College Submission

April 2024

Feedback to the Review of Section 19AB and District of Workforce Shortage (DWS) classification system

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is **the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care**. The College delivers a quality Fellowship program including training; professional development; clinical practice standards, and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality rural generalist model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

ACRRM has more than 5000 members including over 1000 registrars living and working rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

General Comments

ACRRM provided feedback to the *Working Better for Medicare Review* in March 2024, noting that specific rural and remote initiatives and programs are required to ensure Australia is meeting the healthcare needs of rural, remote, and Aboriginal and Torres Strait Islander communities.

The College submission stressed that all policy and programs should be based on the principle that rural and remote models of care should be designed and funded to ensure equitable access to continuous, high quality local primary medical and health professional care along with acceptable and timely access to emergency, secondary and tertiary care.

Any reform of Section 19AB and the DWS should be viewed as part of a suite of workforce solutions which address a range of issues including workforce supply and distribution together with trends such as increasing sub specialisation at the expense of generalism and changing expectations of younger generations.

Response to Consultation Questions

Have Section 19AB and DWS met their objectives?

While there does not appear to be a specific statement of objectives published for either of these initiatives, the assumption is that they have been designed to improve access in areas where people have poor access to medical services, including specialist services.

In the view of the College, Section 19AB and the DWS are relatively blunt tools which should regarded as just one of a number of components of the overall workforce and recruitment strategy.

Workforce maldistribution extends beyond geography, to an increasing preference for careers in specialties other than general practice and the increasing trend towards sub-specialisation. Specialist services are expensive and usually located in larger centres. They do not facilitate the delivery of the services that are most needed in rural and remote communities in a cost-effective manner; nor do they take into account the importance of providing as many services as possible, as close to home as possible, for people living in rural and remote areas.

Many rural and remote people cannot realistically access specialist consultant medical and allied health services. This is evidenced by patterns of usage which show that, compared to levels in major cities, annual utilisation of non-GP specialist services decreased by 25% in outer regional areas and 59% in remote and very remote areas.[1] This being the case, it is important that rurally-focussed healthcare professionals such as Rural Generalists (RGs), with scopes of practice appropriate for rural and remote contexts, should be recognised and incorporated into policy, workforce modelling and planning.

The DWS is problematic as it can support the perverse outcome of exacerbating increased sub-specialisation and cementing inappropriate/uneconomic models of care into health systems. This is because the process does not consider models of care, but rather simply reacts to an identified individual health service need in isolation without considering the optimal context appropriate models of care, or the cost implications when individual decisions are scaled.

The DWS program would benefit from incorporating consideration not just of workforce need but also the appropriate model of care. For example, areas seeking an RG or specialist General Practitioner (GP) may need one with a specific skill set. Likewise, an area applying for a specialist obstetrician may be better served by a RG Obstetrician who can provide general practice services as well as obstetric services.

While the DWS and Section 19AB have met their objectives to a limited extent particularly in terms of short to medium term outcomes, it should be acknowledged that a reliance on an IMG workforce should not be viewed as a longer-term and sustainable strategy for addressing the geographic and skillset health workforce maldistribution in Australia.

There is clear evidence that these policy levers need to be restricted to and/or tailored towards areas of substantive intransigent shortage and other more suitable strategies should be adopted for less difficult to recruit to areas.

[1] AIHW (2021) Medicare-subsidised GP, allied health and specialist healthcare across local area: 2019-20 to 2020-21.

How Appropriate is Section 19AB?

We note that Section 19AB serves as an important enabling mechanism for a range of rural health workforce programs including ensuring the viability of providing GP training on the College Fellowship Program. The GP and RG training and practice space is undergoing considerable change and the legislation will need to be able to support this going forward. For example, the recognition of the specialist field of Rural Generalist Medicine within general practice, if approved, will need to be accommodated. While the College does not expect that this will present any problems, final decisions will lie with the Medical Board of Australia and the Health Ministers' Meeting.

Another key area where Section 19AB is of importance is enabling a range of RG Single Employer Models. The College notes that legislation has historically obstructed these models and while solutions have been negotiated to enable implementation, it is worth noting that it does present and impediment to the flexibility and thus potential success of these programs.

The provision of essential medical services in many rural and remote areas continues to rely heavily on active recruitment of doctors from overseas, usually through recruitment policies which specify their practice in areas of service shortage.

Australian trained medical graduates today are less likely to work either as GPs or in rural communities compared to graduates in previous decades. Rural areas continue to remain substantially dependent on International Medical Graduates (IMGs), who comprise almost half of the general practitioner workforce in rural areas.[2]

ACRRM acknowledges and values the significant contribution that IMGS have made, and continue to make, in providing essential medical services to rural and remote communities.

Rural areas continue to remain substantially dependent on IMGs:

- Rural and remote communities continue to remain substantially dependent on IMGs, with these doctors, comprising 36-38% of all GPs in small rural centres.[3]
- Recent studies have found that IMGs compared to Australian trained medical graduates were significantly more likely to be working in rural and remote areas and to be working as a general practitioner.
- The vast majority of IMGs (approximately 75%) practise in urban areas, however it should be noted that though numerically the largest number are in major cities, IMGs are nearly twice as likely to be in a regional/remote area and 2.4 times as likely to be in a remote/very remote area [4]
- Historically, the greater likelihood of IMGs practising rurally has likely to have been strongly influenced by government policies which facilitate attainment of visas and registration to IIMGs who practice in an area of need, including the requirement for most IMGs to work in an area of workforce need for a period of 10 years to be able to provide Medicare billable services (the moratorium).

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[2] *O'Sullivan B et al (2019) Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence Hum Resour Health 17: 8*

[3] O'Sullivan B et al (2019) Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence *Hum Resour Health* 17: 8

[4] Yeomans N. D. (2022). Demographics and distribution of Australia's medical immigrant workforce. *Journal of migration and health*, *5*, 100109. https://doi.org/10.1016/j.jmh.2022.100109

- Concerningly, IMGs based in rural and remote areas are significantly more likely to be recent graduates, suggesting that many may be relocating to cities at the end of obligatory terms.[5]

However given that rural and remote areas continue to remain substantially dependent on IMGs, the College would view the complete removal of Section 19AB as a solution of last resort, given that it would undoubtedly result in rural and remote areas having limited local access to a doctor.

While the 10-year moratorium has had some positive impact in terms of addressing the rural and remote workforce maldistribution, it does not ensure that these doctors will continue to live and work in these communities. Many of these doctors have left social networks in their former country. They are then placed in a rural or remote community with minimal medical professionals locally available to support them. They may also suffer from a lack of cultural, social and family support. These factors all contribute to feelings of isolation and an understandable desire to return to a more populated area where there are more professional, social and cultural supports.

It should be noted that the recent changes to the DPA program have had a perverse impact on the rural and remote medical workforce. While this previously facilitated employment of IMGs in the most hard-to-recruit areas in MM3-7 by conferring exemptions to them to provide MBS billable services, it has now been extended to comparatively minor workforce shortages in MM2 and outer urban areas. Within a short space of time, this triggered significant movement of IMGs out of rural and remote and into those MMM2 centres which are often within commuting distance to MMM1.

It is imperative that workforce strategies and policies integrate meaningfully to ensure that all doctors, including those serving a moratorium, receive appropriate financial, personal, and professional support to succeed and thrive in rural medical careers and enable them to meet community needs. For example, Specialist IMGs (SIMGs) deemed partially comparable for registration purposes, would benefit from the support provided through the Australian General Practice Training (AGPT) program.

ACRRM already has a number of resources and programs which could be leveraged to harness the opportunity to integrate SIMGs into their local professional networks. The College has a well-trained pool of experienced and expert rural doctor SIMG assessors, alongside pragmatic and highly efficient assessment pathways in terms of both time and cost for applicants. This includes the development and publishing of codified lists of comparable specialist qualifications from other countries that are considered to be substantially equivalent for College recognition and assessment purposes; and robust processes for reconsideration, review and appeal that are available to candidates if required.

It should be noted that, following recommendations of the Kruk review, there may be changes to the way in which IMGs are recruited which could potentially decouple the relationship between IMG recruitment and workforce planning and distribution.

In the view of the College, this should not be supported as it is likely to exacerbate rather than improve the current workforce maldistribution and channel even more of our limited health funding to cities and place rural and remote medical services at greater risk. The new Expedited Pathway is a case in point. This will facilitate a greater flow of specialist doctors into the country but offers no policy levers to direct these doctors to locations of workforce need or away from locations of oversupply.

[5] Yeomans N. D. (2022). Demographics and distribution of Australia's medical immigrant workforce. *Journal of migration and health*, *5*, 100109. https://doi.org/10.1016/j.jmh.2022.100109

How appropriate are the assumptions that underpin the DWS?

Identification of workforce needs requires a more nuanced approach than simply identifying specialties of national workforce shortage. Rural and remote models of care should be taken into account when considering rural and remote populations' needs, however workforce modelling is predominantly based on urban contexts where patients have access to a wide range of specialised healthcare services.

For example, while psychiatry is an identified area of significant national workforce shortage, increasing the number of psychiatrists and particularly sub-specialist psychiatrists may not be the best approach to improving rural access to mental healthcare, particularly if they are based in metropolitan or inner regional areas. In reality, RGs and GPs, nurses and counsellors, actually deliver the bulk of rural and remote people's mental healthcare. RGs with advanced training and skills in mental healthcare (i.e. acute, emergency and chronic care) supported by appropriate skilled nurses and allied health professionals, may be a better workforce solution.

The DWS should recognise that In rural and remote areas healthcare gaps are often filled by teams of healthcare practitioners working in distinctive models of care. Extensively across Australia, RGs work in local healthcare teams to provide general practice and primary services as well as being key contributors to the provision of a more extended range of services including anaesthetic, obstetric, emergency, in patient, palliative, mental health and population health care.

In conclusion, the DWS and Section 19AB provisions should support a coordinated national approach to address health disparities in rural and remote communities. This should encompass and facilitate models of care able to function where workforce and infrastructure is limited, with health providers operating at a full scope of practice and greater integration across sectors to get the most from available resources.

This should be underpinned by the principle that Australians living in rural and remote and Aboriginal and Torres Strait Islander communities should have a minimum standard of access to medical care. This should include the opportunity to access continuity of care provided by an RG or GP providing in-person care wherever possible.

College Details

Organisation	Australian College of Rural and Remote Medicine (ACRRM)
Name	Marita Cowie AM
Position	Chief Executive Officer
Location	Level 1, 324 Queen St, PO Box 2507 Brisbane Qld 4001
Email	m.cowie@acrrm.org.au
Phone	07 3105 8200

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.