Policy Document

Rural Training Pathways Policy

Background

The Australian Medical Students’ Association (AMSA) is the peak representative body for medical students in Australia.

It has been well established that people who live in regional, rural or remote areas have significantly poorer health outcomes compared to metropolitan populations [1-4]. The shortage of medical professionals in non-metropolitan areas exacerbates this access inequity. Such a shortage is due to maldistribution of the medical workforce rather than an overall insufficient number of doctors in Australia. While 31% of Australia’s population live outside of metropolitan centres only 14.6% of surgeons follow suit [5], and other specialties are no different, with an average of just 15% of specialists working outside of major cities [6]. The ratio of GPs drops from 227.8 per 100,000 in cities to just 144.9 per 100,000 in regional areas and just 113 per 100,000 in remote areas [6]. Furthermore, the ratio of specialists in regional areas to the population is just 61.1 per 100,000, and 15.5 per 100,000 for remote areas compared with 144.1 per 100,000 in major cities [6].

The initial approach to correcting this maldistribution nationally is at the very beginning of medical training through the selection, support and teaching of medical students.

- **Selection:** the recruitment of rural background students has been a particular focus for medical schools under the Rural Health Multidisciplinary Training (RHMT) programme. Currently 27% of students are of a rural background, in line with government requirements [7].

- **Support:** scholarships such as Rural Australian Medical Undergraduate Scholarship (RAMUS) have been pivotal in addressing socio-economic inequalities faced by rural students seeking medical education.

- **Teaching:** Rural clinical schools have proven successful in delivering positive rural experiences to students who undertake extended rural placements in a rural area [8-10]. Similarly, the John Flynn Placement Programme provides placements in rural and remote Australia with a heavy focus on the students establishing connections with a community over a period of 4 years.

Bonding programmes such as Bonded Medical Places (BMP) and Medical Rural Bonded Scholarships (MRBS) have also been a large part of government policy, however there is no evidence to suggest this significantly increases the number of rural doctors [11-13].

Medical student programmes are the very beginning of rural training pathways, however the prevocational period is the most proximal to influencing career [14, 15]. Some of the top influencing factors for career choice are role models, mentorship and positive experiences at the end of junior medical officer years [16]. Residents also look at professional and work environment such as intellectual stimulation, diversity of procedures and practice, along with an equitable payment schedule between the disciplines [14]. The literature suggests that addressing these factors is timely as Watmough (2007) found that five years after graduation, physicians perceived their career choice was primarily determined by their postgraduate experience [15].

Evidence shows that extended rural and remote placements contribute to increased retention in these areas. This does however, drop off quickly post-graduation as currently it is difficult for a doctor to complete their vocational training rurally without returning to a metropolitan centre [17]. This relocation is during a crucial time where many life decisions such as meeting a partner, starting a family, buying a home and finding career role models in the city significantly reduces the likelihood of returning to rural practice [17]. Despite having the best of intentions initially, long-term training remains a further barrier for urban students to fully convert.
A rural internship is one pathway towards a rural career, with 19% of interns completing their internship in a rural or regional centre [18]. Rural base hospitals provide a broad spectrum of hospital and community medicine (and therefore training opportunities) that may no longer be available in major tertiary hospitals due to the move towards sub-specialisation that is only sustainable with a high use of resources [19]. Victoria’s Rural Community Intern Training, the Rural Preferential Recruitment in NSW, Rural Practice Pathway in WA and Rural Generalist Pathway in QLD are internship programmes carved out by the states. Nationally, the Rural Junior Doctor Training Innovation Fund targets rural-based interns with opportunities to increase time spent in rural general practice (similar to the Postgraduate General Practice Placement Programme [PGPPP] previously), building on rural training networks already funded by states and territories [20].

The next bottleneck in the training pathway for junior doctors who wish to take up rural practice is for specialty training (including general practice). There is a slow emergence of opportunities to undertake specialty training in rural areas, however the majority must be undertaken in the city. This may be the explanation for the ongoing maldistribution of specialists; despite an emerging number of domestic medical graduates there is a mismatch to the availability of vocational training opportunities [21]. General practice has long excelled in this field with flexible training options such as online modules for distance education as well as a significant number of rural GP supervisors [22]. 50% of places on the Australian General Practice Training programme were located outside of metropolitan areas [23]. Further to the pathway, the Rural and Remote General Practice Programme (RRGP) provides funding to subsidise the expenses of doctors relocating to rural and remote locations. There remains concern however that decentralisation and other measures have not sufficiently created a sustainable rural general practice workforce. Rural medical education initiatives may make a difference however retention rates are suboptimal and outcomes are not readily available [24, 25]. Rural cadets who specialised in general practice however have been found to be more likely to stay rurally than other specialities [26]. This points to the structure of specialty training as another influence to rural retention.

One of the largest barriers to establishing specialty training in regional centres has been the accreditation criteria set by the specialist colleges that exclude rural centers. Criteria such as having a facility with “at least nine medical specialty departments, with two of the departments headed by a professorial or associate professorial appointee based full-time at the hospital as well as MRI and nuclear medicine facilities” as outlined by the RACP [27] can rule out regional centres because they are not funded for sub-specialised care. Therefore the majority of specialty training occurs in city centres. The challenge in keeping the rural pathway open occurs here as metropolitan based-training is metropolitan focused leaving registrars trained for the city rather than suited to the needs of rural and remote Australia [19]. It has been shown that rural rotations with a preferred fixed location has a positive impact on rural career intention [14]. Therefore enabling individuals to conduct the majority of their specialty training in rural locations will create another pathway to rural practice.

QLD rural generalist pathway

Queensland is the only state with a rural generalist pathway. Its aim is to enable graduates to work within the context of rural general practice whilst providing secondary medical care within rural hospitals. Trainees commence on the programme at the start of internship, and following this undertake advanced specialised training in obstetrics, anaesthetics or emergency and general practice training in rural and regional locations [29]. The success of this programme has not only improved the rural health workforce but facilitated health service redesign and enabled the establishment of new rural health service hubs at sites like Longreach and Cooktown [30]. This programme could provide a framework for the establishment of future rural specialist and generalist programmes.

Specialist Training Programme

The Specialist Training Programme (STP) provides inducements and options for doctors to train in non-traditional environments which includes based at regional training hubs. First developed in 2010, it supports 900 training places under twelve specialist medical colleges for registrars in rural areas and areas of workforce shortage. For some trainees it provides the only opportunity to undergo accredited specialty training in a rural area. Currently 41% of these trainees are in regional or rural areas, which has successfully lead to an increased availability of specialist services in these areas [31]. However these placement are only for up to one year which can impede the retention of trainees who wish to remain rurally. The continuation and expansion of the STP in rural environments is supported by the Australia Future Health Workforce - Psychiatry Report, the Australian Medical Association, and the government themselves with an expansion to 1000 places by 2018 and funding secured until 2019 [33][32][20]. Further to this expansion, another initiative to retain graduates in rural areas is the creation of 30 new regional training hubs in rural Australia as part of the Integrated Rural Training Pipeline.
These training hubs will be supported through collaboration with universities, Regional Training Organisations and hospital networks [20].

Queensland is the most advanced in its rural training pathway, particularly in reference to specialty training. Specialist training can be undertaken and completed at large regional hospitals including Townsville hospital and health service, with specialties such as gastroenterology, respiratory medicine, nephrology and endocrinology offered [28].

**Other barriers/opportunities in structure of training**

The large numbers of students coming through the medical training system far outweigh the shortage of medical professionals in rural Australia. As the number of trainees increase, so will the required number of supervisors. Vertical integration has been proposed as a solution to ease the pressure on often overworked supervisors to teach, supervise and practice [34]. The creation of 30 new rural training hubs through the Integrated Rural Training Pipeline will utilise a medical community of students, junior medical officers, registrars and consultants to facilitate this proposal [20].

Rural webinars, practice visits, networking, mentoring, peer support groups, supervisor access, and grants for educational support are complementary supports to retain rural trainees [32]. Beyond training, the Remote Vocational Training Scheme allows medical practitioners already working in remote areas to remain in these communities to practice [18].

**Position Statement**

AMSA believes that rural vocational training pathways are important in retaining rural doctors, and are crucial in addressing shortages in the rural medical workforce.

**Policy**

AMSA believes that:
1. More doctors are needed in rural and remote areas to address medical workforce maldistribution
2. Australia must have a strong rural vocational training programme to increase retention of doctors in areas of workforce shortage
3. The training programme must:
   a. Allow for the majority of specialist training to be completed in rural centres
   b. Provide a diverse range of specialty options
   c. Have strong support from all specialist medical colleges
   d. Be free from bonding and conscription
   e. Expand in line with increasing demand
   f. Provide adequate support to registrars in the form of mentorship, professional development and community integration
4. Rural training pathways must run in conjunction with university evidence based programmes as outlined in the RCS and rural background AMSA policy.
5. Addressing the underrepresentation of specialists availability in rural and remote Australian communities should be a high priority for all Australian State and Territory Governments;

AMSA Calls upon:
1. The Australian Commonwealth Government to:
   a. Continue the expansion of the Specialist Training Programme in proportion to community demand for medical practitioners with a priority on regional and rural sites
   b. Incorporate flexibility in the rural training pathway
      i. Individual choice over bonding to the programme to ensure the doctors who are passionate about rural health are serving rural communities
      ii. Variety of long and short term options
      iii. Facilitation to return to rural after metropolitan rotations
      iv. Provide additional rural training sites for specialty rotations
2. Australian Specialist Medical Colleges and specialist training providers to:
   a. Establish rural training options in their training programmes enabling registrars to complete the majority of the vocational training in non metropolitan environments.
   b. Review the accreditation criteria that excludes rural locations from being a primary training site providing an evidence-base.
c. Ensure trainees are provided with adequate professional development opportunities

3. State Government Hospitals and Local health districts in rural areas to:
   a. Provide positive rural experiences in the prevocational training period
   b. Create long-term registrar training positions in regional, rural and remote Australian public health environments
   c. Advertise these training opportunities widely including to medical students and junior doctors who are in their career defining stages
   d. Ensure equitable rates of pay across specialty disciplines particularly for those in a rural area
   e. Establish mentorship programmes in order to adequately support registrars
   f. Provide support to rural trainees to integrate into the wider community in areas including but not limited to:
      i. Community groups, clubs and societies
      ii. Employment opportunities for partners
      iii. Real estate and other local services

References


Policy Details

Name: Rural Training Pathways Policy

Category: D – Graduations, Internships and Careers

History: Adopted Council 2 2016