

3 FEBRUARY 2017

David Hallinan
First Assistant Secretary
Health Workforce Division
Department of Health
GPO Box 9848
Canberra ACT 2601

Dear Mr Hallinan,

Re: Medical Workforce Assessment

Thank you for the invitation to respond to the Department of Health's Medical Workforce Assessment and associated Discussion Paper. We understand the assessment has a particular focus on where and how medical school/entry level training¹ occurs and the link between this and future medical workforce distribution, especially to regional, rural and remote areas. We note that all Australian universities have also been invited to respond individually to this assessment and believe they are best placed to respond in relation to their particular situations. UA does however make the following few overall points in response to the assessment.

UA recognises that there is a current maldistribution of medical workforce to rural areas of Australia. UA supports adequate access to health professionals across the range of Australian locations and health care settings and recognises the role that universities play in developing Australia's medical and other health professional workforce.

Universities are already undertaking a range of different activities/approaches to support a fairer distribution of the medical workforce. Such activities include: increasing the number of rural origin students enrolled in medical degrees; providing access to rural training and clinical places through a range of approaches – rural clinical schools (RCSs), University Departments of Rural Health (UDRHs), regional location of universities and; ensuring that medical curricula are rurally-relevant. A number of these activities are supported through by the Department of Health (DOH).

All of these approaches contribute to workforce distribution. All of these approaches have had some success in influencing the distribution of medical graduates to rural areas and are

¹ Entry level education and training can occur at both bachelor and postgraduate levels. Postgraduate entry courses are an increasing trend in medical education. They are equivalent to a Masters qualification however are still considered entry level for the purposes of medical registration.

supported by available evidenceⁱ, ⁱⁱ. However, while a number of individual data sets exist, national longitudinal data is lacking as to which, if any, of these particular approaches has the single most impact on future medical workforce distributionⁱⁱⁱ, ^{iv}. On current data, it is therefore not possible to distinguish which, if any, of these approaches is more effective than another.

A number of other factors are also important in influencing workforce distribution. In addition to the activities universities are already undertaking, a number of other factors have also been shown to influence medical career destination choices. These include: opportunities for rural postgraduate intern/specialist training; availability of other health workforce; access to professional development, support and peer mentoring; spousal employment and child education opportunities^v, ^{vi}. Of these other factors, access to rural postgraduate intern/specialist training positions - of which there are currently significant shortages^{vii} - is key.

Many, if not all of these other factors are beyond the influence of universities. Yet all play a role in determining overall medical workforce distribution. Of note, postgraduate intern and speciality training, whilst a component of medical training overall, occurs after medical graduates leave university. Responsibility for postgraduate medical training positions therefore lie largely with state health services and the Medical Colleges.

Of all the factors influencing medical workforce distribution, several seem to be particularly influential – but only when they occur together. Evidence indicates that a combination of factors have the biggest impact on career destination, particularly in regard to rural/remote medical workforce distribution. The three main factors are^{ix}:

- Rural origin of students;
- Quality of and time in rural training placements - generally more is better;
- Opportunities/support for intern and post graduate (vocational) positions in rural areas, for which there is currently a recognised shortage.

All of these factors are important and critically interconnected: while each element plays a role, taken in isolation they are insufficient. They must all occur together to have significant impact on workforce distribution^x, ^{xi}². Ensuring some sort of “training pipeline” to link these three key elements together is crucial. In this regard, UA cautiously welcomes the soon to be announced regional training hubs introduced by the Department of Health as one part of the medical Integrated Rural Training Pipeline and looks forward to talking further with the Department about their implementation.

² Rural origin students are a valuable foundation but the later elements are also needed to help keep the “rural” in such students whilst also offering urban-origin students rural exposure.

Need for an inter-sectoral, intergovernmental approach. Health workforce planning development, and distribution is complex and must take into account multiple, changing variables. Links with health professional education/training must be included, although what the ideal connection should be is still unclear^{xii}. The challenges of workforce development in Australia are further amplified by the divided responsibilities for health professional education and training between sectors, different levels of government / Commonwealth Departments and multiple stakeholders with various (and sometimes conflicting) interests. Entry level clinical training as well as postgraduate positions rely especially on effective interconnections with state governments and health departments. Cost-shifting especially between different levels of government in regard to who funds clinical placements/positions has detrimental effects on training quality and capacity and adds to the challenges of getting students where they need to go, both from education/training and workforce perspectives. Finding ways to better connect these different players is an important step towards improved health workforce planning, development and distribution. Sharing data and information, increasing transparency and clarifying accountabilities and responsibilities for relevant education, training, placements, professional development and workforce activities would assist with this.

In summary: In making this submission, UA suggests that a range of factors be considered in relation to what influences overall medical workforce distribution. Whilst where and how medical school training occurs plays some role in this, it is only one of many factors, most of which are beyond the control of universities, that influence a doctor's overall decision to practice in rural areas. In further progressing this area, there is also a real need for a connected approach between the multiple stakeholders involved, particularly for addressing issues which unnecessarily add to the existing challenges of providing sufficient, quality clinical education and training. UA again thanks the Department of Health for the opportunity to comment on this matter, in keeping with such an approach.

Yours sincerely



Catriona Jackson
Deputy Chief Executive

References

- ⁱ Eley D, Synnott R, Baker P and Chater A. 2012. A decade of Australian Rural Clinical School graduates – where are they and why? *Rural and Remote Health* 12: 1937
- ⁱⁱ Mason J 2013. Review of Australian Government Health Workforce Programs. Chapter 4. <http://bit.ly/2k6V0Lr> Accessed January 2017.
- ⁱⁱⁱ Ibid
- ^{iv} WHO 2010. Global policy recommendations for increasing access to health workers in remote and rural areas through improved retention. Chapter 3. <http://bit.ly/2k1soRe> Accessed January 2017
- ^v Larkins S, Evans R. 2014 Greater support for generalism in rural and regional Australia. *Australian Family Physician* 43,7 487-490
- ^{vi} Laven G, Beilby J, McElroy H and Wilkinson D. 2003. Factors associated with rural practice among Australian-trained general practitioners *Medical Journal of Australia*. 179 (2): 75-79.
- ^{vii} Sen Gupta T, Murray R, Hays R, Woolley T. James Cook University MBBS graduate intentions and intern destinations: a comparative study with other Queensland and Australian medical schools *Rural and Remote Health (Internet)* 2013; 13: 2313. <http://www.rnh.org.au/articles/printviewnew.asp?ArticleID=2313>
- ^{viii} Glasgow, N. 2016. The Australian. Boost postgrad training and doctors will stay in the regions <http://bit.ly/2kXPZpS>
- ^{ix} Sen Gupta T, Woolley T, Murray R et al. 2014 Positive impacts on rural and regional workforce from the first seven cohorts of James Cook University medical graduates. *Rural and Remote Health*. 14: 2657
- ^x Ibid
- ^{xi} Clark T, Freedman S, Croft A et al. 2013. Medical Graduates becoming rural doctors: rural background versus extended rural placement. *Medical Journal of Australia*. 199: 79-782
- ^{xii} Productivity Commission 2005. *Australia's Health Workforce*, Research Report Canberra.