Policy Document

Rural Training Pathways for Junior Doctors (2024)

Executive Summary

Rural Health Maldistribution

Access to quality healthcare remains a pressing challenge in rural Australia, where disparities in healthcare access and outcomes persist. Despite comprising 28% of the population, rural communities face higher rates of hospitalisations and fewer healthcare professionals compared to urban areas. Expanding rural medical education and incentivising rural practice aims to bridge the gap between urban and rural healthcare, ensuring every Australian receives the care they deserve, regardless of location.

AMSA calls upon the relevant stakeholders, such as the Federal Government, to address rural health maldistribution through measures including but not limited to reinstating or introducing national incentive programs to attract and retain medical professionals in rural and remote areas. These programs should target reducing socioeconomic barriers for those most likely to serve their community. To support relocation and retention, a multisectoral approach that invests in rural infrastructure beyond healthcare services is required.

Prevocational Training

Supporting prevocational doctors into rural community practice has been evidenced to support, attract, retain, provide exposure, and increase interest for Rural Generalist (RG) practice, and support the future rural health workforce. Several Federal, State and Territory Governments support programs such as the John Flynn Prevocational Doctor Program, the More Doctors for Rural Australia Program, and prevocational RG pathways in respective states and territories to encourage and support rural medical practice.

AMSA calls upon the Federal Government to incorporate flexibility in rural training pathways and State and Territory Governments to support the quality and training capacity of rural healthcare services.

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General Practice and Rural Generalism Training

Despite General Practice being the most popular choice in specialty amongst junior medical officers, it is clear that the demands of the nation in the near future outpace supply. This crisis impacts rural and remote communities the most as they have fewer General Practitioners (GPs) than their metropolitan counterparts, and their current GPs are increasingly asked to perform services outside their framework of practice. Thus, encouragement of GP training, particularly rural training and the formalisation of the role of an extended skills GP within rural areas, a Rural Generalist (RG), is key to securing the health of Australia. The barriers to this are numerous, though issues include: remuneration disparities amongst specialties, associated costs with rural relocation, benefits instability outside the hospital system, and more.

AMSA calls upon Federal, State, and Local Governments, alongside the training colleges, to address the national GP shortage with a focus on creating an equitable distribution in rural areas. Additionally, rural healthcare services should provide opportunities for more flexible and equitable remuneration schemes.

Specialty Training

Australia's rural health workforce particularly suffers when it comes to the maldistribution of medical specialists. The Specialty Training Program (STP) is a government initiative in place that addresses these shortages by supporting clinicians to pursue accredited training in rural and remote areas. By extending vocational training beyond metropolitan centres, the STP aims to provide specialists with a broad range of experience whilst increasing the workforce in underserved settings. However, amongst other barriers, a lack of access to educational resources, infrastructure, and mentoring, remain significant issues to rurally-based specialty training.

AMSA calls upon the Federal Government to continue expanding the Specialist Training Program in proportion to community demand. Additionally, AMSA calls on Specialty Medical Colleges to establish end-to-end rural training programs and to support trainess financially and professionally.

Rural Recruitment & Retention

Increasing recruitment and retention rates of rural doctors is essential to improve working conditions in health care facilities and to address the many health inequalities faced by people living in rural and remote areas. The factors that influence recruitment and retention of healthcare workers are similar and include career progression, working conditions, rural infrastructure, and family and lifestyle. Rural health and education is often discussed using a deficit approach which likely

contributes to poor perceptions about rural work and training. To address this we call upon specialist medical colleges to recognise and reward rural training. We also call upon rural health services and the state government to implement policies to improve working conditions in rural areas.

AMSA calls upon State Governments and rural health services to address potential barriers that limit healthcare workers' and their families from relocating to rural and remote areas. Additionally, metropolitan and rural health services should partner to provide improved support for rural trainees.

Policy Points

AMSA calls upon:

1. The Federal Government to:
    a. Reinstate the role of Rural Health Minister to oversee the implementation of the Stronger Rural Health Strategy, and monitor its effectiveness;
    b. Continue the expansion of the Specialist Training Program in proportion to community demand for medical practitioners with a priority on regional and rural sites;
    c. Incorporate flexibility in rural training pathways by providing:
        i. A variety of long- and short-term training options;
        ii. Additional rural training sites for speciality rotations;
        iii. Opportunities for clinicians to enter and exit rural training pathways at all stages of their career through Recognition of Prior Learning;
        iv. Rural internships and prevocational training options.
    d. Reinstate/initiate national incentive programs to:
        i. Support rural-origin students to attend medical school, prevocational training, and complete rural placement;
        ii. Support International Medical Graduates performing mandated work in rural areas, adapted to local needs;
        iii. Encourage students to pursue vocational training rurally by promoting the unique and rewarding aspects of rural medicine
        iv. Support relocation of metropolitan practitioners and their families to rural areas by:
            1. Establishing child support initiatives at rural hospitals;
            2. Encouraging flexible working arrangements for partners of rural essential workers where appropriate and subsidising employers for remotely employing the partners of rural essential workers.
    e. Provide transparent information regarding workforce maldistribution, including deficit and surplus, and targets with progress reporting; As well as the impacts of staff burnout and absenteeism on workforce maldistribution;
    f. Mandate standard overtime pay in all health services, with enforcement and/or monitoring by the FairWork commission;
    g. Establish a central database for scholarships and opportunities for those undertaking specialist training in a rural setting to streamline the application and distribution process;

h. Invest in rural infrastructure beyond healthcare to improve industries such as transport, education, and general amenities to living in rural areas more attractive;

2. State and Territory Governments to:
    a. Audit, upgrade, and advertise the training capacity of rural hospitals and generalist practices for undergraduate, postgraduate, and vocational training to:
        i. Increase the training capacity of rural service by accrediting smaller rural hospitals;
        ii. Create long-term vocational training positions in regional, rural and remote environments;
        iii. Increase the desirability of training positions by providing professional and financial benefits including, but not limited to sponsored conference attendance and mentoring programs;
    b. Establish mentorship and educational programmes to support trainees;
    c. Provide subsidised access to anonymous mental health telehealth services for rural doctors;
    d. Address underfunding of rural healthcare services by adjusting the national funding model in line with the recommendations of the Mid-Term Review of the National Health Reform Agreement;
    e. Improve family support provided to rural trainees to better integrate them into the wider community;
    f. Improve access to educational support and daycare positions in rural areas by increasing investments in education and providing subsidies for education;
    g. Create incentives for rural workplaces to employ the partners of rural doctors to help establish them in the community;
    h. Improve locum coverage and access to timely and affordable locum support;
    i. Increase rural specialty training position numbers according to workforce need;
    j. Provide equal access to rural rotations for International Medical Graduates.
3. Medical Colleges to:
    a. Establish end-to-end rural training options in their training programmes;
    b. Support rural and remote health services to gain accreditation;
    c. Provide trainees with adequate professional development opportunities and mentorship, through:

i. Subsidising/ sponsoring access to events;
ii. Providing access to specialists via remote/ electronic teaching;
iii. Creating interdisciplinary groups and mentoring opportunities;
iv. Providing training workshops and upskilling events in rural areas;
v. Providing recognition and awards for rural training.

d. Work with university-based special interest groups and AMSA to promote rural-specific training pathways;

4. Rural Healthcare Services to:
    a. Change the narrative of rural health and training by shifting from a deficit to strength-based narrative.
    b. Encourage staff, particularly new rural trainees and medical practitioners, integration into their communities.
    c. Strengthen the relationship with metropolitan counterparts to:
        i. Gain access to specialist support via outreach and telehealth;
        ii. Support remote teaching and learning opportunities;
        iii. Encourage visiting specialists to teach and upskill staff and students.
    d. Increase flexibility of employment by promoting alternative employer models such as the Single-Employer Model and Easy Entry, Gracious Exit model;
    e. Support staff to upskill by increasing CBD leave and educational funding;
    f. Foster a work culture to prevent burn-out by:
        i. Encouraging staff to clock in overtime hours;
        ii. Support staff recovery and leave following overtime shifts;
        iii. Encourage restrictions on shift and weekly working hours where appropriate;
        iv. Increase leave opportunities to accommodate personal matters and training demands.
5. Metropolitan Healthcare Services to:
    a. Change the narrative of rural health and training by shifting from a deficit to strength-based narrative.
    b. Recognise and reward rural experience, including in specialty program applications.
6. Medical Schools to:
    a. Ensure medical students are adequately informed about vocational rural training options;
    b. Support positive rural clinical experiences by:

i. Acknowledging and promoting the value of rural placement;
ii. Ensuring access to online teaching and learning tools;
iii. Subsidising and providing safe and secure accommodation;
iv. Supporting the wellbeing and finances of students;
v. Creating, encouraging, and subsidising research opportunities.

Background

Australian Medical Service Maldistribution

Access to quality healthcare services remains a critical challenge in rural and remote regions of Australia, where approximately 7 million individuals, constituting 28% of the population, reside [1]. Despite comprising a significant portion of the populace, these areas face pronounced disparities in healthcare access and outcomes, such as reduced life expectancy. For instance, data from 2021-22 Medicare records reveal that the number of non-hospital non-referred attendances per person, such as GP visits, is notably scarce in remote and very remote communities, with only 5 and 3.6 visits per person respectively, compared to 7.6, 6.8, and 7.2 visits in metropolitan areas, regional centres and large rural towns respectively [1]. This disparity is further exacerbated by an increased burden of disease and injury with increasing remoteness, underscoring the pressing need to address healthcare inequities across geographical divides [1]. Specifically, in 2021-22, people living in very remote areas were hospitalised at almost twice the rate as those in major cities, with no observed improvement since 2013-14 [1]. Additionally, hospitalisation rates due to potentially preventable conditions increase with remoteness, being 2-3 times as high in regional and very remote areas compared to major cities [1].

The uneven distribution of healthcare professionals across different regions further exacerbates healthcare disparities. The proportion of Full-Time Equivalent (FTE) medical professionals per 100K population is highest in metropolitan areas, while small rural towns exhibit the lowest rates [1]. For example, in 2021, there are 152.3 medical specialists per 100K persons in MM1 areas but only 20.9 per 100K persons in MM7 areas [1]. Furthermore, the distribution of healthcare professionals across different regions exacerbates these disparities. The number of employed FTE clinicians working in registered professions decreases with increasing remoteness, with more than 386,000 FTE clinicians working in major cities compared to 132,000 in all other remoteness areas in 2020 [2]. A survey by Medical Deans Australia and New Zealand (MDANZ) in 2020 found that while 65% of surveyed medical students preferred to work in capital cities, only 17% expressed a preference for regional cities, small towns, or small communities [2]. This preference for working in metropolitan centres could further lead to an uneven distribution of future Health Care Providers (HCP) working rurally and thus the data from the Medical School Outcomes Database of 2023 highlights the importance of rural placements in shaping career preferences among medical students [3]. Respondents who undertook rural placements longer than one year were significantly more likely to express a preference for practising in regional and rural locations, with 36% indicating such a preference [3]. Conversely, only 8% of respondents who did not undertake a rural placement expressed a preference for rural practice. Moreover, the survey reveals

that domestic students are more likely than international students to aspire to work in regional and rural locations, with 22% of domestic students expressing such a preference compared to 12% of international students [3]. These statistics underscore the urgency of addressing the maldistribution of healthcare professionals and bolstering the rural healthcare workforce to bridge the healthcare gap between urban and rural areas. Efforts to incentivise medical practitioners to pursue careers in rural medicine, coupled with targeted training and support initiatives including promoting rural placements for medical students and junior doctors, are imperative to enhance healthcare access, delivery, and outcomes in rural and remote Australia.

Medical Schools

Australia is implementing a multifaceted approach to mitigate the healthcare workforce deficit in rural and remote areas, spearheaded by innovative programs outlined in the RCS policy. The Murray-Darling Medical School network, a cornerstone of the Rural Health Strategy Initiative, has established five rurally based university medical programs in the Murray-Darling region of New South Wales and Victoria, fostering a conducive environment for medical education in rural settings and enhancing the likelihood of graduates practising in rural areas [4]. Additionally, the government has announced a significant $90 million investment to establish six new medical school programs in rural communities, addressing healthcare workforce shortages [5]. These programs, set to begin development in 2024, will introduce 160 new spots for medical students annually to focus on end-to-end rural medical training, as well as 80 new Commonwealth Supported Places (CSP) being matched by universities that aim to redirect an equivalent number of their existing placements to the six new rural programs [5]. This initiative aims to retain doctors in rural areas post-graduation, bringing economic and social benefits such as community empowerment, enhanced urban doctor understanding, role modelling for rural youth, cultural competency, social bonding, and personal development, to local communities [59]. Moreover, the Rural Health Multidisciplinary Training (RHMT) program, with a robust investment exceeding $81 million, aims to fortify the recruitment and retention of healthcare professionals in rural Australia, evidenced by a significant increase in long-term RCS placements [6]. These placements can lead to more physicians practising rural health because those undertaking rural placements for ≧ 1 year, around 36% of survey respondents expressed a preference for rural health [3]. However, despite the RCS placement providing more opportunities for students to gain more responsibility and closer relationships with colleagues, it can lead to students feeling more anxious due to additional accountability and increased workload compared to their urban counterparts [70]. Additionally, University Department of Rural Health (UDRH)-supported nursing and allied health placements have experienced remarkable growth, soaring from 3000 to

13,000 between 2004 and 2018. Complementing these efforts, the Stronger Rural Health Strategy (SRHS) endeavours to bolster the healthcare workforce through initiatives like the Junior Doctor Training program and the Bonded Medical Program, ensuring a sustainable healthcare ecosystem beyond urban centres [7-9].

Through the Bonded Medical Program (BMP), participants are provided with a CSP in a medical course in exchange for working in regional, rural, and remote areas of Australia after graduation, further solidifying the commitment to addressing healthcare disparities in underserved regions [8-9]. Existing participants of two legacy schemes, Medical Rural Bonded Scholarship Scheme and the Bonded Medical Places Scheme, that have closed to new participants, can apply to opt into the BMP [9-10]. However, the BMP has struggled with a completion rate of less than 1% among its 10,000 participants since 2001, as shown by a 2017 audit, and further underscored by Department of Health data, indicating that out of 13,521 participants across various schemes, only 4.4% have fulfilled their return of service obligation, while 5.8% have withdrawn [68]. Moreover, the insufficient awareness among applicants and fluctuating time commitments, has compromised BMP and thus urgent reforms are imperative to enhance program's clarity and effectiveness, and hence address healthcare disparities in underserved regions [68-69]. Additionally, preliminary work for a new medical school in the Northern Territory is funded and these efforts align with broader strategies to improve healthcare access, including the Working Better for Medicare Review and the Unleashing the Potential of Our Health Workforce Review [5]. In response to these initiatives, the Australian Medical Students' Association (AMSA) calls upon the Federal Government to reinstate the role of Rural Health Minister to oversee the implementation of the Stronger Rural Health Strategy and monitor its effectiveness to not only ensure an equitable access to quality healthcare services but also address the uneven distribution of the health workforce across Australia.

Prevocational Training

The Federal Government, and all State and Territory Governments support a number of programs to support and encourage rural medical practice through prevocational programs:

The John Flynn Prevocational Doctor Program (JFPDP) introduced by the Australian Government in the 2021-2022 budget, beginning January 1 2023, amalgamates 2 former funding streams of the Rural Doctor Training Innovation Fund (RDTIF), core and RG training [11]. The program increases rural primary care rotations for prevocational doctors (PGY1 and PGY2) to 200 FTE doctors, approximately 800 rotations, by 2025, from 110 FTE doctors in 2022 [11]. With the aim to encourage prevocational doctors to work in RG practice, it allows prevocational doctors to

develop skills in managing primary and preventative care presentations, which would not normally be provided in hospital-based prevocational training [11]. Evaluation of the former RDTIF has shown that 57% of doctors in this program state that this has increased their interest for RG practice. As such, the RDTIF helps address rural workforce shortages [12].

The More Doctors for Rural Australia Program (MDRAP) is a 3GA program which allows non-vocationally registered doctors to work in rural areas (MMM2-7 or distribution priority area) and access the Medicare Benefits Scheme from group A7 [13]. This program encourages doctors to join a recognised vocational general practice college, such as AGPT via The Australian College of Rural and Remote Medicine (ACRRM) and/or The Royal Australian College of General Practitioners (RACGP), and the Remote Vocational Training Scheme (RVTS), ACRRM independent pathway, or RACGP PE [13]. The MDRAP itself is a part of the Stronger Rural Health Strategy [7].

RG pathways in all states and territories support prevocational doctors for future RG practice [14]. All states and territories provide rural prevocational training (PGY1 and/or 2) for those with intent to practise RG practice or rural generalism with no requirement to be enrolled in a vocational GP college (ACRRM or RACGP) [15-20]. All states and territories provide support and coordination with relevant requirements necessary for beginning vocational training and attaining fellowship for RACGP or ACRRM [15-20]. Outcomes of RG internships in Victoria has shown that 97% of doctors who completed these internships fulfil at least one of the key indicators for RG extended scope [21]. Hence, RG internships has been evidenced to attract, support and retain prevocational doctors to continue to practise rurally [12]. Strengthening and supporting rural training pathways and opportunities post-graduation, particularly in the prevocational period is necessary for supporting the rural health workforce, and the decisions to live and work rurally [22].

General Practice Training

As of 2018, General Practice is the most popular choice for hospital non-specialists (doctors not in training programs or accredited specialists), accounting for 22.7% of expressed intentions between all specialties [23]. However, it is clear that despite this popularity, 1) this amount is unable to meet the growing needs of the country given there will be an undersupply of 10,600 GPs by the early 2030s [24], and 2) there is an evident maldistribution in the distribution of GPs across Australia with major cities and very remote areas differing by almost 40 FTEs per 100,000 [25]. Additionally, the impact on rural and remote regions goes beyond primary care as GPs are often relied on to provide more specialised services due to the lack of medical specialists [25].

GP registrars in particular, face challenges unique to their situation which makes GP Fellowships both difficult to complete and unattractive to prospective trainees. As described in an article from the Menzies School of Health Research [26], these challenges include: A lack of employment benefit portability where entitlements may be lost as a result of leaving the hospital system, an inflexibility during training constraining those with certain life circumstances from participating, a lack of "prominent leadership and mentoring roles" who can support trainees through their progression, and finally what most consider to be the most significant reason; significant remuneration disparities during training and in fellowship. As of 2021, GPs could expect to earn $190,000 to $210,000 annually, while their specialist counterparts could expect to see $339,000 to $412,000 per annum [27].

Another challenge arises in the intersection between the overall culture of the medical landscape more heavily valuing subspecialists and the stigma of rural practice. The prior point has flow on effects on medical education and prevocational training in preparation for specialties, where despite being the largest makeup of medical practitioners in Australia, roughly 30.5%, it only accounts for a small portion of the student experience in medical school and about only about 22.7% of hospital non-specialists intend to train in it [23], which as explored earlier, is a deficit. The latter point then relates to the general perceptions within the medical community where practising rurally is a form of exile or substandard practice, which overlooks the benefits of rural work, like a greater sense of autonomy and community. Together, these pose quite a significant challenge for the training of general practitioners, and especially for the retention of general practitioners in rural and remote regions.

Similarly, while the need for rural clinicians can seemingly be filled by locum workers, there also remain issues of high turnovers affecting efficiency as incoming staff require training and acclimatisation to their posts, before leaving just as they have begun to settle. This is associated with a stigma against rural settings in general, where urban workers fail to fully understand the experience of their rural patients, often instead applying their own perspectives on health and healthcare practice on the basis of their "implicit urban moral superiority". Thus, the training and retention of rural based general practitioners is a pressing matter.

The training of GPs mainly takes place through the The Australian General Practitioner Training (AGPT) Program: a government program which exists as a means to address the impending shortage of GPs. It hopes to achieve this through the funding of 1,500 training places per year across a range of regions ranging from cities to remote areas and is administered through the two GP colleges: the Royal Australian College of General Practitioners (RACGP) and the Australian College of

Rural and Remote Medicine (ACRRM). By participating in this program, trainees: are able to gain a Medicare Provider Number and claim high value items from the Medicare Benefits Scheme, have some flexibility in training and work location, access further training opportunities like those relating to Aboriginal and Torres Strait Islander health, and finally to have their application and examination fees covered [28].

The AGPT is then evaluated annually by its participating registrars on several key areas, including overall satisfaction with the program, key performance indicators, training organisations, and more. As of the latest report in 2021, the registrar demographics were as follows: 62% were female, 49% were on the rural pathway, and most were between 30 to 39 in age. Half of all respondents were located in MMM areas 2-7. In the 2021 survey, overall satisfaction with education and training amongst registrars was high at 85%. Satisfaction with support was at 84% and 85% for administration. These satisfaction ratings were similar with regard to regional training organisations, with slightly higher numbers specifically relating to the training facilities of said organisations. While there is generally high satisfaction with the AGPT, there are still areas to improve upon, including employment models & salary, where some respondents felt they needed some room for negotiation or paid at a "fixed rate salary commensurate with the jurisdictional average average for at-level hospital doctors [throughout training]", and entitlements, where additional leave for any reason would have been beneficial [29].

Rural Generalist Training

As mentioned earlier, GPs working in rural and remote areas are often called upon to perform primary care and emergency services despite a lack of proper training framework. To that end, there have been efforts to formalise this role by RACGP and ACRRM, culminating in the Collingrove Agreement; proposing Rural Generalism as a new and distinct field of General Practice to the Medical Board of Australia. An RG is then 'a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team' [30].

To facilitate this, programs and schemes were also developed for the training of RGs, including the National Rural Generalist Pathway (NRGP) by the government, and the Rural Generalist Training Scheme (RGTS) by ACRRM. The former is an initiative put in place to advance the recognition of RGs, improve the coordination and support

available for RG training, and to both increase training and retention of RGs in rural and remote communities (JL10). The latter is an ACRRM specific scheme which sees the funding, training, and support of 100 trainees a year for four years, while providing financial support to trainees who may have issues in meeting relocation or training costs.

To further support GP and RG training, grants have been developed by states and colleges. These include (but are not limited to):

1. GP grant program by the Victorian Government [31].
    a. An investment to provide financial incentives for doctors to enter GP training, with 800 grants worth $40,000 each to be awarded between 2024 and 2025.
2. Nationally Consistent Payments (NCP) [32].
    a. Financial support payments made to all eligible participants of the AGPT program, including Supervisors, Practices, and Registrars.
    b. These payments may vary depending on the MMM classification of the training location.
3. RACGP Registrar Support Payments & Placement Incentives [33].
    a. An additional payment on top of the NCP made to registrars who are working in locations identified as an area of workforce need to assist with associated costs.
4. Workforce Incentive Program (WIP) [34].
    a. GP or RG trainees in MM3 to 7 areas may be eligible for this grant, which aims to improve healthcare access in regional, rural, and remote areas by providing financial incentives to doctors who can then support the employment of adjunctive health professionals like nurses, midwives, and allied health.

Specialty Training

The Specialty Training Program (STP) is a federal initiative put in place to support the training of new medical specialists within regional, rural, and remote areas. In doing so, it is hoped that specialists gain experience across a range of different healthcare settings while increasing the workforce in those settings [35]. At its core, the STP supports 900 training posts across specialties, aiming to extend vocational training for specialist registrars into settings beyond traditional metropolitan teaching hospitals. The program works by essentially covering for the annual salary of trainees by funding the specialist medical colleges under which those trainees operate and covering for additional costs associated with their particular training location [35]. This strategic initiative, complementing existing efforts, serves as a catalyst for optimising specialist training in non-traditional settings, demonstrating

the need for ongoing collaboration, sustained funding, and infrastructure improvement to address the multifaceted challenges in Australia's rural healthcare landscape. The program's objectives include increasing the health workforce's capacity, providing training aligned with demand, and developing accredited networked specialist-training arrangements focused on healthcare delivery. The STP not only addresses existing challenges but also enhances the overall quality and accessibility of healthcare services in diverse settings.

However, significant barriers remain. Financial disincentives, stemming from the high cost of education and living expenses, continue to deter potential trainees [36]. Access to quality infrastructure and educational resources in rural areas requires ongoing attention to ensure comprehensive training [37]. Geographical isolation is a challenge that technology, like telehealth, seeks to address, enhancing access to educational resources. Shortages of experienced mentors and supervisors in rural locations impede effective training, necessitating the establishment of robust mentorship programs [38]. Additionally, the lack of clear pathways for career progression for rural clinicians hinders their professional development. To overcome these challenges, a comprehensive and collaborative approach, encompassing sustained funding, infrastructure improvement, mentorship support, and tailored career pathways, is essential for the success of rural specialty training programs.

Recruitment & Retention Challenges

In 2022, there was a greater than 50% increase in GPs moving from more rural and remote areas to regional cities [39]. Multiple studies suggest that the challenges associated with poor recruitment and retention are similar [40]. They can be broadly separated into concerns about career progress, working conditions, and family and lifestyle.

Career Progression

There is a general perception that working in rural hospitals may impede career progress due to fewer learning opportunities, fewer networking opportunities and poorer working conditions as compared to larger metropolitan hospitals [41-42]. These perceptions, as well as rural trainees' experience of insufficient and inconsistent teaching (in part due to staff shortages), likely contribute to individuals' preference for working in metropolitan hospitals. Career progression may also be impeded by advanced procedural training and workshops occurring mainly in urban areas. This also poses financial and familial obstacles to access further training [38]. Additionally, rural doctors have fewer opportunities to take study leave, because rural hospitals struggle to obtain locum support in a timely or affordable manner [43-44] While there are now training programs that allow doctors to complete all their training rurally many specialist programs still require extended periods in

metropolitan hospitals [35]. This likely deters individuals from choosing rural placements due to the instability associated with the imminent geographic change [41].

Working Conditions

Rural doctors work longer hours with less support and a higher incidence of major diseases [43]. They also commonly work at extremes of their scope of practice and have difficulty
accessing desired leave due to insufficient coverage. As a result, this likely contributes to burnout and make practising in rural areas less attractive. In Australia, rates of clinical burnout are high at 65-75% [45]. Burnout is a common reason clinicians leave the practice [46]. In addition, practitioners who felt they had limited autonomy in choosing their workload were more likely to express job dissatisfaction [47]. Rural doctors are more likely to experience very high psychological distress and suicidal ideations compared to non-rural doctors [48]. Long working hours may also contribute to social isolation and poor mental health.

Another challenge faced by rurally-based doctors is professional isolation. The anticipation of or the experience of professional isolation significantly contributes to poor recruitment and retention of rural specialist doctors [48]. The lack of local specialist networks and the perceived reluctance of metropolitan specialists to offer support and advice were reported to be a significant source of work-related stress and contributed to job dissatisfaction. Working in a rural and remote hospital is perceived as less prestigious than working in a metropolitan hospital. The negative stereotype around generalism and the belief that general practice is inferior to specialist training likely contributes to the poor perception of rural health, which is largely generalist [49].

Family & Lifestyle

Inequalities in access to resources between metropolitan and rural areas are a major contributor to poor healthcare worker retention and recruitment. Challenges rural practitioners face because of this include limited career opportunities for partners, limited child support and concerns about further education for children [40-41]. Doctors living in rural and remote regions reported poorer personal health status scores compared to their urban counterparts [46]. Reduced access to healthcare in rural and remote regions may deter some practitioners from living in these areas due to concerns about their health or family's health not being met. Poor access to healthcare for healthcare workers may be further exacerbated by fears around limited anonymity due to the small healthcare workforce. LGBTQ doctors may be reluctant to relocate to rural areas due to concerns about rural communities being less accepting of the LGBTQIASB+ populations due to increased stigma and social

isolation [50]. Concerns about limited retirement facilities may deter some older practitioners from remaining in remote areas [51].

Some practitioners felt that the relocation costs and loss of familial and friend support did not financially justify moving from urban to rural areas, despite salary incentives in rural areas [52]. In addition, social isolation is a major contributor to poor retention of health practitioners. Godwin et al showed that if dental practitioners felt isolated or had an
inadequate support network, they would leave rural practice regardless of
salary offers [53].

Support

Initiatives have been implemented to alleviate the challenges of recruiting, training, and ultimately retaining doctors in areas of workforce shortage. Amongst these are the Easy Entry, Gracious Exit (EEGE) Model. The EEGE model, designed to address workforce maldistribution, targets the recruitment and retention of doctors in underserved areas through a walk-in-walk-out approach. This strategy aims to relieve doctors of practice management responsibilities, allowing them to focus solely on patient care. Financial burdens are mitigated by third-party entities, which provide infrastructure, staff consumables, medical equipment, IT support, and broadband access. These entities, which can include local councils, not-for-profit organisations, or government-funded organisations, take on the responsibility of managing practice burdens. For example, the local council model has been implemented in Wentworth Shire, South-West New South Wales, where the council assumes financial responsibility for practice infrastructure and staff costs. Non-profit-run practices, such as those managed by the Rural and Remote Medical Services (Ltd.) in New South Wales, have expanded services to 13 towns. Government models, like the Remote Area Health Corps (RAHC) in the Northern Territory, attract health practitioners to short-term work in remote Indigenous communities. The Corps provides training and covers transportation costs, while the linked health service offers accommodation and pay [54].

In keeping with these supports, the Single Employer Model (SEM), which was designed by the Murrumbidgee Local Health District, aims to recruit and retain a RG workforce [55]. This pathway is available to junior doctors who are seeking a career as a RG and involves them being employed by an entity separate from the practice they are undertaking training. This allows for employees to retain their salary and entitlements when they move between general practices which aims to increase the comparability of pay between GP and non-GP registrars in a bid to promote GP training [56]. Following the trialling of this model, it has proved successful and has been expanded to 80 places across regional NSW [57].

The Junior Doctor Training Program (JDTP) is a key component of the Stronger Rural Health Strategy, offering two distinct streams: the Rural Primary Care Stream and the Private Hospital Stream. The Rural Primary Care Stream is designed to support junior doctors in rural primary care settings by providing funding for salaries and educational support [58]. This is facilitated through the Rural Junior Doctor Training Innovation Fund (RJDTIF), which enables junior doctors based in rural areas to gain experience in primary health care settings. The RJDTIF funds rotations across various regions, including select areas in New South Wales, Victoria, Tasmania, Western Australia, Northern Territory, Queensland, and South Australia [MR3]. Additionally, the More Doctors for Rural Australia (MDRAP) support package offers payments to cover the costs associated with supervision and education for junior doctors, further bolstering the support available to doctors in rural areas [13]. In addition, 13 specialist medical colleges have agreed to a funding agreement to set professional standards, accredit training settings, and coordinate education and training in an effort to address workforce maldistribution in their fields of medicine [M35].

Furthermore, on July 1, 2018, the Medicare Benefits Schedule (MBS) introduced a new fee structure that acknowledges non-vocationally recognized (non-VR) doctors as a separate group when claiming MBS GP items. This change enables non-VR doctors to bill at 80% of what vocationally recognized (VR) doctors can bill. Additionally, the base rate for standard consultations for non-VR doctors in regional, rural, and remote areas was increased by 20%. These adjustments are aimed at incentivising investment in postgraduate specialist qualifications and encouraging more doctors to work in underserved areas [7].

The Workforce Incentive Program (WIP) Doctor Stream provides direct payments to doctors who deliver eligible services in eligible locations. There are two payment systems: the Central Payment System (CPS) for doctors who bill the MBS and the Flexible Payment System (FPS) for doctors who provide eligible services and/or undertake training not reflected in the MBS. Payments are based on activity levels, length of time in the program, and vocational registration status. The program aims to encourage doctors to practice in regional, rural, and remote communities by providing financial incentives. To be eligible, doctors must provide a minimum amount of eligible primary care services or undertake eligible GP or RG training in specific locations, meet the required number of active quarters, have an eligible Medicare provider number, and provide bank account details to Services Australia. Eligible primary care services include professional attendances, diagnostic procedures, therapeutic procedures, and cleft lip and palate services. Telehealth services within these categories are generally eligible. Incentive payments range

from $3,600 to $60,000 per year, depending on activity levels, location, length of time in the program, and vocational registration status. Active quarters are calculated based on meeting minimum quarterly activity thresholds, which vary depending on the payment system. Doctors must apply through the FPS for all time spent providing eligible services, regardless of whether the services were MBS billed [34].

International Medical Graduates

In the current state of workforce shortages in rural and remote areas, international medical graduates (IMGs) are supported to fill workforce shortages temporarily when local graduates are limited, often through mandating rural practice via restrictions on medicare benefits (section 19AB restriction) [61,62]. However, the successes of mandating rural work has shown to be unsuccessful, as a national survey of IMGs mandated into rural practice has found both professional and non-professional satisfaction was significantly lower in comparison to non-mandated IMGs and Australian-trained GPs [63]. Similarly, the barriers of IMGs and their decisions to leave rural practice is similar to that of the general medical workforce i.e. access to education, employment for partners, and employment satisfaction [64]. Greater support is necessary to retain IMGs in rural areas including financial and non-financial incentives which address the barriers to rural practice similarly to Australian medical graduates [65]. Furthermore, greater professional support, such as cultural training, are necessary to produce a medical workforce tailored to the Australian community [66]. Ultimately, those suited to rural practice, such as intentions to practise rurally, should be prioritised to improve the workforce of rural and remote doctors, including providing adequate support and training to serve these communities, reflecting the position of ACRRM [67].

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