Healthcare Management Advisors

DEPARTMENT OF HEALTH, DISABILITY AND AGEING

Evaluation of the Murray–Darling Medical Schools Network

REGIONAL TRAINING HUB EVALUATION

6 JUNE 2025

HMA

OUR VISION

To positively impact people's lives by helping create better health services

OUR MISSION

To use our management consulting skills to provide expert advice and support to health funders, service providers and users

KBC Australia

This project is being undertaken in collaboration with KBC Australia and in association with Professor Janie Smith and Professor David Atkinson

HMA acknowledges Traditional Owners of Country throughout Australia and recognises the continuing connection to lands, waters and communities.

We pay our respect to Aboriginal and Torres Strait Islander cultures, and to Elders both past and present.

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ABBREVIATIONS

Abbreviation	*Definition*
ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
ACSEP	Australian College of Sports and Exercise Physicians
AMC	Australian Medical Council
AST	Advanced Skills Training
BMP	Bonded Medical Program
BPT	Basic Physician Training
CSU	Charles Sturt University
CTEP	Clinical Teaching and Education Pathway
Department, the	Department of Health and Aged Care
FGAMS	Foreign graduates of an accredited medical school
FRAME	Federation of Rural Australian Medical Educators

Abbreviation	*Definition*
FTE	Full-time equivalent
GP	General practitioner
HMA	Healthcare Management Advisors
IMG	International Medical Graduate
IRTP	Integrated Rural Training Pipeline
JCU	James Cook University
JMO	Junior Medical Officer
LHD	Local Health District
LHN	Local Health Network
MCSHE	Monash Centre for Scholarship in Health Education
MDMSN	Murray–Darling Medical Schools Network
MESO	Medical Education Support Officer

ABBREVIATIONS

Abbreviation	*Definition*
MM	Modified Monash (Model)
NSW	New South Wales
PGY	Postgraduate Year
PHN	Primary Health Network
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCS	Rural Clinical School
RCSWA	Rural Clinical School of Western Australia
RG	Rural generalist
RHMT	Rural Health Multidisciplinary Training
RTH	Regional Training Hub
RWA	Rural Workforce Agencies
STP	Specialist Training Program
UDRH	University Department of Rural Health

Abbreviation	*Definition*
UNDA	University of Notre Dame Australia
UNSW	University of New South Wales
USyd	University of Sydney
UWA	University of Western Australia
VMO	Visiting Medical Officer
VRGP	Victorian Rural Generalist Program
WACHS	Western Australia Country Health Service
WBA	Workplace Based Assessment
WPPP	Workforce Planning and Prioritisation Program

EXECUTIVE SUMMARY

BACKGROUND

The Department of Health, Disability and Ageing (the Department) engaged Healthcare Management Advisors (HMA) to evaluate the Regional Training Hubs (RTHs) funded under the Rural Health Multidisciplinary Training (RHMT) program. The purpose of the RTH evaluation was to understand the role and impacts of RTHs:

- as part of end-to-end medical training arrangements compared with the 'usual' Rural Clinical School training arrangements
- in building medical training capacity in rural, remote, and regional areas.

RTHs were established in 2017 to support the development of an integrated rural medical training pipeline within a region by enhancing and coordinating the stages of medical training from medical school to prevocational and vocational training and supporting the transition of medical students into a rural training pathway.

This evaluation of the role and impact of RTHs is a qualitative evaluation that relied primarily on consultation with key stakeholders. This information was supplemented with qualitative and quantitative information from consultation with RTH staff, university staff, hospital staff and other regional stakeholders, and program documentation.

CONTEXT

Over the last two to three decades, the Commonwealth, state and territory governments have invested in training and employment strategies to increase the medical workforce. A significant part of the Commonwealth's investment has focused on the expansion of medical training places (i.e. doubling the number of medical school places in 2006) and increased medical immigration. However, increased domestic and international supply has not corrected the geographic maldistribution of the medical workforce. The continuing maldistribution places pressure on the state and territory health services to maintain acute inpatient, maternity, general surgery and emergency services in rural and remote locations, and the sustainability of specialist care and services in regional centres.

While significant policy attention and investment in rural medical training has contributed to the capacity and capability of the rural medical workforce, it is recognised that further gains are needed and can be realised through establishing and/or strengthening postgraduate regional training pathways. The Commonwealth Government's investment in RTHs aims to develop, promote and sustain prevocational and vocational training opportunities to strengthen the regional pathway. However, this is a complex space requiring connection with medical students to support their transition from medical school into rural and regional training as well as ensuring there are accredited training posts and employment opportunities. This requires coordinated and collaborative action by universities, health services, general practice and specialist colleges in the first instance. With increased effort and investment in regional medical training, there needs to be professionally rewarding and appropriately remunerated jobs to attract and retain this workforce once fellowed.

EVALUATION SCOPE

The evaluation sought to answer the following questions:

1. To what extent have the RTHs implemented the six core requirements under the RHMT Program Framework relating to RTHs as part of

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Parameter 7 – Regional leadership in developing innovative training solutions to address rural workforce recruitment and retention? Has this been effective?

2. Are the current RTH core requirements still fit for purpose?
3. To what degree are the RTH locations suitable and are there opportunities for consolidation?
4. To what extent are the governance and funding arrangements for the RTHs appropriate?
5. What are the barriers and enablers for RTHs to perform their role effectively?
6. In what ways can the RTH program be improved?

EVALUATION FINDINGS

The evaluation found that overall, the RTHs were a valued resource within their region, and they implemented activities in line with the core requirements and funding agreements, albeit with varying degrees of efficiency and effectiveness.

RTH core requirements

6a. For each training hub identified in the university's funding agreement, the university must appoint a suitably qualified team, including a senior clinical academic, project and administrative staff.

RTHs engaged clinical leadership and project officer staff. However, active engagement of clinical leadership with the health service varied by location, as did the availability of a suitable project officer. Additionally, small fractional appointments for project officer staff limited the effectiveness of RTH activities.

RTH roles that were shared with the hospital and Rural Clinical School (RCS) enabled integration of the RTH into both organisations, which enhanced knowledge sharing. There is no one right way to structure the staffing arrangements; RTHs should maintain flexibility in how they approach this to best suit the needs of their region while considering capacity and continuity.

6b. The university must implement and maintain arrangements with relevant education professionals and health service stakeholders, including local hospitals and health services, state and territory governments, other universities, specialist colleges (including general practice colleges), postgraduate medical councils, local health practitioners and regional training organisations to support the integration of medical training at the local level.

The evaluation found that some RTHs had progressed in the development of longitudinal medical training pathways for some specialties and rural generalists (RGs). These were facilitated by targeted actions to respond to local need, building on relationships and linkages of RTH clinical leads with the health service. However, the commencement of the training pathway, i.e. transition of medical students to rural and regional prevocational positions, continues to be fragile.

With the exception of the Western Australia RTH, RTHs did not have a physical presence at the metropolitan campus to maintain engagement with final-year students. This created a structural barrier to maintaining a connection with students who undertook an extended rural placement in their penultimate year.

State/territory government allocation mechanisms for prevocational training posts can enable or hinder rural pathways. For example, when metropolitan hospitals rotate junior doctors to rural areas for a single term, it hinders the development of a rural pathway because junior doctors then rotate back to metropolitan areas for the remainder of their pre-vocational years, rather than spending the majority of their pre-vocational training in rural areas. Additionally, the readiness of specialist medical colleges to develop and implement rural training pathways varied greatly, creating further barriers and limiting rural workforce efforts.

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There was variation between RTHs in the extent to which they focused on general practitioner (GP) and RG training, mainly due to the lack of clarity in the wording of the core requirements when first released and the requirement for RTHs to report on accredited training posts in hospitals, which implied specialist training, noting that GP training is community based. Most RTHs have an increasing focus on GPs and RGs, while maintaining activities for non-GP specialities. Further work to clarify the roles of RTHs and Rural Generalist Coordination Units is required.

6c. The university must facilitate the development of new medical training capacity through activities including, but not limited to, assisting health services in accreditation processes for new posts and supporting local health professionals to become supervisors.

Under this parameter, RTHs worked with hospitals to develop and accredit new training posts. However, there was variability in the extent to which this support was embraced by hospitals – some RTHs were the 'go to' for assistance, while other hospital executives did not see this as a role for the RTH for several reasons, including existing capability within the hospital to develop accredited positions and that funding and resourcing of posts is the responsibility of the health service. Many RTHs reported activity to support supervisors and/or develop supervisor capacity – targeting GPs, registrars and junior doctors and doctors working in unaccredited roles. However, the reach of this activity within and across RTHs was unclear.

6d. The university must identify university-level medical students with an interest in rural practice and provide them with support including assistance with career planning, placement opportunities and access to mentoring.

Although this core requirement specifies targeting university-level medical students, the evaluation found that most RTHs focus on medical students and junior doctors, with many including registrars in vocational training as well as GPs, specialists and international medical graduates (IMGs) in their professional support, networking and continuing professional development activities. However, the RHMT program, and consequently the RTHs, operate under policy authority that identifies domestic Commonwealth supported students only. Changing this would require a future decision of government.

The lack of engagement with foreign graduates of an accredited medical school who must undertake internships in regional locations under the moratorium is a missed opportunity for RTHs.

Furthermore, bonded medical students who are city-based and do not undertake an extended rural placement are often unknown to the regionally based RTHs and miss out on activities intended to support rural career planning.

6e. The university must identify areas of regional medical workforce need within their catchment area, and work to build medical training capacity in these areas.

The RTH role in identifying workforce needs duplicates the work of other players, including state/territory governments, health services, Primary Health Networks (PHNs), Rural Workforce Agencies (RWAs), and Workforce Planning and Prioritisation Program (WPPP) agencies. In the future, RTHs could bring all parties together for comprehensive regional workforce planning, but this does not appear to happen currently.

6f. The university must report on the training placements available at each level of the medical training continuum within each hub's region of activity

RTHs experienced challenges obtaining training post data because they are not the data custodians, and the rationale for reporting the data was not transparent. Some RTHs developed websites that provide training post information for medical students, junior doctors and registrars. The value of these websites is reliant on the currency of information being maintained.

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Are the RTH core requirements fit for purpose?

Since their inception in 2017, the RTHs have evolved to reflect the regional needs and the changing workforce environment, which includes increasing reliance on IMGs, growth in the number of unaccredited doctors working in metropolitan and regional hospitals and increasing supervision load carried by rural and remote fellows (inclusive of GPs and specialists). While the current core requirements have merit, there are areas where the core requirements are no longer fit for purpose and need to be refreshed. Additionally. the current core requirements lack attention to supervisor capacity and outcome metrics to demonstrate the effectiveness of the RTH activities.

Furthermore, the core requirements lack clarity in that they are specific to medical students (6d) yet seek to support students through to postgraduate training, which requires direct attention to junior doctors and registrars. Given the importance of general practice and RGs in rural and remote areas, these training pathways should also be highlighted in the core requirements.

Opportunities to extend RTH reach and scope

This section describes several opportunities where RTHs work outside their current scope, but provide valuable work that should be considered for inclusion in their remit in future, as follows:

1. **Professional support for IMGs.** The regional nature of RTHs and the increasing reliance on IMGs in regional and rural locations place them in an opportune position to provide professional support for IMGs within their remit.
2. **Responding to overcrowded rural medical training footprints.** The RTH's role is to provide professional support to medical students and junior doctors and collaborate with health providers regarding clinical placements and training posts. Therefore, the focus of the RTH needs to be region-wide. Combined with the external confusion when multiple RTHs operate in one region, this presents an argument that RTHs should be agnostic of universities and represent all students and health services within a region. This will in turn benefit students at universities without an RTH. However, it may introduce challenges in funding arrangements, which are currently administered through universities.
3. **Statewide partnership model.** Regional collaboration between RTHs to create partnership models that reduce duplication of effort and maximise efficiency and effectiveness should be considered.

EVALUATION RECOMMENDATIONS

Based on the evaluation findings, several recommendations for improving the RTH program in the future are presented under three options that are additive (not mutually exclusive), as follows:

- **Option 1 – Minor Change:** RTHs remain under RHMT
- **Option 2 – Moderate Change:** Expanded scope of RTHs with complementary funding mechanisms
- **Option 3 – Major Change:** Integrated Rural Medical Workforce and Training Strategy

Option 1 – Minor change: RTHs remain under RHMT

Recommendation 1 The Department should continue to fund the RTH program.

When engaged with health services and regional stakeholders, RTHs were effective and valuable assets supporting students and doctors across the medical career continuum within their region. While some RTH activities were found to be duplicative with other entities, **the RTH's intent to act as a bridge between medical school and prevocational training to make the transition between medical career stages in regional and rural areas easier was unique, necessary and valuable.** This intent aligns with the National Medical

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Workforce Strategy (2021–2031) goals around increased training in regional areas, supervisor support, and professional support to enhance doctor wellbeing. However, several areas for improvement with the RTH program were identified as outlined in this report and the following recommendations.

Recommendation 2 The Department should update the RTH core requirements to reflect the evolution and maturity of RTHs.

The following core requirements should be amended to include the elements (in green text):

- 6a. For each training hub identified in the university's funding agreement, the university must appoint a suitably qualified team, including a senior clinical academic, project and administrative staff. The clinical academic should be actively engaged in clinical service delivery in the region. The RTH project officer should be employed at least 0.7 FTE in that role. Consideration of fractionation where staff have roles in both the RTH and the RCS or hospital can enhance capacity and facilitate relationship building.
- 6c. The university must facilitate the development of new medical training capacity through activities including, but not limited to, assisting health services in accreditation processes for new posts. RTHs must specifically support the development of general practice and rural generalist training pathways in the region in collaboration with the GP colleges and Rural Generalist Coordination Units. RTHs must support local health professionals to become supervisors. RTHs must build and maintain vertical training and supervision capacity tailored to junior doctors, registrars and fellows. Ideally, supervision training should lead to a micro-credential and/or foundational teaching qualification (e.g. Clinical Teaching Fellowship).
- 6d. The university must identify university-level medical students and junior doctors with an interest in rural practice and provide them with support, including assistance with career planning placement opportunities and access to mentoring. RTHs must establish connections with foreign graduates of an accredited medical school and bonded medical students (during their university degree) to prepare and support their transition to regional and rural internships.

The following core requirement should be removed:

- 6e. The university must identify areas of regional medical workforce need within their catchment area, and work to build medical training capacity in these areas.

And replaced with:

- RTHs must prioritise development of end-to-end vocational training pathways in response to identified workforce need. To build sustainable training capacity and capability and local workforce, the RTH, in conjunction with the Local Health Network, general practice and ACCHO sectors, and key college stakeholders agree on key local and regional workforce priorities (i.e. a regional workforce plan) and develop longitudinal training pathways for those disciplines.

The following core requirement should remain the same:

6b. The university must implement and maintain arrangements with relevant education professionals and health service stakeholders, including local hospitals and health services, state and territory governments, other universities, specialist colleges (including general practice colleges), postgraduate medical councils, local health practitioners and regional training organisations to support the integration of medical training at the local level.

The ordering of the core requirements should be amended such that 6d becomes 6b (and consequently, 6b becomes 6c; 6c becomes 6d) to emphasise that the primary focus of RTHs is on medical students and junior doctors.

Recommendation 3 Universities receiving RHMT funding should support the development of a 'Clinical Education and Training Pathway' tailored to the needs of rural supervisors that can be rolled out by the RTHs.

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As previously stated, supervisory capacity and capability are critical for developing regional training pathways and growing the rural medical workforce. Ensuring clinical supervisors are appropriately trained, including nuanced training relevant for regional, rural and remote settings, is essential. This will support clinicians across the career continuum in supervision activity, aiming to not only engage more clinicians in supervisor roles, but also maintain their interest and willingness to remain supervisors over time. As a consequence, it is expected that student trainees will have superior training experiences, receive optimal supervision and feedback and therefore, be more likely to continue to pursue a rural medical career.

Universities receiving RHMT funding should leverage existing supervision courses (e.g. from their Health Education Department) and tailor them to the needs of rural and remote supervisors. This program should then be made available for RTHs to roll out in their regions at a subsidised cost.

Critical to this, the training should include micro-credentials that can be incorporated into larger credentials/training qualifications if desired. This will promote a level of consistency across regions, enable supervisors to take the qualification with them if they move locations, and reduce future training demands if recognition of prior learning is appropriate.

Recommendation 4 The Department should include outcome measures for RTH reporting.

Outcome measures should include, for example:

- Transition of extended rural placement students/end-to-end medical students to regional internships in the local area and elsewhere
- Analysis of the background of the interns within their region, e.g. end-to-end cohort, extended regional placement cohort, bonded medical students, foreign graduates of an accredited medical school (FGAMS), rural origin, etc.
- Extent to which end-to-end training for identified medical workforce priorities can be completed within the region – GP/RG and non-GP specialties
- Long-term graduate tracking (five and 10 years post-graduation) detailing location (by remoteness) and speciality type (GP, RGs and non-GP specialty)
- Growth in medical supervision capacity in the region

Recommendation 5 The Department should consider development of a research funding opportunity (e.g. through the Medical Research Futures Fund) to enable a multi-university research program focused on rural (MM2–7) prevocational doctors and the medical training journey that led them to rural prevocational work.

There are now a number of university training pathways to support the development of the rural medical workforce (i.e. extended rural cohorts, completion of the final two years in a rural location, end-to-end training, short rural placements), as well as quotas for the selection of rural origin students into medicine and activities to support transition to rural prevocational training through the RTHs. In addition, the states and territories have different mechanisms for intern allocation and prevocational contract arrangements. Identifying the demographic and training pathways of junior doctors into rural work and the extent to which intern allocation and employment contracts contribute to work location would provide valuable information to better tailor selection, education, training and employment arrangements. This would help to strengthen the early rural medical career pathway for improved rural medical workforce outcomes.

This recommendation could be supported by developing a graduate tracking system as described in Recommendation 9.

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Recommendation 6 Universities should support the RTHs to work with universities and health services to increase and coordinate student placement opportunities; this should include financial or resource support as required.

With the increasing number of medical students from multiple universities undertaking placements in a region, there needs to be greater collaboration between universities and rural and regional hospitals and health services for student placements. This will require greater flexibility by universities in the delivery of curricula. A local place-based approach is needed as placements must be planned and coordinated with the regional and rural health services and with several universities.

Recommendation 7 The Department should reconsider the locations of RTHs to ensure one RTH per region that connects with and supports medical students from all universities operating within their regional footprint.

Medical students from multiple universities may undertake short and extended placements in a region. To support the development of regional and rural medical training and workforce, RTHs should be university agnostic and extend their networking, support, career guidance, mentoring, and professional support activities to all students located in their footprint.

Recommendation 8 The Department should consider the development of regional or state/territory-wide RTHs in certain locations.

Through this evaluation, several issues were identified specific to a region or jurisdiction that require particular consideration by the Department. Mechanisms to create collaborative networks that span a region or jurisdiction to reduce duplication of effort and maximise efficiency need to be considered. The WA RTH (governed by a joint university structure) provides a model for consideration, but this is not the only model that could be applied. Flexibility for local nuance governance arrangements must be considered.

Universities and RTHs where a regional/state/territory model would improve coordination are as follows:

- **Riverina RTH (University of Notre Dame Australia (UNDA)), Murrumbidgee RTH (University of NSW (UNSW)) and Border RTH (UNSW).** These RTHs cover the same geographic footprint. While they seek to differentiate their activity, it creates confusion for external stakeholders and is perceived as duplicative. The evaluators suggest that these RTHs amalgamate. There would be a joint university governance arrangement that included UNDA (as lead), UNSW and Charles Sturt University (CSU) (which also operates in the region but does not have its own RTH).
- **Limestone Coast RTH (Flinders University) and Eyre Peninsula RTH (University of Adelaide).** South Australia is a state with a large metropolitan population and widely dispersed smaller regional centres. Limestone Coast RTH focuses its efforts in the Mount Gambier region and the Eyre Peninsula RTH focuses on Whyalla and surrounds. There does not appear to be an RTH covering the Riverland areas of the state. In addition, the Eyre Peninsula RTH and University of Adelaide RCS staff operate under a blended arrangement. Given the challenging geography and dispersed workforce, consideration could be given to developing a collaborative statewide approach.
- **Northern Territory RTH (Flinders University).** The Northern Territory RTH is not well connected with the hospital and health services and has experienced staffing challenges with changes to the Clinical Director and Program Officer. The recent addition of end-to-end medical training at Charles Darwin University provides an opportunity to change the Northern Territory RTH arrangement and develop a territory-wide approach.

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Recommendation 9 The Department funds the development of a suitable graduate tracking system that includes RTH touchpoints.

The main purpose of this RTH initiative, the RHMT program, and the many other government-funded training initiatives (such as the Australian General Practice Training Program, Rural Generalist Training Scheme, STP, and IRTP) is to establish and grow rural, remote, and regional medical training opportunities to increase the medical workforce practising in rural, remote, and regional Australia.

However, few universities had a tracking system in place to determine where students, interns and registrars go in their careers or what GP or non-GP specialty they pursue. Note, James Cook University (JCU), University of Queensland, and University of Tasmania were identified as having good tracking systems in place, and the Western Australian RTH – Central has developed a customer relationship manager system to determine touchpoints with students and junior doctors.

Furthermore, it is not feasible to track medium- to longer-term outcomes from one RTH or one university separate from other initiatives, as medical students from different universities can undertake a placement in a region.

The work to link the Medical Schools Outcomes Database and Australian Health Practitioner Regulation Agency data to track medical graduate workforce outcomes is progressing. Inclusion of RTH touchpoints and activities in the prevocational period could provide insight into the important interventions and potentially 'doses' of interventions that make a difference to rural workforce outcomes.

Option 2 – Moderate change: Expanded scope of RTHs with complementary funding mechanisms

Recommendation 10 The Department could update the scope of the RTH role to include professional support assistance for IMGs, which may require additional funding from appropriate branches within the Health Workforce Division.

Australia is highly reliant on IMGs to maintain access to high-quality, timely and appropriate care, particularly in rural and remote areas. IMGs are twice as likely as Australian Medical Graduates to work rurally due to a moratorium under Section 19AB of the Health Insurance Act [1] and IMGs make up around two in every three doctors in MM4–7 areas. Many IMGs come to Australia with strong clinical training, years of clinical experience and qualifications from overseas. However, given the challenges and isolation of rural and remote work, the complexity of Australia's regulatory and rural training pipelines for IMGs, as well as the unique socio-cultural backgrounds of many IMGs, they often require nuanced support to sustain rural training and employment and achieve career progression.

Identifying and engaging with IMGs (working in regional and rural hospitals and/or undertaking their WBA, as well as IMGs training and/or working in community general practice) to enable access to a suite of professional support activities offered by the RTH and others is an important mechanism to strengthen the retention of this workforce. Professional support offered by RTHs may include peer-mentorship, wellbeing and career development support, assistance with the development of professional networks, and non-clinical skills such as supervisor training and support to integrate into the local community. This support can be extended to doctors working in unaccredited positions in regional hospitals to support retention and potential transition to a training pathway. Note that there will be variation between regions in their reliance on IMGs and hence flexibility in the level of activity required.

Option 3 – Major change: Integrated Rural Medical Workforce and Training Strategy

Recommendation 11 Branches within the Health Workforce Division of the Department collaborate to establish an integrated rural medical workforce and training strategy that spans the entire medical training and beyond along the continuum of the medical career. This could be implemented through a regional-based collaborative approach.

As regional-based entities, RTHs are well placed to coordinate and provide support for medical students, junior doctors, registrars, and consultants, including IMGs. However, the current funding arrangements under the RHMT program, which specify the RTHs should focus activities on domestic medical students, limits the potential of RTHs to provide region-wide support across the medical career continuum. Similarly, affiliation with one university makes providing region-wide support challenging for footprints that contain multiple RCSs and RTHs.

Although the evaluation found that the role of RTHs is hindered by being funded through universities under the RHMT program, there is no natural host for the RTH and a regional-based coordination/support role outside of the universities. Hosting RTHs within health services could a) limit their scope to hospital-based workforce only, excluding medical students and primary care, and b) result in funding being absorbed by the enormity of the health service. Similarly, hosting RTHs in primary care (such as through PHNs or Rural Generalist Coordination Units) could result in lack of hospital-based focus. RWAs have a partial role in regional coordination activities, but they cover the entire state/territory, which is too broad for local-level nuancing and support.

To be truly effective, RTHs also need agency with health services and medical colleges (GP and non-GP colleges) to access data, support training post accreditation, and assist with developing regional training networks where possible. Such a regional-based entity needs buy-in from all key players including local university RCSs, Local Health Networks/health services, primary care and medical colleges. It also requires strong collaboration with RWAs and WPPP agencies.

This evaluation demonstrated that multiple actors and stakeholders are involved in medical training, employment, and workforce development in rural and regional areas. These actors engage with medical students, junior doctors, doctors in training, and fellows at different stages of the career continuum and for different purposes. Furthermore, the various funding sources and focus of programs and policies are not aligned to maximise outcomes.

The co-design of medical training and employment strategies at a regional level offers the opportunity to align activities toward regional workforce outcomes, taking a systems-based approach. This could be progressed by regional collaborations or consortiums that include the relevant university and RCS, RTHs, the Local Health Network (including executive and regional hospitals and Medical Education Units), the RWAs, GP regional training providers/directors of regional training, the WPPP agencies/PHNs, the Rural Generalist Coordination Units and medical specialist colleges relevant to regional priorities.

This collaboration would bring together:

- key education providers across the medical training continuum (medical school, prevocational and vocational training)
- agencies responsible for local and regional health and workforce needs assessments and workforce planning
- agencies that hold or fund the prevocational and vocational training posts
- the Local Health Network that funds rural and regional hospital services
- local GP leadership

Most RTHs have significantly matured since the early implementation evaluation in 2019–20, and more mature RTHs could facilitate and implement a place-based regional medical workforce and training strategy using a collective impact approach, whereby long-term commitments by key players

of different sectors work towards a common agenda to solve a specific problem [2].

The key elements of a co-designed, co-funded, co-implemented approach include:

1. joint planning
2. shared workforce priorities
3. supervision capacity building
4. integrated information communication technologies
5. effective change management
6. aligned incentives
7. training provided to a geographically dispersed medical workforce
8. use of data as a workforce and education planning tool
9. professional development
10. community, consumer, and patient engagement
11. resourcing to support innovation.

1 INTRODUCTION

1.1 BACKGROUND

The Department of Health, Disability and Ageing (the Department) engaged Healthcare Management Advisors (HMA) to

> *Undertake an implementation evaluation of the Murray–Darling Medical Schools Network and develop an outcomes evaluation framework to be embedded into the programs of all participating universities.*

The Murray–Darling Medical Schools Network (MDMSN) has been established under the Stronger Rural Health Strategy to provide end-to-end medical training in rural areas of New South Wales (NSW) and Victoria [3]. The MDMSN end-to-end approach is based on evidence that access to rural training programs increases retention of doctors in rural areas and builds on learnings about appropriate student selection processes and training strategies [4].

1.2 REGIONAL TRAINING HUBS

The concept of Regional Training Hubs (RTHs) emerged from the Review of the Commonwealth's Health Workforce Programs in 2013 [5] as a mechanism to better connect the rural medical training pipeline. RTHs were established in 2017 as a new component of the Rural Health Multidisciplinary Training (RHMT) program, leveraging existing capacity in the Rural Clinical Schools (RCSs) and University Departments of Rural Health (UDRHs).

RTHs were established to support the development of an integrated rural medical training pipeline within a region by enhancing and coordinating the stages of medical training from medical school to prevocational and vocational training and supporting the transition of medical students into a rural training pathway.

1.3 EVALUATION OBJECTIVE

The purpose of the RTH evaluation is to understand the role and impacts of RTHs:

- as part of end-to-end medical training arrangements compared with the 'usual' RCS training arrangements
- in building medical training capacity in rural, remote, and regional areas.

1.4 PURPOSE OF THIS DOCUMENT

This document (draft RTH evaluation report) summarises the findings of the RTH evaluation. It makes recommendations for future improvements to the delivery of the RTHs.

This document is supported by individual summaries of the RTH site visits.

PART A METHOD & CONTEXT

2 METHOD

The evaluation of the role and impact of RTHs is a qualitative evaluation that relies largely on consultation with key stakeholders. This information is supplemented with qualitative and quantitative information as described below.

2.1.1 Consultation with RTHs staff and relevant stakeholders

HMA conducted interviews with RTH staff and relevant stakeholders (e.g. Directors of Clinical Training at local hospitals, local GPs, etc.) during site visits undertaken throughout 2023 and 2024 by one member of the evaluation team, comprising Dr Deborah Roczo, Dr Kris Battye, Prof Janie Smith, Prof David Atkinson and Josh Gordon.

As the evaluation was conducted as part of the broader MDMSN evaluation, RTHs located at MDMSN universities or named comparator site universities were undertaken during case studies at these locations, with two consultants. The remaining RTHs were visited individually with a focus solely on the RTH program (and not broader medical school education/training).

All 28 RTHs were visited in person with the exception of Border RTH in Albury/Wodonga. In-person consultation was supplemented with videoconference as needed.

2.1.2 Documentation and data review

HMA reviewed RHMT and RTH program documentation, a previous evaluation of the RHMT program (2019) and publicly available information on the RTH activities, including university/RTH websites and the Federation of Rural Australian Medical Educators (FRAME) National RTH Toolbox. Relevant policies and peer-reviewed literature were also considered. Program data, including activity work plans and budgets, were provided by the Department. Data on RTH activities was provided by each RTH.

3 CONTEXT

3.1 RURAL MEDICAL WORKFORCE TRAINING

Over the last two to three decades the Commonwealth, state and territory governments have invested in training and employment strategies to increase the medical workforce. A significant part of the Commonwealth's investment has focused on the expansion of medical training places (i.e. doubling the number of medical school places in 2006) and increased medical immigration. However, increased domestic and international supply has not corrected the geographic maldistribution of the medical workforce. The continuing maldistribution places pressure on the state and territory health services to maintain acute inpatient, maternity, general surgery and emergency services in rural and remote locations, and the sustainability of specialist care and services in regional centres.

Developing a rural medical training pathway underpins the Commonwealth's approach to improving medical workforce distribution. Key training initiatives include:

University and medical student focused

- establishment of a rural origin medical student enrolment quota of 25% for universities in receipt of Commonwealth funding
- establishment and ongoing investment in RCS to support extended rural clinical training placements for medical students under the RHMT program
- establishment of the MDMSN to support end-to-end training in the Murray–Darling region
- investment in an additional 80 Commonwealth Supported Places for end-to-end medical training

Transition to rural prevocational training

- establishing RTHs linked to RCSs and UDRH training sites to better connect the rural medical training pipeline from undergraduate to prevocational and vocational training to allow trainees to complete more training in rural communities
- investment in and expansion of rural prevocational training (the John Flynn Prevocational Doctor Training Program)

Vocational training

- investment in specialist training in expanded settings, including private practice and rural settings through the Specialist Training Program (STP) and more recently the STP-Integrated Rural Training Pipeline (IRTP)
- investment in the Australian General Practice Training Program and Remote Vocational Training Scheme for general practice vocational training
- more recently, the development of the National Rural Generalist Pathway, which includes funding for 100 training places for Rural Generalist (RG) trainees
- establishment of Rural Generalist Coordination Units (funding to state and Northern Territory governments) to improve workforce supply by coordinating the training pathway for RGs across the hospital and primary care settings
- investment in additional Advanced Skills Training (AST) posts for RGs and GPs (pilot program of 15 posts per annum for three years)

Additionally, each jurisdiction has workforce policies with some focus on rural medical workforce development and distribution. Employment opportunities, industrial arrangements and workforce priorities differ between jurisdictions,

which is reflective of the demography, health needs and models of care specific to the state or territory.

3.1.1 Importance of tailoring the rural training pathway for rural medical workforce outcomes

The evidence for the importance of rural origin and rural exposure during training to future rural medical practice has existed for some time. The predictors for rural medical practice include:

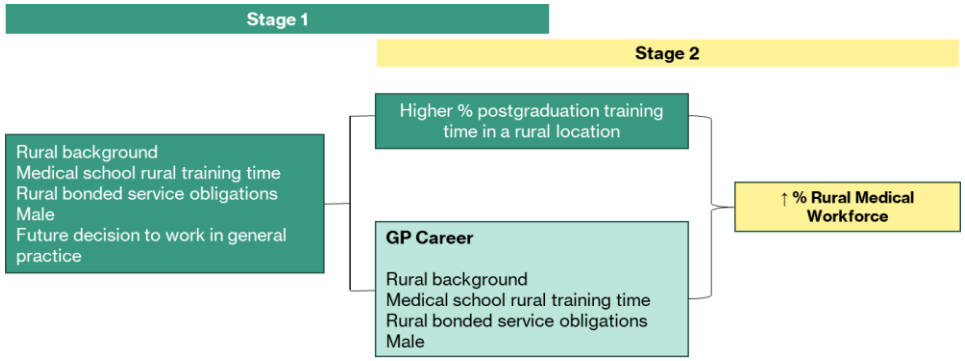
- selection of students of rural background or students with a demonstrated interest in rural health [6] [7] [8] [9] [10]
- the number of undergraduate rural exposure opportunities and longer duration rural immersions (one or more years) increasing the likelihood of future rural practice [6] [7] [9] [10] [11]
- participation in RCS extended clinical placements [7]
- rural clinical placement setting, where the combination of regional hospital and rural general practice has the greatest impact on subsequent rural practice [9]
- rurality of placement, where RCS placements in Modified Monash (MM) 4–7 had a higher likelihood of working rurally than placements in MM 2–3 [11]
- completing internships in non-metropolitan settings [12]
- rural return of service obligation [9].

Among GPs and non-GP specialists, rural background and RCS attendance are independent, duration-dependent, and additive predictors of longer-term rural practice [6] [7] [8] [9] [10] [11].

Recent research provides new evidence of the importance of rural postgraduate training opportunities on subsequent rural work for both GPs and other specialists. It has been shown that spending a higher proportion of postgraduate training time (>40%) in rural areas influences subsequent rural work patterns for GPs and other specialists, after controlling for rural background and medical school rural training time [4].

This research indicates the distribution of the medical workforce is built in two stages (see Figure 3.1), with Stage 1 up to completing medical school (which has been the focus of the RHMT program) and Stage 2 after medical school (postgraduate training), highlighting the need for, and importance of, linkage between the stages and strengthening rural and regional training pathways [4].

Figure 3.1: Two-stage pathway to developing more rural doctors



Source: McGrail 2023 [4]

The ***National Medical Workforce Strategy (2021-2031)*** supports this two-stage pathway through key priorities focused on:

1. **Reforming training pathways with specific actions to increase specialist training in regional, rural, remote and Aboriginal and Torres Strait Islander health settings** with attention to supervision models to support rural training; formalised networked training between metropolitan and regional health services so trainees can be based in regional and rural areas; and medical college selection processes

3 CONTEXT

targeting doctors with generalist and rural experience to grow the rural medical workforce.

2. **Building the generalist capability of the medical workforce** by supporting broader education and experience of generalist skills, rural and remote clinical practice during medical school and on training programs; building specialist training on generalist foundations; supporting informed decision-making for generalist career pathways – through career tools and career counselling; fellows supported to exit training with a broad scope of practice.
3. **Improving doctor wellbeing**, which is impacted by increased care responsibilities of rural and remote doctors, challenges of on-call duties, clinical isolation and poor work-life balance. This impacts the health and wellbeing of the doctor, as well as workplace culture, quality of care and doctor retention [13].

3.2 REGIONAL TRAINING HUBS

The RHMT program funds 22 universities, which includes a national network of 25 RCS, 19 UDRHs, and six dental schools, which support the rural clinical placements of medical, nursing, allied health, and dental students. The program also encompasses the Northern Territory Medical Program and Rural Health Clubs [14].

In recognition of the gaps in the rural training pathway, the need for linkages to support medical students transition to regional prevocational and vocational training, and leakage of rural trainees to metropolitan hospitals, the Commonwealth invested in the establishment of RTHs as a new component of the RHMT program. Additional funds of approximately $600,000 per RTH per annum were provided to universities to establish RTHs under the RHMT funding agreements in 2017.

Under Parameter 7 of the RHMT Program, the RTHs are to:

[Provide] **Regional leadership in developing innovative training solutions to address rural workforce recruitment and retention**

i. Work collaboratively with other universities operating within the university's catchment, as well as within the RHMT network, to support the goals of the RHMT program.
ii. Work with relevant education, professional and health service stakeholders in the region to develop and maintain models such as:
   - integrated rural training pathways for medical students interested in rural careers that support students through to postgraduate training; and
   - service learning models that can increase local health service delivery while supporting high-quality rural training experiences.
iii. Improve connections between the program health providers, employers and funders (e.g. state/ territory governments and private health companies) to promote continuity of rural student training and the sustainability and durability of the rural health workforce.

The core requirements of the RTHs are to:

6a. For each training hub identified in the university's funding agreement, the university must appoint a suitably qualified team, including a senior clinical academic, project and administrative staff.

6b. The university must implement and maintain arrangements with relevant education professionals and health service stakeholders, including local hospitals and health services, state and territory governments, other universities, specialist colleges (including general practice colleges), postgraduate medical councils, local health practitioners and regional training organisations to support the integration of medical training at the local level.

6c. The university must facilitate the development of new medical training capacity through activities including, but not limited to, assisting health

services in accreditation processes for new posts; and supporting local health professionals to become supervisors.

6d. The university must identify university-level medical students with an interest in rural practice and provide them with support including assistance with career planning placement opportunities and access to mentoring.

6e. The university must identify areas of regional medical workforce need within their catchment area, and work to build medical training capacity in these areas.

6f. The university must report on the training placements available at each level of the medical training continuum within each hub's region of activity.

See the full list of RHMT program parameters and core requirements on the Department of Health and Aged Care website here.

There are currently 28 RTHs across Australia, including ten (10) in NSW, six (6) in Queensland, four (4) in Victoria, three (3) in Western Australia, two (2) in South Australia, and one (1) each in Tasmania, the Australian Capital Territory and the Northern Territory. All universities, except Griffith University, Western Sydney University and Charles Sturt University, have been funded for at least one RTH.

While there are 28 RTHs, there are over 40 sites from which hub personnel work [15]. RTHs, along with relevant universities, RCSs and jurisdiction are outlined in Appendix A.

3.2.1 Complex operating environment

RTHs operate in a complex environment where there are multiple actors involved in rural medical training, employment and workforce development who engage with medical students, junior doctors, doctors in training and fellows at different stages of the career continuum and for various purposes.

The extent to which workforce and training policies, funding sources, programs and employment arrangements can come together and align to support regional training pathways is highly variable between and within jurisdictions.

Prevocational training and employment in rural and regional areas

Prevocational training allows doctors to develop applied clinical competencies after completing their basic university medical qualification. The Australian Medical Council (AMC) National Framework for Prevocational Medical Training outlines the outcomes required of prevocational doctors and entrustable activities to be achieved through clinical rotations, education programs and individual learning. In 2024, community terms became mandatory, providing opportunities for junior doctors to be exposed to general practice and other primary care settings.

Prevocational positions are predominantly funded by the state and territory governments, with the Commonwealth funding rotations in rural primary care settings (800 annually in 2025) through the John Flynn Prevocational Doctor Program. While training underpins the prevocational period, these doctors are an important workforce for metropolitan, regional and rural hospitals. Therefore, the extent to which prevocational positions and contracts are structured to support rural training pathways can be challenged by workforce demand.

Vocational training and employment

Medical specialist training posts are predominantly funded by the state and territory governments and established in tertiary and regional hospitals in line with the curriculum requirements of the relevant specialist college and workforce needs. Investment by the Commonwealth in the STP and the IRTP has sought to increase regional training opportunities and expand training opportunities in alternative settings (the private hospitals and practices and Aboriginal Community Controlled Health Organisation (ACCHO) sectors). The STP and IRTP are managed and administered by the 13 non-general practice

medical colleges. STPs are usually of six-months duration and need to be combined with other funding/employment arrangements to create regional training pathways.

Doctors undertaking general practice and rural generalist (RG) training can complete all their training rurally. The continuity of the regional training pathway can be maintained if attention is paid to mapping and collaborative planning of GP and AST posts (where relevant) with accredited training practices, the GP colleges, and registrars. For RG training, the Rural Generalist Coordination Units and regional hospitals are included in the planning.

Supervision

Supervisory capacity and capability are critical for developing regional training pathways and growing the rural medical workforce. However, there are fewer doctors of all specialty types in rural areas, so a greater supervision burden is placed on existing rural doctors. Recent national data indicates that the supervision load for rural doctors is approximately twice that of their metropolitan counterparts (source: National Medical Workforce Data set). This creates tension between the supervisor's clinical and educational responsibilities.

The Medical Workforce Advisory Committee is currently investigating different models of supervision to increase capacity in rural areas, such as remote supervision, hybrid supervision, near-peer supervision and greater use of locums and specialist international medical graduates.

3.2.2 Conclusion

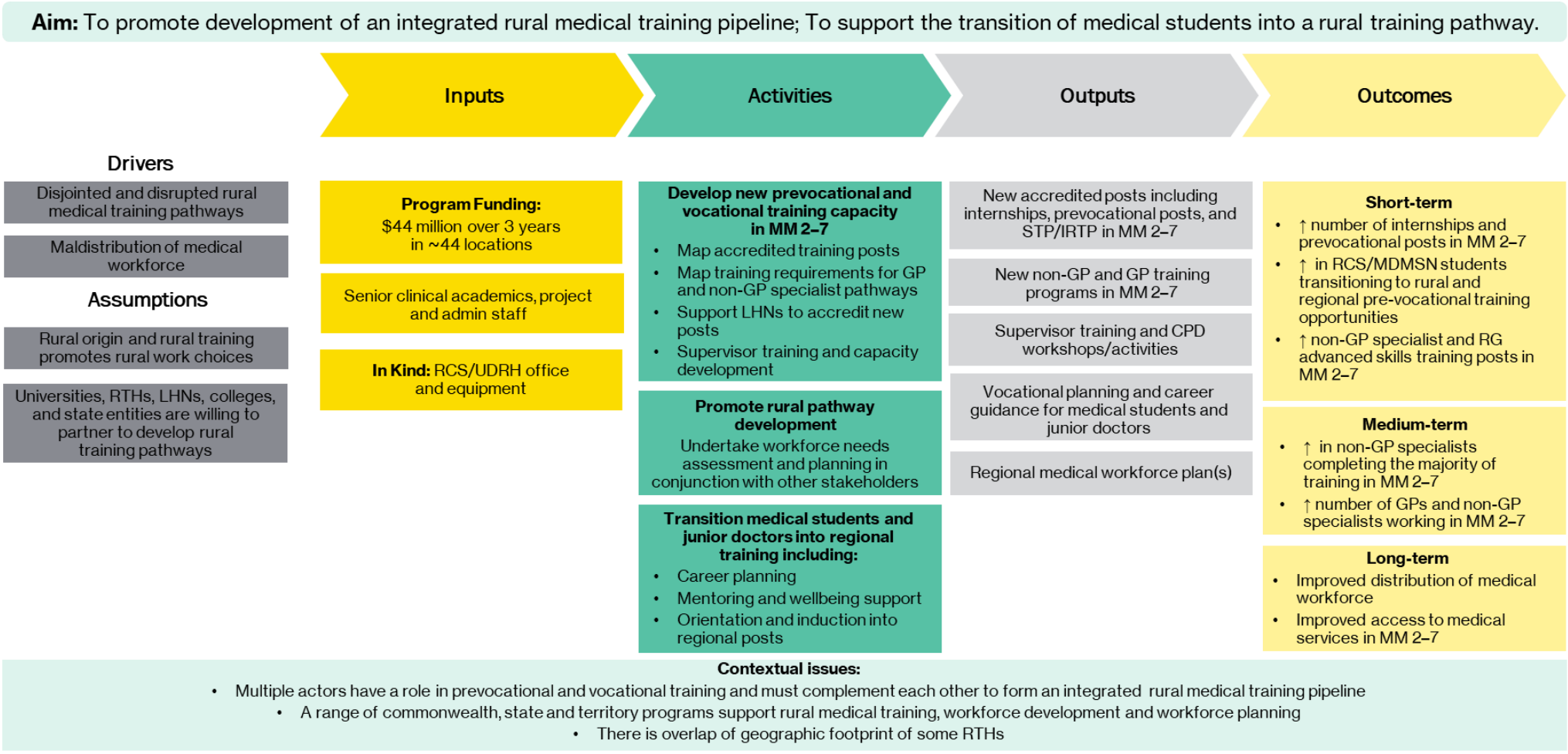
The Commonwealth Government's investment in RTHs aims to promote prevocational and vocational training opportunities to strengthen the regional pathway and facilitate the transition of medical students into rural and regional training. This encompasses both training and employment of doctors and therefore, requires coordinated and collaborative action by universities, Local Health Networks (LHNs) and regional hospitals, general practice and specialist colleges in the first instance, as well as Rural Generalist Coordination Units and Rural Workforce Agencies (RWAs) in relation to GP and RG pathways; highlighting the complexity of their remit.

4 PROGRAM LOGIC

The program logic is a depiction of the relationship between the resources allocated to a program, activities and intended outcomes. The logic map is useful in understanding the intent of the program, and for developing propositions that can be tested in the evaluation. Figure 4.1 on the following page presents the program logic for the RTHs, including external factors that could impact on, or contribute to, observed results. A preliminary program logic was used to prepare evaluation questions. The final program logic (in this document) was updated to reflect our deeper understanding of the RTHs and how they operate upon completion of the evaluation.

4 PROGRAM LOGIC

Figure 4.1: Program logic – Regional Training Hubs



PART B EVALUATION FINDINGS

5 OPERATIONAL FOCUS OF RTHS

This chapter sets out the findings regarding performance of the RTHs against each of the six core requirements.

5.1 CORE REQUIREMENT 1 – ENGAGEMENT OF A SUITABLE TEAM

6a. For each training hub identified in the university's funding agreement, the university must appoint a suitably qualified team, including a senior clinical academic, project and administrative staff.

Overview:

RTHs engaged clinical leadership and project officer staff. However, active engagement of clinical leadership with the health service varied by location, as did the availability of a suitable project officer. Additionally, small fractional appointments for project officer staff limited the effectiveness of RTH activities.

5.1.1 Staffing

RTHs receive funding to employ the equivalent of one full-time project officer and one part-time director of clinical training. Consultation showed that high-functioning RTHs often had a full-time or substantial part-time project officer (not multiple small fraction part-time people), and had engaged a connected clinical director who provided good support and direction to RTH staff as well as having a substantive clinical or teaching role in the health service. Examples where this occurred were North West NSW RTH, Northern NSW RTH, Western NSW RTH, Riverina RTH and Western Australian RTHs.

High turnover rates among staff were observed at many RTHs (project staff and clinical staff), with some RTHs having new staff or vacant positions during the consultation process. Several RTHs also mentioned the difficulty in securing staff, exacerbated by the lack of clarity on the RTH role.

Many project staff worked on very fractional appointments. Some universities split their RTH across two or more smaller sites, resulting in a small number of part-time staff at each site with nominal hours (e.g. 0.2–0.4 full-time equivalent (FTE)), for example:

- RTH funding is shared between the Shoalhaven RTH in Nowra and the Clarence Valley RTH in Grafton, NSW. Although Clarence Valley RTH has a full-time project officer, the associated Shoalhaven RTH staff comprise a coordinator (0.2 FTE) and an academic lead (0.2 FTE)
- Mid North Coast RTH has two sites – Port Macquarie and Coffs Harbour, NSW. The Port Macquarie campus of the Mid-North Coast RTH is staffed by an administrator (0.2 FTE), two part-time clinicians (a paediatrician at 0.1 FTE and a haematologist at 0.2 FTE) and a number of clinical leads with small fractional or conjoint appointments. Similarly, the Coffs Harbour campus of the Mid-North Coast RTH is staffed by a director (0.1 FTE), an administrative officer (0.2 FTE), and an additional small fraction clinical lead.

FINDING 1 Small fractional appointments (i.e. 0.2 FTE or less) for RTH project officer staff can limit what can be achieved in a timely fashion.

RTHs used different models for staffing arrangements. Some RTHs embedded staff within the local hospital. For example, establishing joint appointments (via a Memorandum of Understanding agreement) with the hospital and the RTH. In these instances, RTH staff were physically located in the hospital setting, reporting dually to the RCS and the hospital. This often

resulted in improved engagement between RTH and hospital staff, increased trust, and the ability to support training post accreditation, as well as increased connections with Junior Medical Officers (JMOs) and the ability to provide career pathway support. This model worked well for Northern NSW RTH Lismore (University of Sydney (USyd)), Townsville RTH (James Cook University (JCU)) and North West NSW RTH (University of Newcastle). See Box 1 and Box 2.

Box 1: Northern NSW RTH – staffing structure

The RTH is based in the Lismore Hospital in northern NSW. The RTH Program Manager has dual reporting responsibilities (to the hospital and the UDRH). The Program Manager is supported by three part-time Medical Education Support Officers (MESO), who are allocated specific areas such as emergency medicine, intensive care unit and retrieval accreditation. One MESO covers physician training, intern and PGY1 and 2 training issues, while another works two days per week on the surgery agenda and three days per week supporting the Director of Prevocational Training. This enables sufficient MESOs to focus more closely on their specific domain education and training activities and accreditation of posts, which has seen excellent outcomes in both accreditation of speciality training posts and JMOs who had undertaken their longitudinal program returning to the hospital for employment.

Box 2: North West NSW RTH – staffing structure

The North West NSW RTH staffing establishment includes a MESO and a clinical lead at each site. The Clinical Lead is the clinical dean for the site (0.4 FTE – funded through the RCS component of the RHMT program and the RTH funding). The MESOs are part of the JMO Unit for each hospital, and the Department of Rural Health contributes $50,000 per annum for each of the three positions. This clinical leadership facilitates the negotiation and development of training opportunities in conjunction with the heads of department, general practices, Health Education Training Institute, the Rural Generalist Coordination Unit, and the medical colleges. Furthermore, their regular and ongoing engagement with medical students and JMOs in teaching and supervision roles is a key mechanism for connection into local training pathways. The clinical leads are the glue between students and junior doctors, training posts, teachers and supervisors.

FINDING 2 RTH roles that were shared with the hospital and RCS enabled integration of the RTH into both organisations, which enhanced knowledge sharing. There is no one right way to structure the staffing arrangements; RTHs should maintain flexibility in how they approach this to best suit the needs of their region while considering capacity and continuity.

5.1.2 Funding

RTH funding (circa $600,000 per RTH per annum) is provided to the university RCS (or UDRH) under the RHMT funding agreements. RTH funds are used for salaries and meet the costs of the various activities delivered.

During the consultation process, it was unclear how universities distributed and used RTH funding (which did not appear to be ring-fenced). Most RTHs allocated some RTH funding to fractional appointments for staff who were also part-funded by other streams of RHMT funding. While this supported integrated training, it was not always clear whether the fraction allocated reflected the amount of work done for RTH functions as against their other fractions.

The funding model of RTHs (via the universities and RCSs) were both a strength and a weakness of the program. They were a strength because universities could prioritise the funding to areas of greatest need (e.g. creating two RTH campuses as was done by UNSW at Port Macquarie and Coffs Harbour, and by University of Wollongong at Shoalhaven (Nowra) and Clarence Valley (Grafton)). They also allowed universities to establish employment arrangements with local health services to employ RTH staff

directly with dual reporting arrangements to the hospital and RCS (for example, the arrangements at Northern NSW RTH in Lismore (USyd)).

However, the flexibility of the funding arrangements and simplicity of reporting requirements reduced the transparency of RTH spending. Note, the evaluation did not seek to undertake a financial audit of the RTHs.

FINDING 3 There is limited transparency on how RTH funding is spent.

5.2 CORE REQUIREMENT 2 – INTEGRATED RURAL MEDICAL TRAINING PATHWAYS

6b. The university must implement and maintain arrangements with relevant education professionals and health service stakeholders, including local hospitals and health services, state and territory governments, other universities, specialist colleges (including general practice colleges), postgraduate medical councils, local health practitioners and regional training organisations to support the integration of medical training at the local level.

Overview: The evaluation found that some RTHs had progressed in the development of longitudinal medical training pathways for some specialties and RGs. These were facilitated by targeted actions to respond to local need, building on relationships and linkages of RTH clinical leads with the health service. However, the commencement of the training pathway, i.e. transition of medical students to rural and regional prevocational positions, continues to be fragile.

5.2.1 Transitioning to regional prevocational training

The transition of medical students into rural and regional prevocational training, particularly those who have undertaken an extended rural placement, is a predictor for future rural work [7]. However, this early transition point, which is a key element of the rural medical pathway, is fragile.

Before the commencement of the end-to-end medical programs, medical students usually returned to metropolitan locations for their final year, disrupting the transition to regional prevocational training and potentially pursuing a rural medical career.

FINDING 4 While the RTHs were established to support the transition of medical students to rural internships, they do not have a physical presence at central campus to maintain engagement with final-year students. The exception is the WA RTH. Hence, for the majority of RTHs, there is a structural barrier to maintaining connection with students who have undertaken an extended rural placement in their penultimate year.

Several universities have established rural clinical training that spanned the penultimate and final year of the medical program to maintain the pipeline, enhancing the likelihood that students transition to regional internships (e.g. University of NSW (UNSW) – Wagga and Albury campuses, noting that Port Macquarie was established as an end-to-end program; University of Western Australia (UWA) – Bunbury, Albany, Geraldton, Broome; USyd – Lismore) as well as existing end-to-end programs (e.g. JCU - Townsville, Cairns and McKay, Flinders University – Northern Territory, and Queensland University – Central and Southern Queensland).

FINDING 5 Early indications from UNSW – Wagga, USyd – Lismore, and UWA demonstrate good transition to regional internships when medical students complete the final two years in the RCS.

Mechanisms to fill rural and regional intern and JMO positions are highly variable between and within jurisdictions, impacting the continuity of a rural medical pathway. For example, NSW Health has the Rural Prevocational Recruitment Program, where regional hospitals can directly recruit and employ a JMO on a two-year contract. This was reported by RTHs to be an

5 OPERATIONAL FOCUS OF RTHS

enabler of the direct transition of medical students into intern positions. NSW Health also operates a model where metropolitan-based JMOs rotate through regional/rural hospitals for a specialty term and impede development of local pathways. Workforce demands in metropolitan and regional hospitals can also impact rural pathways where JMOs are employed by the metropolitan or regional hospital (MM2–3) and these posts are filled before filling vacant posts in more rural hospitals (MM4–7). This model limits JMO exposure to RG roles and impacts on service capacity in rural hospitals.

FINDING 6 State/territory government allocation mechanisms for prevocational training posts can enable the transition of medical students to rural training pathways when regional hospitals can directly recruit. However, allocation mechanisms can hinder rural pathways where metropolitan hospitals rotate JMOs to rural campuses for single terms. In addition, JMOs may have limited opportunities for rural work when metropolitan campuses are prioritised above regional campuses, and regional campuses are prioritised above rural campuses.

In Western Australia, prevocational training positions were historically managed centrally, with junior doctors employed by a metropolitan hospital and rotating to regional hospitals within the network for specific terms. Recently, a proportion of JMO positions were established with Western Australia Country Health Service (WACHS) and quarantined for regional hospitals. These three-year prevocational contracts enabled medical students who undertook an RCS placement to transition to training and work in regional hospitals.

FINDING 7 Provision of two- or three-year contracts for JMOs in regional/rural hospitals can be a valuable mechanism to promote retention in rural areas and provide a rural training pathway.

5.2.2 Non-GP specialist colleges – variable focus on rural

Non-GP specialist colleges are complex entities with different training pathways and accreditation processes. The Commonwealth has invested more in promoting regional and rural training and encouraging colleges to establish or increase specialist training posts in regional and rural areas through the STP and IRTP. However, there was enormous variety in appetite for this among colleges. For example, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) developed and implemented a Rural Roadmap to progress end-to-end training in rural and regional areas; the Royal Australian College of Surgeons has progressed the rural equity strategy; and the Australian College of Sports and Exercise Physicians (ACSEP) piloted a remote supervision model as part of its rural capacity building plan. In contrast, the Paediatric chapter of the Royal Australasian College of Physicians recently ceased the requirement for their registrars to undertake a rural term. For most non-GP specialist training, registrars continue to be required to undertake a significant component of training in a metropolitan hospital.

FINDING 8 The readiness of specialist medical colleges to develop and implement rural training pathways varied greatly. Lack of rural training pathways from colleges limited other rural workforce efforts.

5.2.3 Rural generalist training pathways

When the core requirements for RTHs were released, they targeted prevocational and non-GP specialist training pathways. In addition, the requirement for RTHs to report on accredited training posts in hospitals implied a focus on specialist training, and GP training was seen in the domain of community-based training. However, some RTHs worked to develop Advanced Rural Skills Training/Advanced Skills Training posts because rural

5 OPERATIONAL FOCUS OF RTHS

generalism was the predominant model in the rural/regional hospitals in their footprint (e.g. North West NSW RTH in the Hunter New England Health District, Western Australian RTH alliance in Western Australia, and Murrumbidgee RTH in NSW). See Box 3 and Box 4.

Box 3: North West NSW RTH – creating a rural generalist training pathway

The North West NSW RTH has focused on developing RG pathways within its region to meet the service needs of the district hospitals. This has been progressed through the establishment of John Flynn Prevocational Doctor Program posts in general practices that provide Visiting Medical Officer (VMO) services to the district hospitals, coupled with the development of a breadth of AST posts in the regional hospitals. The RTH led the development of John Flynn Prevocational Doctor Program posts in:

- Scone (in place for three years) – JMOs rotate from Tamworth Base Hospital and Scone takes PGY2 in Term 1 and PGY1 for the other four terms
- Gloucester – JMOs rotate from Taree Hospital
- Moree (since 2024) – JMOs rotate from Tamworth (PGY2 only because of higher patient acuity)
- Manilla – JMO rotates from Tamworth Base Hospital and JMO is placed in general practice for 70% of time and 30% in the hospital.

These posts are filled for the full year (five terms) with continuity of JMO placements important for participating practices and the increased workforce capacity provided in hospital and general practice. The RTH is careful in the selection of practices to ensure JMOs have a good term and training experience with exposure to RG work. As such, scaling can be difficult in locations where practices are under pressure.

Working closely with the NSW Rural Generalist Coordinating Unit, the North West NSW RTH has facilitated the establishment of AST posts in Tamworth and Taree. Accredited AST posts in Tamworth include paediatrics, emergency medicine, anaesthetics, obstetrics and gynaecology, and mental health. Accredited AST posts include mental health, palliative care in Taree, and emergency medicine and obstetrics and gynaecology in Armidale.

Box 4: Victorian Rural Generalist Program and Goulburn RTH

The Victorian Rural Generalist Program (VRGP) is a coordination unit that supports an end-to-end training program for the RG workforce to train, work and live in rural and regional Victoria. In Northwest Victoria, the program is called the Murray to the Mountains program.

The program establishes vocational general practice training posts in collaboration with Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP). Last year, it matched 15 interns – 11 from University of Melbourne, one from University of Notre Dame and three from UNSW.

The program works closely with the Goulburn RTH to collaborate on training opportunities, RG workshops, mentoring programs, etc. They say that the RTH value adds to what they do and found that the RTH was instrumental in their success through early exposure to students.

With the growing focus on rural generalism, the requirement for hospital-based training for the majority of advanced skills, its imminent recognition as a specialist field in general practice, and the single employer trials that see registrars continuing employment with hospitals/LHNs as they progress through RG training, RTHs should have a greater role in development of advanced skills posts and supporting the RG workforce in future. Since the Commonwealth also funds the Rural Generalist Coordination Units in each jurisdiction to progress RG training, clarity on roles and responsibilities, and the value-add of each agency must be determined.

FINDING 9 There was variation between RTHs in the extent to which they focused on GP and RG training, mainly due to the lack of clarity in the wording of the core requirements when first released and the requirement for RTHs to report on accredited training posts in hospitals, implying specialist training as a priority. Most RTHs have an increasing focus on GPs and RGs, while

maintaining activities for non-GP specialities. Further work to clarify the roles of RTHs and Rural Generalist Coordination Units is required. This will enable targeting of regional and place-based activities that RTHs can provide to complement the broader statewide focus of the Rural Generalist Coordination Units.

5.2.4 Single employer models supporting RG and GP pathways

Many health services lacked an understanding of the potential of the RG role. This was more apparent in some states than others (e.g. rural generalism was relatively new in Victoria and pathways to employment were still developing. In Queensland, the model was in operation for a long time and was generally well understood. While, in WA there was a move to specialist-led regional hospitals that were previously GP/rural generalist-led). The focus of working from a speciality paradigm within the hospital environment meant that many regional hospitals preferenced specialist training over RG training (AST posts) and RG employment models.

Structural barriers between the hospital and general practice also limited prevocational and vocational training opportunities, such as employment models and lack of transfer of entitlements for trainees. Trials of single employer models, whereby junior doctors and registrars continue employment with hospitals as they undertake general practice rotations or progress through RG training, are likely to reduce these barriers and promote a collaborative workforce. See Box 5.

Box 5: Murrumbidgee RTH – single employer model to promote rural generalism

The Murrumbidgee RTH's major focus is rural generalism. Under the previous clinical director, the focus was on developing the single employer model for GP training, which has been implemented in the Murrumbidgee Local Health District (LHD). Based on the learnings from the Murrumbidgee single employer model and another approach in the Riverland, South Australia, a single employer model trial supported by the Department is being rolled out nationally.

The Murrumbidgee RTH states it is *'striving for a sustainable medical workforce for rural and regional Australia'.* This will be delivered by aligning training to local needs and training medical students and postgraduate trainees in regional and rural areas. Collaboration is seen as central to achieving these aims.

FINDING 10 A role for RTHs to assist with development of AST posts for rural generalism was emerging. This may further increase as single employer model trials roll out across Australia that promote integrated training across hospital and community sectors and offer more flexible employment arrangements for GPs and RGs in training to increase the attractiveness of GP and RG training pathways and careers.

5.2.5 Development of targeted and longitudinal training pathways – single site or networked

In the past, specialist colleges sought to expose trainees to regional and rural environments through a rural rotation during the training pathway, i.e. metropolitan-based trainees undertake one of their six-month rotations in a regional or rural hospital. However, this approach requires a trainee to be based predominantly in a metropolitan centre for most of their specialist training. Anecdotally, this time often coincides with life events such as settling down with a partner and possibly having children. Combined, this model may impact a trainee's intent to practise in a rural location in future.

As such, regional health services are advocating for regional medical training models whereby a trainee can be based in a regional hospital and undertake rotations with their network of rural hospitals, with metropolitan rotations limited to training that cannot be delivered in the regional hospital. This would

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then enable trainees to complete most of their specialist training in a regional or rural area, keeping with the ethos of end-to-end medical training.

Several RTHs were working with their LHNs to establish these types of regional training models in their locations, e.g. (Western Victoria RTH, North West Victoria RTH, North West NSW RTH, Tasmania RTH and Western Australian RTH). See Box 6 to Box 8.

Box 6: Western Victoria RTH – regional training pathway

The Western Victoria RTH is engaged in several advocacy activities to support the growth of the local training pathways and promote rural and regional medical training opportunities at federal, state, and local policy levels.

At a state level, the RTH engages with Barwon Health and local physicians to advocate for local health workforce needs. This included the development of a business case that went to the state government and helped secure $1 million in funding over five years to create a Western Victoria regional physician training program. The RTH is a founding member of the Southern Regional Training Hub Alliance to help develop a collaborative vision for Victoria's regional medical workforce needs. Among other things, the Alliance provides an online summary of what training programs are available in each region, undertakes an evaluation to identify strengths and weaknesses of Victoria's regional training programs, and has consistent six-monthly meetings with the federal and state governments as well as the Australian Medical Association and the specialist colleges.

At a local level, the RTH has a strong connection with the University of Melbourne and Notre Dame RCSs, which also have students in Ballarat that the RTH supports. The RTH also works closely with the local coordinator of the VRGP for the Barwon – South West Region, who is based at South West Healthcare near the RCS and RTH. The RTH and the local branch of the VRGP collaborate on events, and the RTH provides the VRGP with early access to students to promote its program. The RTH also has good relationships with local connections at ACRRM and RACGP, as well as the Western Victoria PHN and supports each of these organisations to deliver information to local junior doctors.

Facilitating the creation of regionally based specialist training programs

A major role and area of significant achievement for the RTH has been to facilitate the creation of specialist college training programs within the Western Victoria region. The RTH has been heavily involved in the development of Western Victoria's *General Physician, Psychiatry and Obstetrics & Gynaecology* programs, while also supporting the administration of the *General Surgical program*. More recently, the RTH is a member of the working group developing the Australasian College for Emergency Medicine's Accredited Training Network program, piloting a regional networked training program with a flexible supervision model.

The creation of the region's college-accredited training programs builds the pathway from medical students to fellowship. They provide the opportunity to undertake all or most of their training in the region while also meeting the individual's family and lifestyle needs.

Basic Physician Training, Grampians Health – Ballarat

Grampians Health Ballarat is a Level 2 teaching hospital and is part of the Greater Western Basic Physician Training Consortium. Basic Physician Training (BPT) is offered at Ballarat Hospital.

BPT Year 1 trainees (BPT1s) rotate through a selection of the following rotations: oncology, cardiology, general medicine, neurology, gastroenterology, emergency medicine, medical admissions, hospital in the home, haematology, perioperative, intensive care, medical night, rehabilitation and palliative care.

BPT2s and BPT3s get exposure to medical registrar jobs, including ward-based general medical registrar roles, admitting registrar, oncology, cardiology, neurology, hospital in the home, aged care, palliative care, and rehabilitation medicine.

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The BPT teaching program also includes a fortnightly Grand Round, case report/journal club, weekly unit-specific education meeting, exam preparation support, mentoring sessions, etc.

Advanced Training in General Medicine, Grampians Health – Ballarat

The Internal Medicine Services at Grampians Health Ballarat provides advanced physician training positions in General Medicine and Acute Care Medicine. The program offers six-month specialty rotations at Grampians Health, University Hospital Geelong, Barwon Health and South West Health Care in Warrnambool through the Western Victoria RTH. Trainees can complete all of their advanced physician training in Western Victoria.

Rotations include respiratory, cardiology, infectious disease, gastroenterology, neurology, general medicine, intensive care medicine, perioperative medicine, haematology, oncology (college appointed), and renal (rotation is via rotation from Royal Melbourne Hospital).

Box 7: Western Australian RTH – championing rural specialist training pathways

The rural psychiatry training program was developed by Dr Matt Coleman, Psychiatric Clinical Lead with the Great Southern RTH, Albany, to establish accredited psychiatry training posts in the Western Australian regional hospitals so that psychiatry registrars could undertake the majority of training rurally. The Western Australian rural training pathway has been foundational to the development of the RANZCP Rural Psychiatry Roadmap [16] implemented at a national level.

To a large extent, the Western Australian RTH have taken a whole of pathway approach to developing rural pathways, initially psychiatry, more recently palliative medicine and now paediatrics. This enables an efficient approach to developing accredited specialist training posts and can concurrently focus on developing an advanced skills post for RGs in the same location.

Box 8: North West NSW RTH – regional psychiatry pathway

At the establishment of the North West NSW RTH, a needs assessment was conducted to determine capacity for and feasibility of establishing specialist training pathways in the Tamworth, Taree and Armidale region. A key decision at the time was for targeted and longitudinal training opportunities rather than an ad hoc approach to developing a range of accredited training posts in the region.

Psychiatry was identified as training that could be networked across the Hunter New England Health District. It was determined that basic training could be delivered in Tamworth, including the two 'pinch point' mandatory terms – Child and Adolescent Mental Health and Consultation Liaison – making Tamworth a desirable training location. To enable the establishment of the Consultation Liaison term, the North West NSW RTH entered into a service agreement with the Mental Health Division and allocated $44,000 per annum for supervision and support of the Consultation Liaison post as well as providing teaching during psychiatry terms for JMOs and medical students. End-to-end psychiatry training is now in place in Tamworth and psychiatry registrars are in positions.

Development of regional medical training pathways needs to be a joint effort among universities, hospitals/health services, colleges and state/territory governments to bring together elements of sustainable training and employment pathways, as follows:

- funding the job/post
- accreditation of posts/terms – across the pathway
- recruitment
- metropolitan link – for rotations of rural junior doctors to get metropolitan experience, or their contract with the rural LHN to facilitate rotations to metropolitan areas for key training terms that cannot be done in the local area
- ongoing and continuity of supply of trainees and supervision

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FINDING 11 Some RTHs worked with health services, GP colleges and non-GP specialist colleges to establish regional training networks in their location. In future, RTHs could play a significant role in this area.

5.3 CORE REQUIREMENT 3 – DEVELOPING NEW MEDICAL TRAINING CAPACITY

6c. The university must facilitate the development of new medical training capacity through activities including, but not limited to, assisting health services in accreditation processes for new posts; and supporting local health professionals to become supervisors.

Overview: Under this core requirement, RTHs worked with hospitals to develop and accredit new training posts. However, there was variability in the extent to which this support was embraced by hospitals – some RTHs were the 'go to' for assistance, while other hospital executives did not see this as a role for the RTH for several reasons including existing capability within the hospital to develop accredited positions and that funding and resourcing of posts is the responsibility of the health service. Many RTHs reported activity to support supervisors and/or develop supervisor capacity – targeting GPs, registrars and junior doctors and doctors working in unaccredited roles. However, the reach of this activity within and across RTHs was unclear.

5.3.1 Funding and filling accredited posts

Under the core requirements of the RTH contracts, RTHs are intended to contribute to the accreditation of specialist training posts to build regional medical training capacity. Many RTHs reported activities to assist with accreditation activities. These ranged from minimally assisting with identifying training position needs, to assisting in developing the submission for accreditation and communicating with the specialist colleges. Recently, RTHs also included a focus on RG advanced skills posts.

Only four RTHs reported a detailed understanding of accreditation issues, assisting with submissions and the complexity of how specialist colleges work. A further five RTHs reported strong collaborations with specialist colleges, mostly ACRRM and RACGP.

The types of training posts being accredited successfully were often in areas where clinical leads had specific expertise and/or where the professional officer had a grounded understanding of the accreditation process and supported the local consultant in their application. While there was a spread of training posts by discipline, the most common accreditations reported were in emergency medicine, palliative care and paediatrics, as well as some in general practice and rural generalism.

However, securing accreditation is only the beginning. Time investment in developing accredited posts must be complemented with funding from state/territory governments, the Commonwealth STP or IRTP, and more recently, the Commonwealth Advanced Skills Training Posts for Rural Generalists and General Practitioners Program (commenced 2024). The reliability and timeliness of funding for an accredited post need to align with the availability of a suitable applicant and adequate supervision capacity (which can fluctuate with changes in personnel).

These issues speak to the importance of robust workforce and training plans at a regional level that span primary, secondary, and tertiary care while also recognising the opportunity for flexibility in filling vacant posts (for example, RG advanced skills training if a specialist registrar cannot be recruited).

FINDING 12 The RTH core requirements outline a role for the RTHs in assisting in accreditation processes for new posts to facilitate medical training capacity. However, RTHs have no authority to allocate posts or funding to support the filling of posts.

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FINDING 13 Many RTHs reported feeling like a *'toothless tiger',* beholden to others to achieve their objectives. Therefore, it was challenging to measure the impact and influence of the RTH when broader system-level issues are in play.

5.3.2 Accreditation of non-GP specialty training posts

The evaluators found that most RTHs focused predominantly on non-GP speciality training pathways based in hospitals through training post accreditation. The extent to which RTHs provided this type of support varied and was dependent on several factors, such as the following:

- **Relationship with the hospital.** While many hospitals embraced the additional support and staffing resources made available through the RTH, some hospitals remained disconnected and cautious of accepting what was perceived as outside help or feared loss of control. This often depended on the personality of the hospital executives and/or the RTH director/clinical lead.
- **Employment arrangements of staff or physical location of staff.** As detailed in section 5.1.1, RTHs that housed staff at the local hospital and/or had employment arrangements with the hospital for RTH staff often had closer relationships and, therefore, provided more support for training post accreditation. Where RTH staff were based in the hospital setting, there was much greater understanding and integration of the RTH role and much more extensive outcomes. This was further strengthened when the RTH clinical leads are also clinically active (as employees or VMOs) in the hospital. Where RTH staff were primarily based in the RCS, hospital staff reported little understanding of the RTH role and how to engage them. During consultation, a few hospital consultants reported that they didn't know what the RTH did, nor how the RTH could assist them with issues such as accreditation of speciality training posts. Examples where RTH staff were based in the hospital setting included Townsville RTH (JCU), Northern NSW RTH (USyd), North West NSW RTH (University of Newcastle), and Western Australian RTHs (where the clinical leads also hold positions within the WACHS).
- **College accreditation and available posts**. As detailed in section 5.2.2, there was considerable variability in the readiness of specialist colleges to introduce rural training pathways for fellowship. In addition, the allocation of training posts by state/territory governments can sometimes work against filling rural and remote posts by preferencing regional hospitals (see section 5.2.1).

5.3.3 Supervisor capacity building

RTHs reported offering supervision training, directed to junior doctors, registrars, GPs and international medical graduates (IMGs). These were often short courses or workshops such as 'Teaching on the Run', leadership training, cultural awareness workshops and networking events. While some RTHs provided data to the evaluation on the number attending various training activities/events it was not clear to what extent these activities reached potential participants.

The North West Victoria RTH developed a specific course to develop supervision skills, initially targeted to unaccredited doctors but with applicability for all doctors. See Box 9.

Box 9: North West Victoria RTH – Clinical Teaching and Education Pathway

North West Victoria RTH developed the Clinical Teaching and Education Pathway (CTEP) program to support unaccredited doctors develop supervision skills. The program enables unaccredited doctors to have confidence and competence to supervise medical students when they do not have access to training through specialist colleges. The CTEP is a three-stage pathway to provide training in collaboration with Monash University's Monash Centre for Scholarship in Health Education (MCSHE). The three stages are as follows:

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- **Stage 1:** a four-hour workshop delivered in person on location by a trained RTH staff member. The RTH developed the curriculum and delivery model. This workshop focuses on the basics of clinical supervision with location-specific/tailored context and scenarios.
- **Stage 2:** a full-day (or two half-day) in-person workshop delivered by a trainer from MCSHE. The focus of this workshop is on effective supervisory practices, advanced feedback conversations, and challenging situations. This workshop is a component of the Quality and Supervision Course from MCSHE.
- **Stage 3:** Quality and Supervision Course assessment. This involves eight to 10 weeks of reflective practice (using an audio diary), providing feedback on other participants' audio diaries (participants work in pairs), a 1,000-word reflection summary and a 3,000-word project report.

Although originally developed for unaccredited registrars, the RTH found the CTEP applicable to all doctors in their region, including GPs.

FINDING 14 At a national level, approximately 14,000 doctors working in unaccredited roles in metropolitan and regional hospitals are not on a training pathway and are currently an untapped supervision resource. Identifying this cohort and extending the RTH-managed professional support activities to them has the potential to increase their contribution to local training capacity and connect them to regional/local training options.

5.4 CORE REQUIREMENT 4 – SUPPORTING STUDENTS INTO RURAL CAREERS

6d. The university must identify university-level medical students with an interest in rural practice and provide them with support, including assistance with career planning, placement opportunities and access to mentoring.

Overview: Although this core requirement specifies targeting university-level medical students, the evaluation found that most RTHs focus on medical students and junior doctors, with many including registrars in vocational training as well as GPs, specialists and IMGs in their professional support, networking and continuing professional development activities.

5.4.1 Reported activities of RTH to promote rural health careers

The evaluation identified that RTHs provided numerous innovative and locally relevant programs to support students and junior doctors to consider a rural career and pathway to rural practice. The majority of RTHs reported undertaking the following types of activities:

- **education activities**, workshops and sessions, or assisting local clinicians in the organisation of these sessions – these were many and broad ranging, and often focused on discipline-specific content, e.g. sexual health, emergency medicine, advanced life support, wellness events and rural days
- **career events/days**, promotion and marketing events, including some high school events and social events such as dinners and trivia nights to promote networking among medical students, junior doctors and local clinicians
- **professional support** for medical students, JMOs, supervisors and (to some extent) registrars. This tended to focus on lifelong career and health and social supports. Examples included:
  - **career planning** (either one-on-one or as part of a small group), including curriculum vitae development and assisting junior doctors plan their rural pathway
  - **mentoring programs** and advocacy work
  - **orientation programs** for medical students and junior doctors

- **networking activities** and collaboration within the RTH network (including website contributions), RCS staff, hospital staff, and other organisations in their region. A few RTHs engaged with their local PHN, and some with local Rural Generalist Coordination Units.

FINDING 15 RTHs targeted medical students for career planning and support to consider rural practice. This effort also extended to JMOs, registrars and other local clinicians, including IMGs. Acknowledging the importance of professional support activities to foster a rural identity and enculturate medical students and doctors into rural practice, it is important that RTHs continue to focus on medical students and doctors across the career continuum.

5.4.2 Extended rural cohort versus end-to-end training

The introduction of the MDMSN in 2021 resulted in RCS having both end-to-end students and extended rural cohort students at the RCS and on placement in the region. This combination of student cohorts will grow as more universities commence end-to-end programs, e.g. Deakin University in Victoria, University of Notre Dame in Western Australia, University of Wollongong in NSW, University of Tasmania, Flinders University in South Australia and University of Queensland.

The evaluation sought to understand if there was any difference in the RTH services provided to end-to-end students compared to extended rural cohort students. Based on case study interviews at the MDMSN university sites (UNSW, USyd, University of Melbourne and Monash University), the evaluators found that RTHs did not make any distinction between students at the RCS (or on placement) who were in an end-to-end medical training program versus an externed rural cohort program on placement.

FINDING 16 End-to-end and extended rural cohort students receive the same services from the RTH at their respective universities.

5.4.3 Engagement with foreign graduates of an accredited medical school (FGAMS) and students with bonded medical program (BMP) places

As previously noted in section 5.2.1, there are structural barriers for RTHs to engage with metropolitan-based students, with only one RTH (WA RTH) having a physical presence at the city campus. Consequently, RTHs did not report engagement with FGAMS and BMP students who were city-based.

FGAMS are not eligible for the Commonwealth-funded extended rural cohort or end-to-end training programs under the RHMT program. Therefore, FGAMS are located at metropolitan-based campuses for the entirety of their medical degree, and unknown to RTHs. Similarly, only a proportion of students with BMP places are in extended rural cohort or end-to-end medical programs. BMP students who do participate in extended rural cohort or end-to-end triangulation were therefore unknown to the RTHs.

This is problematic since FGAMS are required to intern in regional locations under the moratorium, and bonded medical students have a three-year return of service obligation to work in a regional area.

FINDING 17 Lack of engagement with FGAMS and bonded medical students who are city based is a missed opportunity for RTHs.

5.5 CORE REQUIREMENT 5 – IDENTIFYING WORKFORCE NEED TO INFORM TRAINING PLANS

6e. The university must identify areas of regional medical workforce need within their catchment area, and work to build medical training capacity in these areas.

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Overview: The RTH role in identifying workforce needs duplicates the work of other players, including state/territory governments, health services, PHNs, RWAs, and Workforce Planning and Prioritisation Project (WPPP) agencies. In the future, RTHs could bring all parties together for comprehensive regional workforce planning, but this does not appear to happen currently.

5.5.1 Integrated regional workforce planning

Provision of medical services in rural areas is a collaborative system whereby smaller rural hospitals are networked to larger regional hospitals, primary care is often the only medical service in remote locations, and RGs are used in rural areas to supplement the hospital workforce. Developing a pipeline of medical workforce training cannot be done in isolation because of the interconnectivity of the service system. Instead, each region must collectively determine its workforce needs and the most suitable way to address them.

The evaluation found regional health services did not have their own workforce plans in many instances. Those that did tended to focus on immediate workforce shortages with inadequate attention to the future needs and the region's wider workforce needs covering public, private, primary and acute care, to inform training priorities. The evaluation only identified eight RTHs that reported having a workforce plan or strategy in conjunction with the health service, typically developed by the health service.

FINDING 18 Through the core requirements, RTHs are tasked with identifying areas of regional medical workforce need within their catchment area to build medical training capacity. However, many players in this space already exist, including state/territory governments, health services, PHNs, RWAs, and WPPP agencies. RTHs could bring all parties together for comprehensive regional workforce planning in the future, but this does not appear to happen currently.

5.6 CORE REQUIREMENT 6 – REPORTING ON TRAINING PLACEMENTS IN THE REGION

6f. The university must report on the training placements available at each level of the medical training continuum within each hub's region of activity.

Overview: RTHs experienced challenges obtaining training post data because they are not the data custodians, and the rationale for reporting the data was not transparent.

When the RTHs were established, they were tasked with mapping and reporting on training posts. This created tension as this data was held by the LHNs/hospitals and medical colleges (GP and non-GP), and it was not clear why or how it would be used by the RTHs [17]. This was reported to be a challenge by some RTHs still.

The NSW RTH Network, the Southern RTH Alliance and Tasmanian RTH have developed an online resource that maps vocational training opportunities in Southeast NSW. The website includes information on career advice, vacant positions, and if they are funded, available or filled. It is important that the currency of these websites is maintained to be a useful resource to medical students, junior doctors and registrars.

FINDING 19 Some RTHs experienced challenges obtaining training post data because they are not the data custodians, and the purpose of reporting the data to the RTHs and subsequently the Department was not clear to the data custodians or the RTHs.

FINDING 20 Some RTHs developed websites that provide training post information for medical students, junior doctors and registrars. The value of these websites is reliant on the currency of information being maintained.

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5.7 ARE THE RTH CORE REQUIREMENTS FIT FOR PURPOSE?

Since their inception in 2017, the RTHs have evolved to reflect the regional needs and the changing workforce environment, which includes increasing reliance on IMGs, growth in the number of unaccredited doctors working in metropolitan and regional hospitals and increasing supervision load carried by rural and remote fellows (inclusive of GPs and specialists). RTH stakeholders identified several areas where the core requirements were no longer fit for purpose and needed to be refreshed.

Furthermore, the core requirements lack clarity in that they are specific to medical students (6d) yet seek to support students through to postgraduate training, which requires direct attention to junior doctors and registrars. Given the importance of general practice and RGs in rural and remote areas, these training pathways should also be highlighted in the core requirements.

FINDING 21 The current wording of the suite of core requirements creates confusion on the scope of the RTH remit, i.e. medical students only or inclusion of junior doctors and registrars. The nature of rural medical workforce and training also makes it challenging to silo efforts to one cohort along the pathway.

Additionally, geographic structural barriers challenge the engagement of RTHs (based in regional areas) with international medical students (located in the metropolitan campus) who must undertake internships in regional areas upon graduation. Similar challenges are encountered in engaging with bonded medical students who do not undertake an extended rural placement.

The core requirements also need to include a focus on building and maintaining vertical training and supervision capacity to support regional training pathways in line with the priorities of the National Medical Workforce Strategy.

Conversely, the requirement for RTHs to identify medical workforce need duplicates the contract requirements of the RWAs, WPPP agencies, PHNs and the work of LHNs that undertake their own workforce plans. A better use of RTH resources would be a requirement that they work with the LHN, RWA, prevocational medical council, GP and specialist colleges to address their identified workforce needs at a regional level.

Finally, the core requirements would be strengthened through the inclusion of outcome measures (see Chapter 4, Program logic) that enable a focus on desired outcomes rather than process measures that may or may not be effective.

FINDING 22 The current RTH core requirements lack attention to supervisor capacity and outcome metrics to demonstrate the effectiveness of the RTH activities.

6 OPPORTUNITIES TO EXTEND RTH REACH AND SCOPE

This chapter presents a discussion on future opportunities for RTHs to extend their scope and reach. Taking up these opportunities would require changes to the current RTH parameters, and possibly RTH governance and funding arrangements.

6.1 PROFESSIONAL SUPPORT FOR IMGS

The evaluation identified a number of activities pursued by RTHs that could be considered outside scope of the RHMT program. These were predominantly focused on IMGs, who are excluded from support under the RHMT program. However, as regionally based entities, hub staff were cognisant of the composition of the local workforce and needs. Some RTHs developed specific responses while others have sought to include IMGs working in regional hospital and general practice in professional support activities they offer.

The IMG workforce often requires additional professional support measures to understand the Australian health system, cultural differences, communication and consulting skills, and regulatory requirements. Several RTHs in Tasmania, Western Australia and NSW commenced work in this space in response to local need. This work often built on existing activities for junior doctors working in hospitals and with their GP community. See Box 10 and Box 11.

Box 10: Northern NSW RTH – IMG training program

The IMG training program was developed to support the recruitment and retention of IMGs to Northern NSW Local Health District. It was designed by a senior emergency medicine specialist (an IMG) and clinical director of the Lismore RTH in conjunction with other specialists, and medical administration. While the IMG training program commenced in 2018, it was able to incorporate the JMO program (commenced in 2010) and together provided a foundation to become an accredited Workplace Based Assessment (WBA) site in 2021.

The Integrated IMG training program incorporates a three-month orientation program to the local hospital and service system inclusive of observership, skills assessment, training and supervision to develop the doctor's clinical readiness and preparation to transition to WBA program at Lismore Base Hospital. IMGs in the WBA program are integrated into the JMO program and undertake 10-week rotations and required assessments in medicine, surgery, obstetrics and gynaecology, paediatrics and mental health, as well as additional courses to develop emergency skills.

In addition to clinical training, IMGs have a tailored Orientation Manual providing information on Australian Health Practitioner Regulation Agency registration and continuous professional development requirements and other online resources. A WhatsApp – IMG Support Group has been established for all IMGs working at Lismore Hospital and other hospitals in the LHD to enable them to ask questions of each other. The RTH provides local information to support the doctor and their family in obtaining rental accommodation, advice on schools and enrolment processes, and invitations to participate in JMO educational and social events.

Box 11: Western Australian RTHs – supporting IMGs into and on their training pathway

IMGs are a significant component of the rural and remote Western Australian workforce in both regional hospitals and general practice. There is variation between RTHs in Western Australia in their involvement with IMGs, partly

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because of the differences in regions in their reliance on IMGs, i.e. heavily reliant in Kalgoorlie and Geraldton but limited numbers in Albany and also because of differences in the engagement between the local hospital and the RTH. The RTHs offer a range of professional supports to junior doctors, i.e. vocational guidance and career planning, mentoring, peer networks, as well as supporting access to continuing professional development, and there is the opportunity and willingness by the RTHs for this to be extended to IMGs.

A key challenge identified by the RTH in Kalgoorlie (and echoed by other stakeholders in Western Australia and other jurisdictions) was the difficulty of engaging with IMGs as there was no mechanism for the RTHs to be alerted that new IMGs were in the area, i.e. by the GP colleges for IMGs on the Fellowship Support Program, and also in regional hospitals. The key barrier was concerns around sharing the IMG's contact details with other agencies.

While the Northern NSW RTH is working with IMGs undergoing the WBA in a purposeful program, the Western Australian RTHs are working in a more ad hoc manner. There is opportunity for RTHs to engage with IMGs on the Pre-Fellowship Program[1] and Fellowship Support Program and Independent Pathway[2], enabling them to tap into local networking and education activities. Identifying IMGs in these programs would require access to contact details from the RWAs and RACGP, respectively.

FINDING 23 The regional nature of RTHs and the increasing reliance on IMGs in regional and rural locations place them in an opportune position to provide professional support for IMGs within their remit.

6.2 RESPONDING TO OVERCROWDED RURAL MEDICAL TRAINING FOOTPRINTS

The establishment of the end-to-end medical education programs under the MDMSN, in addition to the extended rural placements under the RHMT program, highlighted issues of crowded training footprints, competition between universities for placements, and challenges for local clinicians in teaching and supervising students across different programs and curricula in some locations. With more end-to-end programs being funded by the Commonwealth, these tensions may become more apparent and widespread.

RTHs and RCSs operating in the same footprint have a responsibility to the health services and primary care practices to present agreed clinical placement schedules that are acceptable to the service providers. The impost should not be on the health services to coordinate placements from multiple universities. Nor should the health services have to search for information on placement objectives – it should be made clear from the outset so clinicians and students can maximise the placement opportunity.

There are examples in the Riverina where the RTH has sought to bring four universities together to better plan student placements in Griffith and Wagga Wagga. Under the current model, RTHs are closely linked to their parent university/RCS. However, when the number of universities operating in a catchment area increases, RTHs will need to be 'agnostic' and work across universities and with local/regional hospitals to grow and manage student placements in future. This will also benefit students from universities that do not have an RTH, such as Charles Sturt University (CSU). See Box 12.

[1] Commonwealth-funded program that allows pre-vocational doctors to gain general practice experience before commencing vocational training.

[2] Self-funded GP/RG vocational training programs offered through the RACGP and ACRRM, respectively.

6 OPPORTUNITIES TO EXTEND RTH REACH AND SCOPE

Box 12: Murrumbidgee footprint – Murrumbidgee RTH and Riverina RTH

There are two RTHs located in the Murrumbidgee LHD: Riverina RTH (University of Notre Dame Australia (UNDA)) and Murrumbidgee RTH (UNSW). There is a strong relationship between the Riverina RTH and the Murrumbidgee RTH in Wagga Wagga. Although they are located in the same footprint, they work collaboratively with the intent to focus on different areas to avoid duplication of effort. However, the Murrumbidgee RTH acknowledged that there was some local confusion about the role of the two RTHs and a perception of overlapping roles. The RTH Murrumbidgee Director speculated that many would not mind if the RTHs were amalgamated, provided the funding stayed in the region.

In addition, multiple universities have medical students studying in and on placement across the Murrumbidgee LHD, including Wagga Wagga, Griffith, and its surrounds: UNDA, UNSW, University of Wollongong, and the recently established CSU medical program.

The introduction of CSU student placements caused some friction in Wagga Wagga and Griffith primary care services and hospitals. UNDA Riverina RTH played a key role in working with the academic leads from CSU, UNDA, UNSW, University of Wollongong and medical administration to develop principles for placement sharing and scheduling, particularly in Griffith Hospital. The process has been formalised with an established Terms of Reference that identifies key participants, such as senior medical personnel from each university and a rotating chair. While meetings have occurred and placement schedules have been developed, there appear to be ongoing challenges in adherence to schedules by (some) universities, and hence scheduling tensions have not been resolved. This has been particularly difficult in Wagga Wagga where it was not expected that the CSU would have had an interest in developing placements.

That said, the collaboration process requested by local medical administration and enabled by UNDA Riverina RTH on their behalf, resulted in a tripling of the number of placements in the Griffith Hospital Emergency Department by scheduling placements in mornings and afternoons and opening up placements on weekends. UNDA is now planning to explore this mind mapping model in other sites where there are multiple universities, e.g. Bathurst/Lithgow where UNDA, CSU and Western Sydney University place students. It was reported that the principles and mind map approach are also useful when students from outside the 'usual university footprint' (e.g. Australian National University, USyd, Macquarie University) are seeking a specific placement. The Murrumbidgee Local Health District Medical Administration has also requested the Riverina RTH to support and facilitate placement of medical students from outside the LHD footprint with rural elective placements within the Murrumbidgee LHD.

Finding 9. The RTH's role is to provide professional support to medical students and junior doctors and collaborate with health providers regarding clinical placements and training posts. Therefore, the focus of the RTH needs to be region-wide. Combined with the external confusion when multiple RTHs operate in one region, this presents an argument that RTHs should be agnostic of universities and represent all students and health services within a region. This will in turn benefit students at universities without an RTH. However, it may introduce challenges in funding arrangements, which are currently administered through universities.

6.3 STATEWIDE PARTNERSHIP MODEL

The Western Australian RTH has a unique model that operates as an alliance of RTHs, resulting in coverage of the state across seven regions, while leveraging statewide roles to reduce duplication and increase advocacy. This is a model that could be replicated in other locations as needed. See Box 13.

Box 13: Western Australia RTHs

The RTHs in Western Australia operate within the RCS of Western Australia (RCSWA), a partnership of the UWA and UNDA – Fremantle and Curtin University. The RTHs are funded by the Australian Government via the RHMT

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program with funding to UWA. UWA auspices the RCSWA and hence the RTHs.

The RTHs have teams located in the seven regions of WACHS: Southwest (Bunbury), Midwest (Geraldton), Great Southern (Albany), Goldfields (Kalgoorlie and Esperance), Wheatbelt (Narrogin and Northam), Pilbara (Karratha) and Kimberley (Broome). In addition, there is a central team based at UWA in Perth.

The RTHs have evolved over time with the intent to develop programs that can be implemented across the RTH sites, while recognising the need for nuancing relevant to local context. This has resulted in the increase in type and reach of activities and opportunity to incorporate learnings across sites as programs are implemented. This is facilitated by alternating weekly virtual meetings of professional staff one week and all staff the other. The model is underpinned by the leadership of the RCSWA, which gives autonomy and agency to the hubs to do what is best at a local, regional, state and national level to get the best outcome.

Benefits of staffing arrangements

Crossover roles for RTH medical coordinators and RCSWA medical educators. A number of the RTH medical coordinators also have or previously had a medical educator role with the RCSWA. This crossover enables students to get to know them as medical educators and then connect again with them as interns and registered medical officers when they return to a site. For the student/ junior doctor, this crossover offers continuity of training program support, and ongoing engagement with a clinician they know for mentoring and career guidance. Students and junior doctors can see an accessible and supported pathway. Furthermore, the inter-connectedness of the hub sites is a conduit for students and junior doctors seeking to move across sites.

Medical coordinators have active roles in hospital, general practice and/or medical colleges. A number of RCS and/or RTH clinical staff may also be employed by WACHS, a private hospital (St John of God), private general practice and/or have a VMO appointment or hold a role with a medical GP or non-GP college. Many of the clinical staff have been in their region for a significant period (often in various roles). They are well connected and have good relationships with other key people in key positions or other agencies. This provides opportunity to leverage the relationships to address local/regional, statewide and national issues and develop regional medical training opportunities. Examples include:

- The development of the Rural Psychiatry Training Pathway led by the Psychiatry Clinical Lead in Great Southern RTH, which is now being implemented nationally under the RANZCP Rural Psychiatry Roadmap (2021–2031)
- Establishment of the Rural and Remote Institute of Palliative Medicine, which supports the development of rural training pathways for Specialists in Palliative Medicine and offers advanced and generalist training in palliative medicine in WA (and other jurisdictions). The Palliative Medicine RTH Clinical Lead was instrumental in its development.

Locally based and engaged across the medical teaching and training continuum. Key benefits of the WA RTH model are active involvement of local clinical and professional staff in the medical education and training continuum (medical students through to fellowship); networking and professional support to medical students, junior doctors, registrars and fellows (across GP and non-GP specialties); coordination of the training system at a local/regional level; and opportunities to link medical students and junior doctors with future employers.

Regional WACHS medical educator staff in Geraldton identified the RTH/RCS staff as the '*cement (in the training system) because they are local*'.

While WACHS medical educators in central office (Perth) were of the view that RTH funding would be better directed to WACHS, this was not a view held by other stakeholders (internal and external to WACHS).

Statewide model – share learnings and opportunities across the state. With the statewide RCS and RTH model there is the opportunity to share learnings

and ideas with other hubs – contextualised for place (as outlined in the next section). It also offers a 'one-stop shop' where WACHS and the RCSWA/RTH can negotiate at a state level but implement at a regional/place level.

State-level negotiation – regional implementation: Establishment of WACHS rural internships. Historically in Western Australia, interns were employed by and seconded from large Perth hospitals to regional hospitals. One shortcoming of this approach was the lack of continuity of supply of junior doctors to the regional sites when the tertiary hospital was short staffed. This resulted in service breaks in the regional hospital.

The consolidation and expansion of WACHS employed rural intern positions evolved from the development of the 4th year program/final-year program by RCSWA where students could do Years 3 **and** 4 with RCSWA. The final-year program was initiated in Bunbury in 2019. At this time, Bunbury had five intern positions, and the establishment of the final-year program enabled and provided the option for the transition of final-year students to an intern position in a community and hospital where they were already established. In 2020 the number of intern positions increased to 10 and subsequently to 15 in 2025, partly due to the final-year program and supply of interested students for these positions. Similar expansion of intern positions and uptake by final-year students has occurred in Albany. Building on this success has been a coordinated approach to implementation of the final-year program and WACHS internships in Broome, and earlier than planned WACHS internships in Geraldton due to student demand.

Furthermore, because the RCSWA could demonstrate student demand for internships in regional hospitals, the Australian Medical Association successfully negotiated with Western Australia Health to develop three-year contracts for JMOs with WACHS inclusive of the intern year. There are now 35 internships with WACHS located in Bunbury, Albany, Geraldton and Broome.

The benefit to WACHS has been the maintenance of service capacity, the intern knowing the hospital/WACHS system (because they have been a student there for two years), high-calibre candidates (RCS trained), already having had the 'long interview' so should be a good fit in the hospital, and, with a three-year contract, the junior doctor can move around WACHS hospitals.

A spin-off of the establishment of WACHS internship positions in regional hospitals has been additional funding for the Education Registrar position within the Medical Education Unit to support the intern education and wellbeing program. In Geraldton, this position also supports the orientation of IMGs into the hospital system, where 85% of registered medical officers (i.e. 30 doctors) are IMGs.

FINDING 24 Many of the RTH success stories are translatable to other locations, but this should be considered on a case-by-case basis.

6.4 ENABLERS AND CHALLENGES

This section summarises some of the key enablers and challenges identified during the evaluation, as shown in Table 6.1 on the following page.

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Table 6.1: Enablers and challenges

ENABLERS	CHALLENGES FOR RTHS WITHIN THE SYSTEM	CHALLENGES FOR RTHS TO DRIVE CHANGE FOR REGIONAL PATHWAYS
Crossover roles for RTH and RCS personnel (or very strong connections) enables continuity of engagement with students as they transition to intern/prevocational training (or come back)	**Lack of clarity** of the role of RTHs when there are multiple actors, for example: • accreditation of training posts – roles of the hospital, colleges and RG Coordination Units • workforce planning – roles of state/territory governments, LHN, WPPP/PHN and RWA • JMO support – roles of JMO Units, hospital medical education units, hospital Directors of Clinical Training	**Limited supervision capacity** to support development of training opportunities when there is such a large locum workforce; and/or **rigid college supervision requirements** that are metro-centric and do not consider more flexible options in regional settings
RTH clinical leads are active in local hospital/ health services, colleges and/or at state level – promotes advocacy and development of training pathways	**RTH core requirements** – as RTHs have matured and the training landscape has evolved, the existing core requirements may not be fit-for-purpose	**Structural barriers between the hospital and general practice** – limiting prevocational and vocational training
Use structural enablers – (1) geographic alignment of RTH footprint and LHN; (2) embedding RTH staff in key positions in LHN clinical leadership and medical education units	**Information sharing barriers** impede the ability of RTHs to identify and engage with doctors in the community, i.e. IMGs, participants on college training pathways such as the Fellowship Support Program, Pre-Fellowship Program participants, and GP/RG registrars in hospitals (prior to GPT1)	**Funding and/or continuity of funding from state/territory governments and STPs** to employ trainees to fill new accredited posts
Use RTH professional support activities for engagement and networking – medical students, junior doctors, registrars, supervisors and fellows	**RHMT program limits scope** of RTHs to respond to needs of IMGs and engage with FGAMS	**Churn of hospital administrators/health service executives** – creating a need for RTHs to continuously (re)build relationships with hospital executives in order to have a seat at the table for workforce planning and development of innovations

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This chapter presents recommendations to the Department for the future of the RTH program. The evaluation found that, overall, RTHs provided valuable services to universities, medical students, junior doctors, health services and supervisors within their regions. While all RTHs undertook similar core activities, there was considerable variability in the effectiveness of the RTHs within their region, often hindered by limited engagement with the health service, lack of workforce planning for the region, small FTE of staff, and lack of clarity of the funding core requirements.

The evaluation also found that RTHs should be agnostic of the host university so that they can have a region-wide focus for all medical students/junior doctors via one RTH per region. This, along with greater transparency of roles, would create greater clarity for health service and primary care regarding the role of RTHs and how to engage with them effectively.

Based on the evaluation findings, several recommendations for improving the RTH program in the future are presented under three options that are additive (not mutually exclusive), as follows:

1. **Option 1 – Minor change:** RTHs remain under RHMT
2. **Option 2 – Moderate change:** Expanded scope of RTHs with complementary funding mechanisms
3. **Option 3 – Major change:** Integrated Rural Medical Workforce and Training Strategy

7.1 OPTION 1 – MINOR CHANGE: RTHS REMAIN UNDER RHMT

Recommendation 1 The Department should continue to fund the RTH program.

When engaged with health services and regional stakeholders, RTHs were effective and valuable assets supporting students and doctors across the medical career continuum within their region. While some RTH activities were found to be duplicative with other entities, **the RTH's intent to act as a bridge between medical school and prevocational training to make the transition between medical career stages in regional and rural areas easier was unique, necessary and valuable.** This intent aligns with the National Medical Workforce Strategy (2021–2031) goals around increased training in regional areas, supervisor support, and professional support to enhance doctor wellbeing. However, several areas for improvement with the RTH program were identified as outlined in this report and the following recommendations.

Recommendation 2 The Department should update the RTH core requirements to reflect the evolution and maturity of RTHs.

The following core requirements should be amended to include the following elements (in green text):

- 6a. For each training hub identified in the university's funding agreement, the university must appoint a suitably qualified team, including a senior clinical academic, project and administrative staff. The clinical academic should be actively engaged in clinical service delivery in the region. The

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RTH project officer should be employed at least 0.7 FTE in that role. Consideration of fractionation where staff have roles in both the RTH and the RCS or hospital can enhance capacity and facilitate relationship building.

- 6c. The university must facilitate the development of new medical training capacity through activities including, but not limited to, assisting health services in accreditation processes for new posts. RTHs must specifically support the development of general practice and RG training pathways in the region in collaboration with the GP colleges and Rural Generalist Coordination Units. RTHs must support local health professionals to become supervisors. RTHs must build and maintain vertical training and supervision capacity tailored to junior doctors, registrars and fellows. Ideally, supervision training should lead to a micro-credential and/or foundational teaching qualification (e.g. Clinical Teaching Fellowship).
- 6d. The university must identify university-level medical students and junior doctors with an interest in rural practice and provide them with support, including assistance with career planning, placement opportunities and access to mentoring. RTHs must establish connections with FGAMS and bonded medical students (during their university degree) to prepare and support their transition to regional and rural internships.

The following core requirement should be removed:

- 6e. The university must identify areas of regional medical workforce need within their catchment area, and work to build medical training capacity in these areas.

And replaced with:

- RTHs must prioritise development of end-to-end vocational training pathways in response to identified workforce need. To build sustainable training capacity and capability and local workforce, the RTH, in conjunction with the LHN, general practice and ACCHO sectors, and key college stakeholders agree on key local and regional workforce priorities (i.e. a regional workforce plan) and develop longitudinal training pathways for those disciplines.

The following core requirement should remain the same:

6b. The university must implement and maintain arrangements with relevant education professionals and health service stakeholders, including local hospitals and health services, state and territory governments, other universities, specialist colleges (including general practice colleges), postgraduate medical councils, local health practitioners and regional training organisations to support the integration of medical training at the local level.

The ordering of the core requirements should be amended such that 6d becomes 6b (and consequently, 6b becomes 6c; 6c becomes 6d) to emphasise that the primary focus of RTHs is on medical students and junior doctors.

Recommendation 3 Universities receiving RHMT funding should support the development of a 'Clinical Education and Training Pathway' tailored to the needs of rural supervisors that can be rolled out by the RTHs.

As previously stated, supervisory capacity and capability are critical for developing regional training pathways and growing the rural medical workforce. Ensuring clinical supervisors are appropriately trained, including nuanced training relevant for regional, rural and remote settings is essential. This will support clinicians across the career continuum in supervision activity, aiming to not only engage more clinicians in supervisor roles, but also maintain their interest and willingness to remain supervisors over time. As a consequence, it is expected that student trainees will have superior training experiences, receive optimal supervision and feedback and therefore, be more likely to continue to pursue a rural medical career.

Universities receiving RHMT funding should leverage existing Supervision Courses (e.g. from their Health Education Department) and tailor them to the needs of rural and remote supervisors. This program should then be made available for RTHs to roll out in their regions at a subsidised cost.

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Critical to this, the training should include micro-credentials that can be incorporated into larger credentials/training qualifications if desired. This will promote a level of consistency across regions, enable supervisors to take the qualification with them if they move locations, and reduce future training demands if recognition of prior learning is appropriate.

Recommendation 4 The Department should include outcome measures for RTH reporting.

Outcome measures should include, for example:

- Transition of extended rural placement students/end-to-end medical students to regional internships in the local area and elsewhere
- Analysis of the background of the interns within their region, e.g. end-to-end cohort, extended regional placement cohort, bonded medical students, FGAMS, rural origin, etc.
- Extent to which end-to-end training for identified medical workforce priorities can be completed within the region – GP/RG and non-GP specialties
- Long-term graduate tracking (five and 10 years post-graduation) detailing location (by remoteness) and speciality type (GP, RG and non-GP specialty)
- Growth in medical supervision capacity in the region

Recommendation 5 The Department should consider development of a research funding opportunity (e.g. through the Medical Research Futures Fund) to enable a multi-university research program focused on rural (MM2–7) prevocational doctors and the medical training journey that led them to rural prevocational work.

There are now a number of university training pathways to support the development of the rural medical workforce (i.e. extended rural cohorts, completion of the final two years in a rural location, end-to-end training, short rural placements), as well as quotas for the selection of rural origin students into medicine and activities to support transition to rural prevocational training through the RTHs. In addition, the states and territories have different mechanisms for intern allocation and prevocational contract arrangements. Identifying the demographic and training pathways of junior doctors into rural work and the extent to which intern allocation and employment contracts contribute to work location would provide valuable information to better tailor selection, education, training and employment arrangements. This would help to strengthen the early rural medical career pathway for improved rural medical workforce outcomes.

This recommendation could be supported by developing a graduate tracking system as described in Recommendation 9.

Recommendation 6 Universities should support the RTHs to work with universities and health services to increase and coordinate student placement opportunities; this should include financial or resource support as required.

With the increasing number of medical students from multiple universities undertaking placements in a region, there needs to be greater collaboration between universities and rural and regional hospitals and health services for student placements. This will require greater flexibility by universities in the delivery of curricula. A local place-based approach is needed as placements must be planned and coordinated with the regional and rural health services and with several universities.

Recommendation 7 The Department should reconsider the locations of RTHs to ensure one RTH per region that connects with and supports medical students from all universities operating within their regional footprint.

Medical students from multiple universities may undertake short and extended placements in a region. To support the development of regional and rural medical training and workforce, RTHs should be university agnostic and

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extend their networking, support, career guidance, mentoring, and professional support activities to all students located in their footprint.

Recommendation 8 The Department should consider the development of regional or state/territory-wide RTHs in certain locations.

Through this evaluation, several issues were identified specific to a region or jurisdiction that require particular consideration by the Department. Mechanisms to create collaborative networks that span a region or jurisdiction to reduce duplication of effort and maximise efficiency need to be considered. The WA RTH (governed by a joint university structure) provides a model for consideration, but this is not the only model that could be applied. Flexibility for local nuance governance arrangements must be considered.

Universities and RTHs where a regional/state/territory model would improve coordination are as follows:

- **Riverina RTH (UNDA), Murrumbidgee RTH (UNSW) and Border RTH (UNSW).** These RTHs cover the same geographic footprint. While they seek to differentiate their activity, it creates confusion for external stakeholders and is perceived as duplicative. The evaluators suggest that these RTHs amalgamate. There would be a joint university governance arrangement that included UNDA (as lead), UNSW and CSU (which also operates in the region but does not have its own RTH).
- **Limestone Coast RTH (Flinders University) and Eyre Peninsula RTH (University of Adelaide).** South Australia is a state with a large metropolitan population and widely dispersed smaller regional centres. Limestone Coast RTH focuses its efforts in the Mount Gambier region, and the Eyre Peninsula RTH focuses on Whyalla and surrounds. There does not appear to be an RTH covering the Riverland areas of the state. In addition, the Eyre Peninsula RTH and University of Adelaide RCS staff operate under a blended arrangement. Given the challenging geography and dispersed workforce, consideration could be given to developing a collaborative statewide approach.
- **Northern Territory RTH (Flinders University).** The Northern Territory RTH is not well connected with the hospital and health services, and has experienced staffing challenges with changes to the Clinical Director and Program Officer. The recent addition of end-to-end medical training at Charles Darwin University provides an opportunity to change the Northern Territory RTH arrangement and develop a territory-wide approach.

Recommendation 9 The Department funds the development of a suitable graduate tracking system that includes RTH touchpoints.

The main purpose of this RTH initiative, the RHMT program, and the many other government-funded training initiatives (such as the Australian General Practice Training Program, Rural Generalist Training Scheme, STP, and IRTP) is to establish and grow rural, remote, and regional medical training opportunities to increase the medical workforce practising in rural, remote, and regional Australia.

However, few universities had a tracking system in place to determine where students, interns and registrars go in their careers or what GP or non-GP specialty they pursue. Note, JCU, University of Queensland, and University of Tasmania were identified as having good tracking systems in place and the Western Australian RTH – Central has developed a customer relationship manager system to determine touchpoints with students and junior doctors.

Furthermore, it is not feasible to track medium- to longer-term outcomes from one RTH or one university separate from other initiatives, as medical students from different universities can undertake a placement in a region.

The work to link the Medical Schools Outcomes Database and Australian Health Practitioner Regulation Agency data to track medical graduate workforce outcomes is progressing. Inclusion of RTH touchpoints and activities in the prevocational period could provide insight into the important

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interventions and potentially 'doses' of interventions that make a difference to rural workforce outcomes.

7.2 OPTION 2 – MODERATE CHANGE: EXPANDED SCOPE OF RTHS WITH COMPLEMENTARY FUNDING MECHANISMS

Recommendation 10 The Department could update the scope of the RTH role to include professional support assistance for IMGs, which may require additional funding from appropriate branches within the Health Workforce Division.

Australia is highly reliant on IMGs to maintain access to high-quality, timely and appropriate care, particularly in rural and remote areas. IMGs are twice as likely as Australian Medical Graduates to work rurally due to a moratorium under Section 19AB of the Health Insurance Act [1] and IMGs make up around two in every three doctors in MM4–7 areas. Many IMGs come to Australia with strong clinical training, years of clinical experience and qualifications from overseas. However, given the challenges and isolation of rural and remote work, the complexity of Australia's regulatory and rural training pipelines for IMGs, as well as the unique socio-cultural backgrounds of many IMGs, they often require nuanced support to sustain rural training and employment and achieve career progression.

Identifying and engaging with IMGs (working in regional and rural hospitals and/or undertaking their WBA, as well as IMGs training and/or working in community general practice) to enable access to a suite of professional support activities offered by the RTH and others is an important mechanism to strengthen the retention of this workforce. Professional support offered by RTHs may include peer-mentorship, wellbeing and career development support, assistance with the development of professional networks, and non-clinical skills such as supervisor training and support to integrate into the local community. This support can be extended to doctors working in unaccredited positions in regional hospitals to support retention and potential transition to a training pathway. Note that there will be variation between regions in their reliance on IMGs and hence flexibility in the level of activity required.

7.3 OPTION 3 – MAJOR CHANGE: INTEGRATED RURAL MEDICAL WORKFORCE AND TRAINING STRATEGY

Recommendation 11 Branches within the Health Workforce Division of the Department collaborate to establish an integrated rural medical workforce and training strategy that spans the entire medical training and beyond along the continuum of the medical career. This could be implemented through a regional-based collaborative approach.

As regional-based entities, RTHs are well placed to coordinate and provide support for medical students, junior doctors, registrars, and consultants, including IMGs. However, the current funding arrangements under RHMT program, which specify the RTHs should focus activities on domestic medical students, limits the potential of RTHs to provide region-wide support across the medical career continuum. Similarly, affiliation with one university makes providing region-wide support challenging for footprints that contain multiple RCSs and RTHs.

Although the evaluation found that the role of the RTHs is hindered by being funded through universities under the RHMT program, there is no natural host for the RTH and a regional-based coordination/support role outside of the universities. Hosting RTHs within health services could a) limit their scope to hospital-based workforce only, excluding medical students and primary care, and b) result in funding being absorbed by the enormity of the health service. Similarly, hosting RTHs in primary care (such as through PHNs or Rural

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Generalist Coordination Units) could result in lack of hospital-based focus. RWAs have a partial role in regional coordination activities, but they cover the entire state/territory, which is too broad for local-level nuancing and support.

To be truly effective, RTHs also need agency with health services and medical colleges (GP and non-GP colleges) to access data, support training post accreditation, and assist with developing regional training networks where possible.

Such a regional-based entity needs buy-in from all key players, including local university RCSs, LHNs/health services, primary care and medical colleges. It also requires strong collaboration with RWAs and WPPP agencies.

This evaluation demonstrated that multiple actors and stakeholders are involved in medical training, employment, and workforce development in rural and regional areas. These actors engage with medical students, junior doctors, doctors in training, and fellows at different stages of the career continuum and for different purposes. Furthermore, the various funding sources and focus of programs and policies are not aligned to maximise outcomes.

7.3.1 Co-design/collective impact approach

The co-design of medical training and employment strategies at a regional level offers the opportunity to align activities toward regional workforce outcomes, taking a systems-based approach. This could be progressed by regional collaborations or consortia that include the relevant university and RCS/s, RTHs, the LHN (including executive and regional hospitals and Medical Education Units), the RWAs, GP regional training providers/directors of regional training, the WPPP agencies/PHNs, the Rural Generalist Coordination Units and medical specialist colleges relevant to regional priorities.

This collaboration would bring together:

- key education providers across the medical training continuum (medical school, prevocational and vocational training)
- agencies responsible for local and regional health and workforce needs assessments and workforce planning
- agencies that hold or fund the prevocational and vocational training posts
- the LHN that funds rural and regional hospital services
- local GP leadership

Most RTHs have significantly matured since the early implementation evaluation in 2019–20, and more mature RTHs could facilitate and implement a place-based regional medical workforce and training strategy using a collective impact approach, whereby long-term commitments by key players of different sectors work towards a common agenda to solve a specific problem [2].

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Collective Impact Initiative

The five conditions of collective success are:

A common agenda – all participants have a shared understanding of the problem and a joint approach to solving it through agreed upon actions.

Shared measurement systems – collecting data and measuring results consistently across all the participants ensures alignment and accountability.

Mutually reinforcing activities – participants undertake activities that play to their strengths in a coordinated manner that contributes to the shared goals.

Continuous communication – open and continuous communication builds trust, assures mutual objectives, and creates common motivation.

Backbone support organisation – requires a dedicated staff separate from the participating organisations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and logistical and administrative detail [2].

7.3.2 Design elements

The framework to support the development and implementation of a place-based Integrated Regional Medical Workforce and Training Strategy was described in the Independent Evaluation of the RHMT program in 2020 (Appendix 12) [17].

The key elements of a co-designed, co-funded, co-implemented approach include:

1. **Joint Planning** – The Collaborative develops and maintains a single integrated medical workforce plan for the region, including public, private, acute, and primary care. This plan is developed in open partnership and collaboration with stakeholders, identifying opportunities, capacity, and needs across all levels of the training pipeline.
2. **Shared Workforce Priorities** – The Collaborative has established clinical networks that contribute to the formulation of clinical training practice and policies, design of training and employment models with shared key performance indicators and professional support to enable the development of the region's medical workforce, and continued improvement of patient care and experience.
3. **Supervision capacity building** – The Collaborative develops and implements a supervision training plan to develop supervision skills for junior doctors, registrars, doctors working in unaccredited positions and fellows.
4. **Integrated information communication technologies** – The Collaborative maximises the ICT capacity and capability of the parties to progress innovative methods of education and training, supervision and health care delivery.
5. **Effective change management** – The Collaborative has the leadership capacity to coordinate each party's resources and efforts towards implementing the integrated regional medical training strategy, and shared vision evidenced by willing (voluntary) collaboration at all levels, continued integration and sharing of resources, increased access to training and employment opportunities leading to improved access to medical services for patients and consumers.
6. **Aligned Incentives** – All stakeholders are engaged in a transparent allocation of investment so that the majority of financial and human resources are prioritised to increase regional medical workforce training aligned to regional needs.
7. **Training provided to a geographically dispersed medical workforce** – The Collaborative develops and delivers regional, rural and remote education and training opportunities for medical students, junior doctors, GP registrars and specialists in training to support the development of a medical workforce with knowledge and capability for rural, remote and regional practice.
8. **Use of data as a workforce and education planning tool** – The Collaborative has a culture of accurate and timely decision-making, enabled by sharing data and informed by the collection and analysis of

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data that supports evidence-based education, training, and recruitment. There is a breadth of education, training and professional support activities funded by the Commonwealth, state and territory governments for medical students and medical practitioners across the training continuum. However, connection with, and access to these often-siloed initiatives can be impeded by privacy and information sharing constraints. Enabling agencies to share contact information of target cohorts will increase and improve timeliness and efficiency of access to training and support programs.

9. **Professional development** – The Collaborative has a joint and integrated workforce and professional training and development agenda, ensuring supervisors deliver consistently to agreed education accreditation standards, and junior doctors, GP registrars and specialists in training have access to courses and professional development relevant to their training requirements.
10. **Community, consumer, and patient engagement** – The Collaborative has an engaged community of patients, consumers, and health care providers who actively participate to inform policy, strategic thinking, implementation, and management of workforce and health care improvement initiatives.
11. **Resourcing to support innovation** – The Collaborative has an ingrained culture of sustained innovation to lead the development of a fit-for-purpose, capable medical workforce to deliver health services in rural and remote communities.

8 APPENDICES

APPENDIX A RCS, UDRH AND RTH BY UNIVERSITY

Table 8.1: Rural Clinical Schools, University Departments of Rural Health, and Regional Training Hubs

STATE	UNIVERSITY	RCS	RURAL CAMPUSES	ASSOCIATED UDRH/S	ASSOCIATED RTH/S
NSW	University of Newcastle	Peel, Manning and Tablelands RCS	Tamworth, Taree, Armidale, Moree, Port Macquarie and Coffs Harbour (NSW)	University of Newcastle Department of Rural Health	North West NSW RTH
NSW	University of NSW^	University of New South Wales RCSs	• Wagga Wagga, Griffith (NSW) • Albury (NSW) • Port Macquarie, Coffs Harbour (NSW)		• Murrumbidgee RTH • Border RTH • Mid-North Coast RTH
NSW	University of Sydney^	University of Sydney School of Rural Health (Dubbo / Orange)	Dubbo and Orange (NSW)		Western NSW RTH
NSW	• University of Sydney • Western Sydney University • University of Wollongong	University Centre for Rural Health (partnership between University of Sydney, Western Sydney University, University of Wollongong and Southern Cross University)	• Lismore, and Grafton • Lismore and Bathurst (NSW) • Nowra, Bowral, Broken Hill, Forbes, Grafton, Lismore, Milton, Mudgee, Murrumbidgee	University Centre for Rural Health (partnership between University of Sydney, Western Sydney University, University of Wollongong and Southern Cross University)	• Northern NSW RTH (University of Sydney, University Centre for Rural Health and NNSWLHD collaborative) • Clarence Valley RTH (partnership with University of Sydney and University of Wollongong)

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STATE	UNIVERSITY	RCS	RURAL CAMPUSES	ASSOCIATED UDRH/S	ASSOCIATED RTH/S
NSW	University of Wollongong	University of Wollongong School of Medicine Shoalhaven	Nowra, Bowral, Broken Hill, Forbes, Grafton, Lismore, Milton, Mudgee, Murrumbidgee		Shoalhaven RTH
NSW	Australian National University	ANU RCS	Bega, Batemans Bay, Cooma, Cowra, Goulburn, Moruya, Young		South East NSW RTH
NSW/Vic	University of Notre Dame (Sydney)	Wagga Wagga, Lithgow and Ballarat clinical schools	Wagga Wagga and Lithgow (NSW), Ballarat (Vic)		Riverina RTH
NSW	University of Sydney, University of Wollongong, University of Adelaide		Broken Hill	Extended clinical placement program administered by Broken Hill University Department of Rural Health (not affiliated with RCS)	Far Western NSW RTH (hosted by the Broken Hill University Department of Rural Health for the University of Sydney)
NSW	Charles Sturt University^	CSU RCS (being established)	Cootamundra, Corowa, Griffith, Kempsey, Mudgee, Macksville - Scotts Head, Orange, Parkes (NSW), Swan Hill (Vic)	Three Rivers University Department of Rural Health	
Vic	Deakin University Regional Medical School	• Deakin Rural Clinical Schools (Geelong, Warrnambool and Ballarat) + • Rural Community Clinical School (12-month placement for third-year medical students with RGs and specialists in regional Victoria)	Warrnambool, Ballarat (Vic)	Deakin Rural Health	Western Victoria RTH
Vic	Monash University^	Monash University RCS	Mildura, Bendigo, Traralgon, Bairnsdale, Warragul, Sale, Leongatha	Monash School of Rural Health	• Gippsland RTH • North West Victoria RTH

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STATE	UNIVERSITY	RCS	RURAL CAMPUSES	ASSOCIATED UDRH/S	ASSOCIATED RTH/S
Vic	University of Melbourne^	The University of Melbourne RCS	Ballarat, Benalla, Bendigo, Mount Beauty, Cobram, Corowa, Echuca, Mansfield, Murchison, Shepparton, Wangaratta, Yarrawonga	University of Melbourne Department of Rural Health	Goulburn Valley RTH
Vic	La Trobe University			La Trobe University Department of Rural Health	
Qld	University of Queensland	University of Queensland RCS	• Rockhampton (Qld) • Bundaberg, Hervey Bay (Qld) • Toowoomba (Qld)	Southern Queensland Rural Health	• Central Queensland RTH • Wide Bay RTH • Southern Queensland RTH
Qld	Griffith University	Griffith RCS	Kingaroy, Dalby, Toowoomba, Warwick and Stanthorpe and other rural towns in Queensland, including Gympie, Roma, and Beaudesert		Southern Queensland RTH (University of Queensland)
Qld	James Cook University	James Cook University RCS	Cairns, Mackay, Mount Isa, Thursday Island, Atherton, Longreach, Weipa, Cloncurry	Mount Isa Centre for Rural and Remote Health Central Queensland Centre for Rural and Remote Health (being established)	• North Queensland RTH • Far North Qld RTH • Western Qld RTH
WA	• University of Western Australia • The University of Notre Dame • Curtin University	RCSs of Western Australia (partnership with the University of Western Australia, University of Notre Dame and Curtin University)	16 locations throughout Western Australia (Admin. HQ: Kalgoorlie)	• Western Australian Centre for Rural Health (UWA) • Majarlin Kimberley UDRH (UNDA) • Goldfields UDRH (Curtin)	Western Australia RTHs • Kimberley / Pilbara RTH – Broome • Midwest & Goldfields RTH – Geraldton • Southwest/Great Southern RTH – Bunbury

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STATE	UNIVERSITY	RCS	RURAL CAMPUSES	ASSOCIATED UDRH/S	ASSOCIATED RTH/S
WA	Edith Cowan University			Edith Cowan University Department of Rural Health (being established)	
SA	Flinders University	Rural and Remote Health SA	Renmark, Mount Gambier, Nuriootpa, Victor Harbor, Murray Bridge	Flinders Rural Health	• Riverland RTH/Limestone Coast RTH
SA/NSW	University of Adelaide*	Adelaide RCS	10 sites throughout South Australia and Broken Hill, NSW		Eyre Peninsula and Spencer Gulf RTH
SA	University of South Australia*			UniSA Department of Rural Health	
Tas	University of Tasmania	University of Tasmania RCS	Burnie, Launceston, and Latrobe (Tas)	University of Tasmania Centre for Rural Health	Tasmanian RTH
NT	Flinders University, Northern Territory	NT Medical Program	Darwin, Katherine, Alice Springs and Nhulunbuy (NT)	University Department of Rural Health, Northern Territory	Northern Territory RTH

Source: Adapted from the Department of Health and Aged Care: Rural Health Multidisciplinary Training (RHMT) program, Participating Universities: https://www.health.gov.au/our-work/rhmt#participating-universities
^ University RCSs participating in the MDMSN
*Recent announcements of the merger between the University of Adelaide and University of South Australia will impact on the affiliations of RCSs, UDRHs and RTHs in South Australia.

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APPENDIX B REFERENCES

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