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Mr Richard Beasley SC
Commissioner
Special Commission of Inquiry into health care funding
Via: submissions.hfi@specialcommission.nsw.gov.au

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Dear Commissioner

The Royal Australasian College of Medical Administrators is pleased to provide its submission to the Special Commission of Inquiry into healthcare funding.

RACMA is the only specialist medical college that trains doctors to become specialist medical leaders and managers. Our education programs, including our accredited flagship Fellowship Training Program, are aimed at equipping doctors with the leadership and management skills needed to influence and lead 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, Directors of Medical Services, Directors of Clinical Governance, and Heads of Departments, as well as working in 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.

RACMA continues to play a major role in assisting in government agency submissions and working groups to implement key recommendations from the National Medical Workforce Strategy and hosting the Commonwealth Department of Health program “A Better Culture”, a coalition of health professionals addressing bullying, harassment and discrimination in healthcare and interventions to allow a culture where all people can participate safely and productively. RACMA, through its Fellows, also has a significant role in clinical governance, care quality and safety across the Australasian Healthcare System.

Notwithstanding the broad scope of the Special Commission and the desire of RACMA to comment more generally on all aspects of the review, there are a number of key areas that align to RACMA’s central role in medical leadership, clinical governance and the management of the medical workforce, including credentialing, recruitment and retention to ensure equitable access to both primary and specialist medical services to the people of NSW.

RACMA has been an active contributor to health reform. We have provided submissions recently to the Service Registrar & Career Medical Officer Framework Working Document: National Medical Workforce Strategy consultation and the Kruk Report: An Independent Review of Overseas Health Practitioner Settings. Those two submissions, in addition to our RACMA Position Statement on Remote, Rural and Regional Medical Leadership by Medical Administrators, have contributed significantly to this submission. Copies of those

submissions and position statements can be provided to the Commission to provide more detailed positions, should you deem that valuable.

Yours Sincerely

Dr Helen Parsons CSC FRACMA
RACMA President

A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care, and health services to the people of NSW, now and into the future.

RACMA members contribute to leadership and management roles across the system, providing key contributions to financial stewardship of healthcare organisations across the State.

RACMA would like to highlight the importance of value-based healthcare, with the concept of the quadruple aim to continually improve health outcomes that matter to patients, experiences of receiving care, experiences of providing care, as well as effectiveness and efficiency of care.

RACMA recognises that there are inefficiencies of disconnected and siloed approaches to funding and recommends that improved systems coordination is required, to better integrate contributions of different healthcare funders and ultimately lead to improved efficiencies with a focus on delivery of high value care. This is particularly relevant with the challenges of increasingly complex comorbidity in the ageing population combined with the ongoing advances in healthcare and growing cost of both investigative and treatment modalities.

RACMA would like to propose more coordinated approaches and system consideration of population outcome-based models of care, aligned to changing demographics and the increasing burden of chronic and complex disease care in our communities. A commitment to equitable access to balanced patient centered care models, focusing on longitudinal outcomes is in the best interest of health care and society.

B. The existing governance and accountability structure of NSW Health.

RACMA members play a pivotal role in the clinical and medical governance of NSW Health services, providing key contributions to financial stewardship of healthcare organisations across the State's healthcare system. RACMA would comment that:

- Governing bodies are ultimately responsible and accountable for good corporate and clinical governance, setting the strategy and enunciating the broader culture.
- Creating a safety culture requires productive working relationships between Boards, CEOs, the Executive, consumers, Clinical leaders, and all staff. This requires creating transparency of clinical and financial strategies across the healthcare organisation.
- Governing bodies cannot expect excellent clinical outcomes without the deep engagement of skilled clinicians working at all levels of the organisation, including senior managers and executives.
- Good clinical governance systems are defined by standards, guidelines and policies and supported by skilled trained staff; and
- Corporate and financial governance should be aligned - and sit hand in hand with clinical governance frameworks, with shared accountabilities all underpinned with common goals aimed at optimal and safe healthcare delivery.

In the current NSW structure, it is important to recognise the value of local decision making to support operational planning and decision making to meet the needs of the local community. The current operating model of Local Health Districts (LHDs) supports mechanisms for clinical engagement by way of Medical Staff Councils and representation on LHD Boards.

Prior criticism of Area Health Services' structure in the Garling Inquiry was that they were too large and decision makers were too remote from the people affected by those decisions. RACMA believes the current Local Health District model provides a reasonable balance

between overly centralised control where decision making is far removed from local insights, or a fully devolved system such as Victoria which loses any opportunity for consolidated clinical and financial governance. However, it must be noted that local clinical governance must be properly resourced to be effective.

Privatisation has a checkered history in the NSW health system, with several models over recent years, with few demonstrating long-term viability. RACMA recognises privatisation and outsourced service delivery may remain an operational consideration but does not support the outsourcing of front-line services in principle. Where privatisation is to occur, lessons learned from prior attempts should be considered and incorporated into contracting models to ensure that failures are not replicated.

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW.

RACMA acknowledges progress of the increasingly sophisticated funding system for the public hospital sector, under the framework of the National Health Reform Agreement (NHRA) 2020-25 and as implemented by the Independent and Hospital and Aged Care Pricing Authority (IHACPA). Substantial progress has been made over recent decades in moving away from block funding arrangements in the public hospital sector, to now a predominant case-based funding model for inpatient episodes of care.

Early implementation of quality measures such as hospital acquired complications and readmissions have been incorporated into these funding mechanisms, though the prevailing volume-based approach to funding within outpatient settings has negligible consideration of patient outcomes in the funding mechanism.

It is important to recognise the role of outpatient and community services in supporting chronic disease and continuing care to keep patients well, though there is markedly less funding support for these activities compared to inpatient activity which yields proportional more National Weighted Activity Units (NWAU). There is also significant administrative complexity in NHRA arrangements as they relate to Commonwealth Medicare Benefits Schedule (MBS) revenue to support outpatient activities, and many NSW facilities have traditionally relied upon this to support hospital-based outpatient clinics, via facility fees. Promulgation of *Medicare Billing for Privately Referred Non-Inpatient Services in NSW Public* has adversely impacted MBS revenue streams and risks the scope and viability of future outpatient service offerings. The scope of public hospital outpatient services has already reduced significantly, with some hospitals offering very few public hospital clinics even for the local catchment population. There may be value in clarifying the expected profile of public hospital outpatient service requirements, potentially within the role delineation framework, with appropriate budgetary support.

There are significant continuing challenges which come from applying a single national funding model across all facilities. Smaller scale regional and rural facilities may face heightened cost profiles, without having the volume of complex activity to adequately generate activity for budgeting, as compared to larger facilities.

It is critical to ensure that adequate attention remains paid to the particulars of rural and regional funding mechanisms to ensure they can continue to meet the needs of these communities. This includes the demonstrated role and value of partnerships between metropolitan and rural/regional LHDs to support clinical service delivery as well as training networks, with examples including, but not limited to tele stroke, virtual ICU, and longstanding partnerships in delivery of community aged health ambulatory care in Western NSW.

The principle of leveraging expertise that may exist in larger centres with enhanced outreach mechanisms for either in person or virtual care support is important, though funding mechanisms need to adapt to ensure that such innovation can be effectively financially supported to improve health outcomes for rural and regional communities.

Whilst these models of care are important, 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, and instead see it more as an enabler to help upskill and augment local services.

It is also crucial to ensure the Primary Health Networks (PHN) are funded properly and connect to the public health system. Inadequate resources in the community / PHN results in overloading of the public system.

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency.

RACMA supports the current initiatives underway in NSW Health to ensure value-based care with disinvestment from unnecessary or unwarranted investigations and procedures, with programs such as “Leading Better Value Care”.

RACMA recognises the important role of peak bodies such as the Clinical Excellence Commission and Agency for Clinical Innovation in supporting clinicians and health services to implement new models of care and health pathways and would encourage drivers of change to implement recommendations from sources such as the “Australian Atlas of Healthcare Variation” series, to minimise overservicing and enhance both accountability and efficiencies in the healthcare system.

RACMA also considers that for these changes to be effective, they need to be overseen as part of the broader framework of clinical governance (across the whole of healthcare including public, private, community and PHN), and once again reinforce the importance of RACMA members who play a pivotal role in the clinical and medical governance of NSW Health services and in this context are able to provide the key contributions to financial stewardship of healthcare organisations.

E: Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions.

In principle, RACMA supports the current HealthShare procurement processes but acknowledge that the increasing cost for goods and services may require new partnerships with providers and better system-wide integration of information regarding supply chains and alternatives, given the risk of ongoing disruptions to procurement pathways in the current economic climate and geopolitical events globally.

F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services:

RACMA would like to comment on key contributors to this issue with recommendations including:

Implementation of Recommendations from the National Medical Workforce Strategy (NMWS)

- Creation of a framework of implementation strategies adapted to the needs of NSW and in particular the specific issue regarding healthcare delivery in Mental Health Services, Sub-acute specialties (palliative care) and regional and rural communities.

Maldistribution of the medical workforce with strategies to address the following:

- Mismatch of workload and workforce both in metropolitan and rural facilities.
- Traditional models of resourcing and rostering junior medical officers due to various barriers including the (junior) Medical Officers Award, accreditation of College training posts and college requirements.
- Lack of coordination between Colleges and the jurisdictions in responding to projected deficits in the medical workforce and demographic demand changes.
- Traditionally metropolitan-centric College training pathways.
- Adequacy of pipeline workforce such as rurally bonded medical student placements.

Optimising the use and value of service registrars and CMOs

- A strong framework for Service Registrars and Career Medical Officers (CMOs) which is crucial for establishing a clear and well-defined career path in the medical profession and supports professional development, quality patient care, and effective workforce succession planning, while also contributing to the overall success and stability of the healthcare system.
- A framework for training, education, and credentialing, including extended Scopes of Clinical Practice (SoCP) under LHD credentialing frameworks.
- Mandatory Continuing Professional Development (CPD) & CPD Homes.
- More clearly defined accreditation pathways.
- Remuneration and incentivisation for areas (and scopes) of need.

Award reform and pay discrepancies across jurisdictions

- Addressing pay discrepancies due to industrial Awards and cross-border industrial instruments.
- Address out-of-Award arrangements whilst taking into consideration equitable incentivisation programs to address workforce shortages.
- Contractual models of care – including Fee For Service (FFS) vs Sessional VMO contracts in metropolitan/regional centres.
- The lack of capacity for current NSW industrial Awards to attract and retain many specialties, in particular “procedural” craft groups (e.g., Radiology, Interventional Radiology, Intensive Care, Obstetrics & Gynaecology, as well as surgical specialties) along with mental health/psychiatry.
- Consideration should be given to recruiting Staff Specialists in selected rural locations where the prevailing model of GP VMOs have proven difficult to recruit to.

Locum Workforce

- Considerations of how NSW Health can influence the internal market to ensure a reliable and appropriately credentialed locum/casual workforce.
- Creation of a state-wide casual pool with rate guided escalation points endorsed by Ministry of Health policy.

- Credentialing frameworks to ensure locums are working within their SoCP and avoid the moral hazard of locums employed beyond this, for perceived continuity of service provision.
- Mandatory supervision and training competency expectations for locum workforce.
- Pathways to integrate casual/locum workforce into training programs and/or substantive positions.
- Review of locum payments and creation of a statewide structure for payment. Currently there is a very large difference between locum pay depending on agencies, position and urgency. An hourly rate of locum doctors ranges between $120 to $400, with an equivalent remuneration of around $250,000 to $750,000. Locum doctors' pay rates are usually higher than those of permanent doctors due to the nature of their work. This impacts the availability and willingness of junior medical staff to work in permanent positions.

Extended scopes of practice

- RACMA supports consideration of extended scopes of practice and diversification of workforce roles in health care settings for health practitioners, ensuring practitioners are working towards the top of their scope of practice and providing pathways for professional development and career progression.
- However, any extension of scope of practice needs to be considered in a strict governance and regulatory framework underpinned by the four key pillars of clinical practice, leadership, research, and education. Any extended scopes of practice need to be reviewed regularly and include appropriate recency of practice.
- Consideration should be given to expanding several roles including:
    - Assistants in Medicine.
    - Advanced Nurse Practitioner (NP) pathways, especially in Emergency Departments supporting regional and rural services, with an extended SoCP that has well defined credentialing and competency requirements within supervised clinical governance frameworks.
    - Extended scopes for NSW Ambulance Service paramedics, in particular in regional and rural settings.
    - Clinical pharmacists working with extended SoCP in inpatient and outpatient settings including prescribing of discharge medications as part of an augmented medication reconciliation program under supervision.
- RACMA support a formal credentialing process for any practitioners with extended scopes to ensure they are used safely and efficiently within the organisations.

Gap analysis of activity / workforce in metropolitan and rural area and review of the skill shortages including generalist vs specialist linked to the DoH workforce projections and NMWS.

- Without the baseline data and follow up evaluation, it will not be possible to test which interventions are contributing to improvement of skill shortages and therefore should be invested in.

G. Current education and training programs for specialist clinicians and their sustainability to meet future needs.

RACMA would like to comment on approaches to training and the role of International Medical Graduates (IMGs) with a view to both generalist and specialists in terms of:

- Pathway eligibility and the role of Colleges and LHDs in facilitating regional and rural placements.
- A collaborative approach between Colleges and the jurisdictions in responding to projected deficits in medical workforce and demographic demand changes.

- Trainee employment and incentives linked to pipeline demand.
- Supervisor accreditation and placements.
- IMG experiences and complexities in negotiating training and accreditation frameworks in NSW
- Location and distribution complexities.
- Post-Fellowship issues, including professional isolation sustainability and burnout – especially in regional/rural NSW, Primary Care, Justice Health, Public Health, Pathology, Medical Administration, and other low number College Specialists.
- Retention and recognition strategies.

RACMA recognises the need for oversight and a coordinated approach to training and education for medical practitioners, with support from the Australian Medical Council and the National Health Practitioner Ombudsman (NHPO) for accreditation processes, and better engagement between the State, LHDs and the respective Colleges to ensure that training positions and workforce needs are better balanced both in the immediate and longer term.

H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation.

Innovative models of care are generally supported and RACMA recognises the important role of peak bodies such as the Clinical Excellence Commission and Agency for Clinical Innovation in supporting clinicians and health services to implement them. E-Health also needs to be more strongly engaged locally and have a much stronger clinical governance framework applied to ensure safe quality care.

As discussed in section F above, RACMA supports consideration of extended scopes of practice and diversification of workforce roles in health care settings for health practitioners, to ensure that practitioners are working towards the top of their scope of practice and to provide pathways for professional development and career progression.

However, any extension of scope of practice needs to be considered in a strict governance and regulatory framework underpinned by the four key pillars of clinical practice, leadership, research, and education. Any extended scopes of practice need to be reviewed regularly and include appropriate recency of practice.

I: Any other matter reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is reasonably relevant to the inquiry:

Regional Rural and Remote health Services:

RACMAs proposes that special consideration should be given to health funding in the context of regional, remote, and rural health services. RACMA's key positions as they relate to the Committee's Inquiry are that:

- The Committee note that the context of regional rural and remote 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.
- 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.

- 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.
- Government develops different models of clinical governance that are more appropriate for rural, remote, and regional settings, in partnership with RACMA.
- 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, training and research and draw the most for the whole system from this unique setting.
- Government invests in culture improvement programs which lead to greater recruitment and retention.

Context and Aspirations

Around 7 million people, approximately 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 *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 supports the findings in the Household, Income and Labour Dynamics in Australia (HILDA) survey (Wilkins,2015)[2] 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)[2].

One of the major causes of 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, wherever practicable, resides locally 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 from 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

Healthcare services particularly, remote, rural, and regional, require appropriate 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.

A growing number of studies have focused on the impact of medical leadership on the quality of care provided, measured by process and outcomes indicators. It is important to notice that there is strong evidence of the positive beneficial effects of the presence of clinicians in leadership roles for the quality of care offered in hospitals. 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.

Medical Workforce
As highlighted above, healthcare organisations, particularly remote, rural, and regional healthcare services require a reliable and stable medical workforce that, wherever practicable, resides locally and provides genuine continuity of clinical care and cultural safety to patients and population health services to Australian communities.

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

1. The role of the general practitioners in hospitals and community care.
2. Generalist medical, critical care, mental health, and surgical workforce in the hospital setting.
3. The impact of a locum workforce and the FIFO model.
4. The role of International Medical Graduates (IMGs).
5. Consideration of Scopes of Clinical Practice and expanding that to trainees.
6. Models of care including telehealth and hub and spoke models, but noting that telehealth can only assist and act as an enabler but cannot replace on the ground medical staff.
7. Award arrangements and Industrial Relations.
8. Federated Model of Care.

These are explored in detail below.

1. General Practice in Hospitals and community care

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. If general practitioners as GP Visiting Medical Officers (VMOs) cannot be recruited, consideration should be given to recruiting staff specialists to undertake these roles.

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 GPs 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 kilometers.

2. 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.

3. Locums and FIFO

RACMA 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.
- Putting a structure around JMO locum hourly rates to ensure the process is fair and efficient.

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 residing 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. This lies 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

RACMA has identified the following areas which need consideration and development to ensure a sustainable junior medical workforce addressing effective resource allocation and retention of a skilled workforce:

- Training, Education and Credentialing.
- Time in training instead of days in training.
- Continuing Professional Development (CPD) and CPD Homes.

- Formal credentialing process for all JMOs in training positions.
- Career progression and gap analysis of drop rate of trainees.
- Diversity of Conditions, including pay scales and professional development.
- Accreditation Pathways.
- Cultural Change.

4. 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.
- Providing a formal structured observation requirement and support for entering healthcare settings.
- Improved supervision frameworks.
- Retention and adjustment.
- Employment and professional development support.
- 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.

5. Scope of Practice and alternative workforce

All healthcare settings, particularly rural, regional, and remote areas, require practitioners to be able to practice safely 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.

As described earlier in Section F, extended scopes of practice and diversification of workforce roles in health care settings for health practitioners provide pathways for professional development and career progression. However advanced or extended scopes of practice need to be considered under strict credentialing frameworks and with appropriate clinical supervision.

6. Award arrangements and Industrial Relations

The industrial instruments governing all elements of the medical workforce are limiting innovation, 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.

7. 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.

(i) Clinical Governance

Regional, remote, and rural 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 proactive 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 regional, remote, and rural 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 regional, remote, and rural setting where clinical governance stakeholders are often high-profile members of a local community and Indigenous people.

(ii) Education training & Research

Regional, remote, and rural health 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.

Regional, remote, and rural 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. Regional, remote, and rural 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 regional, remote, and rural 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 regional, remote, and rural 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.

(iii) Fostering Better Professional Environments: "A Better Culture"

Regional, remote, and rural 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[3].

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

References:

1 https://www.aihw.gov.au/getmedia/0c0bc98b-5e4d-4826-af7f-b300731fb447/aihw-aus-221-chapter-5.
2. Wilkins R 2015. The Household, Income and Labour Dynamics in Australia Survey: selected findings from waves 1 to 12. Melbourne: Melbourne Institute of Applied Economic and Social Research.
3. Qualitative Research for Culture Change – A Better Culture (By the Nous Group)