Medical Deans

AUSTRALIA AND NEW ZEALAND

Submission to DOH consultation on Rural Health Multidisciplinary Training Program consultation

Submitted online, Tues 22 September: ANON-YV1Y-3BA3-2

Introduction

a. **What organisation do you represent? (Required)**

Medical Deans Australia and New Zealand (MDANZ)

b. **What is your email address? (Required)**

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No.	Recommendation	Options: (Required) 1. **Support** 2. **Support and comment (max. 500 words)** 3. **Concerns and comment (max. 500 words)** 4. **N/A**
1	The Department, in consultation with the universities, refine the objectives and outcomes of the RHMT program to better reflect the sphere of influence of the universities toward achieving the long-term goal of a health workforce that is clinically and professionally capable and culturally responsive for rural and remote health practice.	2. **Support and comment** Support there being greater clarity on the specific objectives and outcomes, and being clear which of these are within the universities direct remit and which need the universities' broader sphere of influence. The nature and context of medical training and rural communities requires the RCSs and RTHs to have a wide brief, broad connections, and be able to indirectly influence across organisational and jurisdictional boundaries and within their communities and regions. The importance of this influencing and brokering role cannot be overstated.
2	The Department, in consultation with the universities, adopt a set of principles to underpin the objectives and implementation of the RHMT program.	1. **Support**.
3	The RHMT program requires each university to demonstrate how their selection process for rural placements identifies students with a genuine interest in rural health and preferences these students for extended and/or innovative rural placements.	2. **Support and comment** The difficulties in determining "genuine interest" will be substantial, so caution is needed to ensure this is recognised. It would be helpful to have some evidence on effective approaches for this, and further information on how the Dept. considers it could be assessed. However, we believe now is the time for the RHMT Program to focus on the outcomes being sought, rather than the individual aspects of the program, such as selection. This would allow the flexibility needed for universities and local regions to take an approach that suits their context and locale. We also have some concern that too much of a focus on innovation has the potential for tried and tested models to be undervalued. For a number of regions, increasing investment in a successful model where there is capacity to grow might be the most appropriate decision. Therefore, a balance between innovation and successful models is recommended.
4	The RHMT program requires universities to demonstrate that they meet Australian Medical Council (AMC), Australian Nursing and Midwifery Accreditation Council (ANMAC) or professional association accreditation requirements for the inclusion of Aboriginal and Torres Strait Islander health in their health program curricula.	3. **Concerns and comment** Whilst we recognise that proportionately there are often larger populations of Aboriginal and Torres Strait Islander people in rural/remote areas, undertaking learning and reaching an appropriate level of competency in Aboriginal and Torres Strait Islander health is a requirement for all medical students, irrespective of where they train or wish to practice.

		The requirement for universities to meet accreditation standards is very clearly defined and is the remit of the Australian Medical Council (AMC), and medical schools are accredited on this basis. It is unnecessary to have this repeated as an RHMTP requirement.
5	The Department consult with the universities to determine how rural health could be further incorporated into their health program curricula.	3. **Concerns and comment** The RHMTP is based on the core principle of teaching students from, in, and for rural communities. As such, it is vital that rural health is embedded across the curriculum and part of students' assessments, however there is no evidence from the Report that this is not happening. The medical schools' curricula are designed to deliver the outcomes as required by the AMC graduate outcomes statements and medical programs are accredited on this basis. It is inappropriate for the RHMT to take on a role in determining the content and/or quality of medical school curricula. We recommend the focus of the Program is on the outcomes being sought, rather than trying to direct how to apply the individual elements involved. Different regions and different contexts are likely to require different models. With an outcomes-focus, not only would this not be a problem, it would likely drive greater innovation, flexibility, and results. We note that the Evaluators rationale for recommending more rural health content in the curricula was to foster a greater interest in students from a non-rural background. It is worth noting that the Medical Schools Outcomes Database (MSOD) demonstrates that, at the point of exiting medical school, over a quarter of these students express a preference for a future practice outside a capital city, and just under 10% of them have an interest in regional, rural or remote practice. Our member schools highlight that their regional training placements are over-subscribed, demonstrating the already strong interest from across the student cohort.
6	In setting targets and benchmarks for both the RHMT program and individual university levels, the Department should consider several factors including: placement location, placement setting and innovative nature of the placement.	3. **Concerns and comment** The focus of the Program needs to be on outcomes, rather than on placements. It is very reasonable for placements to be measured, but this should be within the broader context of the universities' strategy for fostering a domestic-trained cohort of medical graduates who desire and are well-trained and well-prepared to seek out and progress a rural career. Of course, placements will, and should, remain a key element for the Program. As such, the impact of COVID-19 on placements needs to be recognised; both the impact to date, especially on students in their penultimate or early clinical years, and also the likely ongoing impact.

		While we are strongly supportive of innovation, there needs to be some caution around this. Innovation in and of itself is, we would contend, of less importance than effectiveness. It would be a perverse outcome if a school were incentivised to reduce investment in a strategy that has been proven to be highly effective in delivering the outcomes being sought, in order to create an innovation for the sake of it. We also caution that too strong an emphasis on this brings with it a risk of increasing competition between schools; whereas it has been widely recognised that the high levels of collaboration, cooperation and sharing of best practice amongst RCSs and RTHs has been instrumental to the success of the RHMT Program.
,7	To facilitate longer rural immersive placements, the RHMT program encourages: • Universities to review allied health and nursing curricula and clinical placement requirements to enable longer rural placements in and across acute, non-acute and community care settings reflective of employment options in rural and remote communities. • University Departments of Rural Health (UDRHs) to work with specific and/or like-minded universities or faculties and health and community services to develop longer rural immersions for nursing and allied health students, particularly to sustain student-led service-learning models.	Defer comment on allied health and nursing to others.
8	The RHMT program adopts the Australian Health Practitioner Regulation Agency (Ahpra) definition of cultural safety to inform the development and delivery of cultural safety training for students, staff and supervisors.	3. **Concerns and comment** It is not appropriate to require this. This training is developed and delivered in partnership with local Aboriginal and Torres Strait Islander communities and organisations. It appears contradictory to the intent of this work, and undermining of any authentic partnership, for the non-Indigenous partners to be the ones requiring this. It is also unclear what issue there is with the RHMTP that has spurred this recommendation.
9	Through the RHMT program the universities be required to demonstrate their strategy for ensuring cultural safety of student placements and workplaces for all students, staff and supervisors.	2. **Support and comment** We recognise that the RHMTP might be an opportunity to lead work on cultural safety, however the Dept. should consider transitioning this to the Aboriginal and Torres Strait Islander Health Workforce Strategy as soon as is viable. We believe this is a university-wide matter, rather than the remit of a rural program. It is also more appropriate for the health professional accrediting bodies to be the arbiter of standards and to drive continuous quality improvement.

10	Through the RHMT program, the universities are encouraged to: • Employ senior Aboriginal and Torres Strait Islander academics in leadership positions. • Recognise and value Aboriginal and Torres Strait Islander expertise in addition to academic and/or professional qualifications for employed staff and people engaged on a casual or contract basis. • Develop a team of Aboriginal and Torres Strait Islander staff to work with and enact strategies for ongoing engagement with Aboriginal and Torres Strait Islander health services, organisations and communities, deliver cultural safety training and support Aboriginal and Torres Strait Islander students on placements. • Develop tailored professional development programs aligned to career goals of Aboriginal and Torres Strait Islander staff.	3. **Concerns and comment** We strongly support these objectives however we question whether the RHMT is an appropriate place for matters relating to the support and growth of Aboriginal and Torres Strait Islander academic and professional staff. These are vital issues that must be a priority for all university and medical school campuses and teaching locations, and we have concerns that having them sitting within the RHMT Program inadvertently and inappropriately conflates them with rural/regional matters. These objectives should be key elements for the new Aboriginal and Torres Strait Islander Health Workforce Strategy (Strategy). We recognise however that this new Strategy is not yet developed, and that a focus on and support for these essential matters must not lose momentum. As such, it might be worth considering this recommendation in the context of ultimately transitioning these objectives to the new Strategy when this has been finalised and being implemented.
11	To strengthen supervision capacity and capability in rural, remote and regional sites, the RHMT program encourages universities to engage with current and potential supervisors on a regular basis to identify and implement: • Supports and skills development required to commence or continue to provide supervision to students. • Employment or other engagement and recognition arrangements required recognising possible differences between localities, settings and disciplines. • Opportunities for localised or regional innovative supervision models.	2. **Support and comment** This is an area where engagement and influence across the training continuum is essential. There is substantial expertise and experience within RCSs that could be tapped into for quality supervision for medical students, junior doctors, and specialty trainees. However, the Report missed an opportunity to share insights into examples of good practice or highlighting where there were any areas of concern. In particular, where the impact and potential of technology and remote supervision has enabled improvements. Building a stronger evidence base around supervision is important and should be specifically supported.
12	The RHMT program requires each university to adopt a continuous improvement process to benchmark and review the quality of placements and supervision capacity building strategies.	2. **Support and comment** This is a very standard aspect of all accredited health professional programs. We cannot see what this will add to that already required through TEQSA and the relevant health professional accreditation authorities. There is a risk that reporting can become overly and unnecessarily burdensome, especially if it starts including elements that are not the focus for the Program or duplicating aspects that are already reported on to other bodies.
13	The Department consult with the universities to determine how interprofessional learning could be progressed through the RHMT program.	2. **Support and comment**

		There is the opportunity for this to add value, however it should be recognised that IPL is already within health professional accreditation standards and so the focus should be on how this aspect relates to the overarching objectives of the Program. It is also important to note that the rural/regional context will provide a number of challenges as well as opportunities.
14	In the next iteration of the program, the RHMT program requires all universities to: • Invest to incrementally increase the proportion of placements provided in smaller communities. • Develop and sustain extended medical placements with exposure to general practice, Aboriginal Community Controlled Health Organisations (ACCHOs), primary health care and rural hospitals to enable students to develop knowledge of the clinical skills and professional capabilities required of doctors working in rural and remote generalist models of care. • Develop longer immersive allied health and nursing placements in community and non-acute care settings in conjunction with local health and community care providers.	2. **Support and comment** Whilst we support the intentions behind this, it needs to be recognised that there is the potential for long timeframes and a high initial investment to establish these placements, with likely increased ongoing training costs, and potential interruptions to training due to small community environments, supervisor load, and higher levels of health staff turnover. The impact of COVID-19 on placements must also be considered, recognising that these can be very different for different communities, particularly for remote Aboriginal and Torres Strait Islander communities.
15	Through the RHMT program, the universities be required to demonstrate that they are supporting rural research through the Rural Clinical School (RCS) and UDRH network by: • Delivering high-quality research training, skills development and research support to local health professionals, supervisors, students and broader community stakeholders. • Developing regional consultative mechanisms to identify and respond to local research needs.	1. **Support**
16	Through the RHMT program universities be required to demonstrate how: • RCS and UDRH researchers are mentored and supported to build their research capabilities and careers. • Targeted support and mentoring is provided for rural based early career researchers, mid-level and senior researchers to enable them to join established research teams to address national and global research questions related to rural and regional health and health workforce. • Rural research and teaching is recognised, valued and rewarded.	2. **Support and comment** Whilst it is likely that there will be a strong interest from those involved in researching rural matters, there should be no constraint or expectation from the Program on the topics for the research. Research careers more broadly should be strongly encouraged, facilitated, and supported. Especially with the greater use and reach of technology enabling global virtual research partnerships and teams, living and working in rural Australia should no longer be an impediment to developing a rewarding research career irrespective of the research topic.

	• Collaborations with other RHMT program participants are developed and maintained to progress multi-site, multi-university and cross jurisdictional research to address nationally relevant questions and strategies for translation and dissemination.	
17	Through the RHMT program, Regional Training Hubs (RTHs) place emphasis on engagement with RCS students and junior doctors for individual vocational planning and career guidance, with linkage to a rural clinical mentor.	2. **Support and comment** This is a crucial aspect of effective workforce planning, and those working at RCSs and RTHs are in a unique position to have a strong influence and enabling role in this area. However, thought needs to be given to the impact of continuing to make distinct separations between RTHs, RCSs, and UDRHs. We strongly urge the Dept. to look at this as one Program moving forward, and take this opportunity to properly deal with the amalgam of initiatives that has been brought together thus far, and develop a Program that brings cohesion, consolidation, and connection across the groups, and that reduces the unnecessary operating and reporting burdens and duplications.
18	To enhance the impact of RTHs at a regional level, the Department work with the state and territory governments to explore mechanisms to progress the Integrated Regional Training Pipeline with consideration of a framework that identifies shared goals, joint planning processes, and alignment of resources to support regional training and workforce development.	2. **Support and comment** Key to this is a move to stronger regionally based governance and management of the IRTP and other healthcare training programs, and to a “flipped” model of postgraduate and vocational training for regional areas. This needs to consider and be consolidated with other Commonwealth health workforce programs that it intersects with and impact upon. Universities must be involved in these discussions.
19	The RHMT program requires the universities to have formal consultative mechanisms for engagement with communities and key stakeholders (i.e., health and community services, supervisors, local government) to: • Identify local and regional training, research, community development priorities. • Develop, implement, monitor and review collaborations. • Progress evaluation and quality improvement of program components including placements and supervision capacity building. • Provide feedback on initiatives and activities.	2. **Support and comment** We note however that these are central and crucial elements of universities’ work in regional and rural communities and have underpinned the RHMTP’s success. We reiterate our view the RHMTP should move away from requiring universities to report these process-level activities to focusing on outcomes. To succeed in a new outcomes focused RHMTP, all these points would need to be addressed and addressed well; there would be no need to monitor university activities at this level.
20	To maintain the rural integrity of the RHMT program, the Department has clear contractual requirements to protect and quarantine rural funding and maximise investment of RHMT program funds in the regions. This includes evidence of:	2. **Support and comment** While strongly supportive of all these elements, care needs to be taken that the flexibility and adaptability required by local needs and contexts is not undermined.

	• Identifying and reporting on investment of RHMT program funds in rural communities. • Involvement of rurally based academics in university and faculty governance processes. • Purchasing locally wherever possible. • Employment of local staff and engaging local contractors. • Engagement with community targeted consultative mechanisms. • Articulation and quantification of in-kind contribution by the university. • Delivering full or extended components of university degrees in regional campuses. • Senior leadership living rurally. • Employment arrangements for rurally based staff comparable to metro counterparts.	
21	The Department consult with universities to review current approaches to [medical] graduate tracking to determine an agreed methodology and variables in order to enable comparison of outcomes across universities.	2. **Support and comment** MDANZ is committed to contributing to this, and leverage the long-established MSOD survey of exiting medical students and the current work linking this data with Ahpra Medical Registration data and potentially other data sources. Enabling a national approach to this would be sensible to reduce the burden on individual universities to develop and implement their own systems. Refinement of existing surveys and data sources should be the focus, rather than imposing more on students who already suffer from survey fatigue. However, we are concerned that the focus for this is to “enable comparison” of universities, rather than measure the outcomes of the Program itself and the contributions being made by each of the universities. This belief and reliance on competition as a driver belies the evidence of the Evaluation Report that collaboration, cooperation and sharing of best practice were fundamental to the significant achievements to date.
22	The Department review the current requirement for UDRHs to track individual allied health and nursing students under the RHMT program agreement.	Defer comment on allied health and nursing to others.
23	The Department develops a national monitoring and evaluation framework for the RHMT program.	2. **Support and comment** This is a key element to the Program. It is vital that it is developed collaboratively with the key university and rural stakeholders involved. Noting, however, the heavy workload of reporting. The new framework needs to clarify and, we suggest, streamline to a core set of reporting requirements that also

		supports universities to highlight where new approaches and initiatives have been effective.
24	The Department require each RHMT program funded university to conduct an evaluation of their RHMT program in the next iteration of the program, using the national monitoring and evaluation framework.	1. **Support** This would follow from the above
25	In recognition of geographic gaps in the delivery of multidisciplinary placements, the Department investigate the feasibility of the RHMT network expanding functions into these regions or establishment of additional UDRH(s).	Defer comment on allied health and nursing to others.
26	The Department review the [UDRH] funding allocation formula for the RHMT Program to take into consideration remoteness for the delivery of the whole program.	Defer comment on allied health and nursing to others.
27	In the next iteration of the RHMT program, the Department considers: • Establishing an innovations funding pool to support and drive new initiatives including training, research and community engagement, to enable universities to be agile and responsive within the changing rural environments in which they operate. • Targeted investment to increase training in MM 4-7 through universities that can demonstrate their capacity to deliver high quality, value for money placements in rural and remote areas.	2. **Support and comment** The need for flexible approaches and solutions is vital for local needs and context to be taken into account. However, this needs to be recognised in the design for the whole RHMT, and not restricted to an additional pool of funding. Long-term sustainability for regional training infrastructure and capacity is vital, and providing certainty for those working in the regions and to secure university investment is key.
28	In the next iteration of the RHMT program, the Department resources the universities to extend the role of the UDRHs to facilitate transition of allied health and nursing students into graduate roles in rural, remote and regional areas. The key functions include: • Augment the supervision capacity and capability of local health and community services to enable these agencies to establish graduate and early career positions (i.e., Post-Graduate Year (PGY) 1-4). • Engage with students on placement to provide career guidance outlining pathways to rural work and rural careers. • Provide additional education, professional development and mentoring support to new graduates and early career practitioners.	Defer comment on allied health and nursing to others.
29	The Department of Health consult with the Department of Education, Skills and Employment on the National Regional, Rural and Remote Education Strategy to determine the feasibility of extending the role of UDRHs into the pre-university sector and in supporting students enrolled in online health courses.	Defer comment on allied health and nursing to others.

30. Please provide any other comments or views on the RHMT program evaluation (Max. 500 words).

While the evaluation report and recommendations refer to a new Program and single national reporting framework, the continuing references to the separate elements and initiatives in the recommendations seemingly contradict this and maintain the profusion of disparate and often overlapping objectives, activities, and reporting requirements.

There was also a missed opportunity to articulate how the RHMTP should align with and contribute to the other Commonwealth health workforce strategies and programs. This must be a key element of the discussions and planning in the coming months.

Much has happened and changed since this evaluation was undertaken due to the COVID-19 pandemic, and this consultation and consideration of the new Program is being done at a time of continuing change and uncertainty. The pandemic drove a range of innovations and adaptations that have been very beneficial and these have the potential to offer much to the new Program, particularly the use of technology and a more competency-focused, programmatic approach to assessments. The opportunities afforded by this situation need to be properly explored as they might provide an ability for step-change in certain areas. One example is the demonstration that telehealth and tele-supervision are far more viable and effective than many thought. For a range of professions, working in regional and rural areas has become more possible and more acceptable in terms of a career choice. Now is the time to capitalise on this and support a transition to regions being more empowered and accountable for determining, supporting, and managing their medical training needs and health provider workforce.

However, the impacts and pressures on the university sector and on healthcare services have been and continue to be immense. Care must be taken to ensure unrealistic expectations are not inadvertently applied, as that could create a very real risk to the Program's momentum and ability to build on its achievements.

31. Please provide any other comments or views on the future of the RHMT program (Max. 500 words).

The new RHMT Program must take this opportunity to move to a more outcomes-focused model, with a clear set of objectives and desired outcomes, a reduced focus on directing universities' processes, and improved national and individual level reporting on results and effective practice.

There needs to be a whole-of-training perspective. The regional medical education infrastructure and capabilities provided by the RHMTP provides an important and probably unique opportunity to be further built upon and leveraged to connect entry-level education with postgraduate training and create an aligned regional training pathway across the training continuum. It is time for these to be governed at a local, regional level, rather than continuing to expect decisions made by city-based committees to be informed and appropriate. This would build on the investment and gains to date, enable more locally driven and flexible approaches to be taken, and facilitate planning and decision-making across organisational and jurisdictional boundaries. Even in their short timeframe to date, the Regional Training Hubs have demonstrated their value in facilitating and coordinating local solutions for postgraduate and specialty training needs. Medical Deans has long advocated for the "flipped" model of regionally based postgraduate and specialty training with rotations to metropolitan hospitals if needed, and the RHMTP is an opportunity to progress this

It is the case that people and organisations manage what is measured. It is crucial that the National Reporting Framework being proposed focuses on the outcomes being sought by the Program and supports the sharing of useful insights and examples. If the reporting focuses at a process level, then so will the activities – and much of the flexibility and adaptability needed by the Program will be lost.

Existing valuable data needs to be leveraged, and a collaborative national approach taken, including to tracking graduates; noting that this is needed at a university level in order to have an appropriate baseline. The Medical Deans' Medical Schools Outcomes Database (MSOD) and longitudinal tracking project could provide a very strong and solid basis for this work.

Funding needs to be at a level that recognises the costs involved with regional training, increased remoteness, and expanded placements. The success of the RHMTP needed the long-term perspective to be able to establish the necessary infrastructure and build regional capacity. As such, it is strongly recommended that the new Program should move to 5-year funding agreements to provide the security and certainty needed.

Note: Medical Deans has previously provided a number of submissions and proposals regarding rural health workforce matters. Our views and overarching recommendations remain consistent with our comments within this submission. The documents can be found on our website:

- Policy Proposal, October 2019: Medical schools' contribution to addressing the medical workforce shortage in regional and rural Australia
- Submission, February 2017: Submission on the Assessment of the Distribution of Medical School Places in Australia