in the rural context. Where possible, there should be participation in networked rotational or other educational support systems.

The remote, rural and regional setting provides a unique opportunity for horizontal and vertical learning and a mandatory term for all medical training in such a setting should be considered. Effective Medical Leadership and Management skills provided by those specialty-trained in Medical Leadership and Management is critical to ensuring that education, training and research, based on a foundation of population health, are provided to a high level to support excellent clinical care.

RACMA Members have acquired specialist knowledge of the medical specialist training college system. In addition, many work with medical schools to establish and support local medical student training as part of building a sustainable medical workforce and assist in developing vocational training programs for rural generalists. RACMA Members are trained in research and able to work to build diverse research capacity.

Fostering Better Professional Environments: - "A Better Culture":

Remote, rural and regional health services need to address cultural issues in healthcare and fostering a better professional environment for medical practitioners across Australia.

A Better Culture project is funded by the Commonwealth Department of Health and hosted by RACMA. It is a national, whole of profession project engaging with all specialist medical colleges, the leadership of organisations that employ doctors and other health professionals. A study conducted as part of this project sought to explore the challenges and experiences of healthcare leaders in addressing cultural issues in healthcare and fostering a better professional environment for medical practitioners across Australia.

The key recommendations from the study "Qualitative Research for Culture Change; A Better Culture" are to:

1. Ensure training measures reach all entrants into the system, and reinforce it throughout their career progression
2. Prioritise buy-in from the professional
3. Align culture change initiatives to a uniting purpose
4. Shift towards a proactive approach
5. Effect culture change which is best supported by a broader effort to improve the safety and sustainability of the healthcare workforce

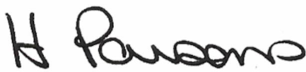
Summary

RACMA's key positions as they relate to the Committee's Inquiry are:

- That the Committee note that the context of rural medicine and the delivery of health services is different to metropolitan areas, requiring effective medical leadership as a leader in a community and a deeper skill set in Indigenous and population health.
- That when seeking improvements and new programs, it is recognised that the unique rural context also means a greater need to integrate primary health care and hospital care.
- That action on the medical workforce is urgent, particularly:
  - Measures to increase the numbers of GPs in rural and remote areas, particularly working in rural hospitals.
  - Considering upskilling GP proceduralists with advanced scopes of practice in Obstetrics, Anaesthetics and General Surgery.
  - That governments commit to the principle of FIFO and locum services being for emergency workforce needs, not an ongoing structural solution to rural, regional and remove workforce shortages.
  - That a strong framework for Service Registrars and Career Medical Officers be established to ensure a clear career path.
  - That international medical graduates do initial placements in hospitals so they can be assessed to ensure they have the skills to work independently.
  - That whilst a valuable adjunct, telehealth and virtual health are not regarded as replacements for locally based services.
  - Rural, regional and remote practitioners are supported to be able to practice at the top of their clinical scope.
  - That the government review the industrial instruments for the unintended consequences of limiting medical workforce in rural, regional and remote areas, with a particular focus on a greater number of locality-based retention allowances.
  - That the committee notes that the federated nature of health funding is slowing down innovation and progress to the detriment of the rural, regional and remote communities.

- That government develops different models of clinical governance that are more appropriate for rural, remote and regional settings, in partnership with RACMA.
- That regional and rural communities are not considered an education, training and research afterthought, and merely 'receiving' services. Government should commit to locally planned medical education and training and draw the most for the whole system from this unique setting.
- That government invests in culture improvement programs which lead to greater recruitment and retention.

Yours Sincerely



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