Hansard, House of Representatives
Dr S Stone MP, Member for Murray
2 December 2013

Dr STONE (Murray) (11:22): I move:

That this House:

(1) celebrates the success of Rural Clinical Schools (RCS) around Australia, commenced in 1999 by the then Minister for Health, the Hon. Dr Michael Wooldridge MP, and continued by his successor, the Hon. Tony Abbott MP;

(2) notes that:

(a) RCS were designed to overcome the maldistribution of all doctors including general practitioners across Australia, which left country regions short of general practitioners and other specialty doctors;

(b) students undertaking training in rural locations have academic results that are equal to or better than their metropolitan counterparts;

(c) published data from public universities show high rates of RCS graduates working in, or intending to work in rural areas; and

(d) the information gathered through an independent project tracking all Australian and New Zealand medical students—Medical Schools Outcomes Database—demonstrates that long term placements in a rural setting through RCS have a significant impact on the vocational choice and intention to practice in a rural or remote setting as well as future career specialty focus; and

(3) calls on the Government to:

(a) continue its support for these excellent initiatives; and

(b) examine opportunities to increase intern and postgraduate training places in rural locations to enhance the future of specialty medical service delivery with a focus on general practitioners in rural and regional Australia.

I rise to commend this most important motion to the House. I believe this motion will have bipartisan support, given that the previous government continued to support and encourage rural clinical schools following their establishment nearly 14 years ago. I thank all speakers to this motion, including members of the opposition. Ensuring there are adequate medical services in rural and remote areas in Australia is beyond party politics.

The Medical Deans of Australia and New Zealand's fact sheet of 2013 reported that there were 18 medical schools in Australia, which together doubled the number of commencing medical students from 1,660 in 2000 to 3,469 in 2010. Despite these numbers and their steady increase, peaking and plateauing in 2014, when it is expected there may be 700 unemployed doctor graduates, most people will tell you there is a shortage of doctors in Australia. But this is not true. The reason some country patients have to wait weeks for a GP appointment or hours in an accident and emergency centre is that we have a chronic maldistribution of medical practitioners across populations.

The very good news is that things are dramatically improving due to our Rural Clinical Schools. In 1999 the then Minister for Health, the Hon. Dr. Michael Wooldridge, introduced the concept of Rural Clinical Schools. These were bold in concept. They required medical students to spend a significant amount of time out of the cities training in rural settings. Today, in places like Shepparton, Wangaratta, Ballarat and Alice

Springs, we take this rural training situation for granted. But in in 1999, students, mostly born and bred in our cities, had to be gently nudged out of their comfort zone into rural hospitals and clinics. They were exposed to life in country towns and to work in small communities and larger regional centres. Impressive amounts of Commonwealth capital built state-of-the-art rural clinical school campuses and accommodation in these regional settings. Leading academics were attracted from the metropolitan medical schools or from overseas to lead in the establishment of these new Clinical Schools.

On 5 August 1999, John Howard turned the first sod for the building of a rural clinical campus at Shepparton. It poured rain that day and then failed to rain for another 10 years, pretty much, but no-one regrets that momentous sod-turning on that very wet day. Today there are 17 rural clinical schools associated with 16 universities, funded by the Commonwealth in every state and territory but with significant state collaboration and cross-university and health service cooperation. It is not just general practice that is involved but all of the specialties. Every Australian medical student now undertakes a rural clinical placement, while, as a consequence of the rural clinical schools, at least 25 per cent spend a year or more training and experiencing the culture and different health perspectives in a rural population.

Although it takes 10 to 13 years to produce an independent practising doctor, there is now good data to show that these rural clinical schools have succeeded beyond expectations. While the first urban campus based students had to be cajoled to go bush, now there are waiting lists, for example, at the University of Melbourne's medical school, as students vie for a place at the Shepparton campus. It is the same with other universities. The medical student outcome data, the MSOD, surveys every medical student in New Zealand and Australia at the beginning of their studies, upon exit and three years after graduation in order to have a comprehensive understanding of the student, graduate experience and destinations. This data is showing that, as a result of at least a year's rural training experience, a significantly greater number of students now convert from intending to practise in a city to wanting to practise in a rural area.

University of Melbourne data shows that 40 to 45 per cent—that is nearly half—of their rural clinical school graduates are training or working in an RA2+ location six years after graduation from the 2006 graduating cohort or earlier. While this university, like so many others, is targeting rural-origin students for its medical student intake, it has found that, as a consequence of its rural clinical schools, the conversion of urban-origin students to prefer a rural practice after graduation is also now very high. Published data from rural clinical schools reports that students from Flinders University, the University of Queensland, James

Cook University, the University of Western Australia and the University of New South Wales all show high rates of rural clinical school graduates working in or intending to work in rural areas. These students have also shown a change in intended medical discipline as a result of their rural training experience. At the commencement of training many students wish to become surgeons. At the end of their medical training, many more instead want to become general practitioners, obstetricians, gynaecologists, paediatricians, anaesthetists and pathologists. University of Melbourne data that compares examination results of rural clinical schools and urban clinical schools has also found that students in the RCSs performed better than those from the urban clinical schools.

But there is more. The University of Melbourne realised that it was very difficult to find training places in one- or two-person private GP clinics, often with an ageing couple of doctors in small country towns. So they embarked on a further innovation, building with the Commonwealth's assistance a Shepparton GP training medical centre. This is the first purpose-built general practice for clinical training. It is located on the rural clinic’s campus across the road from Goulburn Valley Health, also known as Shepparton Hospital. The operating costs are self-funded, so there is no additional cost to governments. The medical centre has 20 consulting rooms and two procedure rooms to enable parallel consulting, where a medical student is first responsible for assessing the patient on their own prior to the academic GP supervisor input.

The 40,000 strong Shepparton-Mooroopna community, with its large Indigenous and multicultural population, has embraced this medical student focused and supported service. There are over 6,500 active patient cases on the books. At the most recent Shepparton Chamber of Commerce Business of the Year Awards, the community voted this clinic the best enterprise and service provider of the year. So much for worries about having a medical student diagnose your child's flu or broken ankle. Waiting times at the hospital emergency department across the road have been reduced. Bulk-billing is the norm and needed in this community, where the food-manufacturing industry has been the major employer and where 25 per cent are now on welfare support.

This purpose-built GP clinic, which provides excellent service to the community at the same time that it facilitates medical student training, is clearly a model to be emulated wherever there is a problem in placing students in private GP clinics in country towns. It also provides a successful alternative model to the Superclinics, which are having troubles. This is the type of innovation and evolution that is typical of the universities rural clinical schools across the country.

The University of Melbourne has also partnered with one of the last public pathology laboratories in regional Victoria—in fact, one of the last in regional Australia. This vital piece of medical infrastructure, which includes a blood bank, employs some 95 medical scientists in Goulburn Valley Health. Their jobs and critical services are now secure as a result of this partnership and collaboration. Again, this is typical of the cooperation which local hospitals and clinics in regional Australia experience when they have the good fortune to be located near a Regional Clinical School.

The original vision of Michael Wooldridge, followed by successive health ministers Tony Abbott, Nicola Roxon, Tanya Plibersek and now Peter Dutton, has delivered us a way forward in training health professionals who want to practice in the bush. However, there is a roadblock in this otherwise triumphal story. Unless there are more intern places and specialty training places in regional and remote settings, the investment in these regional training experiences for undergraduates can be lost.

In the *Review of Australian government health workforce programs*, dated April 2013, the author highlights this problem. In summary, she says that we have to also have specialty training places in rural and regional Australia. She says:

In the other specialties, this lack of rurally-based intern positions is further hampered by limited rural training opportunities for trainees seeking fellowship of a specialist medical college, noting that the—

Commonwealth—

STP's … have made some difference in this area.

A recent Senate inquiry came to a similar conclusion. The problem is not hard to understand. If you have to return to a capital city for a number of years to do your specialist training at a critical stage in your early lifecycle, you are likely to stay. Your partner will need to obtain work there, your children will need to go to school there and you will tend to stay.

All we need—and it is simple—is adequate specialty training places relocated to rural centres. We need these places for GPs, general surgeons, obstetricians and gynaecologists, general medicine, emergency medicine and anaesthetics. We have the proven RCS model in place with its infrastructure, excellent staff and well-established cooperation and coordination with local hospitals and health alliances. We can overcome this final hurdle in the maldistribution of medical practitioners in Australia.

I commend this motion to the House. We do not need more medical graduates; we need graduates who are able to seamlessly move between metro, outer metro and rural populations. We have achieved this. Our

maldistribution continues now not as a consequence of lack of will or ignorance about the joys of country life but because we need the supporting specialty training places. *(Time expired)*